HOWARD: [RECORDER MALFUNCTION] 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, the members of the committee to introduce themselves starting on my right with Senator Murman.

MURMAN: Hello. I'm Senator Dave Murman from District 38, seven counties south of Kearney, Grand Island, Hastings

WALZ: Lynne Walz, District 15, all of Dodge County.

ARCH: John Arch, District 14: Papillion, La Vista, and Sarpy.

WILLIAMS: Matt Williams from Gothenburg, Legislative District 36, that's Dawson, Custer, and the north portion of Buffalo Counties.

CAVANAUGH: Machaela Cavanaugh, District 6, west central Omaha, Douglas County.

HOWARD: Also assisting the committee is our legal counsel, T.J. O'Neill; and our committee clerk, Sherry Shaffer; and our committee pages today are Taylor and Nedhal. A few notes about our policies and procedures: please turn off or silence your cell phones. This afternoon we'll be hearing four bills and we'll be taking them in the order listed on the agenda outside the room. On each of the tables near the doors to the hearing room you will find green testifier sheets. If you are planning to testify today, please fill one out and hand it to Sherry when you come up to testify. This will help us keep an accurate record of the hearing. If you are not testifying at the microphone but want 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's policy is that all letters for the record must be received by the committee by 5:00 p.m. the day prior to the hearing. Any handout 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 ten copies and bring them to the page. We do use a light system in this committee. Each testifier will have five minutes to testify. When you begin, the light will be green. When the light turns yellow, it means you have one minute left. When the light turns red, it's time to end your testimony and we'll ask you to wrap up your final thoughts. When you come up to testify, please begin

by stating your name clearly into the microphone, then please spell both your first and last name. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters of the bill, then from those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given the opportunity to make closing statements if they wish to do so. We do have a strict no-prop policy in this committee. And with that, we'll begin today's hearings with the gubernatorial appointment of Robert H. [SIC] Feit to the Commission for the Deaf and Hard of Hearing. Welcome, Robert.

ROBERT J. FEIT: And you did the Feit very well, usually it's feet. Thank you. My name is Robert J. (Bob) Feit. I'm from here in Lincoln. My son testifies down here a lot on diabetes, so he's telling me what I have to do today. I finished school-- I'm, I'm not sure what you want for it.

HOWARD: Well, we were hoping you could tell us a little bit about yourself--

ROBERT J. FEIT: That's fine.

HOWARD: --and your interest to serve on the Commission.

ROBERT J. FEIT: I've been a school board member for 16 years. I stopped doing that and became a Southeast Community College board member. I'm finishing up my 22nd year. And now I'm going onto a different type of board and I came forward and think that I can give-- since I've had a hearing loss for over 50 years, I think that I can impart some help to those people who need it, another voice on the board.

HOWARD: That's wonderful. All right, let's see if there are any questions from the committee. Are there questions? Senator Williams.

WILLIAMS: Thank you, Chairwoman Howard. And thank you for being here. And we met your son yesterday--

ROBERT J. FEIT: I thought so.

WILLIAMS: --in Banking Committee talking about diabetes. As you mentioned, you had a hearing loss, what is your goal and what do you

think the Commission of the-- excuse me, of the Deaf and Hard of Hearing should be doing for our state?

ROBERT J. FEIT: OK, as was a new member, I don't believe that I have the right to say, I come in with a preconceived idea. I'm going to come in, listen to what's going on and add my input as someone who has been hard of hearing for 50 years. I don't have any goals. I'm not trying to remake it.

WILLIAMS: Thank you.

HOWARD: Senator Cavanaugh.

CAVANAUGH: Thank you. Thank you for being here and your willingness to serve. It sounds like you've done a lot of work on boards previously. Do you plan to bring some of that expertise with you to this Commission?

ROBERT J. FEIT: Whatever they will let me use. [LAUGHTER]

CAVANAUGH: Well, thank you for coming and thank you for being willing to serve for this.

ROBERT J. FEIT: Thank you.

HOWARD: All right, any final questions? Seeing none, we're very grateful for your willingness to serve.

ROBERT J. FEIT: Thank you.

HOWARD: Thank you. All right, this will close the gubernatorial appointment hearing for Robert Feit. And we'll open the gubernatorial appointment hearing for Candice Arteaga for the Commission for the Deaf and Hard of Hearing. Welcome, Candice. Good afternoon.

CANDICE ARTEAGA: Hello. Do you want me to spell my name or--

HOWARD: Yeah, that would be great if you could spell your name.

CANDICE ARTEAGA: Yes, my name is Candice, C-a-n-d-i-c-e, last name Arteaga, A-r-t-e-a-g-a, and I'm here for my reappointment to the Nebraska Commission for the Deaf and Hard of Hearing's full board.

HOWARD: That's wonderful. So we were hoping you could tell us a little bit about your background and sort of your experience serving on the board so far.

CANDICE ARTEAGA: I've been here for a long time, been very involved within the deaf community. I'm a deaf advocate to the deaf community, most importantly, deaf children. Parents who are struggling in the school systems needing interpreters, I support them. And I'm also president reelected for the Omaha Association of the Deaf. It's my third term there. And so I've been an advocate in the community-- more of a liaison between NCDHH and the community keeping them informed about deaf rights and interpreters, when the hearing aid bill was passed, the ASL bill we have pending right now and the one with LEAD-K that we have pending right now. And as of now, NCDHH has really made huge strides in the last two years, a lot of changes have been happening, so.

HOWARD: That's-- do you want to tell us about those changes?

CANDICE ARTEAGA: For, for example, the hearing aid bill, the insurance for, for children, we got that bill passed changing the term hearing impaired in all of state language to deaf and hard of hearing. I understand that Senator Howard was a part of that so we want to thank you very much for that. And then we also stopped doing the interpreter referral service program, we've offloaded that, and so the Commission can now focus more on more important issues. For example, ASL bill that we have currently pending and recognizing ASL as a language and then LEAD-K language acquisition from-- for kids from zero to 5-years-old.

HOWARD: That's wonderful. Let's see if there are questions from the committee. Are there questions? Senator Cavanaugh.

CAVANAUGH: Thank you for being here, and your willingness to serve on this Commission. I, I remember Senator Blood's bill for the hearing aids, and I know that was a really exciting day when we got that passed, so thank you for your work on that and for being an advocate. I'm just interested in, in what are some of your goals moving forward now that you have achieved some of those other things that you talked about? What would you like to see next?

CANDICE ARTEAGA: One of the goals I'm hoping to see is interpreter access at hospitals. A lot of people struggle with communication

access. A lot of hospitals have what's called VRI, which stands for Video Remote Interpreting. A lot of them struggle because it's not an effective way to provide interpreting services. The Video Remote Interpreting can be choppy and it's not a smooth access for patients, so I'd like to see that improve. And that's still a struggle that we are facing and people who are deaf complain about that still, so that's one of the goals is seeing some improvement there. Also having open captioning at movie theaters, and it's not only for people who are deaf and hard of hearing, but also for senior citizens who have a hearing loss. So we're hoping to see them be able to enjoy attending movies just like everyone else.

CAVANAUGH: Thank you. I, I will tell you something personal, my husband is here today so he's probably gonna laugh at this, but I watch all TV with captions. So, so I would appreciate that at the movie theater. Thank you again for your willingness to serve.

HOWARD: All right. Any final questions?

CANDICE ARTEAGA: No problem. Thank you.

HOWARD: All right, seeing none-- oh, whoa, Senator Murman sneaking in.

MURMAN: I, I appreciated the presentation the other day in the Education Committee about American Sign Language being taught in public schools. I just wondered if you might want to expand on that a little bit?

CANDICE ARTEAGA: American Sign Language is a language for people who are deaf, and it's our first language. My first language being born, my first language was sign language. That's how I learned, that's how I learned to read English. And so the next person you're appointing is Jonathan Scherling and he'll have a better explanation about that than I do.

MURMAN: Thank you.

HOWARD: All right, any final questions? Seeing none, we very much appreciate your willingness to serve.

CANDICE ARTEAGA: Thank you very much.

HOWARD: Thank you. All right, this will close the gubernatorial appointment for Candice Arteaga and open the gubernatorial appointment

for Jonathan Scherling to the Commission for the Deaf and Hard of Hearing. Welcome, Jonathan.

