HOWARD: Welcome to the Health and Human Services Committee. My name is Senator Sara Howard, and I represent the 9th Legislative District in Omaha, and I serve as chair of this committee. I'd like to invite the members of the committee to introduce themselves, starting on my right with Senator Murman.

MURMAN: Hello. I'm Senator Dave Murman, District 38: Clay, Webster, Nuckolls, Franklin, Kearney, Phelps, and southwest Buffalo County.

WALZ: Lynne Walz, District 15, Dodge County.

ARCH: John Arch, District 14, Sarpy County.

WILLIAMS: Matt Williams from Gothenburg, Legislative District 36: Dawson, Custer, and the north portion of Buffalo County.

HOWARD: Also assisting the committee is our legal counsel, Jennifer Carter; and our committee clerk, Sherry Shaffer; and our committee pages, Cooper and Erika. A few notes about our policies and procedures. Please turn off or silence your cell phones. This afternoon we'll be hearing three bills, and we'll be taking them in the order listed on the agenda outside of the room. On each of the tables near the doors to the hearing room you will find green testifier sheets. If you're planning on testifying today, please fill one out and hand it to Sherry when you come up to testify. If you are not testifying at the microphone but would like to go on record as having a position on a bill being heard today, there are white sign-in sheets at each entrance where you may leave your name and other pertinent information. Also I would note: If you are not testifying but have written testimony to submit, the Legislature policy is that all letters for the record must be received by the committee by 5:00 p.m. on the day prior to the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. We would ask if you do have any handouts, that you please bring 10 copies and give them to one of our very capable pages. We use a light system for testifying. Each testifier will have five minutes to testify. You'll have four minutes with the green, one minute with the yellow, and when the light turns red we'll ask you to wrap up your final thoughts. When you come to testify, please begin by stating your name clearly into the microphone, and please spell both your first and last name. The hearing on each bill will begin with the introducer's opening statement. Then we'll hear from supporters, then those in opposition, then anyone wishing to testify in a neutral capacity. And

then the introducer of the bill will be given an opportunity to make closing statements if they wish to do so. We have a strict no-prop policy in this committee. And with that we will begin today's hearing with LB468, Senator Walz's bill to prohibit additional services and populations under the Medicaid managed care program. Welcome, Senator Walz.

WALZ: Good afternoon, Chairwoman Howard and members of the committee. Welcome to what I hear is Senator Walz Day. It is also Friday, so that is good. [LAUGHTER] For the record my name is Lynne Walz, L-y-n-n-e W-a-l-z, and I'm here today to introduce LB468. LB468 is a bill to prohibit additional services and populations from being added under the Medicaid managed care program until a critical evaluation is performed at the at-risk capitated managed care program of the medical assistance program and the success of the managed care program is proven or until January 1, 2020, whichever is later. I have an amendment drafted that I have already introduced to clarify the intent of the language that I hope you will pass along as the committee amendment. What this amendment does is change the date from 2020 to 2022 and strike additional services and populations and add long-term care services and supports; long-term care services and supports being defined as skilled nursing facility, nursing facility, assisted living facility, or home- and community-based service. Currently these facilities are operating under the fee for service model. There has been talk by the department about moving them under the managed care program. What we are hearing from providers is that they are experiencing a number of problems with managed care. One problem is payment for services rendered to individuals. Oftentimes it can take months for the facilities to receive the payment they are due. The department has provided my office with contrary information detailing that 90 percent of payments are being adjudicated. My gosh, I don't know why I can't say that-- or completed within the first 10 days. However, some of these adjudicated claims are being adjudicated incorrectly. For example, if an individual is dual eligible, meaning eligible for both Medicare and Medicaid, and they are rended-- rendered a service that cost, let's say hypothetically, $100, Medicare pays for the initial amount, covering the first $80 of this cost. The MCO would then be responsible for the remaining $20 under Medicaid, but these are being paid at $0. The provider then has to file a claim to dispute the nonpayment. What we are seeing here is that these claims are not being paid. You will hear a lot more about this from those who will testify behind me. I have seen documents showing claims being filed more than five times. The cost, time, and-- this costs

time and money, time and money that small facilities do not have the ability to invest, simply to regain the $20 originally owed to them. I don't presume to know the exact reason why there is so much difficulty for these companies to make these payments. It could be a disconnect in the sense that these MCOs are Fortune 500-plus companies and they can handle a month or two delayed payment with little difficulty, unlike the facilities in Nebraska. It could be that if they-- it could be that if they make it more difficult for these facilities to receive payment, the facilities will give up and the MCO will keep that money. What I do know is that there are facilities who are crying out to us, saying that there is a problem here. All I'm asking is that a critical evaluation is performed before these facilities are moved under the program. It is my understanding that we will be hearing a lot of conflicting testimony today. I would encourage the committee to listen carefully and please ask plenty of questions. There is a bit-- this is a very complicated issue and we can get easily distracted by the data, but it is important to remember that-- why we've been elected. We've been elected for the people of Nebraska. That is why I brought this bill today. There are nursing homes and assisted living facilities in Nebraska that are struggling. Small businesses cannot wait for payment or to hire someone to file claim after claim over a number of small unpaid bills. These facilities are serving a very vulnerable population and for that reason, I would like to err on the side of caution before we make any drastic change to one of their largest sources of income. With that, I would be happy to try and answer any questions, but there are going to be people behind me who have a lot more knowledge on the subject that will be doing a much better job, I'm sure.

HOWARD: Are there questions? Senator Arch.

ARCH: Senator Walz, I'm sure you've been asked this question and thought-- you know, wrestled with this. I just noticed in Section 2 it identifies the success, right? Evaluation is performed at the at-risk capitated managed care program of the medical assist and the success of such managed care program is-- is proven. Do we-- do we understand what success looks like with these managed care programs?

WALZ: I think-- I'm sure it's very, very broad. But I would say that, you know, our priority is to, number one, make sure that they're successful in getting providers paid on time.

ARCH: So in your mind that's very, very-- I mean, that's probably number one on the list of quality of care and all the other things that--

WALZ: Yeah.

ARCH: --that go into success. But it's the processing of claims that is most concerning.

WALZ: Yes, at this point.

HOWARD: Other questions? Senator Walz, do you agree with the cost of the evaluation study of about $600,000?

WALZ: I am going to let somebody else to answer that.

HOWARD: Would you consider that high?

WALZ: I think--I think that's very high. Yes.

HOWARD: All right. Thank you. All right. Anything else? All right. Seeing no further questions, we'll invite our first proponent testifier up to speak on LB468. Good afternoon.

JENIFER ACIERNO: Good afternoon. Good afternoon, Chairperson Howard and members of the Health and Human Services 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 support of LB6--LB468 with the amendment. And thank you, Senator Walz, for bringing this bill. LeadingAge Nebraska is an association that represents 70 nonprofit providers of long-term care services in Nebraska including nursing facility, assisted living, independent living, and adult day services. Our members include large metro multisite providers and small rural community providers. We work to provide education, advocacy, and technical assistance to our members. The past few years have been tumultuous in the world of long-term care. As you may know, over 30 long-term care facilities have closed in the past three years and over 30 have gone into receivership during that same period of time. Nebraska's nursing facilities are in the midst of a crisis due to, in part, unrealistically low Medicaid reimbursement. Many providers are on the brink of being unable to sustain operations and communities have resorted to implementing local taxes and actually having fundraising activities to keep their long-term care facilities open. In addition to the low Medicaid rates, our providers are dealing with what I'll

call the fallout of the implementation of the Heritage Health Program in 2017. While long-term care broadly is currently not a part of managed care, some of the services provided to long-term care residents such as therapies are. I am here to say that managed-- I'm not here to say that managed care can never work. But I am here on behalf of our members to tell you that it is not working well now. Long-term care providers are struggling to get payment for therapies, in particular when a resident is eligible for Medicare and Medicaid, or dual eligible claims that should have been paid by the MCOs are being processed as "paid zero" in cases where Medicaid payment is due. The only way for a provider to obtain what is due from the MCO is to go back to the claim, manually calculate what should have been paid, and then pursue the claim with each respective MCO. You will hear more about this in the testimony to follow. But what this does is put the burden on the provider to pursue a claim that should have been paid to begin with, in a time where a majority of small providers do not have the time or resources to dedicate to pursuing the payment. The costs of pursuing the payment versus the benefit of recovering it results in many providers essentially forfeiting those funds to the MCOs. A number of our members have submitted letters of support. Please read them, as you will see other examples of challenges faced with managed care, such as the inability to get necessary durable medical equipment approved for residents. I am here to relay that the current rollout of Health-- Heritage Health is still fraught with problems for our providers and for other provider types who you will hear from later and that our providers have grave concern about being added to a broken-- broken system at all; but in particular, during this time when it's a long-term care crisis. The things that are already broken need to be corrected before we add more to the fix-it pile. We have an obligation to be invested in and care for our vulnerable seniors and to prioritize their needs for services and access to care. You'll likely hear from DHHS and perhaps the MCOs that they adjudicate a high percentage of their claims quickly. Please ask the hard questions. Are the claims being paid correctly? Are the systems working properly? You will also likely hear that there are only a few outstanding issues on what's referred to as an issues log. But please know that there are other global issues like the ones that I mentioned earlier that have never been added to that log, much to the dismay of providers. You will also likely hear from DHHS that their aging claims system is going to require a multimillion dollar replacement to continue to process those long-term care claims, and that there is one single other option, which is moving to managed care. Please ask questions about other options. I've reached out to other LeadingAge state

associations, including our bordering states, Kansas and Iowa, which have had struggles with implementation of managed care for long-term care services. There is a great deal of information available related to the challenges faced by those states. One of my colleagues pointed out definitively that moving long-term care services and supports into managed care did one thing. It increased the complexity and administrative burden on providers, with no discernible improvement in outcome for residents. Access to long-term care services in rural Nebraska communities has decreased and continues to be threatened. Please prioritize the needs of our seniors and their families by allowing time for long-term care needs in our state to be critically evaluated to determine if managed care makes sense; and if so, to ensure that any transition includes a reduction in administrative burden on providers and an improvement in access and outcomes to the residents. Please support moving this bill with the amendment out of committee. Thank you and I'm happy to answer any questions.

HOWARD: Thank you. Are there questions? All right, seeing none, thank you for your testimony today.

JENIFER ACIERNO: Thank you.

HOWARD: Our next proponent testifier. Good afternoon.

DARSEY HAMM: Good afternoon. Good afternoon, Chairperson Howard and members of the Health and Human Services Committee. My name is Darsey Hamm, D-a-r-s-e-y H-a-m-m. I am an owner of PHT Consulting and Billing. Thank you for the opportunity to testify in support of LB468. For over 12 years, I have done third-party consulting, billing and old A/R collections and currently provide services to over 30 nursing facilities in the Midwest. We are members of the LeadingAge as well as the Nebraska Health Care Association. The potential expansion of managed care to room and board is very concerning. As a third party, I want to make clear that I do not have a horse in this race. The issues with Heritage Health actually help our business. However, I feel the need to be a voice in what these nursing facilities have experienced in this transition. I could address these challenges individually. However, based on past testimonies at hearings related to Heritage Health, you likely are already aware. Even with these past testimonies, we are still at a place where it isn't if long-term care room and board will be moved to Heritage Health but when. PHT has a client in Nebraska and due to privacy reasons I will refer to as Facility A. Facility A is a 165-bed skilled nursing home with Medicaid being around 45 percent of their overall revenue. PHT has participated

in old A/R projects initiated by the LeadingAge Nebraska, Nebraska Health Care Association, and State Medicaid with Facility A. As each project drew attention and got some of our claims cleared up, newer ones were added. It's been too easy for Heritage Health representatives to say that providers are the ones that are in the wrong and for reports to show that 90 percent of all claims are getting processed within 7 to 14 days. PHT spent 291 hours in 2018 for Facility A to prove that our claims were not getting paid correctly. That obviously leaves this gray area for the decision makers of who really is at fault. Well, your answer can be found in the handout representing 281 Heritage Health payments for Facility A, processed in the last 12 months. Claims marked with an X represent adjusted claims; 45 percent of payments over 60 days from dates of service were tied to adjusted claims due to Heritage Health errors. Of these 281 payments, 68 percent took over 60 days to pay. Twenty-five percent took over a year. Even more alarming, 13 percent took over 500 days to pay correctly. Before Heritage Health, these claims, as well as claims in surrounding states, processed correctly within two weeks and take roughly 24 hours a year versus 291. In July of 2018, each Heritage Health provider rep set up a conference call with myself and their claims processors. We went over each claim to explain why they processed our claims incorrectly. As you can see by the attached payments, they finally listened. I thank them for their help in getting these claims paid, and I don't fault the provider reps. Unfortunately they're unable to fix that Heritage Health as a whole can't accurately process claims the first time on a consistent basis. I am speaking out of concern that the new normal to get these claims processed accurately has become such an administrative burden that for some, the cost to collect outweighs the payment. Our other clients as well as other Nebraska facilities that I have talked with don't have the resources for this fight, so claims just go unpaid. Heritage Health handles less than 1 percent of Facility A's overall revenue and they had to hire on PHT. I hope you can see why their concern of Heritage Health processing another 44 percent of their revenue is concerning. The attached claims may have originally processed within 14 days. But this is proof that they did not process correctly. Given Heritage Health's six-month timely filing rule, the fact that we are still getting payments almost two years after the date of service further supports this. So I ask, what about the nursing facilities that don't have the resources to fight for these payments? What if our room and board claims are processed at the accuracy rate and timeliness of these claims? Is it really worth the risk to turn over that part of the revenue that determines if our Nebraska nursing

facilities' doors stay open? Thank you. I am happy to answer any questions.

HOWARD: Thank you. Are there questions? Senator Hansen.

B. HANSEN: You did talk to the provider reps. Did they explain what took so long-- would take so long for some of these?

DARSEY HAMM: Oh, absolutely. There's so many issues that-- I mean, I could sit up here for 30 minutes and tell you the reasons. Sometimes they don't know. They have to get back to us. And sometimes they will explain. I can give you an example on one. UHC, which is actually our least problem of the three, they-- if you have a UHC primary claim and then you try to bill a coinsurance to them, they will read that as it's a primary claim. So they will just continue to deny on our claim as a duplicate. So they suggested, from-- going forward, that we actually, you know, adjust our claim that's already been paid by UHC or already been paid by Medicare to-- so it will get through their door correctly. Because their-- their person that's opening up the mail and getting this claim, they can't tell whether or not it's a UHC primary claim or it's a UHC secondary claim. So they will put it in the UHC primary claim and it will get denied out, where it needed to go in the UHC secondary claim pile to be processed correctly. And I think that's an issue with a lot of them is that just the training on the front end, you know, our claims end up getting put into the wrong part of the system, and then it goes through the wrong edits. So we get these denials that make no sense, if that helps.

B. HANSEN: OK. Thanks.

HOWARD: Other questions? Senator Arch.

ARCH: Thank you for coming. You mentioned-- you mentioned just now that you have a piece of paper opening like, as though-- are you filing your claims by paper, not electronically? Is that the majority of claims that are going in?

DARSEY HAMM: So when Medicare is primary, usually you'll hear of crossover claims. Those are the ones that go in electronically. However, a lot of Facility A's claims have a Medicare replacement plan. UHC, Blue Cross/Blue Shield, they are paying primary. So when you have those Medicare replacement plans that are paying primary, you have to then basically take their EOB and put it with UB-04 and put it

in the mail. You can file on-line with them as well, but we have-- we have the same issues.

ARCH: Now, is that-- is that because of the capability of the provider or-- I don't understand. Is that the nature of the system?

DARSEY HAMM: That's the nature of the system. Yes. Each one of the MCOs actually have where you can file on-line, but we have more issues with that than even putting it in the mail. So--

ARCH: Thank you.

DARSEY HAMM: Uh-huh.

HOWARD: Further questions? Senator Williams.

WILLIAMS: Thank you, Chairperson Howard. Thank you for being here. And you do consulting, as you mentioned, for a number of these facilities. Help me understand. What kinds of services are you billing through the MCOs?

DARSEY HAMM: OK. So just for the MCOs, it's the coinsurance, so Medicaid is secondary. That is what we are billing and are having the most issues with. We have several where Medicaid was primary, it's rare-- won't go into details but to be honest, those haven't even been paid yet. And one is from July of 2017, when they were actually primary. But these are secondary claims to either Medicare or a Medicare replacement plan, so they just should be paying the coinsurance, whether it's Part A coinsurance or Part B coinsurance. That's all we're wanting them to pay. In fact, on Part A's all we need are a paid zero. And those are the ones we end up getting denials for, you know, actual denials, where Part Bs, you know, they will sometimes overpay. And in fact right now if you asked me how many claims Facility A-- Facility A had outstanding, it wouldn't be so much the claims. We're overpaid right now, but those have to be adjusted too. They have this-- they have issues in their system where they're not recognizing that they are the secondary payer, so they're paying these claims as if they were primary, and now our claims are getting overpaid. So it is as one issue gets taken care of, another issue comes up it.

WILLIAMS: Switching gears from that, before you, Ms. Acierno talked about the number of nursing homes that have closed in our state thus far--

DARSEY HAMM: Uh-huh.

WILLIAMS: --and those that are in receivership--

DARSEY HAMM: Uh-huh.

WILLIAMS: --and the concerns with that long term. And you're doing, not only the billing work, but consulting work.

DARSEY HAMM: Uh-huh.

WILLIAMS: Do you do business planning work for any of your clients?

DARSEY HAMM: No. We work with management companies that handle any kind of business planning. We do more of consulting on admits, you know, what-- admitting a resident. And if it's, you know, if it's good for them.

WILLIAMS: So whether a facility is adapting their business model to changes that have happened over a period of time is not the type of consulting that you would be involved?

DARSEY HAMM: Correct.

WILLIAMS: OK, thank you.

DARSEY HAMM: Correct.

HOWARD: Other questions? So one of my-- when we consider the billing for managed care and some of the delays that we've seen to providers, none of these have been instances where somebody has been in a residential care or nursing home situation. Correct so far?

DARSEY HAMM: All of our claims are with nursing homes.

HOWARD: No, but for Heritage Health-- everything that we've had delayed, for Heritage Health, is that for somebody? Is it for their residential care?

DARSEY HAMM: Not for-- like room and board--

HOWARD: Right.

DARSEY HAMM: --like long-term-- no.

HOWARD: Yeah.

DARSEY HAMM: We have one for this particular home. Like I said, it was a rare instance where they were supposed to pay for room and board. Won't go into the details but that one's still on the books.

HOWARD: And you may not be the right person to ask this question of, but if there was a delay in payment for someone's room and board for over a year, would that facility just keep them or if they weren't getting paid for that service?

DARSEY HAMM: That probably would not be the best question for me. But yes, I mean, they just can't-- they can't, you know, kick somebody out because of a Heritage Health error, especially when they're supposed to be paying. They would never-- they would never turn somebody away because of that. Now would some homes change their business model to not pay-- to not take as much-- as many Medicaid residents because of the issue? Absolutely, I've heard talk of that. You know, we are only going to accept 25 percent of our overall room and board to be Medicaid instead of 50 percent, you know, based on issues with Medicaid.