JONATHAN SCHERLING: Hello. My name is Jonathan, J-o-n-a-t-h-a-n, last name Scherling, S-c-h-e-r-l-i-n-g. I am honored to be serving on the board for the Commission for the Deaf and Hard of Hearing as a new appointee. I believe that I am taking Dr. Frank Turk's position. You may be aware of him. He is very involved in the deaf community in educating and serving civil rights for more than 60 years. So now that's transitioned to me, and I feel like his shoes are like the size of Shaq O'Neal's for me to fit and so I am looking forward to serving. I want to-- I'm grateful that I have had many mentors throughout my life, including Dr. Frank Turk, that have helped polish me to become a better leader and teach me how to develop more followers to make them have the best possible life as a person who's deaf and hard of hearing in Nebraska. So I want to tell you a little bit about myself. I grew up in a small town by the name of DeWitt. I believe it's under district number 32, home of the Vise-Grip Factory. Maybe you know that, maybe you don't. Very small town. I grew up attending a public school in the Tri County Area. I was the only deaf student there. I was the first deaf student to attend school there. Everything was new, the teachers had limited resources. Thankfully, my parents are also deaf. A very small percentage of children have deaf parents. It's only a 6 or 7 percent. Luckily, my parents knew what resources they could get to share with the school, so I'm grateful for that. The problem I had was with interpreters, especially having a qualified interpreter. My parents searched, as the school district, district did, too. There was one that lived 30 miles away from my hometown. That interpreter, bless their heart, drove 30 miles each way, meaning 60 miles a day to provide interpreting for me all day long at school. I was thankful to have that interpreter. Now do we have other ones that are equivalent to that? We don't. And so I do cherish education for the children in deaf-- in the deaf and hard of hearing children in Nebraska. I'm thankful for the opportunity to fight for the quality of education for deaf children, including qualified interpreters improving resources in Nebraska. Attending a public school, I had planned on transitioning to the Nebraska School for the Deaf in high school, my parents graduated from there. Omaha to DeWitt is close to a two-hour drive so it was time for my mom and dad to let me go. I was looking forward to that, unfortunately, the School for the Deaf closed. So then I was able to attend the Iowa School for the Deaf, and I thank the Nebraska School District in supporting me to attend the Iowa School for the Deaf. It

was a very difficult journey growing up in a mainstream public school so I look forward to children who need to have deaf peers having that interaction in their school journey. So I'm looking forward to making that happen as well, their access to interaction with peers so that they can increase their self-esteem, build that confidence in themselves for their future, they are our future, those deaf and hard of hearing children, they're very important to us. Being involved with the Commission, those children are a priority for me, and that's because of the experience I went through, my brother and my sister as well. I've been involved in the Nebraska deaf community for many years in a lot of nonprofit organizations. Now with this opportunity moving-- or coming up, I just moved here from Iowa. My sister attended the Iowa School for the Deaf and lived with me so she could attend that school. So I'm now back in Nebraska and I'm looking forward to serving Nebraska, not only for education, but in job opportunities so people will move to Nebraska and prosper. There are lots of things related to deaf issues like the bills that I'm involved with. Senator Howard and I worked together to remove the term hearing impaired from state language. I'm very thankful to you for that and for you giving me that opportunity to be involved in that experience. Now we have bills pending, one's called LEAD-K to improve access to language to deaf children prior to kindergarten and then also recognizing ASL as an official language. So I think that will help our deaf and hard of hearing children in Nebraska, and I'm looking forward to being involved in that. So anything related to deaf and hard of hearing is where I am at and I am willing to empower and help people through that. So I'm looking forward to serving on the Commission.

HOWARD: Thank you.

JONATHAN SCHERLING: Thank you for your time.

HOWARD: Let's see if we have any questions from the committee. Are there questions? Senator Cavanaugh.

CAVANAUGH: Thank you. Thank you for being here. Every day in the Legislature, it seems like we learn new things. And I just want to thank you for teaching me that DeWitt is the Vise-Grip Factory location in Nebraska. I will think of you when I win that trivia question. Thank you so much for your willingness to serve.

JONATHAN SCHERLING: Thank you.

HOWARD: And Jonathan, I just want to ask you, what is the best legislative district in the state?

JONATHAN SCHERLING: Oh, number 9.

HOWARD: Yes.

JONATHAN SCHERLING: Yes.

HOWARD: Wonderful. Wonderful.

JONATHAN SCHERLING: I moved to Omaha to be in your district. I'm honored that I'm under you, but don't tell your friends. [LAUGHTER]

HOWARD: That's wonderful. Well, we very much appreciate your willingness to serve. And thank you for coming to chat with us today.

JONATHAN SCHERLING: Sure. Thank you.

HOWARD: Thank you.

JONATHAN SCHERLING: Thanks for your time.

HOWARD: All right, this will close the gubernatorial appointment for Jonathan Scherling and we will open the hearing for LB1105, Senator Hansen's bill to change audit provisions under the Medical Assistance Act. Welcome, Senator Hansen.

B. HANSEN: Thank you, Chairperson Howard. Chairperson Howard and members of the Health and Human Services Committee, which I hear is the greatest committee in the Legislature, my name is Ben Hansen, spelled B-e-n H-a-n-s-e-n, from-- representing District 16, which is the best district in Nebraska.

HOWARD: Whoa.

B. HANSEN: I am here today to introduce LB1105, which I brought to address a problem with the Medicaid Program integrity audits that this committee heard about during the interim. Medicaid audits are an important tool to address fraud, waste, and abuse in a healthcare system. It makes sense that we should review the use of Medicaid funds as nationally we spend over $400 billion annually on Medicaid services. Keeping fraudulent providers out of the Medicaid system and identifying them quickly prevents the loss of state and federal resources and Medicaid payments for substandard or inappropriate care

puts our state's citizens at risk. But there is a balance that should take place, healthcare practitioners choose to provide Medicaid services, Medicaid providers take on some of our most difficult healthcare patients who have some of the greatest needs and they provide these services for a much reduced fee with substantial bureaucratic oversight. Providers don't treat Medicaid patients because it is lucrative, but they often do so because they believe that it is their obligation to give back to those who are in need. The balance has to be finding a way to ensure integrity in the Medicaid Program without treating the many good providers as criminals in the process. Audits are appropriate, inquisitions are not. Encouraging and ensuring the efficient use of state and federal resources is appropriate, discouraging providers from delivering care to our Medicaid population is not. This is especially true as we are about to embark on Medicaid expansion and will need to add Medicaid providers to respond to a likely large influx of Medicaid eligible needed care. LB1105 attempts to strike that balance. The bill keeps a strong state program integrity audit program while implementing, while implementing commonsense guidelines. We want to cast a large enough-- we want to cast a net large enough to catch fraudulent and abusive behavior, but not to penalize mistakes, clerical error, or appropriate care. The Affordable Care Act required states to work with CMS on Medicaid audits that has been the state's responsibility prior to that time. Recently, CMS decided to combine Medicaid and Medicare audits under one contractor referred to as a UPIC auditor, stands for Unified Program Integrity Contractor. CMS hires one contractor per region of the, of the country. This contractor works on all Medicaid audits in that region in conjunction with the state Medicaid agency. It is clear throughout the federal guidelines that state law controls Medicaid UPIC audit procedures and is meant to be a coordinated effort between the state and the federal audit contractor. While we have heard that the state has little to do with unified program integrity audits, the Medicaid Program Integrity Manual specifically states, and I quote, the scope and execution of program integrity activities vary by state, collaboration between the state and the auditor may differ from state to state. The auditor shall coordinate and confirm the use of its investigative approach at the onset of the collaboration, and the auditor shall follow the guidance established by the state during the investigation. LB1105 clarifies Nebraska's procedure for Medicaid audits. LB1105 builds on the protections created in LB315 passed by, by this committee in 2015. LB315 sets forth the Department's responsibilities under Medicaid audits utilizing the audit contractors

used in 2015 or RAC auditors. This bill makes it clear that the rules currently in place for RAC audits are the same rules that will be in place for UPIC audits because the UPIC auditors perform the same functions as the prior RAC auditors. LB1105 insures that the protections of the audit process--gesundheit-- will apply to all program integrity reviews, investigations, and audits no matter what name the contractor operates under. Following me will be a brief explanation of the changes in the bill and a reminder why these changes are essential. In summary, LB1105 maintains a strong program integrity audit process that is focused on fraud, waste, and abuse and not on penalizing providers trying to navigate what can be from experience a complicated and changing federal Medicare-- or medical program. I would be happy to answer some questions. But that being said, this is not a my way or the highway approach to this bill. I've heard the concerns of others who will probably testify behind me and I'm willing to work with them to make sure that this bill is the best that it can be and make sure we can incorporate all their concerns that we can. And so with that, I will be handing out some response to maybe some of the concerns that the Department might have, too, as well. Now I'll be happy to take any questions that I can, but there will be people behind me that can maybe answer them better than I can.

HOWARD: Thank you, Senator Hansen. Are there questions? All right, seeing none, will you be staying to close?

B. HANSEN: Yes.

HOWARD: Wonderful. Thank you. And then, Taylor, do you want to grab the handouts? All right, we'll now invite our first proponent testifier up for LB1105.