HOWARD: OK. And they wouldn't move them into, like, a county facility because they can't afford to be in a private nursing home anymore?

DARSEY HAMM: That would not be a question for me either. [LAUGHTER]

HOWARD: OK. Maybe someone behind you can.

DARSEY HAMM: I hope so. [LAUGHTER]

HOWARD: Thank you so much.

DARSEY HAMM: Yes.

HOWARD: Any other questions? All right. Thank you so much for your testimony today.

DARSEY HAMM: Yes.

HOWARD: Our next proponent testifier. Good afternoon.

LOIS JORDAN: Good afternoon. Good afternoon, Chairperson Howard and members of the Health and Human Services Committee. My name is Lois Jordan, L-o-i-s J-o-r-d-a-n. I'm the president and CEO for Midwest

Geriatrics in Omaha, and we are a provider nursing home. We are also a member of LeadingAge Nebraska and I served as the past president of LeadingAge Nebraska Board. Thank you for the opportunity to testify on behalf of LB468. Midwest Geriatrics provides long-term care services to 95-100 seniors in Nebraska and more than 60 percent of those individuals are on Medicaid. With the shortfall in Medicaid reimbursement that fails to meet our actual costs, we operate with a very thin margin, if any margin at all, for some years. Our ability to break even and not lose money is dependent on the payer sources our residents have, including private pay, VA, Medicaid and Medicare. Accordingly, any delays in payment by such payer sources results in a dramatic impact on our ability to meet operating expenses such as payroll, utilities, and supplies. As you've heard today, 2000-- in 2017 Nebraska Medicaid rolled out the Heritage Health to replace its managed care plans for physical health, mental health, and pharmacy services. Heritage Health contracts with UnitedHealthcare, Total-- Nebraska Total Care, and WellCare to deliver those health care needs-- the therapy services, medications and mental health-- to the Nebraskans who qualify for Medicaid. Heritage Health does not contract with these insurance companies to pay nursing home room and board. Currently Nebraska Medicaid continues to pay room and board claims for the long-term care residents outside of the Heritage Health. For example, on a weekly basis any room and board claims submitted to Medicaid by Friday of that week are generally paid the following Wednesday. Under Heritage Health, we do not receive payments in the same timeframe and it's having a detrimental effect on our ability to continue caring for Nebraskan seniors who are Medicaid recipients. On a daily basis, we spend significant time and staff resources addressing Heritage Health claim denials, loss claims, claim overpayment, or underpayments, corrections that drag out for months. We still have three individuals who have not-- who we have not received payment for services back to June of 2017 that are under the Heritage Health plan. Caring for 60 percent of our population served by Heritage Health and having this type of delay in payment creates significant concern-- significant concern for our ability to continue to serve this population. When Heritage Health was first rolled out in Nebraska, the plans were given the directive to reimburse for the 20 percent coinsurance for any Part B Medicare claim for therapy services in our community. However, effective July 1 of 2017 there was a change in the state's computation and any provider willing to accept a dual eligible resident no longer was reimbursed the 20 percent coinsurance that any senior with the commercial supplemental plan would still pay. There is now a complicated formula that compares the Medicare payment

amount for each billing code to the Medicaid fee screen, and communities who accept these dual eligible residents are now being reimbursed very little for any of the coinsurance or deductible adjudicated on the Medicare therapy claim. Time-consuming manual calculations are required to determine if a small payment or any payment by the Heritage Health plan is correct. Many communities are writing off the differences with the manual calculations due to the time it takes to evaluate the accuracy of the Heritage Health payment. In our community, we've had to increase one of our part-time billers to a full-time position just to help with this analysis. In 2018 we had to write off a total of $22,000 in unreimbursed Medicaid coinsurance related to these claims. Had these individuals been enrolled in a Medicare supplement to cover their 20 percent coinsurance, we could have been reimbursed for the $22,000. The gap is widening, making it more and more difficult to be able to serve this vulnerable population when payments or cash flow keep getting negatively affected to this degree. The Heritage Health plans have had tremendous difficulty in processing these dual eligible coinsurance claims correctly. These are what we call the crossover claims. Prior to Heritage Health, Medicaid would pay according to how Medicare adjudicated the claim. Heritage Health has not been able to replicate accurate processing of these claims. We have been told by Nebraska Total Care that we needed to wait for two more years for all of this to be figured out at their company. Business models like we have-- what we have seen with Heritage Health will not result in the proper care Nebraskans deserve if we expand into managed care, because nursing homes cannot fiscally operate in these conditions. I'm here to testify in support of LB468. Thank you and I'm happy to answer any questions you might have.

HOWARD: Thank you. Are there questions? As a person who is president and CEO of a nursing home--

LOIS JORDAN: Uh-huh.

HOWARD: --can you tell me what would happen if you didn't get paid for somebody for over a year? What happens? Do you ask them to go to the county? I mean, so for instance my father-in-law is in a nursing home in Omaha.

LOIS JORDAN: Uh-huh.

HOWARD: And he-- he has Alzheimer's and dementia. So sometimes he likes to move furniture and/or fight with people, and our concern was

always that if something happened with him, that they-- he would get moved to Douglas County--

LOIS JORDAN: Uh-huh.

HOWARD: --Hospital. Is that an option in every county? Is that what you would do or--?

LOIS JORDAN: No. We don't-- we don't ask our seniors who are sort of at the mercy of this processing of claims-- we don't ask them to leave because Heritage Health hasn't figured out their payment systems. We thankfully have had a very supportive board that helps us and supports us in serving this size-- this sizable population of Medicaid. But it is becoming to the point where we had mentioned earlier that our business model needs to be evaluated. The unfortunate thing, the thing that we-- that stops us from saying, we are not going to take this number of Medicaid, is, no one else will. No one. Everyone else is going to experience the same type of difficulty. It's not because of our processes or what we are or are not doing. This is the way that system is working; and if anybody accepts Medicaid, they're vulnerable to that system. So if we don't take care of them, I don't know who will. Referring them out to another community, their beds are full. People are limiting-- they're reducing the number of beds that they reserve or they'll hold open for Medicaid, and due in part because of the reimbursement. There's just simply the shortfall in the reimbursement is already kind of a kick when you're down. The shortfall is already significant. So we know we're not going to get paid our costs. Now factor in, we're not even going to get our-- paid our costs on time so we don't even have the resources coming in that are not meeting all of the expenses that we have. So it's putting us in sort of a double jeopardy here. We're we're not getting paid the cost of our care, and then we're not getting it paid timely. So we won't ask them to leave. But it is forcing us to sit back and say, what are we going to do? We have-- something has to change, and we need to figure out what that would be. And we don't want the senior to suffer. It is not their fault that the cost of care or the care processing for the reimbursement is what it is. So we want to do everything we can to care for them.

HOWARD: Senator Williams.

WILLIAMS: Thank you, Senator Howard. Thank you for being here. It seems like we've got two different issues we're talking about here. We're talking about the services that you're billing for today through

Heritage Health that up until two years ago, when we switched to the Heritage Health model, you were getting your reimbursements back on those reasonably quickly. And that has changed. So my question on that particular issue is, have you seen that improve at all with any of the three MCOs during this last two-year period of time?

LOIS JORDAN: No, we have not.

WILLIAMS: So that-- the problems that you are experiencing on the front end are still the same problems that you are experiencing today?

LOIS JORDAN: Yes, we see different-- as the previous speaker had mentioned, it may correct one issue, and then the next issue comes up or then it goes back to this issue. Turnover in their staff, you know, results in us retraining. So again the--

WILLIAMS: So the second issue then, is the question of moving your room and board payment, your bread and butter--

LOIS JORDAN: Right.

WILLIAMS: --to a managed care situation.

LOIS JORDAN: Right.

WILLIAMS: And what I hear you saying is, until they can get it right on the first part of that, you're very concerned about going to that model on the second part.

LOIS JORDAN: Absolutely.

WILLIAMS: Thank you.

HOWARD: Other questions? Senator Arch.

ARCH: Thank you for coming. And since you have such in-depth experience as a provider, I will ask you the same question. So what is acceptable performance, knowing that even under the Medicaid program previously, nothing is perfect, right? So what-- what is acceptable in your mind? Do you have a, I mean-- as a provider, do you have a place where you'd say, OK, that's OK, not perfect, but OK?

LOIS JORDAN: Timely, timely payments.

ARCH: Timely. OK.

LOIS JORDAN: Yeah. I mean, we'll take care of the care. We'll do everything we can to provide quality care and do all of the things that create success for that individual. But there comes a cost to that and that cost, when we ask for the reimbursement, just needs to be timely. We got to continue to keep the lights on to provide that care. And if we don't get paid, and it takes two years and more staff to try to get that payment, that's not doing any business model any good.

ARCH: Thank you.

HOWARD: Any other questions? So what happens when a nursing facility closes? What happens to those folks?

LOIS JORDAN: And that's happened in Omaha specifically. So then our social workers will get the call. They'll say, you know, we have so many days to move all of our residents to a safe plan of discharge. And so we will look at the availability that we have and the capacity that we're able to take. We'll take as many as we can. But those folks then are moving to locations that are further away from their loved ones, may not even be in-- for us in Omaha. It may be in Plattsmouth or in another town. For rural communities, certainly they're moving much further away from their loved ones and their family. So-- and then you're-- you-- we're also a very large employer in that community, and everybody there is needing to look for jobs. Balancing that, too, with your staff, you don't want them to leave before your last resident does. So it's very, very difficult transition to be in for everybody, the senior and the staff.

HOWARD: Thank you. Senator Murman.

MURMAN: I've just got one quick question, kind of a continuation of Senator Arch's question. So your complaint isn't so much about the amount of the payment, it's the timeliness of the payment.

LOIS JORDAN: Oh, no. No, I would say that the amount of the payment is completely inadequate. But-- and I shouldn't say completely inadequate-- it's less than desirable.

MURMAN: But the timeliness is the most extreme.

LOIS JORDAN: Timeliness just adds insult to injury.

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

LOIS JORDAN: Thank you.

HOWARD: Our next proponent testifier. Good afternoon.

MATT ROSS: Good afternoon. Thank you, Senators. My name is Matt Ross, M-a-t-t R-o-s-s. Thank you for allowing me the opportunity to visit with you about this important legislation. My father, Ron Ross, was unable to attend the hearing today. Many of you may know my dad. He was the director of Health and Human Services for five years from 1999 to 2004. He then helped Nebraska clean up a mess when he was appointed State Treasurer from 2004 to 2007. I am a sixth-generation Nebraskan, and my two daughters now make the seventh generation. I'm the vice president of Rural Health Development. We are a health care consulting and management company. My dad and his brothers started the company 29 years ago in Nebraska and we currently manage nursing homes in the following Nebraska communities: Ainsworth, Beemer, Benkelman, Bertrand, Callaway, Crawford, David City, Humboldt, McCook, Mitchell, Stuart, Sutton, Verdigre, Wakefield, Wauneta, Whiteclay, and Wilber. We do not own or lease these facilities. We manage nonprofit nursing homes for these small communities. We also manage one nursing home in Wyoming, one in Iowa, and two in South Dakota. We have witnessed managed care in other states, and that is why I am here today. First, let me express my gratitude to the employees of Nebraska's Health and Human Services: the caseworkers, the claim processors, and other dedicated employees. They do a good job of qualifying appropriate residents and getting our facilities their money timely. Our experience in other states has been that the managed care companies are slow to qualify residents and slow at paying claims. In the early years, RHD managed several small hospitals and clinics. As we watched managed care start to help Nebraska's Medicaid people with their acute and clinic health care, this appeared then and now to us to be appropriate. The premise behind managed care is that an organization, perhaps an insurance company, is better equipped to help Medicaid citizens find the appropriate level of care at the appropriate price versus state workers. Managed care for long-term care does not make sense to us in Nebraska. Between the Area Agencies on Aging and the state caseworkers, they assure that only residents who qualify for long-term care are receiving those services. So why is there a push if only qualifying people are receiving the appropriate services? We question whether reducing the number of state workers and yet costing

more in administrative costs of a managed care company is in the best interest of Nebraska's taxpayers. The idea of reducing state government might sound good, but in reality, we believe it would cost more and be less effective. I thank you for this opportunity today to speak with you on this matter. My father and I plan to testify again before the Legislature later this month regarding some other imperative bills that also pertain to the future of Nebraska's nursing homes. We have concerns about the way the department has treated the nursing homes the last couple of years and we believe that they are putting our residents at a tremendous risk. Our elders deserve better, and we look forward to providing information on some serious issues that need attention. Thank you.

HOWARD: Thank you. Are there questions? Seeing none, thank you for your testimony today.

MATT ROSS: Thank you.

HOWARD: Our next proponent testifier.

TONY CRIBELLI: Thank you, everybody. You've heard a number of detailed-- detail on the delayed care. I'm here to cover the-- maybe the more personal side and some other actions, past actions, that have impacted us. I am Tony Cribelli, T-o-n-y C-r-i-b-e-l-l-i, Chairman of the Board of Trustees, Village of Wauneta, Chase County, Nebraska. We border Colorado and we are about 30 miles north of the Kansas border. Our population is 600, and for a community our size we have a vigorous business community. The village owns our nursing home facilities that employ 65 people. We cannot afford to lose this facility. I'm here to vigorously protest the recent cuts in Medicaid payments because even before the reductions, they did not cover the cost of the care. The private pay people made up the difference with the help of Medicare rehab funding. Now the difference is too large, even for this solution. Our community is dismayed by the state's apparent lack of commitment to properly care for our disadvantaged elderly citizens. I admit, my knowledge of managed care is limited, but I've been around long enough to recognize a government spin when I see one. I turned 81 last month. This appears to me to be an example of bureaucrats shifting the responsibility to some other entity, so that entity can take the heat instead of the bureaucrats. What heat am I referring to? I mean the amount of money in the Medicaid budget will be reduced by the administrative cost of managed care company, no doubt, probably an insurance company. Sad experience tells us-- and I've heard that today-- that they are pros at paying kick-- they are pros at playing--

paying claims slowly to benefit themselves in interest earned. Now an issue of vital importance to me and my family and others with similar circumstances: the close proximity of our loved ones and their tremendous care they get. My wife and I have been married 57 years. Fifteen years ago, she was diagnosed with early stages of Alzheimer's. Four years ago, Jannie had progressed to stage four. I could not continue to care for her. Fortunately, our facility had room and after a traumatic period of time she adjusted. Now she is fairly content and comfortable. My-- moving my wife to another facility would be a traumatic disaster. Once again, moving my wife to another facility would be a traumatic disaster. I urge you in the strongest possible terms to pass important Legislature, plus replacing the past cuts and find a way to fund these nursing homes. I plan on being at future hearings that address these bills on how the state is treating our nursing homes. Thank you very much for hearing my testimony today and I will answer questions.

HOWARD: Thank you. Are there questions? Senator Williams.

WILLIAMS: Thank you, Senator Howard. And thank you, Mr. Cribelli, for being here today--

TONY CRIBELLI: You are welcome.

WILLIAMS: --and coming all that way. From-- from your testimony I couldn't tell for sure, is the-- does the community own and operate your nursing home in Wauneta?

TONY CRIBELLI: Yes, sir. Five years ago, it was privately-owned company and they decided to close it and-- and lose the-- their beds to Omaha, a larger facil-- larger area, larger populated area. We were able to purchase beds or licenses from a close-- a nursing home that was closing. So the town voted and came up with the money, about $800,000, and we borrowed some money and we used some city money to put this all together and we could-- when we took over the nursing home ourselves and the responsibility of overseeing it came to the city council. So that's how we acquired it.

WILLIAMS: Talk a little bit about geographically from Wauneta and around that area. How far would a person have to go to get to another nursing home?

TONY CRIBELLI: McCook has a next-- has a larger one; that's 46 miles. Imperial has one; that's 19 miles, but they are in the same boat we're

in. So we just-- we just recently voted to pass a sales tax, which brings in just probably enough to pay our bond payments. But the people of Wauneta are very supportive, and they will do what they possibly can to keep this facility open.

WILLIAMS: OK.

TONY CRIBELLI: But--

WILLIAMS: And I'm assuming that's the largest employer in Wauneta?

TONY CRIBELLI: Yes, the school and we have a very large--

WILLIAMS: But you have a consolidated school, right?

TONY CRIBELLI: We have Wauneta-Palisade.

WILLIAMS: Right.

TONY CRIBELLI: Yes.

WILLIAMS: Thank you.

TONY CRIBELLI: You bet.

HOWARD: Further questions? Thank you for your testimony.

TONY CRIBELLI: Thank you, Senator Howard.

HOWARD: Our next proponent testifier. Good afternoon.

DALE JOHANNES: Good afternoon. My name is-- my name is Dale Johannes, D-a-l-e J-o-h-a-n-n-e-s. And I'd like to thank the Senator Howard and the rest of the committee for giving me this opportunity. Because of my life experiences, I'm able to offer a longer view of the need-- of the need of LB486 than most. Thirty years ago, I was in a serious car accident that kept me in the hospital for three months and forced me to go through an additional two months of outpatient therapy. I sustained multiple serious injuries, with the most serious being a brain injury. And because of that experience, the focus of my life for the last 30 years has been on making life easier for individuals who have suffered a variety of life-changing injuries, with the focus being on brain injury. After college I went to work in a facility called Quality Living or QLI because they needed to be able to use what I went through to help someone else who was going through a brain injury. QLI opened in 1990 for young adults with brain injury, and

many of the original residents were still there at the very beginning of my employment. Shortly after I [INAUDIBLE]-- shortly after I started [INAUDIBLE] QLI opened a second campus just up the hill from their core campus. And that facility became focused on long-term care and assisted living for individuals with brain injury. The reason that second campus was opened was that the need for individuals with brain injury had grown significantly since the time of my injury a decade earlier. When I survived my injury, I was very much an anomaly or an outlier. But over-- over the first 10 years after I was injured, brain injury survival became more and more common due to ever advancing drugs and lifesaving techniques. I bring up my story to illustrate one end of the spectrum of care. Because brain injury was very much an unknown at the time of my injury, it was reasonable for doctors to do everything they felt needed to be done in order to restore my life. But as I mentioned, the prevalence of brain injury was increasing very rapidly. And with that increase in lives saved, came a corresponding increase in cost to insurance companies and Medicaid. With that increase in survival rate also comes an ever increasing need for individuals to receive care that runs contrary to the whole idea of managed care. And this has resulted in a decrease in the amount of care that a brain injured individual receives. I would argue that this, 30 years later, is the other end of the spectrum of-- being able to care spectrum that I brought up from the beginning. For the last five years, I've worked at Tabitha here in Lincoln. Tabitha is a long-term care and rehab facility. And I went to work there because of a position I hold on the Nebraska Brain Injury Advisory Council. In 2008 the council received our first million dollars HRSA grant that broke the council up into four different groups. One of those groups was the elderly population and brain injury and I became the leader of that group. For the first five years of my involvement with this group, I read as much information and as much research as I could find, but still I didn't feel that I had a good understanding of this issue at all. Because of that, I went to work to Tabitha in the hopes of gaining a better understanding of this issue. In my time at Tabitha, I have worked almost exclusively with the rehabilitation population. I've observed a couple of main points. One, brain injury in this population is significantly more prevalent than anyone understands; and two, the amount of time and-- the amount of time that an individual are allowed to rehabilitate in care facilities is at an ever decreasing amount of time. And this comes at the expense of the individuals receiving the care. In addition to rather substantial decrease in care that I've seen over the last 30 years, the providers that serve this and other populations, i.e. developmental disabilities

and as well as other groups, face a constant struggle of being able to provide care for these individuals for a variety of reasons. Timely claims payments, timely authorization for services, a collaboration with providers, and the list goes on. It's the-- you should each have this list in front of you. LB468 would allow the state time to resolve some of these issues that came up after the 2017 statewide expansion of managed Medicaid before-- before adding any additional populations and services. To this point, the state has not shown that it can effectively manage the populations that they are currently serving. How does adding any additional population services make sense? Through my talk today I referenced both ends of the care spectrum. My hope is that if LB468 were to pass, ideally the state would be able to find a happy medium between the two extremes illustrated in my story. And with that, I'm open the questions.