KIM ROBAK: Senator Howard and members of the committee, my name is Kim Robak, that's K-i-m R-o-b-a-k. I'm here today in support of LB1105 on behalf of the Nebraska Dental Association. And I've also been asked to speak on behalf of the Nebraska Hospital Association in support of the bill. Senator Hansen, first of all I want to thank him for his willingness to bring this bill forward and the work that he's done to, to try and assist in the problems that you heard earlier this year with regard to Medicaid audits. In, in 2015, there was a bill, LB315 that took care of some concerns that took place way back then dealing with RAC audits. And so we took the federal legislation, we took the federal guidelines and we put them in statute that said these are the parameters for RAC audits. There is now a new type of audit called a

UPIC audit. And because our RAC audit bill doesn't say UPIC, we wanted to clarify that the rules in place right now should also apply to all program integrity audits. So I'm gonna real briefly go through the bill and tell you why the changes are there and where they came from. And so if you want to start on the first page, the first section of the bill on page 2, the new language is simply intent language. The first section comes directly from the large document-- let's see if I can pull it up, got lots of research here called the Medicaid Program Integrity Manual. If any of you want this, you're welcome to it. I didn't think you wanted more paper, but it is, it is all the federal guidelines with regard to these types of audits. But the, the, the legislative intent, the first paragraph is taken directly from that. The second paragraph simply says the state and the feds should coordinate. The rest of the, the bill, anytime the word recovery audit or RAC audit was used, we now say program integrity audit so that it will refer to all audits, not just that one audit. If you go to the bottom of page 3, we add language there that says if you did something that was considered inappropriate as the result of a new interpretation by the Department, they hadn't had this interpretation before, they came up with this new interpretation, you can resubmit that claim to determine whether or not you can be paid for that claim. It doesn't say that Department has to pay you, but you certainly could resubmit it, making the argument that, look, this is brand new, we thought we were doing the guidelines as they were set out by you so would you consider paying us. So that, that is new language that we've added. At the top of page 4, we're adding the information with regard to established clinical practice guidelines. This is the issue that we talked about during the briefing earlier this, this-- or last year, I guess it was, that dealt with the fact that with pediatic-- pediatric dental audits, they didn't deal with the standard of care that everyone is taught with regard to pediatric dental services. So that language would be added and I should also note that similar language was added in a federal bill with regard to intention that, that specialty care should be given specialty oversight. And I do have-- I don't have that with me, but I can provide it to, if you want, that the federal government has also adding similar language. It was intent language in an appropriation bill. On page 4 again, there is new language here, this language deals with the coordination between the state and the feds. We've been told over and over that this audit is completely controlled by the CMS and that the state has no control. Actually, the guidelines in the Medicaid Program Integrity Manual don't say that, they say exactly the opposite. Medicaid is a program

that is run by the state. The feds set broad parameters and then the state operates the program based on their own state statutes. What, what this language does is take language directly from this Medicaid Program Integrity Manual in Sections 1.4 through 1.7. Again, I'm happy to provide this document to you that sets out how the coordination should take place, that there should be coordination and that state statutes should comply, apply, and that we should then make sure that we maintain this information in the audit. Then finally, there's a couple last pieces on page 5, we specifically deal with the fact that if it's a clerical error, that you shouldn't have to pay back for a mere clerical error. If they're-- the purpose of, of the whole Medicaid audit process is to take care of fraud, waste, and abuse that's set forth in Section 1.2 of the Medicaid Program Integrity Manual. So if it's a mere clerical error and you can establish that, then that's not fraud, waste, and abuse, and it should not have to come back. Now if there's a series of clerical errors that happen over and over and over, then that's waste. And that's something that the Department would be able to deal with. Extrapolated overpayments are not allowed under the Medical Assistance Act, this is gonna cause a lot of concern. I see my time is up. I have two last comments to make. May I make them?

HOWARD: Sure. Yeah.

KIM ROBAK: On the extrapolated overpayments specifically in, in the Medicaid Program Integrity Manual, it states that in Section 1.7.3 that, that UPICs must first determine if each state allows for the use of extrapolation. The only data that I could find was from 2014. There were seven states in 2014 that did not allow extrapolation in their audits at all, and that was from a NCSL review. I couldn't find any more current data than that. I do know that several states have introduced legislation since then. Georgia, I know, and Wyoming introduced legislation to prohibit extrapolation. I will say if there is a concern that there is need for extrapolation, the federal government last year introduced a language in Medicare audits that said that they will frown on extrapolation, they don't like them. But if you have an error rate over 50 percent, then you could extrapolate because it would save time. But extrapolation should not be used in instances where if you have a small error rate and you extrapolate through the entire course of your documentation. The, the final two things in the bill are definitions: extrapolated overpayment comes directly from the manual, the definition. And then there's a definition of program integrity audit because it encompasses all the

audits and then program integrity contractor is a new definition as well. So those are the new, new items in the bill and I would be happy to answer any questions.

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

ARCH: Thank you. And thank you for coming.

KIM ROBAK: Yes.

ARCH: I'm glad you're here for content expertise. Would you consider incorrect coding to be a clerical error?

KIM ROBAK: Potentially, potentially. And the, the reason I say that is that would be an instance, Senator Arch, where you could-- there is language in the current statute as it exists today that you could resubmit a claim if they deny it. So in that case, if it is an incorrect code, then you could resubmit the claim because you actually provided the service and you provided care. And if it's reasonable, then you should be paid. So currently under current statute, should be able to recover for that.

ARCH: So the language that you're proposing here regarding, regarding clerical errors, I guess my question is if there was, if there was incorrect coding and the state says you need to pay that back,--

KIM ROBAK: Um-hum.

ARCH: --you incorrectly coded, that is not the code you should have used,--

KIM ROBAK: Um-hum.

ARCH: --you have to pay that money back and then you can resubmit the claim and rebuild, but you have to pay that money back. Am I, am I correct?

KIM ROBAK: Well, that's the way the Department would, would respond to it. What we would like to see is the Department take a position that audits are for fraud, waste, and abuse and not for mere errors. And so in that instance, that's an error. Rather than actually making you pay back, why not just submit the form appropriately and then we can pay, pay you for that service or you can keep the funding. So you could have to go through that process, pay it back, and resubmit, however

the Department wants it. But yes, you should be able to be paid for a mistake that's made as opposed to actual fraud and actual abuse of the system, which is not-- I don't think happens in those cases.

ARCH: Yeah, fraud, fraud and abuse, is that not a question of intent?

KIM ROBAK: It should be, it should be, sometimes if you-- there would be abuse where somebody didn't run the system well enough that they continually made-- they, they just weren't trying. In that case, I don't know if you intended to actually defraud the state. But yes, you would be in that instance doing massive similar documentation errors. So yes, you could say that was abuse in that case. I hope that's helpful.

ARCH: Thank, thank you.

KIM ROBAK: OK.

HOWARD: Other questions? Could you walk me through the fiscal note? Just-- I was a little confused, it says that a change from-- the definition changes brought into the scope so that they wouldn't be able to use federal contractor. Can you help me understand that?

KIM ROBAK: There should be absolutely no fiscal note to this bill. This bill does absolutely nothing other than what is currently required under federal statute. Federal regulations require that they coordinate with Medicaid Program integrity contractors. They have to coordinate based on state law, state law currently exists. So I can't imagine how this bill would cause any increase in, in any, any obligation by the state, so. In fact, I was, I was surprised to hear that the Department felt that there was. I wasn't even gonna look at the fiscal note because I just assumed by expanding or putting in statute what the feds are currently requiring, there are, there are a couple of things that the state can look at, but it doesn't in any way prevent them from contracting with a federal contractor. Right now, the current RAC bill, the RAC audit bill in place says that if you are already being audited by someone, then you can't get audited twice. The federal regulations say that they want to avoid duplication, so they don't want duplicate audits. You don't want a provider to be audited by one entity and then another. So I'm, I'm not again understanding why there would be any concern. So I'd like to hear it if that's at all possible.

HOWARD: OK. Thank you. Senator Arch.

ARCH: Thank you. I've got a follow-up question.

KIM ROBAK: Um-hum.

ARCH: I want to go back to this concept of correct claims processing versus fraud. Right?

KIM ROBAK: Um-hum.

ARCH: And in what you're saying, though, in the language that is being proposed here, that would not stop the state from making sure of accuracy of claims processing, right,--

KIM ROBAK: Absolutely.

ARCH: --because, because we, we need to accurately process claims.

KIM ROBAK: Absolutely. That's, that's correct, Senator Arch.

ARCH: And so but however, that being not punitive but corrective in its approach and get it, get it correct, educate, this is incorrect claims processing, needs to be done this way. And it's very complicated, claims processing is very, is very complicated, one little, one little dash and one little number and you're in another world, so I, I, I understand.

KIM ROBAK: Yeah, exactly, it is complicated. And what's happened both under Medicare and Medicaid is because these audits are so-- can be so punitive, they have taken the position both in Medicare and nationally in Medicaid and the RAC audits that they're trying to figure out how to educate providers. So both statutes, Medicare and Medicaid statutes and the RAC and UPIC audit language requires education of the providers to help them when they make mistakes, exactly your point. And, and I was gonna comment that Administrator, Seema Verma, who's the CMS Administrator, was very proud of the fact that she is still doing strong appeals, but they are figuring out ways to work with providers. And she quotes, we have identified areas where we could reduce provider burden and appeals and increase program integrity while enhancing program oversight and effectiveness. She gave a speech last May 2019, it's three-pages long. I'm, I'm happy to get you a copy of it, but her point is she's trying to figure out how to keep

providers in the system while still having an effective audit process. And that's what this bill attempts to do.