HOWARD: Thank you. Are there questions? Seeing none, thank you for your testimony today. Our next proponent testifier. Good afternoon.

JANET SEELHOFF: Good afternoon. My name is Janet Seelhoff, J-a-n-e-t S-e-e-l-h-o-f-f. I am the executive director for the Nebraska Home Care Association. Our members are the home health agencies, as well as companies that provide companion services to citizens, so services range from activities of daily living all the way to skilled care for individuals with chronically complex needs in our state. And we work very hard with our members to make sure that people can remain independent at home for as long as possible and knowing that that is the lowest health care delivery option in our state. I'll just echo what everyone prior to me testifying has said, that our members as well are dealing with many challenges with authorizations, challenging medically necessary services that are not being authorized correctly or in a timely manner, and also not being paid timely and accurately. And we have one situation I mentioned here in my written testimony where an agency almost had to close its doors, and that's an agency that serves some of our most fragile and vulnerable citizens. We have another one that had to take out a line of credit to make payroll. And so those are some of the most extreme examples, but those are situations that have been happening since managed care took effect in 2017. And so we are very concerned about adding more individuals into managed care until the systemic issues are resolved. And so I just really want to focus on recommendations that our members have given to me and that I've observed, and I can tell you I spend a number of hours every week just addressing issues and trying to go to bat for our members and really working at the leadership level to get

resolution. So some of the things that we would offer under the heading of authorizations would be that there would be an on-line system for all levels of care that require authorization and approve the sharing of eligibility files between HHS and the managed care organizations, that there would be uniform credentialing authorization and claims processes in place, as well as uniform reimbursement among the managed care plans for all individuals, groups, and facility providers. We've had a couple of agencies that have had issues with getting Medicaid ID numbers issued for newborns and just the lag time in that and trying to get out and provide services and getting pushback on that. So that's an ongoing challenge that we'd like to see resolved. In terms of enhanced communications, just the turnover that we see in the managed care organizations and making sure that our providers constantly know who their provider relations representatives are. And that there's really good education and training at all levels, so that no matter who they call they can get an accurate answer and when they call they can get an authorization that first time, and not have to call back and challenge those processes. So that, that's an ongoing issue that we're seeing. And then in terms of credentialing again, making sure that credentialing happens within the 30 days after applications are submitted so that individuals are not getting delays in services. And in payments in terms of reimbursement, making sure that the managed care plans are reimbursing at the Medicaid rates, that if interest payments are to be issued that that is happening when there are overdue claims, and that there's a feedback venue so that providers can request the reassessment of potential interest due. For example, a provider could provide the claim number and assert why they're seeking reconsideration for interest payment. This could be a quick feedback approach with some oversight and accountability built into the system. The provider would presumably already be paid the contracted reimbursement by that point. But the MCOs would be increasingly held responsible for paying legitimate percent interest for delay and the burden of delayed payments is placed on the MCOs rather than back on the providers. And then just accountability measures and outcomes, that we're really holding the plans accountable to fix their issues with claim processing, [INAUDIBLE] within 30 days so that our providers can be reimbursed in a timely manner, and that we're addressing all these systemic issues rather than just fixing them one issue at a time as they arise. And then finally, that accurate data is being reported to the state on claims that are submitted that are not paid and stating the reason why. And most importantly, that we have an adequate network of providers across the state. We're concerned that our providers are

going to restrict or stop services altogether and that's certainly not what we want. So with that, I'll be happy to answer any questions.

HOWARD: Thank you. Are there questions from the committee? Senator Williams.

WILLIAMS: Thank you, Senator Howard. Thank you, Ms. Seelhoff, for being here. And thank you for not just coming and telling us it isn't working, coming and giving some ideas or suggestions for solutions. Have these potential solutions been communicated to HHS and the managed care companies?

JANET SEELHOFF: Yes, they have. In fact, we have a coalition representing virtually every health care organization in Nebraska, and we have presented these recommendations previously and certainly had representatives attending the stakeholder meetings with HHS and continuously asking for help in these areas.

WILLIAMS: How's the communication and the response to your suggestions been?

JANET SEELHOFF: I would say that it's improved. I think that when we go and work with the leadership of the managed care plans, we do eventually get responses and resolution. But yet as I mentioned, we're still seeing more issues cropping up all the time. So-- and I can't pretend to know what their resources are to deal with this.

WILLIAMS: And when you say more issues, are they the same issues or are they different issues?

JANET SEELHOFF: Sometimes they're the same issues, and then there are new ones that come up. For example, I just was notified this last week that a couple of our agencies that provide private duty nursing are now getting pushback and being told that if parents need respite care, they need to give them specific schedules-- of their work schedules hour by hour, to make sure that-- and how they're going to approve those hours of respite care. So that is adding administrative burden back on our providers.

WILLIAMS: And I know this is a little bit of a hard question to answer. But I asked it earlier also, and you work with a number of your association members and we've been with Heritage Health for a little over two years now. How would you rate the improvement or lack of improvement during that two-year period of time?

JANET SEELHOFF: Great question. I would say overall we've seen improvement with payments and not the volume of providers waiting on payments that are past a year due. I think we're still seeing though just consistent issues with the lack of authorizations and payments, so there's still-- the systemic issues are still there.

WILLIAMS: OK. Thank you.

JANET SEELHOFF: Sure.

HOWARD: Other questions? Senator Murman.

MURMAN: I apologize, I'm new here but I assume two years ago we didn't have managed care in the state.

JANET SEELHOFF: There was. There were different contractors. Two of the three were different at that point.

MURMAN: OK, I was just wondering and I probably missed it-- you're-- you've been here longer than two years.

JANET SEELHOFF: Yes.

MURMAN: So how did it-- how does it compare in the last two years to before?

JANET SEELHOFF: That's a great question. There were many similar challenges prior to 2017.

HOWARD: Other questions? Seeing none, thank you for your testimony today.

JANET SEELHOFF: Thank you.

HOWARD: Good afternoon.

JINA RAGLAND: Good afternoon, Chair Howard and members of the Health and Human Services Committee. My name is Jina Ragland, J-i-n-a R-a-g-l-a-n-d. I'm here today testifying in support of LB468 on behalf of AARP Nebraska. AARP is a nonprofit, nonpartisan organization that works across Nebraska to strengthen communities and advocates for the issues that matter most to families and those 50-plus in our state. Between 2015 and 2050, the age 85-plus population in Nebraska is projected to triple or nearly triple, from 42,000 to 121,000, which is a change from 2 percent to 5 percent of the U.S. population. People

ages 85-plus are the most likely to need assistance with activities of daily living such as bathing, eating, transferring, and toileting. Additionally, nearly one-third of this population has dementia, often requiring higher levels of care and assistance. The Silver Tsunami is upon us, and with that comes the need to review and make changes at all levels. It's important to note that AARP does not completely oppose the implementation of managed care for long-term care services. But we believe at the present time in Nebraska we are not ready. It needs to be done cautiously and with specific attention to payment reimbursement, transparency, oversight, consumer choice, as well as input from consumers, caregivers, and providers. As this population is one of the state's most vulnerable, we have to raise caution and ensure that rolling out the program is done in an effective manner, and we protect and ensure adequate access to services and programs that are already in place. AARP Nebraska has been following the implementation of Medicaid managed care since its debut in January 2017. Our concern has always been, and will continue to be, ensuring adequate access to providers and services across the state for consumers utilizing such programs. We certainly agree that progress has been made with managed care since the inception of the program, and we appreciate and recognize the department's implementation of the administrative simplification meetings with the MCOs to highlight and discuss relevant issues and identify problems. While there appears to have been progress made in addressing many of the challenges with the program, we continue to hear, and you heard earlier today also, from provider groups that issues are still very relevant. And many providers are still struggling overall to make the program successfully work. We're fortunate that many providers who have or continue struggling with the program continue to provide and maintain services and relationships to Medicaid consumers, many of which are struggling to keep their doors open. Long-term Medicaid managed care takes on an entirely new meaning for managed care in our state. It's critical that necessary services focus on our most vulnerable residents, not just on managing the costs of care. Medicaid managed care long-term care services provide many opportunities and challenges in care delivery and financing. The opportunities can include the use of care coordinators and better outcomes of care, including unnecessary hospital admissions. Certainly the fixed payments to managed care make Medicaid costs more predictable for state governments. Oftentimes though, fixed payments then make-- may also create incentives for plans to restrict, limit, or deny access to necessary services for people who have costly health care and long-term needs. Reimbursement issues continue to be of concern.

Adequate payment rates adjusted for health and functional levels is critical to the success of these programs. These rates should be set at levels that pay the appropriate amount to reduce the risk that need-- the needed care would or could be denied to beneficiaries. If adequate reimbursement rates continue as this program is implemented, potentially MCOs that enroll members with more serious health problems will be at greater risk, which in turn could put at risk avoiding enrolling members with greater health problems or denial or limitations on necessary services for those enrolled or potentially giving many smaller facilities no choice but to limit numbers of these admissions, which you kind of heard a little bit previously also. You've also heard over the last three years, 33 facilities have closed their doors in Nebraska. Just like other services, long-term care costs continue to rise, while often just meeting the bottom line continues to decline. Some of these closures have occurred in small towns that have few or no options for a relocation and are often many miles from another operating nursing home. Nursing home closures can take a significant physical and emotional toll on residents, some of which suffer what is known as transfer trauma or relocation stress syndrome. These conditions can cause displaced residents to become depressed, agitated, socially isolated, withdrawn which in turn can lead to falls, weight loss, or complacency about caring for themselves, which in turn increases the overall health care costs and mental well-being of the resident. Adding another complicated layer to these issues further ensures bigger issues as a result, and in turn a negative result on our long-term care residents. We do support the concept of managed care, but we feel more time and study, as well as further improvement in our current system, is necessary before transitioning and implementing this program to our most vulnerable population. Thank you for the opportunity to comment and I'd be happy to answer any questions.

HOWARD: Thank you. Are there questions? Seeing none, thank you for your testimony today. Good afternoon.

HEATH BODDY: Good afternoon, Senator Howard. Good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. I'm 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. NHCA is a family of health care associations that spans the entire state and primarily does services in the long-term care space. So today I come to you on behalf of our over 400 not for profit and proprietary skilled nursing and assisted living and hospice members across the

state in support of LB468. My intent is to not restate information that you've already had, so I thought I might just stay away from the handout that you have in there and just hit a few key points that I thought, sort of came out and emphasized today. In this role I get the opportunity to visit with my colleagues from the other-- from 49 of the 50 states and the District of Columbia and to hear about their systems and their Medicaid payment system as it may be. And there's two unique things that stick out to me in that way about Nebraska. One: our current long-term care payment system seems to be pretty effective and to be pretty timely. And that's not the case in every other state. I think another unique thing about Nebraska is we have many more stand-alone facilities. To be exact, about 25 percent of the state is a stand-alone, so either may be a private, for-profit stand-alone, or a small town facility by themselves. And the reason I bring that up is, as you've heard about these pressures about billing and rebilling and claims that are wrong and then you have to try to sort them all out, they don't necessarily have the bandwidth from a labor perspective to be able to sort that through, like some of them would if they had a corporate support or other things. And so as you've heard other associations, our association, too, spends a tremendous amount of time trying to help navigate for members those claims and the issues with the claims. There's been multiple questions about, has it improved? And I would say, maybe much like a few of the last testifiers, surely there's been improvement. It was rocky to start, and the thing that's concerning me about where we stand today is to hear stories that we still have two-year-old claims. We still have unresolved issues now from '17 into '19 and to know what seems to happen from the involvement that I get, is that we deal with things in specifics, i.e., we deal with that claim and that resident and that facility. Yet we don't necessarily deal with the systemic problem or more of the system. Maybe systemic is unfair but the system of why. And it would seem to me-- and I've said this at meetings with the department and the MCOs-- that the goal, if we're trying to serve Nebraskans well, should be to fix the system that's created those issues. So I think that remains an issue. This week I had the opportunity to be in a lunch with one of the three MCOs here in Nebraska. It was a good lunch. They're good people. I truly believe they really think there's good things that they can offer Nebraska going forward. So I'll offer you the same suggestion I offered them. I said, if this-- if managed care really is the right thing for Nebraska, if this is really a good idea, why don't we sit down and fix the issues with managed care and all the other health spaces that are already involving?. Because let me say this: what we're doing right

now is the easy part of health care. You've heard a few of the testifiers say, it gets really complicated when you talk about long-term care, who is paid in a per diem, who adjust every month based on their care levels. And it would seem to me that if this is the right thing, then let's show an effort of good faith and sit down and work through those things, whether that's together with the MCOs or with the department. Our association members have offered letters of testimony and I'm sure those will be read into the record at some point. And so I just want to make sure that that those were part of this and, you know, we've seen in other states, you've heard a couple of mentions today. Some of what-- we're often compared to our neighbors, and we've got some good examples of how managed care for long-term care hasn't gone well at all with a couple of neighbors. Maybe Iowa and Kansas might be the two best examples. We believe that it's not worth the risk for Nebraska's most vulnerable-- the most complex payment system to do this too fast before the system would be squared away. I really appreciate Senator Walz using LB468 so we can shine a light and have a conversation around managed care. Senator Arch, I would just-- if I can go back to your question about what a success looked like, I would reflect on the stated goals of managed care to improve access, improve quality, improve care coordination. We used to say, save money; now we say, reduce costs, reduce individual costs. And so for me, those would be some measures that a study would be able to say, is it doing that? Is it doing that clearly? And do we have success as it relates to that? And with that, I'd be happy to answer any questions.

HOWARD: Thank you. Are there questions? Senator Williams.

WILLIAMS: Thank you, and thank you, Mr. Boddy, for being here. You mentioned your counterparts in the other states and citing again Iowa and Kansas as maybe poor examples to look at with managed care in the long-term care setting. Are there good examples to look at out there?

HEATH BODDY: So let me answer this in two ways, Senator, and thank you for the question. I-- I keep asking and not have-- have not been shown data to show there are good examples. I would say my colleagues in Arizona, some 30 years after the initial implementation of managed care, would say they've got it figured out. So if the definition of getting it figured out, which would probably indicate some stability in claims, claims payment, hopefully that's some of the indications that are the stated goals about quality and access. I'm not sure if

they're the poster child, but they would be the ones that I would say, that state would say, they've gotten to a better place with it.

WILLIAMS: From a philosophical perspective, does the type of care that is-- type of care that is provided with long-term care lend itself to managed care?

HEATH BODDY: I would say the complexities of the system of long-term care, in my mind, would be suspect for a system like this. Most of that is a reflection on-- I keep ask-- I'm a data person and I keep asking for, show me the numbers where this really makes sense, and you know frankly where it's not a provider or an MCO, some other party that's showing us, this really works, and I don't see the data. There could be an argument that if long-term care, the way that long-term care is paid for-- that it evolves over time, there may be a day it would be a better candidate for this. Maybe that fits. It would worry me greatly at this point, especially with the way Nebraska's system is set up to roll it in today.

WILLIAMS: Thank you.

HOWARD: Senator Hansen.

B. HANSEN: I've got a pretty simple and quick question. How would you fix this? [LAUGHTER] I am being a little facetious. I have to give Mr. Boddy a hard time, because I sat and had supper with him last night, and we kind of discussed on this already before. But if you had to pick one thing you think that could probably be fixed or that you would like to see fixed, one of the biggest-- Senator Arch kind of talked about this a little bit, already. What's, like, one of the biggest things that you think that can be fixed first, or your biggest problem that you have?

HEATH BODDY: Senator, of the current system or of the projected?

B. HANSEN: Current system.

HEATH BODDY: Thank you for the question, Senator Hansen. I am a believer that reasonable people can sit around the table with discussion and come up with reasonable solutions. It's beyond me why we're in 2019 and can't fix some of the rudimentary parts of this payment thing, of which the old system was seemingly paying pretty well. So if I was going to fix something, I'm not exactly sure on the how, but if I was going to fix something, I would start there, to

systemically fix and--and grease the skids, if you will, so these claims, which in many cases are pretty normal and claims that should just pay through, create problem after problem. So I would start there. And I think the upside of that was that providers in the state would start to have some faith that this is not going to create a calamity if we roll in more parts of health care.

B. HANSEN: Thank you.

HOWARD: Right. Other questions? Seeing none, thank you for your testimony today.

HEATH BODDY: Thanks.

HOWARD: Our next proponent testifier. Seeing no one else wishing to testify as a proponent, we have several letters for the record: Matthew Blum, the Good Samaritan Society, Superior, Nebraska. Peggy Reisher, Brain Injury Alliance of Nebraska. Jeff Fritzen, Gold Crest Retirement Center, Adams, Nebraska. Nate Schema, Good Samaritan Society. Kyla Sprakel, Good Samaritan Society, Bloomfield, Nebraska. Kalyn Barton, Good Samaritan Society, Valentine, Nebraska. Judy Nichelson, Brain Injury-- Nebraska Brain Injury Advisory Council. Tim Burton, QLI. Dianna Epp, Good Samaritan Society, Syracuse, Nebraska. John Turner, Brookstone Meadows, in Elkhorn, Nebraska. Brenda Ewers-Nordhues, Brookfield Park. Annette Dubas, Nebraska Association of Behavioral Health Organizations. Kari Wockenfuss, Louisville Care Community. Silvester Juanes, Azria Health. Tricia Steager, St. Joseph's Villa and Court. Alice Smith, Highland Park Care Center. Patrick Fairbanks, Immanuel Fontenelle. Kristin Mayleben-Flott, Nebraska Council on Developmental Disabilities. Larry Van Hunnik, Summer Place Skilled Nursing and Rehabilitation in Lincoln. Zoe Olson, Nebraska Association of Area Agencies on Aging. Members of the Nebraska Association of Service Providers. Kathy Engel, St. Joseph Villa, in David City, Nebraska. Eric Gurley, Immanuel. Allen Moravec, St. Joseph's Villa in David City. Sarah Watson, Blue Hill Care Center. Seth Stauffer, Sunrise Country Manor. Theresa Naber, Cloverlodge Care Center. Kevin Moriarty, Holdrege Memorial Homes. Stacy Neubauer, Good Samaritan Society, Alma, Nebraska. And Robert Tank, Bethany Home, in Minden, Nebraska. Is there anyone wishing to testify in opposition to LB468? Good afternoon.