ARCH: Thank you.

HOWARD: All right, any final questions? Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman Howard. Thank you for being here, Ms. Robak. Kind of going back to Senator or Chairman-- Chairwoman Howard's question about the language change, that seems to be in looking at the fiscal note, the crux of it that the Department believes that we won't be able to use the federal auditors because of the change from program recovery audits to program integrity.

KIM ROBAK: So, so I believe what the Department is attempting to say is that if, if we can't do audits anymore, then we won't be able to get some federal funding because we won't be able to prove that there's actually fraud, waste, and abuse in the system. And there still is going to be fraud, waste and abuse in the system, but we won't be able to catch it because you're preventing us from doing that.

CAVANAUGH: So are we-- we're removing the word audit, and that's the sticking point?

KIM ROBAK: Well, we're removing the word recovery, recovery auditor and then we're turning them into program integrity auditors. If the Department believes that what we're attempting to do is prevent them from auditing, we'll clarify that, that's not the intent, they still get to audit. If the Department is believing that they can't audit the MCOs, we want to clarify that, they should be able to audit the MCOs. What they shouldn't be able to do is if the MCO audits the provider, they shouldn't have to reaudit the provider because we're paying the MCO to do that. So, so if we, if we need clarification, we're happy to clarify that, but that is not the intent of the bill.

CAVANAUGH: Thank you.

KIM ROBAK: OK.

HOWARD: Seeing no further questions, thank you for your testimony today.

KIM ROBAK: Thank you.

HOWARD: Our next proponent testifier for LB1105. Good afternoon.

MARTY KILLEEN: Good afternoon. My name is Marty Killeen, M-a-r-t-y K-i-l-l-e-e-n, and I'm here today to voice my support for LB1105. I'm a pediatric dentist here in Lincoln and I'm the first pediatric dentist in the state to go through this recent type of CMS UPIC audit and the only one to have completed the process. After reviewing, reviewing LB1105, I feel that many of its provisions will greatly enhance protections for the dental Medicaid safety net and it will reduce the disaster effects-- disastrous effects that poorly run audits can have on the ability of Nebraska children in need to find a pediatric dentist. Some of you will remember the story in my audit, in the 14 years I've practiced, I was proud to be a Medicaid provider and I never had any problems with Medicaid. Then I received a letter from CMS stating that I was being audited. CMS didn't allege that I provided treatment where there wasn't tooth decay, they just wanted a different type of filling. They wanted a cheaper solution that didn't fall with the American Academy of Pediatric Dentistry's guidelines. I had no warning of the audit, no offer to educate me on their thoughts, or for me to show the pediatric dental guidelines I was following. Prior to my audits, I used my Fridays to treat high-risk kids at the Lincoln-Lancaster County Health Department. The routine was that if a general dentist at the Health Department wasn't able to treat a child on Medicaid due to advanced decay or difficult behavior, the child was rescheduled with me. So my Fridays were reserved for the most challenging kids in the clinic. My numbers probably look skewed since the intent was for me to see the youngest kids with the worst decay, and because I was the only pediatric dentist at the Health Department. The fallout from my CMS UPIC audit was devastating for me. I'm no longer able to use my skills to help kids in need at the Health Department. And by my choice, I'm no longer a Medicaid provider. I loved that job and I enjoyed it for 14 years. So my patients still have not been able to find a pediatric dentist. Last week, the director of the clinic called to tell me that she still has not been able to find a pediatric dentist to hire. Consequently, one misdirected audit just blew a giant hole in Lincoln's dental safety net. There are three main provisions in LB1105 that I fully support because I feel that if any one of these three would been in place, I would still be a provider in the Medicaid network and my patients would still have a pediatric dentist. First, I fully support the provision requiring a pediatric dentist to be audited by a pediatric

dentist. This provision alone would have squashed my audit from day one. I wouldn't want an orthopedic surgeon being reviewed by a dermatologist, nor would I want an oral surgeon being reviewed by an orthodontist. If you remember from my previous testimony, my provider rebuttal was reviewed by a nurse. Secondly, I fully support using acceptable standards and guidelines put forth by professional organizations. The term standard of care can be vague and defining it will help both auditors and providers. Additionally, this will remove the ethical dilemma of Medicaid telling a provider to practice one way when our national guidelines tell us to practice another. Lastly, I fully support the elimination of extrapolating data. In my audit, the audit contractor, AdvanceMed, recommended to not extrapolate the initial findings because the error rate was actually quite low. However, our state's Medicaid Office chose to extrapolate the data anyway, and this single act changed the dollar amount of my overpayment from $7,500 to $88,000. These three components of LB1105 will help keep the focus of audits on finding fraud, abuse, and waste. It will help facilitate constructive communication between program integrity and providers in the Medicaid network. These changes will be encouraging for prospective providers and will help retain current providers and ultimately LB1105 will help key pediatric dentists seeing children who need their care. Every taxpayer in the state wants children to have access to dental care and program integrity to run effective, efficient, successful audits.

HOWARD: Thank you. Let's see if there are any questions. Are there questions? Senator Cavanaugh.

CAVANAUGH: Thank you. Thank you for being here again and reminding us of what you went through with this audit process. I wondered if Senator Hansen's bill was to move forward, could we entice you back into taking Medicaid patients?

MARTY KILLEEN: That's definitely something I'll look into. I-- I've loved the Health Department, and I think you'll hear some-- from some of my Health Department friends and it really was some of the best, best components of my job helping the kids that are in need, so I miss it.

CAVANAUGH: Well, thank you for your work and for your advocacy.

MARTY KILLEEN: Thank you.

HOWARD: Senator Arch.

ARCH: Thank you.

HOWARD: Oh, nope.

MARTY KILLEEN: Yes.

ARCH: Not quite. In, in, in referencing professional organizations in, in standards and guidelines, do you-- is, is that gonna be easy? I mean, are there conflicting-- are, are sometimes professional-- do professional organizations conflict? I guess, so you have pediatric dentistry, you have general dentistry, do you find or perhaps other associations of dentists, do you find them conflicting?

MARTY KILLEEN: Yeah, that's an easy one. No, not at all. In fact, if you were to look at the comments that have been made about this, my specific instance, you've got the national leaders of the American Dental Association hand-in-hand with the American Academy of Pediatric Dentistry, writing letters in support, saying, listen, we're all on board with these universal guidelines. I mean, this is not a-- there's not a discrepancy-- in fact, when it comes to pediatric dental care, you go right to the national organization. They're the ones that are the, the standard. I mean, it's, it's quite simple. And then, in fact, if you were to look at those standards they're, they're actually referenced on the federal level to be used for audits. So no, I don't, I don't think you'd have much of a discrepancy in different specialties butting heads, if that makes sense.

ARCH: Thank you.

MARTY KILLEEN: Yeah.

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

MARTY KILLEEN: Thank you.

HOWARD: Our next proponent testifier for LB1105.

BEN REIMER: Hello. My name is Ben Reimer, B-e-n R-e-i-m-e-r, and I'm here speaking in favor of LB1105. I'm a second-year pediatric dental resident at the UNMC College of Dentistry in Omaha. I grew up in Hastings, Nebraska, went to Hastings College, and completed my dental

training at the University of Nebraska Medical Center, College of Dentistry. I grew up the son of a family physician and so healthcare was always my plan for a career. I was proud going around town with my dad and seeing him recognized by his patients of all ages and all backgrounds. One of the main reasons I went into pediatric dentistry is that I believe with children you have the opportunity to give everyone tools to take care of his or her teeth for a lifetime. As a pediatric dentist, I educate families on diet, oral hygiene practices, and build trustful relationships with children and their families. We do this for families from all different socioeconomic settings, so seeing patients with Medicaid is important to me. We also provide treatment for these children when they develop dental disease. And our goal is to treat them with their overall health in mind, not just as another set of teeth. I want to practice in Nebraska when I get done with my program because it's home. I plan on being part-time in private practice and part-time in public health in Omaha focusing on serving the underserved areas of central Omaha and north Omaha. Learning about the recent audits in our state concerns me seeing a dentist like Dr. Killeen, who served a similar patient population at Lincoln Lancaster Health Department go through-- serving a similar patient population I plan to see you go through this audit, gives me-- makes me consider pursuing public health as, as a viable option. I also ponder whether the attached strings are worth the hassle of an already low reimbursement rate for provided services. I'm a young practitioner, my training is focused on the art and science of my clinical profession, it hasn't covered billing and insurance protocols in much detail. I worry that if I make a simple error on my note or accidentally bill out the wrong code that I'll receive an audit years later that puts my developing business under stress. These audits are not peer-to-peer, they haven't followed the American Academy of Pediatrics Dentistry guidelines for treating children that I have learned over the course of my education and they do not consider the patient as a whole. Rather, they focus on one decayed part of one tooth and tell us to pick a short-term, low-cost treatment instead of choosing what is the best evidence-based practice for the patient and what is often the lower cost in the long-term. Please know, I think audits are a healthy part of practice, I plan to conduct internal audits at my offices. However, we need fair audits that look for those that are taking advantage of the system, not those practitioners that choose a treatment that will actually be more cost effective in the long run and better overall for the patient. We need pediatric dentists reviewing fellow pediatric dentists. We need healthy

conversation between managed care organization-- organizations and providers to avoid errors and promote lifelong learning and quality assurance. That's my hope for Nebraska dentistry as I began my career here. Thank you, and I'm happy to take any questions.

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

MURMAN: Thank you, Senator Howard. And thanks for coming in, Ben. I've got to apologize, I didn't recognize you.

BEN REIMER: I recognize you, though. [LAUGHTER]

MURMAN: Well, I thought you'd change the most but apparently I haven't changed that much.

BEN REIMER: That's probably a good thing.

MURMAN: But I'm glad you are in Nebraska, when I was reading you were hoping to come back to central Omaha, I was hoping that'd say central Nebraska. But--

BEN REIMER: That's not out of the realm of possibilities long-term, but--

MURMAN: Well, great. Yeah, I'm sure your dad would like to have-- your family would like to have you back. But yeah, I just wanted to remind you there are, are underserved kids in central Nebraska, too. I'm sure you realize that, but thanks a lot.

BEN REIMER: Yeah.

HOWARD: Senator Walz.

WALZ: I just have a-- I'm, I'm trying to find this section or maybe it's not here, but who makes up the auditors? I mean, what experience do the auditors have? Do you--

BEN REIMER: That's a really good question and I'm probably not the person to answer that. My-- from what I've heard, just being in that kind of education stage of things is that it can vary a lot. And that's one of the things the bill's trying to address. And my goal or what I would hope when I get out and practice, if I were to come in, come here and have a situation like this is I would be peer-to- peer. I don't know how do you determine that, but kind of like Dr. Killeen

said, have, have someone who's had similar training and, and does the similar, similar things day-to-day. That's who I'd want reviewing me.

WALZ: Thank you.

BEN REIMER: Um-hum.

HOWARD: All right, other questions? How do you know Senator Murman?

BEN REIMER: Oh, that's, that's a long story. So he's-- it's not a long story, he was actually the football coach for midget football, I think the Lions in Hastings won championship, 2006, so. I played with his son, I played with his son.

HOWARD: Oh.

MURMAN: Could you remind them who the quarterback was?

BEN REIMER: That's right, Chase Murman.

HOWARD: Chase Murman.

BEN REIMER: That's right.

HOWARD: Oh, that's wonderful. Well, thank you so much for your testimony today, we very much appreciate it.

BEN REIMER: Of course, thank you, guys.

HOWARD: All right, our next proponent testifier for LB1105. Good afternoon.

JESSICA MEESKE: Good afternoon. My name is Jessica Meeske, J-e-s-s-i-c-a M-e-e-s-k-e, and I'm speaking in favor of LB1105. I'm a pediatric dentist with practices in Hastings, Grand Island, North Platte, and Omaha. And kids with Medicaid compromise more than half of our patient visits. As you're aware, Medicaid is by far the worst payer of all the insurance plans we accept. And on average, it pays us about 30 percent of our fees. In addition, they are our most challenging patients. Medicaid is also a complex system of rules that doesn't mirror commercial insurance carriers. In dental school, we're not taught to be coding specialists. And because of these audits, I now find myself thinking less about what's the right care for my patient and should I provide the type of care that's gonna keep me out of a negative audit finding. And knowing that probably if I'm to do

that, I'm not going to provide treatment that's gonna to last the life of that baby tooth. Or if I treat the child going against national guidelines and that treatment fails, am I then gonna be audited in two or three years because my treatment failed and now I have to do the treatment again and bill Medicaid again because the kid's in pain, a much more costly outcome for the state. Most dentists understand when you participate in a government program, it's necessary to assure that the funds are used appropriately, but where our concern lies is how the audits are done. In observing the most recent dental UPIC audit, it targeted pediatric dentists in the state. Why? Because pediatric dentists see the most patients on Medicaid, which is kids. And you know that children make up the bulk of the population that qualifies for Medicaid. So in our practice that goes across the span of the state, we have thousands of kids that have Medicaid and these kids have a lot dental disease. And the more we fix their teeth and relieve their pain, the more likely we are to get an audit, and I understand that. In addition, you get flagged for an audit when your claims look different from your peers and no consideration seems to be taken that you might spend a day, your Friday, your day off in a public health clinic. Maybe you're the only bilingual dentist in Fremont, which as you know, if you're from the Fremont area, we have a high number of kids in poverty that live in Fremont, or you're the only dentist in a four county area taking new patients of Medicaid, which is the situation we're faced with in North Platte. So we literally feel we're at high risk for the state coming after us because, after all, if you're billing a lot for Medicaid procedures, you must be doing something wrong in the eyes of the state Medicaid agency. There's ways to fairly audit providers such as: number one, using same specialists to review same specialists; number two, applying as opposed to ignoring national clinical guidelines; and three, placing reasonable limits how far the audits can go. To move away from this pay-and-chase system would be a huge step in the right direction. Wouldn't it be great if the Governor and the CEO of HHS would instead create a program that would reward providers for following the rules and instead educate those who need to do it differently than the system that's very penal that we currently have. Program integrity is using the audit process to really do what managed care is supposed to do, and that is look at the kind of services being provided and determine what's appropriate and most cost efficient. The managed care contract, it's still new. It was just implemented in 2017. They're calling me all the time and saying we, we need you to start doing it this way. And I'm like, OK, that makes sense, I'm willing to make those changes,

it didn't have to be a penal thing or a payback thing. Let them do the job you're paying them to do. They're able to run reports and ask providers to work within agreed upon limits to assure that the money allotted will stretch as far as possible. I'll end my time with this true story: last spring, my sister was pulled over for speeding on Highway 6 on her way to camp for her middle schooler at CCC, she was running late. Annoyed that she was pulled over and now would be even more late, she told herself she was gonna be a good example to her middle schooler. She was gonna show him how she was gonna take responsibility for driving over the limit. Unfortunately, to make matters worse, she had just renewed her insurance, but left the proof of insurance in the pile of mail on the kitchen counter. We can all see how this can happen. But here's how the state patrolman handled it, he stated the reason for pulling her over and he checked her driving history. Noting she had a good driving record, he said, ma'am, if you can remember the name of your car insurance, I think together we can find proof of it on-line. If we did that, I wouldn't need you to write a ticket. Sure enough, there it was. He gave her a warning to slow down and to stay safe. My nephew observed an effective interaction between how law enforcement keeps us safe and yet still holds us accountable. Also, there was no mention of extrapolating that potential speeding ticket. That could have been one very large speeding ticket depending on any of us. By passing LB1105, it'll be a strong step in letting our state Medicaid agency know that audits have to be fair and the focus should lie in fraud, waste, and abuse. Every effort should be made to keep providers in the Medicaid network. And with the Medicaid adult expansion coming, this is such a crucial time that we need to be engaging dental providers in the Medicaid system and not alienating them if they're making errors which can be identified, they can be educated, and those errors can be corrected without a punitive measure. Thank you.

HOWARD: Thank you. Are there questions? All right, seeing none, thank you for visiting with us today. OK, our next proponent testifier LB1105. Good afternoon.

RICK VEST: Good afternoon, Senator. Thank you, all. Good afternoon, Senator Howard and members of the Health and Human Services Committee. My name is Rick Vest, spelled R-i-c-k V-e-s-t. I'm a member of the Lancaster County Board of Commissioners and I am here to testify on behalf of the Lancaster County Board in favor of LB1105. The basis for Lancaster County support for LB1105 is set forth in the letter from the County Board, which has been provided to you. I won't read that

letter. I would like to emphasize a few points from our letter where Lancaster County is particularly affected. The impact of the current Medicaid dental audit process is having a harmful impact on our vulnerable children in Lancaster County in need of dental services. Tooth decay left untreated in children lacking access to care will only create needless pain and suffering for those children and will result in higher costs for treatment that could be resolved by access to prevention. Also, both Lancaster County and the state have a critical shortage of Medicaid dental providers. The current Medicaid audit process undermines our ability to recruit dental providers and maintain adequate provider networks. LB1105 can help attract more Medicaid providers by fixing this flawed audit process. Audit standards using professional clinical guidelines and the best practices established by licensed professionals from specialty areas will help guarantee that quality care is being given and providers are being treated fairly. Thank you for the opportunity to testify. I would be sort of happy to answer questions.

HOWARD: Thank you. Are there questions?

RICK VEST: Thank you all for what you do.