MATTHEW VAN PATTON: Good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. My name is Dr. Matthew Van Patton. That's M-a-t-t-h-e-w V-a-n P-a-t-t-o-n. I'm the director of

the Division of Medicaid and Long-term Care in the Department of Health and Human Services. I am here to testify in opposition to LB468. LB468 would prohibit us from adding any additional people or services into managed care until January 1, 2020, or until a successful evaluation of managed care is completed, whichever is later. The proposed amendment is narrower in focus-- excuse me, scope, but longer in duration. As amended, this bill would prevent us from adding long-term care services and supports into managed care until January 1, 2020, or until a successful evaluation of managed care is completed, whichever is later. People in long-term care include residents of assisted living, nursing, and skilled nursing facilities, as well as people who need this level of care and choose to receive it safely at home. LB468-- including as amended-- would negatively affect the people that we serve by negatively affecting our ability to be good stewards of the taxpayer dollars. For the last few years, Medicaid has been building, restructuring, and recalibrating our focus away from merely being a payer of claims towards a modern delivery system that focuses on good results. We are focused on the quadruple aim, which is improving the patient experience of care, improving the provider experience of care, improving the health of populations, and reducing the per capita cost of health care. A major component of this effort has been the systematic integration of services and populations into managed care. Indeed, the majority of Medicaid services and populations are now in managed care. The next logical step is extending the benefits of managed care to people in long-term care. This would provide significant improvements, including active care and case management. These enhancements would provide beneficiaries access to trained professionals to help them understand their options and receive the right care, at the right place, and at the right time. We are concerned that this bill would inhibit our ability to deliver quality health services to Nebraska's most vulnerable populations. The entire goal of managed care is the sustainable delivery of positive health outcomes in a financially stable and relatively predictable manner. This bill would relegate the Medicaid program to an outdated, inefficient model of health care management. Additionally, I would like to make the committee aware of a business reality that we are facing and why we cannot continue to pay claims the traditional way, in fee-for-service. Our current claims payment system, MMIS, is nearing the end of its life cycle. MMIS is 40 years old, and lacks integration and interoperability functionality with other modern management systems. If the department is required to keep paying long-term care's care claims outside of managed care, the state is going to have to buy a new claims payment system or contract with a

claims broker system. Either of these options is likely to cost in the tens of millions of dollars. In conclusion, LB468 would severely impede our ongoing work to improve the Medicaid health care delivery system. This bill would lead to increased expenses, duplicative expenses, and inferior results. For these reasons we oppose LB468. Thank you for the opportunity to testify. This now concludes my remarks.

HOWARD: Thank you. Are there questions? Senator Arch.

ARCH: Thank you for coming in.

MATTHEW VAN PATTON: Yes.

ARCH: You've heard the issues.

MATTHEW VAN PATTON: Uh-huh.

ARCH: How do you-- how do you respond to that? I mean the concerns are real, obviously. It's-- they're struggling with the processing of claims and those issues. How-- what's your perspective on that, I guess is my question?

MATTHEW VAN PATTON: Senator, our contracts are very specific with our MCOs. And as I've briefed and recently shared with this committee, a scorecard that we now have ascribed to the MCOs and they report that data back to us on a monthly basis, is updated, and we meet as I have said, every two weeks in my office with the CEOs and their executive teams. We tackle issues as they come to us and are made known to us. And when I look and hear the commentary about the claims processing piece, it is not only a contract standard that each of the plans have their own plan standards, and then we have a quality performance standard, which is even above our contract standard. And that quality performance standard goes to money that is held back, that they can earn back if they hit that-- that standard. So as Senator Walz alluded to, and I'll just pull one from our dot scorecard from the end of last year, this goes to one of our plans without going into all three, but the turnaround time on 10-day claims processing. The QPP standard is 95 percent. The contract standard is 90 percent, and the health plan standard itself is 95 percent. For the year, they processed within 10-day turnaround time 95.73 percent of all claims. So there again, we are hitting those metrics and we do assess those metrics. It's very important to stay on top of that and again, as the contract standard to which--which we manage. In terms of those claims processed within

60 days, I had my team pull over the last year and 0.77 percent of claims and 0.9 percent of claims' dollars [INAUDIBLE] 20 constituted NTC's percent that went past 60 days. For WellCare it was 0.03 or 0.34 percent of claims' dollars processed in 2018. For United it was 0.35 percent of claims and 0.0-- 0.03 percent of claims' dollars in 2018. Furthermore as was alluded, there is a provision that goes to a 12 percent interest assessment on anything that goes past 60 days. So they are highly incentivized to make sure that they pay those claims on time. And as you can see from the rates that I just presented there, I believe we're hitting that metric fairly well.

ARCH: A follow-up question. That-- obviously, that's quite different than the testimony heard. Do you have any idea why, I guess, you know, the definition of processing clean claims, all of that-- are we in that discussion? What-- why would there be such a difference in testimony or the results that you see compared to what we have heard today?

MATTHEW VAN PATTON: Frankly, I'm as perplexed by it as you are. And as I go through these metrics, again, they're very prescriptive within the constructs of those contracts. And it is a metric that we stay on top of and we discuss every two weeks to make sure that we're hitting those numbers. And they come in monthly, so it's not like we're looking at them annually and one time annually. We're looking at them monthly to make sure that they're hitting those things. Now that's not to say, Senator, there aren't issues that do develop. As I've said, we have a process for addressing issues. So if a particular provider has an issue, we can address it in a very quick turnaround time. Coming out of the hospital environment as a former provider, I know that you have turnover in your billing department. You have new clerks who are coming in and who are coding, and so there can be errors made. And we try to stay on top of that, their provider relations activities, which again, if you look at the scorecard that we keep with the MCOs, we monitor their touchpoints that they have every month across the state with the provider community. So I would say at this time that the state, within the constructs of Heritage Health, is taking all due appropriate measures to, number one, manage the contracts that we have in place, as well as to have assurances that we're having those proper touchpoints to stay on top of those issues when they come up, and then to have a venue for bringing them into the known space of Medicaid, so that we can turn around those responses. I can tell you last year that, with some members of this committee, we had issues that were brought to us. They enter into our suspense log, they enter into again

the issues log with the MCOs, and I even reached directly out to those providers in that space to make sure that we had closed out their issue to their satisfaction. So I would tell you we've been very proactive in reaching out and addressing issues when they're known to us. And when we have the ability to work through those issues quickly, we get them done.

ARCH: Thank you.

HOWARD: Senator Hansen.

B. HANSEN: Yeah. So those metrics and those numbers you just listed off to us, were those payment of claims?

MATTHEW VAN PATTON: Those were the percentage of claims paid within that 10-day-- 10-day window there, Senator.

B. HANSEN: OK.

MATTHEW VAN PATTON: So we do keep track. If you look at the scorecard that-- that we provided to you and it was submitted earlier in the week to you, we tracked the number of claims received, the number of claims processed, claims paid, claims paid by RX, percentage of claim rejected, percentage of claim denials, turnaround time within 10-day time period, and the turnaround time within a 60-day window as well. All those are tracked within the scorecard on a monthly basis.

B. HANSEN: Thanks.

MATTHEW VAN PATTON: Yes, sir.

HOWARD: Senator Williams.

WILLIAMS: Thank you. And, thank you, Director, for being here and I will certainly thank you for reaching out directly to some of my providers and doing that. I've got some follow-up questions following testimony. In Ms. Acierno's testimony, she talked about what she would call the bordering states Kansas and Iowa's struggles with implementation of long-term care. What did they do wrong and what could or what could you commit to doing right so that we would not have that same experience here?

MATTHEW VAN PATTON: Well, I think, certainly, Senator, the constructs of where we are within Heritage Health today, those performance measures that we were just talking about, thinking proactively around

what we need to be looking at and looking at consistently to, again, ensure that we are assessing our performance against the objectives of the quadruple aim that I just mentioned in my testimony there. The provider experience, the beneficiary experience, improving the health of populations, and reducing the per capita in-- per capita cost of health care. Those are paramount importance to me in how we manage the Medicaid program. So I think setting those performance measures up front, knowing what you want to assess yourself again and then, when you move into a managed care structure, that you have performance measures prescribed up front, known, and agreed to, within the construct of your contract that you make with your MCOs. So you know exactly what you're managing to, in terms of performance and in terms of delivery as time progresses. And if you have issues within the construct of that contract, you can then have a methodology for addressing those issues and remediating those issues.

WILLIAMS: We have three managed care companies. Do you know if they are the same managed care companies that are dealing in Iowa and Kansas?

MATTHEW VAN PATTON: I know that NTC or wouldn't be Nebraska Total Care, but a Centene product, and United, I believe, is in that market. I'm not sure if there-- if WellCare is in Iowa or not, Senator, but--

WILLIAMS: Also, in testimony we heard today from Mr. Ross, who deals not only with nursing homes in Nebraska, but nursing homes in surrounding states-- experience of managed care in this space is-- slow at qualifying residents and slow at paying claims. Have you got a response to that, how we would avoid that?

MATTHEW VAN PATTON: Again, I would-- I would go back to the claims issue again. Could be a contract standard that you administered in the same construct that we're already administering yet within the space of our health benefit, our behavioral health benefit, and our pharmacy benefit. In terms of determination of enrollment and eligibility, again, within our division, we set very high performance standards on our turnaround time for making determinations of eligibility. And I will tell you that Karen Heng's team stays on top of those numbers with great precision and has worked very, very hard over the last year to bring down our application time frame and our turnaround time into what I would consider very worthwhile metrics. I'm sorry to say that I don't have those eligibility numbers in front of me; but if that's something you would like to see, I can very easily follow up with you

on the metrics, as well as where we are today with that turnaround time.

WILLIAMS: I'd like to follow up on a question that I asked Mr. Boddy. First about-- and you analyze this and then all around our country, is there a successful business model for managed care in the long-term setting? And follow-up question to that is the philosophical question of, does long-term care lend itself to success in the managed care space?

MATTHEW VAN PATTON: Currently, Senator, I believe there are 22 states who are now engaged in long-term care managed care. I submitted to you-- and forgive me, I gave you a number of documents that I would like to share with you so that you have it for reference. One of them is the colored document demonstrating the value of Medicaid MLTSS programs. This is produced by NASUAD, which is the National Association of States United for Aging and Disabilities. Excuse me-- within the construct of this report you'll find that they began-- On the executive summary on page 3 you'll see that they began to frame out the constructs of how we began to assess the value of what we're buying in this space. And I think where they're going rebalancing the Medicaid LTSS spending, improving member experiences, quality of life, health outcomes, reducing waiver waiting list, increasing budget predictability of managing cost. I think those are the baseline metrics of how you begin to assess the real value of what's happening in this space. I would also tell you, I think time and data coming in as you do begin to set metrics and begin to formulate national standards, I think you will begin to see--

WILLIAMS: I'll go back and ask the question. Is there a good business model out there that's being operated in a successful manner?

MATTHEW VAN PATTON: You know, Senator, I think you would see states like Kansas, and I believe, my former Medicaid director peer is in the room, and I think you may hear from him today as well. I think they had a successful implementation in Kansas, not to say it wasn't without hiccups. Things happen in business processes as you move things in. The more planning you can do, again, up front, the more constraints and constructs you put in those contracts will help you get there. So yes, I do think there are some examples and I think in the narrative from NASUAD you'll begin to see some of that, if you'd like to read through.

WILLIAMS: As I understand Senator Walz's bill with the amendment, you talked about-- I think you used the word-- that it would stop us from implementation. Would a better definition be, it would delay us in potential implementation?

MATTHEW VAN PATTON: Yes, Senator. I think I have been very transparent and I have said, we're on a slow march to long-term managed care and [INAUDIBLE], that skilled nursing per diem rate into the system, in part because of what I go back to with my business reality around how we currently are paying those claims within that 45-year-old MMIS system.

WILLIAMS: But on that slow march, and I want to be sure that I understand this, that the situation we were in-- are in-- today, would allow DHHS to independently make the decision to implement managed care in the long-term space.

MATTHEW VAN PATTON: For long-term care-- is that the question?

WILLIAMS: Yes.

MATTHEW VAN PATTON: At this juncture, because our rate setting methodology, the way we calculate the per diem rate is codified in regulation. It's about 150 pages of regulation that has a very prescriptive formulary as to how we calculate. Unless that is removed from regulation, we would have no flexibility to, number one, change the way we make those payments to those skilled nursing facilities, which is problematic for me on a number of levels. Number one, including the fact I can't accommodate quality, which is now a very prominent part of the national dialogue around what's happening in--

WILLIAMS: Let me restate my question.

MATTHEW VAN PATTON: I'm sorry, go ahead.

WILLIAMS: You're going down the wrong direction from what I'm asking. What I'm asking is, right now, as I understand where we're at, DHHS could make the decision to implement managed care in the long-term [INAUDIBLE]

MATTHEW VAN PATTON: Not without taking it out of-- not without taking a rate setting methodology out of regulation, because it's prescriptive as to how we, the agency, have to make that calculation.

WILLIAMS: Is that a--

MATTHEW VAN PATTON: So I could not do that in the [INAUDIBLE]--

WILLIAMS: --is that a decision that it is made internally at DHHS?

MATTHEW VAN PATTON: So we would have to go through the process of taking it out of regulation which we've started that process of removing it from regulation, which involves a number of public hearings, the normal regulatory process. So we have engaged in that process independent of this. So yes, I would say that is underway currently at DHHS Medicaid.

WILLIAMS: So we're on that-- that-- that march, that direction, and you mentioned-- any implementation like this takes significant planning and proper planning. So delaying the process is not always bad. The last question I have is you mentioned technology and the cost of the problem. How do we justify the fact that lack of technology on the part of the state could lead us to have to make what many would consider to be a poor business decision in moving to managed care?

MATTHEW VAN PATTON: Lack of-- I'm trying to follow that thread there. The lack of technology, so--

WILLIAMS: I'm not sure I followed it.

MATTHEW VAN PATTON: Well [LAUGHTER]--

WILLIAMS: Our technology system-- one of the benefits to the state of going to managed care is we don't have-- the state does not have to spend millions of dollars propagating--

MATTHEW VAN PATTON: [INAUDIBLE]

WILLIAMS: --its system and I'm trying to justify that as a reason to move to a managed care system, when I'm struggling personally, philosophically, whether that's the right system for the long-term care space.

MATTHEW VAN PATTON: I got you. So I would say it's multifaceted response. Number one, keeping up the MMIS system today is about a four million dollar a year proposition for the department just to keep that engine going. Point one. Point number two, I would tell you is that we are already buying claims brokerage services in triplicate. WellCare, Nebraska Total Care, and United process claims. And so I can simply

carve in this population or this service into the existing constructs of our managed care system with their claims brokerage systems, and I can begin to sunset that MMIS platform and reduce that 4 million dollar a year annual prop-up support that we have in MNO cost on that enterprise. And also as a matter of cost avoidance, we already know, having looked out to see, our-- where do we go with replacing the MMIS claims brokerage component. We already know from a quote that we have, which is $22.8 million, I believe off the top of my head, cost that we would have to incur to buy that platform. And I would just as soon rather save that, and again, when I'm buying claims brokerage processing already in triplicate from those three MCOs at this juncture.

WILLIAMS: Thank you, Doctor.

MATTHEW VAN PATTON: Thank you, sir.

HOWARD: Other questions? Senator Arch.

ARCH: We've heard-- we heard today that-- really, the two issues. One is the timely processing of claims, and the other is rates. And you mentioned rates just a few minutes ago in your testimony. Where are you now in rate methodology? I mean, I'm, again, new. I'm sure this has been discussed so many times but, first time for me, so could you bring me up to date, please, with where you are--

MATTHEW VAN PATTON: Sure.

ARCH: --where you're going? How close are you to, I guess, making changes, recommending changes, anything like that, please?

MATTHEW VAN PATTON: Let's see, Senator, let me jump here. There is a pie chart that you have, and I'm just going to walk you through the pathology of the work that I started when I came in, conversational narratives that I've had thus far with the folks in the industry, including Mr. Boddy and Mrs. Acierno, and conversation points around the quality narrative, which is a very important component at this juncture. I did not print it because it's over 250 pages, but I will reference it for you to pull up. It is a 2014 report produced by the OIG within the Department of Health and Human Services nationally that quantified within the constructs of Medicare that 22 percent of all Medicare beneficiaries entering into a skilled nursing facility experienced an adverse or sentinel event within that space, resulting in the need for additional health care services to stabilize and/or

restore life; that for the month of August of 2011 was quantified at $208 million spend. Over time, I think the report indicated it was a $5.8 billion spend in health services delivered. So starting at that point saying, OK, if we have a quality issue, if there is a service delivery issue within the construct of our delivery system, what am I buying on behalf of the beneficiaries in the state of Nebraska? And that's a legitimate concern for me. What services are we getting and at what level of quality are we buying them? So the pie chart that you see here, Senator, represents where we fall in 2018 rates, according to quality. So you can see, and this is using CMS's star rating system, CMS produces a star rating based on-- I know I'm telling you something you already know, Senator, so forgive me for the redundancy. But it's based on safety. It's based on staffing. It's based on facilities' reports. All go into creating multiple levels of star assessment as well as in at-- an amalgamated star that produces one rating that you see here. If you look, 30 percent of our facilities in the state are functioning at a five-star level, and on average all the facilities in the state, we group them and then took an average of their per diem rate, they're paid $190.36 on average. Now flip over to the other side of that pie chart, those one-star facility providers, 19 percent of our state at one-star level, we're paying $176.88 on average. Now to me, here's a $13.48 delta between what we're paying our top providers who are functioning at a four- and five-star level of service and who have operated at an extremely high level of administrative efficiency, and those at the bottom level of performance. Again, a difference of $13.48. Where in our methodology do we provide an incentive to help those providers at the bottom pull themselves up so that we improve their performance, as well as improve again the value of the buy and the experience that our beneficiaries have in their space? So this is-- this was my genesis. This is the work that I did at baseline to look at where we are in this state and to begin to socialize this narrative with the provider community. From there, we entered into dialogue, and Mrs. Acierno and Mr. Boddy rendered to the department a recommendation, a proposal of a rate methodology that they would like to see us move into. It does have some component of quality integrated into it, but it does have some issues in that it is still based on the old rate-setting methodology codified in regulation. We'll be working towards a new methodology that we would like to socialize with the public and that's a multiple stakeholders, not just the industry that provides the services, but those who are on the advocacy side around those who are buying those services in that space. I think this needs to be a broader stakeholder conversation at this point. And we have a long-term care redesign

working group that's been in effect for quite a while. As matter of fact, that working group and NASUAD in 2017 produced a report for the state on long-term care redesign services. And if you all are interested in that report, we'll be happy just to give you that as well. But from there, I think, March the 6th is a date that we'll have another long-term care redesign and we're going to talk about where we are with constructs of a methodology and things we'd like to see put into that methodology. At the same time, NASUAD's going to come in and they're going to talk about the utilization of home- and community-based services, and how we plus those services out. Because if you look demographically and statistically, individuals prefer to age in place, to stay at home for as long as possible. And I think within the constructs of effective managed care where you can wrap those clinical care protocols, as well as those social and economic determinants of care through care planning, you can help those individuals stay at home and in place longer and avoid a [SIC] early utilization of a facility. And I think that is, that is part of where our policy narrative needs to be moving as well. How do we provide rates that honor and respect quality and make sure that we're buying good services in good facilities through working at a high level of quality for those beneficiaries, at the same time we're working with those beneficiaries to manage their experience, such that they get the services that they need in their home and they stay there at a longer-- for a longer period of time?