HOWARD: All right, seeing none, thank you for visiting with us today. Our next proponent testifier for LB1105. Good afternoon.

GWENDY MEGINNIS: Good afternoon. My name is Gwendy Meginnis, G-w-e-n-d-y M-e-g-i-n-n-i-s. I am the manager of the Division of Dental Health and Nutrition Services at the Lincoln-Lancaster County Health Department here in support of LB1105 on behalf of the Lincoln-Lancaster County Health Department. You have heard from the dental community about the impact of the current Medicaid audit process on dental practice. I want to talk to you about the impact of the Medicaid dental audit on the dental program at our department. Our community lost our dental clinic's pediatric dentist due to a misguided Medicaid audit process. Dr. Killeen provided dental care for the most vulnerable children of Lincoln and Lancaster County for the past 14 years in our clinic. The loss of our pediatric dentist is having a significant negative impact on the very young children in our clinic. They no longer have the access to the expertise of a pediatric dentist in treating children with complex dental needs. These are children as early as age 1, children with behavioral challenges, children with specialized medical needs, and children that require treatment in a surgical care center or hospital for treatment. As a

local city and county health department, our resources are directed to serving the most vulnerable, at-risk populations in our community and county. Of the dental clients seen in our clinic, over 70 percent are children, 79 percent are enrolled in Medicaid, 85 percent are of racial and ethnic minorities and white non- English speaking, and over 62 percent have language barriers requiring the use of an interpreter for treatment services. Our dental clients don't easily access the private sector for services because of language barriers and cultural influences. The Lincoln-Lancaster County Health Department provides on-site interpreters and outreach specialists that are instrumental in our dental staff's ability to build trust and provide services for the most vulnerable children and adults living in Lincoln and Lancaster County. The Lincoln-Lancaster County Health Department supports the provisions in LB1105 for ensuring the integrity of the Medical Assistance Act and for maintaining a vital Medicaid provider network for the state of Nebraska. LB1105 will establish critical audit provisions in the use of licensed, healthcare professionals from the specialty areas of practice for peer-to-peer review, assure that auditors will utilize the professional clinical guidelines and best practices of the specialty organizations that are responsible for establishing the professional standards, and prohibit contract auditors from extrapolating overpayments from providers. The Lincoln-Lancaster County Health Department encourages the Health and Human Services Committee to support LB1105. In addition to my testimony, I provided you with a letter of support for LB1105 from the Lincoln-Lancaster County Board of Health. Thank you. Any questions?

HOWARD: Thank you. Are there questions?

GWENDY MEGINNIS: Thank you.

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

GWENDY MEGINNIS: Thank you.

HOWARD: Our next proponent testifier for LB1105. OK, seeing none, is there anyone wishing to testify in opposition? Good afternoon.

JEREMY BRUNSSEN: Good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. My name is Jeremy Brunssen, J-e-r-e-m-y B-r-u-n-s-s-e-n. I am the interim director for the Division of Medicaid and Long-Term Care within the Department of Health and Human Services. I am here to testify in opposition to

LB1105, which will change provisions surrounding program integrity contractors utilized by Medicaid in performing functions like audits and investigations. LB1105 generalizes the requirements implemented for Recovery Audit Contracts to all program integrity contractors and adds new requirements for all program integrity contracts. While those contract-- or those requirements are reasonable for Recovery Audit Contracts, or RAC contracts, because they are paid on a contingency basis, they are not reasonable for all program integrity contracts. In effect, this will limit the scope of what Medicaid can audit and the resources we utilize in performing these audits limiting the Department's ability to perform program integrity functions. Program integrity audits and investigations are performed to protect the Nebraska Medicaid Program and clients from error, fraud, waste, and abuse, not to harass providers. Audits and investigations are conducted in compliance with state and federal law and are initiated when there is a complaint where a provider is identified as billing in a manner substantially different from their peers. Audits and investigations focus on reviewing the provider documentation to ensure that it substantiates that the client needed the care, the treatment was most appropriate for that individual, that the care was actually provided, and that the provider was qualified to perform the service. So I want to take a second and talk a little bit about just to address some of the, the previous comments as well. The audits through the UPIC contract are not asking or requiring that providers deviate from medical evidence- based best practice. What it's requiring is that there's sufficient documentation to demonstrate why that was the appropriate course of action taken in the care provided and billed to Medicaid. The provider is responsible for maintaining the documentation and their clinical records and supplying it to the Department or the contractors upon request. While some providers are referred to law enforcement due to a credible allegation of fraud, most providers are not. Other interventions include provider education, claim adjustments, and refunds for care that is not appropriately claimed and documented. Appropriate care for clients and provider compliance is always the goal in an investigation or audit. This bill limits the claims subject to review for audit purposes to within two years of the payment, which is problematic when conducting an audit or investigation other than RAC. Our federal oversight bodies, CMS, the Office of Inspector General, and the GAO, just to name a, name a few, continuously audit the Nebraska Medicaid Program for periods well beyond two years. And this limitation is a significant deviation from standard auditing practice in Medicaid. I

want to take a second and touch on the fiscal note-- I know there have been some questions on that. Currently, the state of Nebraska, the Medicaid Program partners with CMS to leverage the UPIC contractors. And those are contractors that work across all the lines of business with Medicaid and as well as in partnership with-- I'm sorry, with Medicare as well as with Medicaid. And it's at no cost to the state of Nebraska. And so the fiscal note that we've included here is essentially how we would envision needing to supplement our current staff in order to have appropriate program integrity resources that's currently being augmented through the UPIC resources that we have through the UPIC contracts. So we did not put any fiscal note assumptions around what we would anticipate or try to project not recovering as a result of not doing the audits. We don't want to be in that business. We want to assume that all providers are doing the right thing, but we are required, obviously, and it's best practice to audit. So that's really the comment I want to make sure that we have and I'm happy to take any questions on that. Additionally, disallowing the program integrity contractors from auditing and investigating, investigating claims paid through a capitated arrangement or managed care eliminates the Department's ability to use those contractors to audit not only providers but the managed care entities. The vast majority of claims and services are rendered in managed care and this limits our ability to audit these claims. The Department believes that the bill will likely put us at risk of being deemed out of compliance with federal law on those managed care claims. We have significant concerns with the bill eliminating or prohibiting the use of extrapolation. CMS and OIG both use extrapolation when auditing in LTC, the Medicaid Fraud Patient Abuse Unit of the Nebraska Attorney General Office uses extrapolation on civil cases, the U.S. Attorney Office also uses extrapolation in federal cases. Provider self-disclosures are accepted when they use extrapolation to avoid 100 percent review. So when they're actually self-reporting items rather than doing a case-by-case, all-claim review they can opt to do extrapolation instead. And by eliminating and limiting, eliminating and limiting, eliminating extrapolation and limiting the number of claims, the bill limits our ability to perform required program integrity functions. Assuming only 5 percent of the claims can be reviewed, 95 percent of the errors could not be assessed and collected. I'd also like to note, again, we're, we're comfortable with that from RAC because RAC is paid on a contingency basis where this is not the case for all program integrity contractors. Finally, I'd like to point out that the Department is subject to a Payment Error Rate

Measurement, or PERM, review with CMS. This review looks at the accuracy of eligibility determinations of claims processing and of medical necessity. The dollar amounts found to be an error are extrapolated for the state. Starting with this review cycle, CMS may begin to penalize the state's federal financial participation when the error rate exceeds a certain percentage and the state may be required to refund the extrapolated amount. The program integrity contracts available at no cost to the state have been, are, and would continue to be a useful tool to help address errors and help bring providers into compliance. The requirements in this bill will eliminate this tool and could put the Department at risk of losing federal financial participation. Ensuring taxpayer dollars are spent wisely is a priority for Nebraska Medicaid. And if LB1105 were to be enacted, we would have fewer auditing tools available to make certain funds are being properly used. Limiting the Department's ability and tools to audit providers at the same time the eligible population is expanded, does not make good fiscal sense. We respectfully request the committee oppose this legislation. Thank you for the opportunity to testify. I will say, we'd be happy to work with individuals on this bill and work through the concerns. Otherwise, I'd be happy to answer any questions you have.

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

WILLIAMS: Thank you, Senator Howard. And thank you, Mr. Brunssen, for being here again in, in your role with, with the Department. And, and you've heard all the testimony that, that we heard today and you've heard some of that before also, and I think we are all here to try to solve an issue with kids that need dental services that are, that are paid for by Medicaid. If this legislation isn't the solution to addressing those problems, what is the solution that we need to move forward with?

JEREMY BRUNSSEN: I think it's gonna be a complicated solution. I don't think I can answer it here in the hearing. But what I am committed to do, is working with whomever we need to work with to find the solution. I can tell you that I personally have had several meetings with Dr. Meeske, who had testified today. And, you know, I'll be very frank, she-- early on when the audits were going on, she had brought some of the concerns to, to our attention specifically around the selection of the auditor that the contractor hired, a Nebraska Medicaid dentist that was not-- did not have the pediatric specialty background. She brought that concern to our attention. And, you know,

we've committed to, to ensure that moving forward we work with the providers that are being audited and finding what is a reasonable auditor for that specific audit. So just so we can talk a little bit about how that works, essentially, we get a list of interested, appropriately qualified auditors, so typically we first screen to ensure that they have-- that they're, they're Medicaid, they're enrolled with Medicaid. We also look to ensure that they actually have seen Medicaid patients, understand what it's like to serve as a provider in the Medicaid Program. I can tell you, we did have a dentist that met those criteria, but was not a pediatric specialist. But we're, we're willing to, to make-- and I think I've even-- I know I've put in writing that we're willing to work and do those things. We were already in the course of the middle of the audit and changing that just in the middle of an audit didn't make sense from a consistency standpoint. But I think there are a lot of different things we can work through. But what we want to make sure is that we don't go too far in the effort of-- you know, we, we want providers to, to obviously be in the system. This is not-- like I said, we are not attempting to harass or, or create burdens. It's, it's a balance of ensuring that documentation matches what was done and why and what was billed against making sure that it's not overly burdensome. So we've heard the concerns, I, I understand the concerns, and we're willing to work towards a reasonable solution, but we can't support some of the information-- some of the proposals that are in the bill as they're written.

WILLIAMS: And I appreciate your, your proven record of working on these issues and bringing people together to find solutions. Thank you.

HOWARD: Other questions? Senator Arch.

ARCH: Thank you. Under, under our present system, who defines best practice?

JEREMY BRUNSSEN: So it's in our, in our state statute, I believe in our regs, I, I have it in here, but I can follow up in more specifically-- it's-- there's kind of a generic overlaying statement that says medically-- medical evidence-based best practice. So it kind of catches all whatever provider type or, you know, specialty area or whatever it is. So we're not specifically-- the intent of the audit is not to determine or change a provider's practice, it's to ensure that the documentation provided for what was billed matches why the service

was rendered. So if it's more appropriate to put a crown on and not do a filling, it just needs to be documented as to why that was done that way.

ARCH: OK. Thank you.

HOWARD: Other questions? I just have a couple. First, Mr. Brunssen, I'm very grateful for the work you're doing in Medicaid. I really appreciate it. So I just want to ask a couple of questions related to your testimony. So I'll sort of walk through them just so that I have a better understanding. So at the bottom of page 1, you talk about the two-year requirement, and the two-year requirement, what I'm seeing is that it's already in statute and wouldn't the UPIC auditors already need to follow that?

JEREMY BRUNSSEN: No, so the current state statute was created and written specifically to Recovery Audit Contractors. This is a different type of contractor, so--

HOWARD: Spoiler alert that was-- I did that bill.

JEREMY BRUNSSEN: Yeah, so, so-- I mean, that's-- UPIC contractors are not RAC contractors. I don't-- I can follow up on the specific definitions of what they all are, but we actually don't even have a current RAC contractor because there are no vendors that really are interested in the market because most of our services are in managed care and RAC was specific to fee for service. So we saw it and have received approval for a waiver to no longer do RAC. And that's kind of the, the short history, I guess.

HOWARD: OK, perfect. OK. And then on page 2, you talk about the disallowing program integrity contractors from auditing claims through a managed care arrangement. And my understanding was that if you were gonna have an audit from your managed care, then you wouldn't have a second audit through, like a say, UPIC contractor because that would be duplicating the same audit on the same service.

JEREMY BRUNSSEN: Sara, I think there's a misconception that managed care is auditing all the claims to start with, that's certainly not the case. Our Program Integrity Office within the Nebraska Medicaid team works with the managed care entities who have program integrity units within themselves. So oftentimes, you know, they're, they're sharing things with us and we're sharing things back. It's not that we're duplicating necessarily, I think that's not really what's

happening. What this bill stated was-- and there's a specific line I can reference, what it did is it basically-- because-- well, I'll find it, I think it'll be cleaner if I just find it and walk through it with you,--

HOWARD: Thank you.

JEREMY BRUNSSEN: --rather than fumbling through off memory. But-- here we go. So on page 4, line 25, where it begins, it says, the department shall exclude the following from scope of review of the program integrity contractors. The next one is (a) claims processor paid by a managed care program. So this unintentionally says that we can't audit, use like a UPIC or any other contractor to audit any claims paid by a managed care company.

HOWARD: OK, thank you. Thank you for explaining that.

JEREMY BRUNSSEN: Yeah.

HOWARD: I, I really appreciate it. And then the other-- in the middle of page 2, you talk about the issue of extrapolation. And just so I'm clear, the-- a state couldn't decide whether or not to allow extrapolation. Is that correct?

JEREMY BRUNSSEN: Yeah, I'm-- I just received some feedback, I think the same document that was passed out to you all. So I, I can't dispute that we have the opportunity to choose whether or not we do it, what I can tell you is it's a standard practice in Medicaid and it's a standard process across the board. So--

HOWARD: It's a standard practice for Nebraska Medicaid or it's a standard practice for everybody?

JEREMY BRUNSSEN: Well, I think if you-- I can follow up to find-- to, to give you more specific information. But we have found not only historically in Nebraska, but also working with other partners, and we experience it through PERM. We experience it through many other audits with OIG and GAO when they're auditing the Medicaid Program that if you're not going to increase sample size, extrapolation is commonly used.

HOWARD: OK. But-- OK. And then on PERM, on the bottom of page two, you say that PERM-- is it-- it's not that we wouldn't-- there's nothing in

this bill that says we couldn't do, we couldn't have a Payment Error Rate Measurement review by CMS.

JEREMY BRUNSSEN: No, that's a required. What we're saying is that this is one of the tools, having the UPIC is one of the tools to help us identify where we have error-- errors in payment, that way we can fix it. So when we have our cyclical PERM audits, we can fix things as we go more effectively than it getting caught in PERM and us having to go through a cycle of corrective action plans with the federal government. Right? So it's, it's proactive monitoring, it's program integrity functioning is our concern that it limits our resources to do that work.

HOWARD: OK. So in your interpretation, you view LB1105 as preventing you from effectively doing program integrity audits?

JEREMY BRUNSSEN: Certainly limits what, what we're able to do because it limits the number that we can audit, doesn't allow for extrapolation, and doesn't allow us to look back and actually get, get a good statistical sample for specific services, because-- and oftentimes if it's a two-year window, you know, we wouldn't audit something that is from a month ago, we would look back because we have claims lag that happens as well.

HOWARD: OK. And then do you-- there were three things that a, a dentist mentioned, so do you have issue with specialists being able to review specialists?

JEREMY BRUNSSEN: Absolutely not, that's, that's what I was speaking to with our conversation with Dr. Meeske.

HOWARD: OK.

JEREMY BRUNSSEN: We're, we're fine with working with-- I mean, there are things that we can do better. I-- we talked about that with Dr. Meeske, and that's one of those things, and we're committed to doing those things.

HOWARD: OK, great, thank you. All right, any other questions? All right, seeing none, thank you for your testimony today.

JEREMY BRUNSSEN: Thank you.

HOWARD: All right, our next opponent testifier for LB1105. Seeing none, is there anyone wishing to testify in a neutral capacity? Seeing none, Senator Hansen, you are welcome back. And while he's coming back, we have two proponent letters: Joni Cover, from the Nebraska Pharmacist Association; and Dr. Todd Hlavaty, from the Nebraska Medical Association. One letter in opposition: D. Mark Collins, the Office of the Attorney General. No letters in the neutral capacity. Welcome back.

B. HANSEN: Thank you. I hope that was enlightening for everybody when it comes to audits and the process and some of the issues I think we are facing and we could face especially with Medicaid expansion. So one of the things I know Mr. Brunssen mentioned that he was concerned about is that it would limit the number of audits they could do. I think one of the reasons why is because they consider errors fraudulent. And I'm hoping under this bill that they don't because they view that as a reason to do integrity audits. We're hoping that the Department can work with providers and educate them and work with them instead of seeing it as a reason to do an audit. So I think that would limit the number of audits that they're probably gonna to do. So the best that I can say is I think this is something that is needed, that it's something that we're gonna have to definitely look at. And I appreciate, you know, the Department coming up here and giving their testimony, help shed some light on maybe some things that we can both work on together, which I'm expecting that we're going to be doing here and we are willing to work with them and make this a better bill if we can. So with that, I'll take any questions, if I can.

HOWARD: Thank you. Are there questions? All right, seeing none, thank you, Senator Hansen.

B. HANSEN: Thank you.

HOWARD: This will close the hearing for LB1105 and the committee will take a brief break, we'll reconvene at 3:05.

[BREAK]

HOWARD: And this will open the hearing for LB1184, Senator Arch's bill to require standards for certain psychiatric services under the Medical Assistance Act. Welcome, Senator Arch.