ARCH: So just a quick follow-up then, is, and thank you very much, that was very helpful. Is the right methodology discussion then independent of the MCO discussion?

MATTHEW VAN PATTON: I would say it is in part, because when I said we're on a slow march towards, I'd like to work within the constructs of finding a new rate methodology that gets in place a quality component, such that when we move towards long-term managed care, there's a methodology that we're working in that's functional and that is able to hand off into the constructs of managed care. That would be ideal for me. And that's why, again, starting with the pathology, starting with where we are, what's our baseline, history and physical if you will, within the industry, where do we go from here, what components are out there that we should be thinking about that are already in the narrative of our health delivery system and how we pay and purchase health services, how do we enter that into this narrative around rates here? And then at some point once we get that introduced,

socialized, and codified, then it allows us to have a seamless handoff, in my opinion, to those MCOs at the right place.

ARCH: Thank you.

MATTHEW VAN PATTON: Yes, sir.

HOWARD: Are there questions? Can you remind me what's currently being built through our MMIS system now?

MATTHEW VAN PATTON: There are a few remnant populations still in MMIS, Senator, but we are working towards-- this year, as a matter of fact, some of those remnant services and populations will be carved in to managed care. For example, nonemergency medical transportation is currently in that system but will be carved into managed care July of this year.

HOWARD: July of this year?

MATTHEW VAN PATTON: Yes, ma'am. And so that represents about 485,000 claims currently processing through the old MMIS claims brokerage system. That then leaves claims for inmate services, spenddown population. Of course, the skilled nursing per diem rates are in there, as well as refugees, the payments that we have for refugee services. That's in there but that will be carved in in July of this year, TANF was--

HOWARD: Refugees are being carved in in July of this year?

MATTHEW VAN PATTON: Of this year, that's the intent, yes, ma'am. And then the TANF population was carved in January of '19. So we've been systematically working towards moving those remnant populations and remnant services out of the old MMIS so that we can get to a place where we can sunset that enterprise.

HOWARD: Inmates, spenddowns, skilled nursing, per diem, refugees, and TANF. Am I missing anyone?

MATTHEW VAN PATTON: Our capitation rates are currently paid in that platform as well.

HOWARD: Oh, our cap rates to the--

MATTHEW VAN PATTON: To the MCOs.

HOWARD: --are paid through the MMIS.

MATTHEW VAN PATTON: That's correct.

HOWARD: And so if we didn't have the MMIS, how would we [INAUDIBLE] the cap rates?

MATTHEW VAN PATTON: Well, we don't have an answer for that just yet. We're still working through the constructs of how that would be transitioned. But--

HOWARD: OK, and so we're carving in-- I just want to make sure I'm clear. So my understanding is that your goal is to sort of retire our MMIS system.

MATTHEW VAN PATTON: Yes, ma'am. And the DMA was part of that as well, which we've talked about because that was the encounter piece. And so the data management and analytics tool we're building with Deloitte will pull that component in, which was another component of our existing MMIS infrastructure.

HOWARD: OK, so-- and what kind of federal funds are we getting for the Deloitte project?

MATTHEW VAN PATTON: Deloitte, I believe, is 90-10 funding.

HOWARD: Have we gotten funds before to address our MMIS system? Is this our first project on that?

MATTHEW VAN PATTON: No, there are allocation of federal funds to support the MMIS activity, although that percentage has been diminished over time. And at this juncture, Senator, I'm reticent to answer what that exact percentage is, but I can get it for you and debrief you later, if that's OK.

HOWARD: So when we say that we're spending $4 million on that MMIS, that's just for its function and how much of that is--

MATTHEW VAN PATTON: That's the maintenance and operation-- and maintenance and operation of just keeping the old enterprise functioning.

HOWARD: And how much of that is paid for by the federal government?

MATTHEW VAN PATTON: Again, I don't know what that exact percentage is off the top of my head, but I can go back and follow our accounting team and get you an exact answer.

HOWARD: And what's your time line-- well, OK. So we had the redesign study that was completed last year.

MATTHEW VAN PATTON: That redesign study that was produced by NASUAD, I believe-- let me look here quickly. August of 2017 is when that was published.

HOWARD: OK. And then did that recommend a move into managed care for long-term care, long-term services and support?

MATTHEW VAN PATTON: I believe that that was a component of that report, yes.

HOWARD: And so without this legislation, what's your time line for moving long-term care into managed care?

MATTHEW VAN PATTON: I think we've got to get through, again-- first things first, we've got to work towards removing the rates from our regulation. And I think that that's probably a process that's anywhere from eight, nine months to a year as I understand it. I think from there you get into that. During the course of that activity, I'd like to begin to socialize what the new methodology would be, again, with the stakeholder community, not just the providers, but also the advocacy groups who've come in to talk about their issues within the constructs of how we're delivering this service at this juncture as well. So I'd like to work on that over the next year. And then from there, I think, move into a normalization of those rates, and get that rate set. But from there-- I just don't want to have my hands tied to be able-- not to be able to move quickly once we move through certain things. And I think if you put a limit on that, then that precludes the agency's ability to respond to business dynamics that could be accelerated and we could may-- move things forward quicker. Again, I go towards a contractual term that we're going to have to work on if we have to go into a new claims brokerage system. If I have to go and procure that, what's the time frame for that and working that through procurement? So there are lots of business considerations that would have to be made on our behalf.

HOWARD: So I'm trying to get my arms around some of the time line on this, partially because it appears as though you're modifying what the

managed care companies are doing, or adding on to what they're doing, at a time when you've already expressed to this body that you have a broad challenge with the Medicaid expansion population. And so tell me a little bit about how your agency is managing retiring an MMIS system that appears to be functioning for providers. I don't get complaints about what's going through the MMIS system. I do get complaints on what's going on through the managed care companies and-- and retiring an MMIS system while bringing in an expansion population and adding additional services to the MCOs and adding an 1115 on to the expansion of services and adding on to a long-term care population. That seems like a lot to me. And so of those priorities--

MATTHEW VAN PATTON: Uh-huh.

HOWARD: --in my opinion it would seem as though MMIS is a little bit lower. That being said, you wouldn't be able to move long-term care until 20-- what do you think, 2020? 2021?

MATTHEW VAN PATTON: Well, given the dynamics of the narrative that we've been discussing around engagement with the stakeholders on socializing our right methodology. And I think giving a proper amount of time to put something out and engage with those stakeholders, get feedback back, I think that needs to be incorporated into a time line. Again, abutting what we would have to do to remove that rate-setting methodology from regulation, I think we'd have to work backwards from that time line. So, Senator, I'm not going to put a date on it until I go through and can really socialize exactly how much time we would need from those two points that would be part of the consideration.

HOWARD: So under this bill you couldn't modify until 2020. Is that right?

MATTHEW VAN PATTON: Under this, 2022.

HOWARD: 2022?

MATTHEW VAN PATTON: That's the amendment.

HOWARD: OK. I'm just trying to get my arms around how that's different than the time line that you're currently talking about. It does sound like it's going to take you quite a long time.

MATTHEW VAN PATTON: Well, we're already, again, the activities around changing the rate methodology, that's already underway, number one. Number two, we're already deep in conversation. We've taken the

recommendations from the trade associations, we've had internal conversations, we've engaged with other external groups to solicit feedback much in the same way we've approached our other-- build our service lines. And then again, on March 6 we'll be introducing the concepts that we would like to see folded into this methodology with this broader stakeholder group. So I would say these activities are part of our normal business operations. It's something that's been engaged in really long before we entered into the work scope of work for expansion. And so stopping that seems to not make sense since we're already so progressively along at this juncture.

HOWARD: Is your understanding that the evaluation study called for by LB468 a mirror of the redesign from long-term services and supports that was done--

MATTHEW VAN PATTON: I would say it would be a redundancy.

HOWARD: --in '17. Because to me it reads like it's an evaluation of whether Heritage Health is functioning well enough to take on this population. Is there a way to nuance the language to be clear that it's really more about whether or not Heritage Health can pull in this population effectively and pay their claims timely, as opposed to whether or not we should redesign the entire system?

MATTHEW VAN PATTON: Well, I'd have to see whatever language was drafted, and then make a determination after seeing the language before I'd comment on anything, Senator.

HOWARD: And then my question then, this-- and this is probably my last one. When we consider claims and timeliness of claims, we have continuously heard that there is a difference between claims that get paid and clean claims or claims that need edits. And that's what really impact timeli-- timeliness. And so it's hard for me to hear that we're at 95 percent accuracy from you, and then hear from a provider that they're waiting for over a year to get paid for services rendered. And so help me understand why there might be a difference between what's being paid, and why there's a long time line, and what's a clean claim because. I think those are important nuances for the committee to understand.

MATTHEW VAN PATTON: Sure. And so you also have in the packet that was disseminated a chart that looks like this, that's labeled

adjudication. And for those members who are carrying over from last year, it's probably a familiar-- a familiar chart.

HOWARD: I don't believe we have that.

MATTHEW VAN PATTON: You did not get that in your packet. Well, if it pleases the Chairman, then maybe what I would be best suited to do is to disseminate this with a response on the adjudication process or walk you through a narrative, and then get this back to you, whichever is--

HOWARD: That sounds great. Cooper, would you mind running and making copies for the director for us?

MATTHEW VAN PATTON: If I give you a copy, then I can't speak from my notes. [LAUGHTER]

HOWARD: Oh, he'll take it right when you're done. How does that sound?

MATTHEW VAN PATTON: So, the adjudication process is really in construct, a very simple thing. So first of all, let me say, within the nomenclature of the business enterprise that is managed care or commercial coverage, there is really no such thing as a, quote, clean claim. It's sort of something that's crept into the nomenclature. But in terms of function, it doesn't really exist. So in adjudication, a claim that is submitted and is rejected is one that never enters the adjudication process. It is rejected for a number of reasons, and you'll see it from this, it's an incomplete or inaccurate record, meaning that maybe it was the wrong provider number that was entered into on the front end, or that claim did not have necessary documentation with it to enter into the process to adjudicate. So there are a number of reasons why a claim could be rejected on the front end and not hit the system. So once it enters the adjudication system, it goes in as a claim. It's either paid, or it is denied. So in the space of a denial, and that's why when you see within the metrics of our scorecard that we presented, we present the denial rates and the rejection rates, because they're two different things in construct. So a denial-- the top reasons for a denial include that it could be a duplicate claim, meaning that the claim's already been submitted and was paid. So that would get kicked out or would be denied. The provider had not billed the primary and Medicaid was a supplemental in that case. And so if the primary hadn't been billed, the claim would be denied. They didn't submit within the timeliness filing criteria. Benefit providers must submit their claims within six

months. So we do have providers who do not submit their claims within that timeframe and so, if it goes in, it will get denied because it didn't have timeliness of submission. Those are the top reasons and we do have, again, an ongoing list and I can supplement that for you as well, because we do keep up with what those reasons are. Again, that goes back to how are we managing the experience. If we know there's a particular provider who had X number of claims that went in that were denied because they put in the wrong provider rate, a provider number, then we can address that. So that's why we also have the provider response teams that are unique to each of our three MCOs so that they can work with those providers and make sure that those up-front issues are addressed.

HOWARD: Do we have that same process and/or problems with our MMIS system?

MATTHEW VAN PATTON: So we do have issues from time to time and we do have to address that with providers. Yes. And we have a team within the constructs of MLTC that's devoted to that level of customer service.

HOWARD: And you probably don't know this off the top of your head, but what's the longest open claim on our MMIS system for skilled nursing?

MATTHEW VAN PATTON: Open claim?

HOWARD: So sort of like, you are thinking of, like, when somebody says, oh, I've got a claim that hasn't been paid for over a year, I could-- I would consider that an open claim. Maybe you could go back and see-- are there claims that haven't been paid for over a year sitting on our MMIS system?

MATTHEW VAN PATTON: So I did hear that question asked and I had a text or an e-mail sent back to staff. We had one issue that went back to 2017, and that particular issue had 53 modifiers associated with it. But that issue has been resolved and there are no open issues at this juncture on the issue log and that's specific to Heritage Health. Now your question goes to MMIS and that's a different set of data that I don't have in front of me. So to your-- to your credit, you are accurate--

HOWARD: [INAUDIBLE].

MATTHEW VAN PATTON: --in saying, I don't have it, and I'm not going to give it to you off the top of my head.

HOWARD: Wonderful. Any other questions for the director? Seeing none, thank you for your testimony today.

MATTHEW VAN PATTON: You're welcome. Thank you.

HOWARD: Our next opponent testifier. Good afternoon.

JON HAMDORF: Good afternoon, Chairperson Howard, members of the Health and Human Services Committee. My name is Jon Hamdorf, J-o-n H-a-m-d-o-r-f. I'm the former Medicaid director in Kansas. I was Kansas's Medicaid Director from 2017 to 2019 'til just recently where I stepped down to go pursue my Ph.D. In health policy. First thing I'd like to do is congratulate you. Your Medicaid director is smarter than the Medicaid director in Kansas that just was because he has done some amazing work, I think, around the space. Just listening to his testimony, I was kind of blown away. The second thing I'd like to mention is this: I'm here to answer your questions. It's interesting. You know, listening to testimony, it's kind of like being in a party, and nobody knows who you work for, and they're talking about your employer and you're sitting in the back row, kind of just listening. But the other thing that I know from my time as Medicaid director is that working with my stakeholders, my legislators, my associations, we all have passion. We all have compassion and we all recognize the individuals on the Medicaid program are people that we serve and we want them to have that-- the absolute best experience possible. I've also found that usually when there's an issue, it is a communication issue. Rarely issues blow up that happen when there's good communication. So I just want to mention that, from my perspective, Also, you know-- I mean, I guess the way I looked at and approached the job-- I think most Medicaid directors do-- is we have two main responsibilities. First is, we serve the individuals in the program. And I always like to say individuals, because I know they don't like to be called members, they don't want to be called beneficiaries, they are individuals with individual needs. The second thing is, we have to be responsible stewards of taxpayer dollars. There was a comment made that there is no data on this subject. There is data on the subject. The director provided a long report. I broke down that entire report, unbeknownst to me that he was sending this to you in a PowerPoint, so you can look at it really easily with bullets. I find better that the pictures are more understandable sometimes than long narratives. So one of the things I'd like to start with is, let's look at page 6. And

this is from the Congressional Budget Office. This is not from a state, not from an individual, is-- what you'll see on the left-hand side is just average monthly spending per beneficiary on managed care versus fee-for-service in Medicaid by 20-- in 2012. I just create a little box here and underneath you to illustrate the percentage managed care, and then how much of the overall spend, you know, was accountable to them. So what you see is a nonelderly, nondisabled 70 percent are managed care while only 57 percent of the spend. But what I really want to call out is like elderly disabled beneficiaries. So over half in 2012 were in managed care. They only made up a third of the costs. So this is one of the things that CBO kind of identified as, yes, this is one place that managed care and long-term services supports can be effective is at controlling costs, not just through budget predictability, but also through better coordination of care. So in other words, the amount of money saved isn't because people aren't getting services, and I'll explain that with more data in here, but it's because the services are better coordinated, and there's not duplication, and that a person's needs that may manifest with the symptom is treated for the root cause versus what just is assumed without knowing the entire picture of the individual. So for example, we know somebody who is living in their home, who may have a physical issue that caused them to take a medication that makes them dizzy. Well, if I'm only managing their physical care, all I can do is treat them medically. If I'm managing their whole person care, I can say, oh, I know you're going to be dizzy. We're going to go assess your home and make sure that you have a safe way to get out the bathtub so you don't fall. So that's a nonmedical service that brings in that takes care of comprehensive care. One of the things that was mentioned is a good model. What is a good model for treating this population? Well, the one-throat-to-choke-model is the best model, is one MCO managing the entire health of an individual, both with their medical and nonmedical needs, because I have one throat to choke. I have one place to go when there's an issue, and one person to hold accountable for those problems. That's what I have seen from my experience in Kansas as a benefit. So we kind of hit on one point of, OK, it's-- could be less costly to move a population in managed, care that's fine. But what's more important is how is the quality of their care? Is it better? Is it worse? Let's look at, well, slide 11, let's start there. Slide 11 breaks out that entire report that the director gave you into really the goals of Managed Long-Term Care Services and Supports. First, rebalance Medicaid LTSS spending. Second, improve member experience, quality of life, health outcomes. Third, increase access to services, increase budget predictability. Let's focus on

number two. Let's talk about the individual that here we're trying to serve, so that would be slide number 15. So on slide number 15, and this is from NASUAD, an independent, nonpartisan body, set aside the goals: a seamless experience, improved quality of life, and reduced complexity. Have a single person that this person can talk to about their whole person needs. Incentives for managed care organizations: incentivize managed care organizations to say not only responsible for their medical treatment, but also their satisfaction scores. Are they being-- are they having a good experience? Do they know about the resources available to them? Next page talks about all the successes, successes in Minnesota, the successes in Kansas, successes in Florida. Things like outpatient ER visits being reduced, inpatient days being reduced, things like reduction in hospital stays, reduction in overall, fewer stays, more likely to receive HCBS services, more likely to receive dental services. This is all in that report that you guys have at your fingertips. I think I am overtime, aren't I?

HOWARD: I'm awfully sorry, the red light is on.

JON HAMDORF: I'm really sorry. I am verbose.

HOWARD: Let's see if the committee has any questions. [LAUGH]

JON HAMDORF: Sorry.

HOWARD: Are there questions? Senator Williams.

WILLIAMS: Thank you, Senator Howard, and thank you for being here. And you've heard that-- you've been sitting here and hearing the questions. And coming from Kansas, there's been criticism of managed care in the long-term space in Kansas. What could you tell us about that?

JON HAMDORF: Sure. The biggest problem in Kansas is eligibility, which actually does not even touch on the managed care organizations whatsoever. And let me explain. Our biggest problem with the nursing homes is that we can't determine people eligible soon enough, and the nursing facilities have to take on the expense of caring for somebody without getting paid at all. So one of the things that we did to do that, to kind of address that issue is we prepaid. So if a nursing facility said, you know, we've been waiting 60 days for you to determine this person eligible so you can start paying us. We want to have a prepayment. We want you to pay it back, pay us for the day of the application. And then once you determine that person eligible,

then we'll essentially have the MCO pay them, and then we recoup those dollars. So our biggest challenge in Kansas was not really around managed care or claims payment; it was around eligibility. And you can see that in all the newspaper articles in Kansas. You can see that me testifying in front of my oversight committee, saying that we had eligibility applications that were not processed for 60, 70, 80 days, and therefore all that burden went on the nursing facilities. But we put in a program in place to be able to pay them in a faster manner before eligibility was completely determined, which we had to do with all state funds based upon CMS regulation. But then once they were determined eligible, then the MCOs would pay them, and then they would pay us back essentially that loan, that temporary loan, to make sure that they could stay solvent over that short period of time.

WILLIAMS: Thank you.

JON HAMDORF: Certainly. Do you mind if I say one more example?

WILLIAMS: Go ahead.

JON HAMDORF: Thank you, sir. This is a challenge that does relate to claims, a challenge that I had serving my autistic children. We had a provider who had a lot of trouble getting claims in. Now they were using paper claims, they were mailing those in, but the reason why they were having so many challenges is because the individuals they were serving were-- had private insurance and Medicaid. And as you've heard from the director and others, Medicaid is a payer of last resort. That has to be filed with private insurance first before our MCOs even got it, to be able to pay the remaining balance on that, those claims. Sometimes that took 45 days before our guys even hit it. So one of the things I did in that situation is, besides sit down with all these providers and discuss and kind of educate back and forth, is we decided to take some action. I assigned an individual from each one of the MCOs to meet with them weekly, and they did for three months. I met with legislators in the morning and the evenings to talk about how we're trying to resolve this. At the end of the day, we found out that they were using an out-of-state biller in Florida who didn't know our billing practices. Essentially, long story short, we were able to transform their business to be able to want to be successful and get their claims paid in a timely manner. So while it seemed like there was a breakdown in technology, it was a breakdown in understanding and process, a breakdown in communication if you will. And that's honestly what I experienced as a Medicaid director in two years. Usually most

of these issues came down to just a breakdown in communication and breakdown of understanding.

WILLIAMS: Thank you.

JON HAMDORF: Certainly.

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

JON HAMDORF: Thank you.

HOWARD: Our next opponent testifier for LB468. Seeing none, is there anyone wishing to testify in a neutral capacity? Seeing none, Senator Walz, you're welcome to close.

WALZ: All right. Well, thank you for sitting through again today and the patience. I just want to make sure that you understand-- I think that we need to be very, very, very careful here. There are so many questions on this issue. We have questions on the processing and questions about claims. They may be being processed quickly, but they are not processed correctly, and I think we need to get some more information on that. We have questions about Kansas and other states, and I think that we need to remember to keep in mind that the Kansas's point of view, the Kansas example or what we've heard, is the point of view of the state Medicaid director and not the point of view of the providers. So we need to ask questions to, maybe, the providers in those other states. We have questions about-- I have questions about how the performance rating system will affect the already struggling facilities, and what supports we will be providing those facilities so they don't close. I even have questions on the fiscal note for sure. We definitely need more specifics in the language to determine what is being evaluated. I believe that we can reduce the fiscal note. I don't think it's a $600,000 fiscal note. And we have heard that, you know, we want to be fiscally responsible for our taxpayers and I don't think that a $600,000 study is being fiscally responsible to taxpayers. So again, I think we all need to be very careful here. These providers are saying that there's a problem. We have MCOS and DHS saying that there's no issue here at all. And we clearly have an overwhelming disagreement on that. We have already seen a significant amount of facilities going into receivership in rural areas. It will not only be a drain on their economy, but the people who live there will most likely be sent to facilities that are a lot farther away from their home and their families. This will undoubtedly decrease the amount of

times that they'll be able to spend time with their family. If we're worried about the cost for replacing the MMIS or the maintenance of the MMIS system, which I'm also getting conflicting reports about, I would ask that you consider the cost of facilities closing because they're not receiving the proper payment for services. In what world is it acceptable for anyone delivering a product to not get paid in full? I wouldn't accept it, and I know that many of you wouldn't either. Heritage Health is getting a lump sum payment, either way. It is apparent that it is not being reciprocated to the providers the way it should be. With that I would like to thank you again for your patience and for your listening and considering. If you have any questions, I'll try to answer.

HOWARD: Further questions? Seeing none, thank you, Senator Walz. This will close the hearing for LB468 and the committee will take a brief break. We will reconvene at 4:00 p.m.

[BREAK]

HOWARD: Welcome back to the Health and Human Services Committee. This will open the hearing for LB571. Welcome again, Senator Walz.

WALZ: Again, thank you, Chairwoman Howard. My name is Lynne Walz, L-y-n-n-e W-a-l-z, and I'm here to introduce LB571. LB571 requires the department to establish and maintain-- and maintain a database of grievance review procedures that are provided to an applicant of an assisted living facility, as provided under subdivision (3)(d) of Section 71-5905, and make it available upon request to the Deputy Public Counsel. Currently each of the-- each assisted living facility must establish and implement a process for addressing all grievances received from residents, employees, and others, including but not limited to a procedure for submission, documentation of efforts to address the grievances, and the telephone number and address of the department for those who wish to lodge complaints. Last year I introduced LR296, which established a committee to investigate mental health assisted living facilities. One of the things that we noticed during our investigation is that there is a wide variance in policies on these grievance review procedures. This bill would provide a database to be made available to the Public Counsel and would expedite our ability to review these procedures and help identify issues and inconsistencies with these procedures. With this bill, the department will be required to establish and maintain a database of the grievance review procedures to be made available to the Ombudsman's Office. This will allow us to examine these procedures for any discrepancies and

determine if there are any changes that need to be made. Thank you for your time. I'll make this quick and I'll try to answer any questions for you. If I cannot, I know that Jerall behind me will be following and he will be able to answer your questions.

HOWARD: Are there any questions? Seeing none, thank you, Senator Walz.

WALZ: Thank you.

HOWARD: Our first proponent testifier for LB571. Good afternoon.

JERALL MORELAND: Good afternoon, Senator Howard, members of the Health and Human Services Committee. I am Deputy Ombudsman for Institutions Jerall Moreland, J-e-r-a-l-l, Moreland, M-o-r-e-l-a-n-d. I am testifying in support of LB571. I also want to thank Senator Walz for inviting us to make remarks concerning this bill, as it would also continue the process of creating a Nexus from the Ombudsman's Office to assisted living facilities, but it will also shed light on the ALF system. First, as Senator Walz has shared with you, what the LR296 and this office observed was not only extremely disappointing but highly inhumane. Due to these findings, we are of the opinion that increased oversight should be considered in this area to effectuate a more robust view of the problems associated with ALF. Additionally, the Ombudsman's Office is very familiar with different types of grievance systems. Although I mention different systems, we find that effective systems really are not that different from each other, but instead have similar elements in the process to retain fairness and integrity. Also during the LR296 site visits which I participated in, I was struck with the amount of residents I observed and spoke with who talked about how-- about the many complaints they brought up to the attention of their caregiver without response or redress. Let me note this perspective is from the resident and underscores a need for further insight to what is going on in this area. Finally in our view, the bill simply requires the department to place a grievance from ALF into one database that allows access by the Ombudsman's Office at one central portal. Placing all grievances in one portal will allow efficiency in analyzing data. So I'll end with we have the ability right now and authority to review these grievances. However, they are on an individual basis. What we're asking for here is for the department to take those grievances that they review as part of their compliance surveys, put those in one database to allow us to analyze the data. Thank you. I am open for any questions.

HOWARD: Thank you. Senator Arch.

ARCH: Just so I understand, this isn't-- this isn't asking the assisted living facilities to report every patient grievance, but rather those grievances that the department investigates to assemble into one database.

JERALL MORELAND: No. Senator, what this is asking, right now ALFs are required to put in place a grievance system that the residents can participate in.

ARCH: Yes.

JERALL MORELAND: A way to address--

ARCH: At that facility.

JERALL MORELAND: Yes.

ARCH: Right.

JERALL MORELAND: The Department of Public Health's licensure regulation, they do compliance checks.

ARCH: Uh-huh.

JERALL MORELAND: And one of the areas they check would be the grievance system that's in place. One of the things we found during our visits during LB296 is that apparently administrators change-- policy change. So what we're asking is when they do their compliance or when they decide to submit a license to an ALF, to obtain a copy of that grievance system that has been put in place by the ALF and start a one portal database.

ARCH: OK. So again it's not the complaints, it's the procedure for dealing with a complaint.

JERALL MORELAND: Yes. Yes.

ARCH: Thank you.

HOWARD: Senator Hansen.

B. HANSEN: Do you expect each one of these ALFs-- that it will cost them money to do this?

JERALL MORELAND: No. And the reason why, Senator, is, I'm not sure if the burden is placed on the ALF with what we are looking at. Currently the ALF already has to put in place a grievance system.

B. HANSEN: OK.

JERALL MORELAND: What we're asking the department to do is obtain a copy of that grievance system, bring it back to their site and put it in a computer database.

B. HANSEN: OK. Thanks.

HOWARD: Senator Cavanaugh.

CAVANAUGH: Thank you, Senator Howard. Thank you for being here today. I am impressed by the small fiscal note of $16,000. I have a fair amount of familiarity and background with databases, so I'm assuming that this doesn't require a complicated or new purchase. This database could be something like an Access table or Excel. Is that correct?

JERALL MORELAND: Senator, I have to admit you just surprised me.

CAVANAUGH: Oh, I'm sorry.

JERALL MORELAND: I was not aware of the fiscal note on that.

CAVANAUGH: This was not a gotcha question [LAUGHTER].

JERALL MORELAND: That missed-- I missed that apparently. No. I think currently we do know they have the ability to go out and do compliance checks.

CAVANAUGH: Uh-huh.

JERALL MORELAND: We know they have that ability to obtain a copy of those grievance systems. What we're asking them to do is download that information. So if it's at $16,000, I believe that I'd be surprised and would want to look at details on why it would be at that amount.

CAVANAUGH: Oh that's really low--

JERALL MORELAND: Yeah.

CAVANAUGH: --is what I'm saying. So I'm assuming that they're-- this bill doesn't require the state to build a new database so much as just

giving you the information and we're calling that a database, like give you a spreadsheet or give you an Access--

JERALL MORELAND: I guess in my view, Senator, I think what we're looking at is making a copy of a documentation that has been provided--

CAVANAUGH: Yes.

JERALL MORELAND: --to the department, scanning that into a database system.

CAVANAUGH: OK.

JERALL MORELAND: [INAUDIBLE].

CAVANAUGH: Thank you.

JERALL MORELAND: Yes.

HOWARD: Other questions? Mr. Moreland, I have several new members of this committee. And so when you talk about what the LR296 committee and your office has observed--

JERALL MORELAND: Uh-huh.

HOWARD: --as inhumane, could you just give us an idea of what you mean by that?

JERALL MORELAND: Yes. So as LR296, was created in part due to Palmer.

HOWARD: Tell us a little bit about Palmer--

JERALL MORELAND: --death facility. There was a death in the Palmer facility, created in part due to the receiverships that happened over the last period of time and just basic complaints of environmental issues at ALFs. We as Ombudsman's Office participated in the LR296 committee site visits. During those site visits, we ran into conditions such as bedbugs in many of the facilities-- such as residents complaining about other residents' assaults-- were running into conditions of flies in living locations, very unclean, unkempt situations, that we believe are public safety issues. And so I would preface that with although we've run into those conditions, there are many facilities that we believe operated well and they do operate well, but unfortunately we do have those who do not. And so we think

that there needs to be a further examination into assisted livings in general. And so that's how-- that's what brought our interests, the Ombudsman's Office, into this, is basically on the conditions of those facilities. And I think the providers have a story as well because part of their story is a lack of resources to really provide the quality type of service that they would want to provide. But I think that requires more digging into the issue and this is what part of this bill is supposed to do.

HOWARD: Thank you.

JERALL MORELAND: Sure.

HOWARD: Any other questions? Senator Arch.

ARCH: OK so what do you want to accomplish by simply seeing the procedure?

JERALL MORELAND: Ombudsman's Office, we have always-- we have a model of learning a system by the individual cases. So we want to see individual cases, we want to see individual ways-- processes are supposed to work. And so in particular this particular bill here, required-- gives us, gives us the ability to look at what kind of grievance systems are out there. It allows us to be able to respond to questions as far as, is my complaint being accepted as valid? Am I getting the redress on my complaint? What kind of trends could it possibly give us? Are there certain elements in grievance systems that the department should require to make sure that they're timely, so if I make a complaint today, am I hearing something three months or four months later? And so there's certain elements that we believe should be part of a grievance system. So our goal is to review those grievance systems, and because we do know there are changes in administrators, there will be updates that we'll need to continue to look at.

HOWARD: Senator Cavanaugh.

CAVANAUGH: Thank you. And I apologize if this is down the wrong road. As Senator Howard said, I'm new [LAUGHTER]. So when you do, these site visits--

JERALL MORELAND: Yes.

CAVANAUGH: Are there, are you-- are you confined to report or follow up on only certain things, even if you see additional? So if you're

there to inspect that there's bedbugs and you find that there's assaults happening-- are you confined to take action-- from taking action?

JERALL MORELAND: Let me clarify. There are bills in place, Senator, right now to expand our jurisdiction. We have jurisdiction based on our authority to investigate administrative agencies, so we have jurisdiction through licensure and public health. Our jurisdiction does not allow us to go directly to a list-- assisted living facility at this time. There are bills that have been heard in other committees that are looking at that now. And so when I started my testimony, I mentioned that this is one of the bills that's going to create that nexus for us. During our site visits and during visits that we have had by invite to these places, we have been able to put eyes on the conditions of these places.

CAVANAUGH: But you-- are you allowed to take action based on that, if it's outside of the scope of what you're there for?

JERALL MORELAND: In terms of--?

CAVANAUGH: I guess I'm not really sure. If you're there on a site visit for a specific reason and you witness something outside of that scope, are you able to then do follow up of what you witnessed outside of the scope?

JERALL MORELAND: For example, several visits we had away from-- apart from the LR296 committee--

CAVANAUGH: Uh-huh.

JERALL MORELAND: --we went out to the site with the surveyors.

CAVANAUGH: Uh-huh.

JERALL MORELAND: At that time we observed several things, and we brought those to the attention of the surveyors. We followed up in-- those areas were followed up by the surveyor and so, yes, we have that ability.

CAVANAUGH: OK. Thank you.

HOWARD: Correct me if I'm wrong, but that's not quite the same for an inspector who is coming in from the Department of Public Health. You

are able to look at more than just what's in the grievance, but an inspector is maybe more limited?

JERALL MORELAND: So my response to Senator here was with the inspector. If we go right now, we don't have direct jurisdiction to go into a ALF by ourselves. That is being handled and-- and being determined in another committee right now. If we run into an issue such as condition, complaint, we have the ability to go to Licensure Regulation and see what they have done with that particular investigation, or to ask that we go out with them on the site visit.

HOWARD: Thank you. Any questions? Seeing none, thank you for your-- thank you for your testimony today.

JERALL MORELAND: Thank you.

HOWARD: Our next proponent testifier for LB571. Anyone else wishing to testify in support? We do have one letter from Mary Sullivan from the National Association of Social Workers, the Nebraska Chapter. Is there anyone wishing to testify in opposition to LB571? Is there anyone wishing to testify in a neutral capacity?

DARRELL KLEIN: Good afternoon, Chairman Howard and members of the Health and Human Services committee. I am Darrell Klein, D-a-r-r-e-l-l K-l-e-i-n, and I'm a deputy director for the Division of Public Health for the Department of Health and Human Services. And I'm here to testify in a neutral capacity. And in interests of dispelling any suspense that might have, I'm going to jump to the end of my prepared testimony which is-- the department met with the senator's office to express our concerns. And as a result of the meeting, we're suggesting that references to a database be removed, as the department could obtain the grievance procedure provided to applicants for admission to each assisted living facility from the assisted living facilities and make these available to the Deputy Public Counsel for Institutions, possibly by posting these on our Web site. So going back to the rest of it, the bill as written requires the creation of a database of grievance procedures for assisted living facilities or ALFs that are provided when the applicant for admission to this facility is provided by the assisted living facility. And the bill provides that the database must be available to the Deputy Public Counsel for Institutions. The databases that are currently used by the Licensure unit of the department to maintain information on assisted living facilities are the ASPEN Central Office and the ASPEN Complaint Tracking System. I think you've heard the testimony about this in

other contexts. And these are part of federal databases better used to maintain data related to federally certified health care facilities and services. Now ALFs are not federally certified facilities; they are state licensed only. However, the federal database is used by Nebraska with the permission of CMS to house data related to all health care facilities and services regulated by the department. And that's actually a money saver is what it comes down to. And the current system we're using is outdated and it's not easily adaptable. It is scheduled to be replaced beginning in 2020. But the Centers for Medicaid and-- Medicare and Medicaid Services do restrict access to these databases to persons within the department. So a new and separate database would have to be created to house the grievance procedures of ALFs in order to be accessible by the Deputy Public Counsel for Institutions. There would be additional costs to create the database as well as a duplication of effort, requiring staff to enter information on ALFs into two separate systems. ALFs are not currently required to provide grievance procedures to the department. These procedures are reviewed by the Licensure Unit surveyors when a facility is inspected. And grievances-- the grievances themselves are considered to be an ALF's internal process to address the concerns of its residents. It would be challenging to maintain a database of grievance procedures because ALFs update their procedures and policies annually at a minimum. And we inspect them at a minimum of once every five years. So along with the system, regulations would need to be created to require the ALFs to provide updates of their grievance procedures on an ongoing basis to ensure the information in the database is accurate. However, we think if the bill was changed to not make a reference to a database but to still maintain the requirement that the department have these procedures available, that there would be other less duplicative and less costly ways to achieve the same end results. And with that, I'll answer any questions you may have.

HOWARD: Senator Cavanaugh.

CAVANAUGH: Thank you. Thank you for being here.

DARRELL KLEIN: Uh-huh.

CAVANAUGH: So you said that part of the obstacle is that they update annually their procedures. How do you currently receive their procedures? Do they email it to you? Do they send you it electronically or by snail mail?

DARRELL KLEIN: Currently the ALFs have to give their procedures on how they handle grievances to any applicant for admission, and they have to maintain that in their files. So currently the way we would see their procedures would be when we went out on an inspection, either routine or complaint.

CAVANAUGH: So you don't keep a record of it--?

DARRELL KLEIN: We don't. We don't have a centralized repository of this information currently.

CAVANAUGH: OK, so you just go into the office and look at it--

DARRELL KLEIN: Among other records.

CAVANAUGH: --and then it stays there.

DARRELL KLEIN: Yeah. The regulations themselves-- and I'll be testifying to this a little bit later-- the regulations set a number of requirements on the assisted living facilities aimed at keeping the residents safe. And among those are they have to have a procedure on how they're going to handle and respond to grievances. So they're not mandated to have any specific language. They just have to show the resident. That-- that would there'd be a personal choice to them. If you knew what their procedures were compared to another facility, you might base your choice on that; but currently you get that information when you go to the individual assisted living.

CAVANAUGH: Sure. But the Department of Health and Human Services does not keep a record of what those procedures are. I know that they don't mandate what they are, they mandate that they have them.

DARRELL KLEIN: Yeah. Yeah.

CAVANAUGH: Is there a reason that if you don't walk out of the facility with a copy-- I'm sorry, I'm asking all questions.

DARRELL KLEIN: If there was a complaint or if we discovered when we were out on a routine survey that they didn't have-- the way an assisted living facility right now would fail the standard is if they didn't have the procedures, so that would be noted. That would be a violation of the regulations and would be grounds for discipline. But right now if they have a procedure, we verify that they do have it and they gave it to the residents. So we probably don't carry them out

because if they did have one, they've met the standard, if that makes any sense.

CAVANAUGH: Yes.

DARRELL KLEIN: Yeah. So right now, no, we don't. We don't really have these in our possession. We do look and check that the facilities do.

CAVANAUGH: Thank you.

DARRELL KLEIN: Uh-huh.

HOWARD: Do you need any more great insight, maybe how long it should take you to gather these?

DARRELL KLEIN: Well, my guess would be, if there's-- if the statute mandates that we would put the information out to the facilities, we would tell them that it's now a requirement. It would probably be helpful to achieve everybody's purposes if the statute required them to keep it current and up to date. And then I am not a web designer, but I assume we would take these procedures and scan them in. And I don't know whether that-- I don't know the details but I imagine you create a viewable version of these documents. I don't believe the procedures in and of themselves would implicate any privacy problems. So the procedure itself could probably just be posted up on our Web site--

HOWARD: OK.

DARRELL KLEIN: --and you'd be able to link to it. So if that is the approach that we would use, then this information would not be restricted to the Public Counsel on institutions. It would be available.

HOWARD: Senator Hansen.

B. HANSEN: Thank you for coming.

DARRELL KLEIN: Thank you.

B. HANSEN: And I just have a couple of quick questions. How often do the licensure unit surveyors inspect a facility? Is it once a year?

DARRELL KLEIN: I think they're required to. I don't have the exact details in front of me. They select a percentage and no facility can

go longer than five years without having been inspected. So that is the outside. I don't have the statistics with me today as to how often-- what periodicity is actually achieved. The law requires that nobody can go longer than five years without being inspected. We aim to inspect 25 percent of them each year.

B. HANSEN: OK. And do you see some growing trend in grievances on why the Ombudsman's Office would need to have [INAUDIBLE] database to collect grievances to review?

DARRELL KLEIN: Personally, I do not. I've been in my position a grand total of about seven and a half weeks. I am over the Licensure Unit; and as an attorney, I was one of the attorneys who took actions against health care facilities. And in that capacity, my answer is no. I don't see a [INAUDIBLE], a trend.

B. HANSEN: OK.

DARRELL KLEIN: And the unfortunate circumstances that happened at Palmer, that was not an assisted living facility.

HOWARD: What was Palmer?

DARRELL KLEIN: I think it was a mental health center. I was not involved but I believe it was licensed in a different category.

HOWARD: Sorry about that.

B. HANSEN: This one?

HOWARD: Any other questions? Do you want to tell us what happened in Palmer?

DARRELL KLEIN: You know, I don't lack-- I don't have the background, I wasn't involved in the LR study. There was a death at the facility and that is, you know-- I mean to say, something like that is the opposite of what we aim for. It is a gross understatement. That triggered a look at the conditions and what may have led to that. At the same time, we've been having some, and I think this was testified to, a growing number of facilities licensed in a number of different categories have been undergoing a little bit of distress. So it kind of, you know-- increased the look of it, that everyone's taking at, the issues. So yeah, I lack personal knowledge to give you a really good answer, Senator. Sorry.

HOWARD: Thank you, Mr. Klein. Any other questions? Seeing none, thank you for your--

DARRELL KLEIN: Thank you.

HOWARD: --testimony today. Our next neutral testifier for LB571. Seeing none, Senator Walz, you are welcome to close. She waives closing. [LAUGHTER] OK. All right. This will open the hearing for LB597, Senator Walz's bill to require reporting of incidents and development of policies for assisted living facilities. Welcome, Senator Walz.

WALZ: Good afternoon again. For the record, my name is Lynne Walz, L-y-n-n-e W-a-l-z, and I am here to introduce LB597. LB597 is a bill to strengthen the reporting language around assisted living facilities to require them to report any incidents involving: violence between residents; violence between a resident and a staff member; any incident involving an injury to a resident, an employee of the facility which requires urgent and immediate medical treatment and restricts the person's usual activities; and any incident of bedbugs. I have an amendment that changes the division these facilities are required to report to from the Division of Behavioral Health to the Division of Public Health. It also changes the word "owner" to "administrator" on page 2, line 12. This bill came to me through conversations with the Ombudsman's Office over the LR296 committee. If you are unfamiliar with this committee, it was a special committee known as the State-Licensed Care Facilities Investigative Committee. It was designed to provide oversight over state-licensed care facilities in Nebraska. Again, as we talked about and I'm going to try to get some more specific information about Palmer for you on my closing, but this was an investigative committee. And through our investigations, as Mr. Moreland pointed out, we encountered some really horrible living conditions. It became apparent right away that these problems were often not properly reported, and we feel it's just imperative that we expand our reporting requirements. This is an effort to try and strengthen the language in the reporting requirements to hopefully increase the department's oversight in this matter or on this matter. I want to thank you for your time and I'll be happy to try and answer any questions that you have.

HOWARD: Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman Howard. Thank you, Senator Walz. I'm still reeling a little bit from Director Klein's comments that there's

no copies that sit with the department of the procedures. And so I appreciate this requiring of the reporting of incidences, but I guess I'd like to ask, how did you come to this?

WALZ: How did we come to this?

CAVANAUGH: No, you. How did you come to this sort of bringing this forward? How did this come to your attention?

WALZ: Uh-huh. Initially it came from an incident that happened at the Palmer House where a-- I'll just do the best I can to try. I don't have the specifics, but I'm just going to do the best I can. There was a client, an individual who lived at the Palmer House and complained about diarrhea and throwing up, and they complained for a few days about this. Finally, there were some people from the community who, I believe, called the department asking them to go and do an investigation because this person was sick. The department came out and did an investigation-- Oh, no, no, no, I'm sorry. The department came out and did an investigation and went back to-- went back without-- any recommendations. The report that they made sat on somebody's desk. In the meantime the veteran, a vet-- the individual who lived at Palmer House, died. And that's kind of why we decided that we just need to increase oversight on what's going on in facilities. I apologize. I don't have the specifics. I hate to--

CAVANAUGH: Oh, no. I just. I mean, this--

WALZ: --give you any false information.

CAVANAUGH: I'm sorry because I haven't been here as much the last two days for other hearings, and I'm shocked by the lack of, I guess, paper trail that we seem to currently have in place for this. So I appreciate what you're trying to do here and I just wanted to hear a little bit more from your personal side of it. So thank you.

WALZ: Sure.

HOWARD: Any other questions? Seeing none-- Oh, Senator Williams.

WILLIAMS: I do, thank-- I'm sorry to be late on the draw there, Senator Howard. Senator Walz, as I'm looking at this, and correct me if I am wrong, and I'm getting part of this from the fiscal note, this requires reporting, but there is no further requirement on the part of HHS or with your amendment, the Division of Public Health to do any

investigation or follow up. So what are we accomplishing by only reporting?

WALZ: I am going to let Jerall speak on that.

WILLIAMS: OK.

WALZ: OK.

WILLIAMS: I would also add-- and, Mr. Moreland, if-- when you're hearing me, how do we determine what is the definition of violence between residents and violence between residents and employees? You know, is that in the eye of the beholder or-- you know what I'm talking about, Jerall.

WALZ: Uh-huh.

WILLIAMS: Thank you.

HOWARD: Why only bedbugs? Why not like, mice and roaches and that sort of thing? Or is it just because those are the things that are happening right now?

WALZ: That, Chairwoman Howard, is a very good question. And actually that's something that we're going to have some conversations about.

HOWARD: Perfect. All right, any other questions? Senator Hansen.

B. HANSEN: Just one quick. Thank you. I'm just-- maybe I'm surprised that these weren't being reported already. Is there-- you know why? Violence, this violence. Like some of these aren't reported.

WALZ: They should be reported already.

B. HANSEN: OK.

WALZ: Yes.

B. HANSEN: OK. This-- I was wondering.

WALZ: Yeah.

HOWARD: All right. Any other questions? Seeing none, thank you, Senator Walz. Our first proponent testifier for LB597.

JERALL MORELAND: Good afternoon again, Senator Howard, other members of the committee. I prepared this testimony and it's going around now. I think what I'll do is jump right into some of the questions, if that's OK. In regards to the question about the frequency of inspections, it's my understanding that there should be a full inspection, which what we've learned usually could take anywhere from two to four days every five years. Every assisted living facility has to go within five years. That's one type of inspection that the surveyors would do. The other type of inspection is more targeted, more focused, and based on maybe a complaint that has come in through either the hotline or so forth. That, I think, goes back to your question, Senator Howard, as far as-- or Senator Cavanaugh. Can you extend that inspection? The answer is in between. When they-- if there is a full inspection, they look at everything, every-- all compliance issues. If it is a partial or focused inspection, they are looking at essentially the complaint that brought them to the facility. If they find something that falls within, I think, right as far as life or safety, then they can extend it. But they couldn't or typically come in on an abuse case, and then look at the kitchen and-- as an analogy. So hopefully I addressed the question on that piece. One of the things the committee found is that out of the full inspections, there were zero last year. No full inspections were done last year on assisted living facilities, which means we don't have coverage on many of those facilities. Why, we ask. What we have learned is that there are two surveyors to complete approximately 236-- inspections on approximately 236 facilities. So you take your full compliance inspections that you need to do, and then take an increase in individual complaints, either coming from the residents, families of residents, guardians of residents, and we're seeing that a lot of their time is spent on the more focused complaint, not on the overall inspections that the state is expecting. In regards to Palmer, I'll kind of describe it. It's been a while so I don't want to-- it's been a while since I looked at it, but I'll be more than happy to come back and share with each member some of the details again. But if I recall, what we had is numerous complaints being made to the agency on conditions, on issues such as drug paraphernalia, such as assaults, et cetera. And there was a belief that there was no action being taken by the agency. And so law enforcement, if I recall, was also making these complaints. There were several meetings that were scheduled between the community and the agency. This probably happened around about four or five months later. These conditions continued to be reported, certain type of conditions continued to be reported. And then we have the death. And so that's what led to, in part, the creation of the LR296. I know that

I think they just passed some additional information out on you. Like I say, I'll be more than happy to provide additional information to you in writing as well. In closing, we had-- we have an issue. There is an issue with assisted living facilities. What does that issue look like? I don't know. And so the purpose, Senator Williams, I guess to go back to what are we trying to do, we're trying to-- as I mentioned, one of the modes, the way we operate is, let's look at what-- how things should work, what is working. And many times, we-- those-- that information comes to us on an individual basis, and then hopefully make some determinations on the systems issue. The purpose of the reporting is to increase those things, and so there is already expectation that caregivers, staff, employees of caregivers report if they see suspected negligence or abuse. The key there, to me, in one sense is employee of the case-- of the case giver and case giver. We know that we have tremendous turnover with employees, so we know also that we have some turnover with administrators. So what we're trying to do in some senses is close that gap and make sure that if an employee sees something, that the case giver or the administrator also is aware of that, sees it, and reports that to the appropriate entities, which would be either law enforcement or to DHS directly. Once they get that report, then those steps should-- any investigative steps should move forward. I think one of the reasons-- there was a-- one of the reasons to land on violence is the definition. In other words, we had many conversations with this individual on a resident who hit another resident. That's the in between line of reporting. So I'm not sure if that is covered under the current reporting requirements. I can share with you that just the last, just today I was told about two potential sexual assaults in assisted living facilities that may have happened within the last 30 days. So we have an issue with not only the caseworker or a case giver and the resident, but also resident-resident. We have a lot of residents who can be taken advantage of. We also are aware that many-- we're seeing that some of the residents have some type of mental health needs. And so it's a vulnerable population. And so I'll go back and probably end with this piece here. And that is the intent of the Legislature was to recognize the need for an investigation and provision of services to certain persons who are substantially impaired or unable to protect themselves from abuse, neglect, or exploitation, as often such persons cannot find others able or willing to render assistance. This comes out of the Adult Protective Service Act. I am open for any questions. Thank you.

HOWARD: Thank you. Senator Cavanaugh.

CAVANAUGH: Thank you. Thank you so much for your words today and for the work that you are doing. So if an abuse complaint is made, they cannot inspect the kitchen, is what you said just a few moments ago. So if somebody-- if one of these two surveyors comes in for an abuse complaint and they walk through the kitchen and there's feces in the kitchen-- mice feces in the kitchen, they can't do anything about that?

JERALL MORELAND: I hesitate-- they can't do anything about it. It depends on if they determine that that falls under safety of the resident. And so not have that language--

CAVANAUGH: Of the resident that they are there to-- for the abuse complaint. So they really can't-- they have to find a loophole to do something, and they can't just-- there's feces in the kitchen. This falls under the safety of all the residents in this building, we are going to do something.

JERALL MORELAND: It's my understanding that that's probably-- that decision is probably going to be made at the discretion of the surveyor.

CAVANAUGH: OK.

JERALL MORELAND: But typically the guideline is, if there is a focused reason to go to the facility

CAVANAUGH: Uh-huh.

JERALL MORELAND: --and that's what they're going to look at, unless it falls under that safety piece and I can't-- I don't recall the language.

CAVANAUGH: That same surveyor or one of the two surveyors are the exact same individuals that work for the state that go in, in theory if they have the capacity, and do the full inspections. It's just those two people?

JERALL MORELAND: In-- yes, in general, yes.

CAVANAUGH: OK.

JERALL MORELAND: Yes.

CAVANAUGH: So we have two people who are supposed to do full inspections of these facilities every five years, just so, you know, whatever, throughout the year. But they're not able to do the full inspections because they're busy doing the complaints. But they can't do anything beyond the immediate complaint when they're in the spaces that are clearly in violation if they were to do a full inspection.

JERALL MORELAND: I think that's the materials, that's the data, and that's what we have seen today, yes.

CAVANAUGH: OK. Thank you.

JERALL MORELAND: Sure.

HOWARD: Thank you. Any other questions? Seeing none, thank you for your time today.

JERALL MORELAND: Thank you.

HOWARD: Our next proponent testifier for LB597.

EDISON McDONALD: Hello, committee, my name is Edison McDonald, E-d-i-s-o-n M-c-D-o-n-a-l-d, and I'm representing The ARC of Nebraska. I didn't plan on testifying because it's been a long day and I didn't want to make you all wait any longer. But a few things that I just wanted to point back to. Number one, this isn't just about one facility. Also, previous facilities that have been under investigation include Coolidge, Pawnee, Parkview and Hotel Pawnee in particular. I'll talk about, and I think is a good example of why this is necessary is there is a petition in town with 470 signers asking for an investigation. I think, you know, it was very evident and clear to the community that there were issues there. However, ultimately there was no real investigation started and it took a long time. And I think that expediting this process and giving them further access to the Ombudsman's Office to be able to dig into this is really important. I think, you know, really digging back into the LR296 report, there's some great information in there, and I think ultimately this is all about helping to ensure that we ensure the safety of our citizens and also avoid potential litigation. I think the 12 visits that the committee did and the work that they did really led them to some results that I think were shocking for many of them. And I think the heart of the report in particular I just wanted to draw attention to

says, these facilities as currently operated and funded are not well suited to serving these people. And I think that that really just needs to be remembered, that these are not well-suited facilities. It's not just one case. There are multiple cases. There are many instances and I think that we really need to further and make sure to pass legislation like this that allows for further investigation and allows for further data collection to ensure that we can really understand the trends-- understand some of the issues that are happening here. Thank you.

HOWARD: Thank you. Are there questions? Seeing none, thank you for your testimony today. Our next proponent testifier? Seeing none, is there anyone wishing to testify in opposition? Oh, my goodness. There's a letter for the record for the proponents. Thank you, Sherry. One letter for the record. Mary Sullivan from the National Association of Social Workers, Nebraska Chapter. All right. Welcome. Thank you.

HEATH BODDY: Chairwoman Howard, 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 today I'm here on behalf of our 232 not-for-profit and proprietary assisted living members across the state. And I'm here to speak in opposition to LB597 as it's written. And I'd just like to talk a little bit more about this dialogue and this discussion. So what happened that created LR296. Senator Walz has rightly had a big interest in trying to create some highlights on this. I want to be clear that this bill, our opposition to this bill is not to try to stand in the way of what Senator Walz is trying to accomplish. We've had a good discussion with Senator Walz and Mr. Moreland. But what we're doing here is we're casting a net over every assisted living in the state. And what we're talking about in these examples is 7 percent of those assisted living. If we back up some years we took about three extra levels of care, three total levels of care: room and board, domiciliary, and residential care. And we called it assisted living. When we did that, we took providers that primarily care for people with mental health and lumped them into this big thing that we're calling assisted living. So all of these stories today are not primarily who were-- who is an assisted living provider in the state. It's about 7 percent of the providers in the state. So our opposition is not again, not to stand in the way of what's trying to be accomplished, but yet, let's get clear about who we're trying to accomplish it with. By adding these extra requirements on providers who already have significant reporting requirements, we talked about the things with the individuals in those places. The Adult Protective

Services Act already requires every employee in assisted living that has reason to suspect abuse, neglect, or misappropriation to report it. There's already an ombudsman program in-- in the long-term care space that has the opportunity to go in and investigate. When 73 percent of our assisted livings in the state of Nebraska participate in the Medicaid waiver program, there's a caseworker that's in that building every month that has-- that oversees what happens and not to speak of the licensure that we've discussed. A couple of points of clarification. I'm a-- I'm an assisted living provider by background before I came to the association. If you have a licensure surveyor in your facility and they see rat droppings or whatever the examples were before, they'll absolutely take a look at it. A surveyor has the purview to make sure that they're in compliance with the regulations for that level of licensure. In assisted living, their kitchen would absolutely have to be in compliance with that and the surveyor could take a look. Again, I just want to be clear, what happened in Palmer is awful and you'll never find me at this table trying to justify behavior like that, providers like that. But what we're doing here is we are casting a very wide net over what really is a very narrow part of this licensure level of providers. So our suggestion would be, and we've had discussions with Senator Walz, there may be an opportunity to try to channel the scope of this bill to make sure it's affecting what they're trying to accomplish. And that's something that could help remove our opposition. So Senators, with that, I'm happy to answer any questions. But thank you for having me here. Thank you, Senator Walz, for bringing the bill but having good discussion with us as we've gone along.

HOWARD: Are there questions? Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman. Thank you, Mr. Boddy, for being here. And maybe you can provide some clarification. I'm a little confused still as to what your opposition is in just re-reading over what this bill is requiring of assisted living facilities. I guess I don't understand what the barrier is for-- basically, what I'm hearing from you is there are 7 percent bad actors or 7 percent is who we're talking about. So we're essentially punishing 93 percent, but I'm not sure how we could be punishing people if these things aren't happening. So--

HEATH BODDY: Well, today's sort of been an evolution. I'm sorry, Senator.

CAVANAUGH: Well, so-- if so-- if these things are happening, then they should be reported no matter what the facility is. So could you, I guess, speak to that?

HEATH BODDY: Sure. Excuse me for--

CAVANAUGH: No, that's OK.

HEATH BODDY: Today has been a little bit of an evolution. I wasn't aware of the amendment, so that's evolved this a bit. This started out as reporting to a whole another entity, of which assisted living providers already report to four. My point about the 7 percent is not the bad actors 7 percent. It is really a group of providers that are caring for a different type of Nebraskan, a different level of needs Nebraskan.

CAVANAUGH: Sure.

HEATH BODDY: And so in that it would seem, you know, years ago I'm not sure what the wisdom was, why we-- why we put it all together but in that, it's caused extra ramifications if you will, burden and cost to more than just who it's trying to affect. The biggest change with the things that I've heard today from an amendment standpoint would be that we would have-- I don't think bedbugs is necessarily reportable thing today, and the-- see, a resident hitting a staff member is not reportable. Staff member hitting a resident? Already required. Resident hitting a resident? Already required. But I don't believe a staff member-- excuse me, a resident hitting a staff member is required. So as the day's evolved, the things that are required are not as onerous as they seemed like before we started the hearing. I think the unfortunate thing is we're-- we're casting disparaging things upon a group that really isn't primarily what this group is, is laid out to be. This assisted living group is-- does not primarily care, and they're not the focus of the LR296 committee.

CAVANAUGH: Well, I don't think that we're casting anything disparaging. We're working to protect vulnerable populations. And I guess I'm concerned with the opposition to reporting bedbugs. Could you elaborate as to why you would be in opposition to bedbugs being reported?

HEATH BODDY: I don't know that I am in opposition to that at this point, Senator. That's one of the things that evolved today from

changing from Behavioral Health to Public Health, which is already required.

CAVANAUGH: OK. OK. Thank you.

HOWARD: Senator Hansen.

B. HANSEN: I think, if I am not mistaken, I think-- you might've mentioned here in the fiscal note that any bodily harm injury to employees does have to be reported to work-- workmen's comp or OSHA. Am I right.

HEATH BODDY: Absolutely, Senator.

B. HANSEN: So there's some kind of reporting if employees do get injured. So thanks.

HOWARD: Any other questions? Seeing none, thank you for your testimony today. Our next testifier in opposition.

JENIFER ACIERNO: Hello, Chairperson Howard and the members of the Health and Human Services 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. I want to thank you for the opportunity to testify here on this bill today. We represent-- we're an association that represents 70 providers nonprofit across the state of long-term care services. And so I think that Mr. Boddy's covered a good portion of the things that I wanted to also cover. But I think there were two main things I wanted to point out. One really goes to what Senator Hansen has brought up, and that is that reporting-- I don't think anybody opposes the reporting of these things. In fact, the reporting of these things for the most part is required under Nebraska statute. So that's already being done by our providers of whatever level of service, whether it's assisted living, nursing facility, or any other level of care. If they suspect that there's a reasonable chance that circumstances may result in any sort of abuse or neglect to a vulnerable adult, they're already required to report that. Or if it actually occurs they're required to report that, and that reporting actually goes to Adult Protective Services, the licensure unit with DHHS, and law enforcement, if they choose to report directly to law enforcement. So I think that this would, in some ways, be duplicative. What I heard today, though, is this is maybe moving to Public Health, which is already aware that reporting is being done. So-- and I think to the point about staff-- injuries to staff, it's the same thing.

There is already reporting that's being done in that regard. It is going most likely to OSHA or workers' compensation, but they're already reportable incidents. So the reason that I'm really here is to say-- it seems duplicative for our providers to be reporting the same events to multiple areas. And if they're reporting them already to APS and Public Health, that seems like the place to get that information versus having them report it again. The other thing that I wanted to clarify is that I hear reference to the LR296 report that the facility that's being referenced, which is Palmer, was not an assisted living. They were actually licensed as a mental health center. So if you really want to get to issues related to a specific level of care, you have to look at the right level of licensure or how those facilities are licensed. So I think that's all that I have. If you have any questions, let me know. And I'm glad to answer them.

HOWARD: Questions? So you used to be in the Department of Public Health.

JENIFER ACIERNO: Correct.

HOWARD: And so when we think about licensure, I'm curious as to how it works when there is a report that comes into Public Health for any of these instances. I understand how it works on the Adult Protective Services side, but how does it work on the licensure side?

JENIFER ACIERNO: So Darrell Klein, who is going to be following me, might have more recent information on that, but what I can see is, generally it is shared between those two divisions. When an APS report comes in that looks like it relates to a facility, it was shared with Public Health and vice versa.

HOWARD: OK. And is the reporting just on-line where you submit something on-line? Or how does that work?

JENIFER ACIERNO: Again, I think a lot of the reporting, at least the Adult Protective Services, is done via phone. But I think that there may be that option and-- I'm sorry, I don't know that for sure.

HOWARD: No, that's OK. All right. Any other questions? Seeing none, thank you for your testimony today.

JENIFER ACIERNO: Thank you.

HOWARD: Our next opposition testifier.

DARRELL KLEIN: Good almost evening, Senator Howard and members of the Health and Human Services Committee. My name is Darrell Klein, D-a-r-r-e-l-l K-l-e-i-n, and I'm the deputy director of the Division of Public Health for the Department of Health and Human Services. And I'm here to testify in opposition to LB597. I do want to point out as Heath did-- part of the reason that I'm here in opposition is the way the bill was originally written, as opposed to how it's amended. And I'll speak a little bit to both. The department did meet with Senator Walz and her aide to express our concerns and gain a better understanding of the intent of the bill and I'll address what we learned from that meeting later. But briefly I want to address the bill as written. The bill requires incidents of violence, injury, and bedbugs in assisted living facilities to be reported to the Division of Behavioral Health. Assisted living facilities are licensed and regulated by the Division of Public Health. Any report of these incidents to the Division of Behavioral Health would need to be referred by that division to the Division of Public Health for investigation and potential disciplinary action. And this additional step would create unnecessary delay in investigating complaints which could potentially endanger the health and welfare of vulnerable residents. After meeting with the senator and her aide, the department believes the intent is to have assisted living facilities make reports of these incidents covered by the bill to the division with enforcement authority, the Division of Public Health. As a result, I'm not going to focus on the role of the Division of Behavioral Health. Division of Public Health Regulations at Title 175, Nebraska Administrative Code, Chapter 4 already require assisted living facilities to report incidents of abuse and neglect in accordance with Nebraska Revised Statute, Chapter 28-372, which is the Adult Protective Services Act or in the case of a child, in accordance with Neb. Rev. Stat. 28-711. The Division of Public Health actually administers the Complaint Intake line, which is a telephone line, investigates complaints, and takes disciplinary actions against licenses of assisted living facilities. And failure of an assisted living facility to make such a report is already among the grounds for disciplinary action against a facility. And the regulations also already require facilities to ensure that residents are free from abuse or neglect and be protected from accident or injury. The regulations also require the facilities to prevent the entrance, harborage, or breeding of rodents, flies, and all other insects or/and vermin. Violation of these regulations is a ground for a complaint and their subsequent investigation and subsequent disciplinary action. And finally, and this was touched on a little bit earlier, we expect the

requirement of assisted living facilities to report any evidence involving violence between a resident and an employee, meaning violence inflicted by a resident on an employee, to generate a number of questions from assisted living facilities without a definition of violence. And the other testifiers have touched on some of those issues. But of course, with any questions I'd be happy to answer and I appreciate the opportunity to testify today.

HOWARD: Thank you. Are there questions? Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman. Thank you, Director, for being here today. So if the amendment were to go through with where the reporting goes, then would you be in support?

DARRELL KLEIN: The remaining issues then would only be the-- we foresee confusion or consternation on the part of the facilities on the reporting of violence from a resident to a staff member. If-- in assisted living facilities-- Mr. Boddy testified to this-- the folks who live in them, it could be you or me.

CAVANAUGH: Yeah.

DARRELL KLEIN: And I could-- I could form the intent to assault a staff member. And if I did that, that would be a criminal act and it could be reported to law enforcement. If I were suffering from dementia, I wouldn't be able to form that criminal intent.

CAVANAUGH: Sure.

DARRELL KLEIN: My act wouldn't necessarily even be-- in the years that I've looked at health care facility instances, I think sometimes, when a resident strikes a staff member, it can even be characterized as reflex.

CAVANAUGH: Uh-huh.

DARRELL KLEIN: So I think that that may cause some of the facilities' issues there on trying to determine what they're doing. The next instance is, and I think this is reflected more in the fiscal note-- there we anticipated, if we were investigating injuries to staff members, that's where the main fiscal impact would be.

CAVANAUGH: Uh-huh.

DARRELL KLEIN: And if you're a regulated facility, I think you might err on the side of caution. And so they may be reporting a number of things simply to report it. The last aspect of it would be-- there's a little bit of redundancy. Well, more than a little bit of redundancy. Most of the required reports are already required elsewhere. So I would anticipate some additional confusion under the APS statute and the CPS for child abuse or neglect. You can report either to the department or to law enforcement. And once you've done that, you've met your statutory duty. I would expect there'd be some confusion about, all right, I've made one report to the department, does that cover me for APS and for this regulatory? And I'm not saying we couldn't overcome these, but these are-- this is a bit of confusion that I can anticipate the facilities might face. Bedbug reporting-- an infestation of bedbugs isn't per se a required report to us. If there is a bedbug infestation, that is a violation of the regulations. And the regulation is-- just kind of as a side note for some of the other questions-- the regulations themselves set how often we go out and look on a routine, full scope investigation and they also specify the instances under which we'll go out and do a focused one. And I believe prior testimony is correct. If you go out on a focused investigation, clearly you're going to look at what the complaint referenced. But it's kind of like for law enforcement and in plain sight. They might go into the facility because they heard a loud, loud noise. They might walk in thinking, I'm going to ask the people to turn the stereo down. If when they walk in to do that they see drugs on the coffee table, they don't just leave when the stereo is turned down. We're the same way. If we go out, even if we're going out for a focused investigation, if we see other violations they will be dealt with.

CAVANAUGH: So-- sorry. So the bedbugs, you didn't quite address. It is a violation, but what is the issue with having it be required to report it?

DARRELL KLEIN: That wouldn't really cause us any, any grief--

CAVANAUGH: OK.

DARRELL KLEIN: That impact would be more on the assisted living facilities themselves.

CAVANAUGH: Right.

DARRELL KLEIN: Yeah. And, and I just-- I wanted to note, we've got it covered partially. I guess that would be the best way I would say it.

It's already a requirement that these facilities be free of that problem along with others. And I guess it would then also-- and this is not of great import to the, to the department-- but it does raise the question, well, we're mandated to report bedbugs but not rat feces. I mean, it's-- and those right now are all covered under the same requirement that the assisted living facility keep the place clean. It wouldn't cause us much problem. It would impact the assisted living facilities.

CAVANAUGH: OK. Thank you.

HOWARD: Other questions? No? OK. No, I think I have a question for you. How many inspectors do you have?

DARRELL KLEIN: Right now we've got two that are dedicated to assisted living facilities. I believe that is accurate.

HOWARD: And then when Mr. Moreland tells us that there were no full inspections done last year, is that to your-- accurate to your knowledge?

DARRELL KLEIN: All I can tell you is that we have made changes. I don't have the actual statistics for the prior year.

HOWARD: OK. I'm trying to--

DARRELL KLEIN: I can get those for you if you would like.

HOWARD: That would be really helpful, thank you. And then when I'm looking at the fiscal note it says you're utilizing cash funds to pay for your additional staff member that you need, the additional surveyor--

DARRELL KLEIN: OK.

HOWARD: --that you're saying you would need. Is that accurate?

DARRELL KLEIN: You know, I know the folks who put these together and they are very smart and they're very capable. So I will say yes without having any personal knowledge, Senator.

HOWARD: I'm just wondering which cash fund they would be coming out of.

DARRELL KLEIN: I can get that information to you too.

HOWARD: OK, perfect. Thank you. And you believe that you would need an additional person to do this work, even with the amendment?

DARRELL KLEIN: That yes, because the calculations for the additional person are, I believe, based upon investigations of violence toward a staff member--

HOWARD: OK.

DARRELL KLEIN: --which is an additional requirement that isn't currently, as everybody's testified, that is not currently mandated.

HOWARD: And then just a quick question out of the scope of this hearing a little bit. Do you feel like you have adequate staff to provide oversight to these facilities?

DARRELL KLEIN: We are, yes. And we're working to make it better every day.

HOWARD: OK.

DARRELL KLEIN: You know, it's a work in progress.

HOWARD: So you feel as though you have enough staff--

DARRELL KLEIN: We've made changes, and--

HOWARD: --2 inspectors for almost 300 facilities?

DARRELL KLEIN: Well-- it's-- I think I would say that the fact that the staff, if the staff did not make any routine full investigations last year because they were busy following up on complete investigations, then I think they're focusing on the correct thing because they're not ignoring a complaint about a place where we have information there's an actual problem and going into a facility that nobody has complained about. So it may not be an ideal world. But I believe we've got very capable staff, they're dedicated and they're paying attention to the right things. And we are continually improving our process.

HOWARD: Are you in statutory compliance then if you need to be doing these full inspections every five years?

DARRELL KLEIN: Actually, that-- the provisions for the periodicity of the investigations or the compliance reviews is set in regulation.

HOWARD: OK.

DARRELL KLEIN: And one of the grounds-- the easiest way to say it is, we aim for 25 percent every year. The regulation that's a "may" as opposed to a "shall". And then secondly, one of the grounds warranting a special investigation is if the facility has not been investigated in the last five years. So in effect, these are requirements that we set on ourselves. And so we are still focusing on the correct thing, I believe. Even if we are investigating every complaint at the-- and I'm not saying this is the case-- but if we follow up on complaints at the expense of walking in and doing a routine survey where we don't have any evidence of any problem, I think that's-- we're looking at the right thing.

HOWARD: So then I just want to be clear. If it's a focused--.

DARRELL KLEIN: Uh-huh.

HOWARD: --investigation, that would count for your five-year clock.

DARRELL KLEIN: Yes. Yes, because of the way the regulations are written. Yes. My answer is yes.

HOWARD: OK.

DARRELL KLEIN: One of the triggers that could cause us to go out and do a focused investigation is if the facility hasn't been inspected within five years. So if an assisted living hasn't been inspected in five years, they're automatically moved into the category as if we had received a complaint upon them.

HOWARD: OK.

DARRELL KLEIN: OK. So basically the folks that we have no complaints about that have been inspected within the last five years, they would essentially be lower on our priority list than somebody we hadn't visited in five years or that we had a specific complaint about--

HOWARD: OK, thank you.

DARRELL KLEIN: And the glorious regulations are on-line and they're easy reading.

HOWARD: Wonderful. Thank you. Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman. Sorry, I was done and then I got more ideas. [LAUGH] Senator Howard asked a question that I wanted to ask as well, about whether or not you felt you had the staff you needed. And I'm looking at the fiscal note of 285 facilities, two employees. They all need to be inspected once every five years. That would assume that each one of your two employees inspected 28.5 facilities annually spent based on what we heard to take how long it takes to fully inspect a facility that they each would spend 114 days inspecting--

DARRELL KLEIN: We--

CAVANAUGH: --doing the full inspection-- one moment-- out of 260 working days annually leaving 146 days for these other inspections that we all agree are very important to be done.

DARRELL KLEIN: Uh-huh.

CAVANAUGH: But instead of doing that this past year, they spent all of that 260 days doing these other inspections, which to me says that we're not doing a very good job of making sure that these 285 facilities are up to snuff. So if I were in your seat, just from the last 30 minutes, I would be saying to the legislative body, I do not have enough staff to serve the people in these facilities. I do not have enough staff to make sure that we aren't running around like the house is on fire 260 days doing reactive inspections instead of proactive inspections. So I'm concerned that that's not what I'm hearing from you, because we should be doing 114 days annually of proactive inspections, and we're not. We're doing 260 days of reactive inspections. So with that said, you really truly stand by two people is enough?

DARRELL KLEIN: We have cross-trained surveyors. I'm at a bit of a disadvantage because I'm here to testify about the bill and--

CAVANAUGH: I'm sorry.

DARRELL KLEIN: And-- but we do have cross-trained staff so that when there is an urgent need, people can be shifted around. And we are making every effort to see that we are fully staffed and that we're meeting the requirements so that folks will have the protection they deserve.

CAVANAUGH: So if we offered your department the funding to hire additional staff, would you find that useful?

DARRELL KLEIN: I'm in a position today to talk about this bill. I can't speak for the administration. The-- one of the issues is we're trying to be responsible stewards of the taxpayers' money.

CAVANAUGH: That's our responsibility--

DARRELL KLEIN: Sure.

CAVANAUGH: --as the Legislature. Your responsibility is to execute the duties of the office.

DARRELL KLEIN: If such amendment was offered, then we would analyze it and we would-- we would get back to you on that.

CAVANAUGH: OK. Thank you.

DARRELL KLEIN: Thank you.

HOWARD: Any other questions? Seeing none, thank you, Mr. Klein.

Our next opposition testifier. Seeing none, is there anyone wishing to testify in a neutral capacity? Seeing none, Senator Walz, you are welcome to close.

WALZ: All righty. OK, first of all I want to thank you again for your time. And I want you to know that I-- we as the committee and the people behind me, we understand that there are a lot of great facilities out there. And the last thing we want to do is overburden great facilities with reporting requirements that even with all the coverage Mr. Boddy talked about, we still have so many issues. And we understand that assisted living facilities-- that's another thing that we really looked at-- that is so broad. And one of the things that the committee is doing is that we're looking at recommending or recommendations on, should all of those facilities fall under assisted living facility? So just wanted to clarify that's something else that we're looking at in our on our committee. On the other hand, you know, if we limit reporting to only facilities that have a majority of the residents as Medicaid recipients or the majority of people with mental health illnesses, we're afraid that's going to cause an unintended consequence of having facilities then reject individuals who are Medicaid or have a mental health illness. And we want to definitely not have that happen. That would be it-- and again, an unintended

consequence. That would be a direct contradiction of the goal that we're trying to accomplish here. As Mr. Moreland said, we have an issue and we really, really do have an issue. We started out the committee investigation with a hearing or a briefing with DHHS, and we were able to ask a lot of questions about their ability to survey the number of facilities that they're supposed to be serving and investigating. And although they felt that they had adequate staffing, which it was really disappointing for me to hear, knowing that we have so many issues for people out in our communities. That was another recommendation of the committee, that they hire additional staff. As you heard right now, they are investigating complaints and not being able to get ahead of the problems. They're just investigating complaints. And I find that that is a systematic problem. We're not ever going to fix the system if we just keep putting Band-Aids-- hopefully-- on what's going on. And I also wanted to point out that currently the department did not ask for any additional money to provide another surveyor or a staff person. I want to make sure that everybody understands that we are willing to work with all of these groups to come to a compromise. The number one thing, again, and I know I said this a few times, but the number one thing we have to do is protect people. We have a duty to protect people: the people who live in Nebraska, and especially people who are vulnerable. I would encourage the committee to advance this bill and move Nebraska forward and protect people who need our support. With that, I'd be happy to answer any questions.

HOWARD: Further questions? Seeing none, this will close the hearing for LB597 and end our hearings for the day. Happy weekend.