ARCH: Thank you. And good afternoon, Senator Howard, members of the Health and Human Services Committee. For the record, my name is John

Arch, J-o-h-n A-r-c-h, and I represent the 14th Legislative District in Sarpy County. And I am here today to introduce LB1184. It's a very simple bill. It is in response to a Medicaid regulation related to direct care staff for inpatient psychiatric services in a psychiatric residential treatment facility for individuals under 19 and regulations in discussion regarding direct care staff for inpatient psychiatric services in a hospital for juvenile clients, two different settings. Currently under Title 471, Chapter 32 of the Nebraska Administrative Code, direct care staff for inpatient psychiatric services for juveniles in a psychiatric residential treatment facility must be at least 21 years of age and at least three years older than the older resident. Additionally, last year, the Division proposed adding a new requirement that providers of mental health and substance abuse treatment services for clients under 20 can only hire direct care staff who are 20 years of age or older and are either actively pursuing an education in human services or have two years of education in the human services field or a two-year combination of education and work in the field. So you can tell from my discussion here, these-- this-- these requirements have been under discussion for some time and this is an attempt to clarify that. The green copy of LB1184 would prohibit the Division of Medicaid and Long-Term Care from setting standards for inpatient psychiatric units and psychiatric treatment facilities for juveniles that are more restrictive than national accreditation standards for direct care staff. Current national accreditation standards do not have age limitations nor do joint commission regulations. However, they do provide for comprehensive staff training and competency standards. I do appreciate the Department of Health and Human Services for reaching out to me regarding its concerns, and I will, and I will concede that the bill as written is very broad. I do have an amendment and I believe that amendment now has been handed out that puts into statute the outline of the current rule for direct care staff for inpatient juvenile services in a psychiatric residential treatment facility and a psychiatric unit of a hospital but lowers the minimum age from 21 years of age to 20 years of age and requires a staff to be at least two years older than the oldest resident, as opposed to three years older. The current regulations do create a hardship for inpatient units and facilities trying to hire direct care staff. With respect to the proposed regulation, the requirement that an individual also be actively pursuing a specific educational path is counterproductive. Many young people decide to pursue a particular career after having been exposed to it through early job experience, and these types of

jobs would provide that experience. Given Nebraska's work force shortage, particularly in the area of behavioral health, it doesn't make sense to place arbitrary roadblocks to employment opportunities. It is my understanding the proposed amendment to Chapter 32 have been put on hold at this time, but LB1184 gives us the opportunity to get ahead of that issue and to reexamine the current age restriction in place for inpatient psychiatric services in both psychiatric residential treatment facilities and hospital units. So let me just go back and say that again, that got a little convoluted. So currently there are regulations in place for psychiatric residential treatment facilities regarding the hiring of age. There was some discussion of putting that in also into the inpatient unit regulations, that's been put on hold. But we want to cover both of these and the amendment that, that I presented to you, just to clarify for both PRTFs, as well as the inpatient units in hospitals, these would be the requirements then for the hiring of direct care staff. So I'm gonna to stop at this point, there's testimony following me that will speak to the current challenges facing providers in finding available, qualified staff and how these age restrictions exasperate the problem.

HOWARD: Thank you. Just be-- so you want us to consider AM2479 because it replaces the green copy?

ARCH: Correct.

HOWARD: Correct. And then it only applies to facilities with juveniles?

ARCH: Correct.

HOWARD: OK, perfect, thank you. Other questions? All right, seeing none, will you be staying to close?

ARCH: I will.

HOWARD: Thank you. Our first proponent testifier for LB1184. Good afternoon.

PAT CONNELL: Hi. Good afternoon. Good afternoon, Chairperson Howard and members of the committee. My name is Pat Connell, P-a-t C-o-n-n-e-l-l. I serve as the vice president of Behavioral Health and Government Relations for Boys Town National Research Hospitals. I'm here today offering testimony as chair of NABHO Legislative and Regulatory Committee. We are in strong support of LB1184. NABHO's

46-member organizations provide comprehensive mental health services in substance abuse treatment services in every Nebraska county. NABHO has made it a priority to encourage the Legislature and the Executive Branch to simplify state healthcare-related statutes and regulations. NABHO has personally worked with at least four Nebraska Health and Human Services directors and six Nebraska Medicaid directors on revising and improving the Department's regulations and process over the last 30 years. A successful example of this collaboration was with Vivianne Chaumont, former director of Nebraska Medicaid. After multiple meetings with Medicaid and her staff, NABHO was asked to come up with some specific recommendations on how to change the regulations and make them more useful and clearer. We provided those recommendations and numerous positive changes were made by HHS. Unfortunately, Miss Chaumont became ill and was unable to complete this project and specifically fixing the staffing regulations. LB1184 is to correct an overly prescriptive and unnecessary regulation from our perspective, that has been in effect, as I said before, for almost 30 years. I was there at the very beginning of how this all transposed. It was kind like Genesis of the Old Testament. What happened was the state of Nebraska decided it wanted to pursue managed care in-- specifically in behavioral health. They went to CMS and because they wanted to add a lot of different services that wasn't in the state's plan or in the state Medicaid regulations at that time, inpatient care was there, outpatient was there, but psychiatric residential treatment facilities, therapy group homes, and some other services wasn't there. So they had to modify the state plan and they had to get the regulations approved back then by CMS because this was such an innovative concept called managed care. So they submitted-- they developed these plans, and what happened was when we saw the plans, they brought the stakeholders and providers in, we had several different meetings, both in Omaha and Lincoln. We gave them feedback. I, I got to tell you, the feedback was not well-received. It turned into some very heated discussions because we thought the regulations were overly prescriptive, inconsistent, conflicted with other sections, and, and a variety of other, other reasons. The state went ahead with those regulations and made some minor, minor modifications and said, we'll fix them. And so now 30 years later, we're still in the process of fixing them. The state has fixed a variety of different regulations, especially with Governor Ricketts, is a mandate for them to rewrite the Medicaid chapters. We've reduced a lot of redundancy. So today why we're here is, if you turn to the third page, it states up here what John was talking-- Senator Arch was talking about the,

the current regulation that's in effect. And then the state proposed this regulation at the, the second italicized section down below. And that second italicized section really kind of-- has kind of annoyed because it made it more complex and more confusing. And, and we have a really tight work force in the, the state, unemployment is almost next to nothing. We in healthcare are competing with all kinds of industries for these young people to come and work for us. And so getting them in at the age of 20 is very important to us. So what we're gonna do-- I'm gonna stop-- oh, I still got the go green light. OK, good. So what, what we want to do here is actually we want to get these people in at the age of 20. We want them to find out what it's like to work in healthcare. We want to train them and then we want them to stay with us for a number of years. If we have to wait until they're 21, they're gonna be graduating from college and then they're gonna go onto another career field. And we're not gonna get the payback for all the training that we've given them to, to make them staff. So I got one-minute warning. OK. So this afternoon, you're gonna have-- you're gonna hear from three other members of NABHO. We're gonna make our testimony brief, succinct in, in less than five minutes, and we're gonna talk about the following areas: the impact of program quality and therefore access to services, staff recruitment and retention, which affects both program quality and cost, and the cost to the state in enforcing this unnecessary regulation, and the role of accrediting bodies on hiring, training, and ensuring competencies of quality. So with that, we'd like to thank, Senator Arch, for introducing the bill and I would like to answer any questions if you have any at this time.

HOWARD: Thank you. Senator Williams.

WILLIAMS: Thank you, Senator Howard. And thank you, Mr. Connell, for being here. And just one quick question, you've testified in, in favor of LB1184, are you also supportive with your whole group of the amendment that has been handed out? I just want to be sure that we are tracking.

PAT CONNELL: That's a great question. We, we believe that it's a very reasonable approach--

WILLIAMS: Thank you.

PAT CONNELL: --solving this problem at this time.

HOWARD: Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman, Chairwoman Howard, sorry. Mr. Connell, I have a very important question for you today. What is the best legislative district?

HOWARD: Oh, no.

PAT CONNELL: Well, as my neighbor, I would have to say District 6, but on, but on second and more thought about this, I would have to say that every district that's represented around this table today are-- is my favorite--

CAVANAUGH: Don't [INAUDIBLE],--

PAT CONNELL: --and are the best ones to be serving on HHS.

CAVANAUGH: --just stick with your original answer. Thank you.

HOWARD: All right, any other questions? Seeing none, thank you for your testimony today.

PAT CONNELL: Thank you.

HOWARD: Our next proponent testifier for LB1184. Good afternoon.

MARILYN RHOTEN: Good afternoon, Senator Howard and members of the committee. My name is Marilyn Rhoten, M-a-r-i-l-y-n R-h-o-t-e-n. I am here today representing CHI Health in support of LB1184. Thank you for allowing me to testify. CHI Health is a regional health network consisting of 14 hospitals, two stand-alone behavioral health facilities, a freestanding emergency department, 136 employed physician practice locations, and more than 11,000 employees in Nebraska and southwest Iowa serving communities from Corning, Iowa to Kearney, Nebraska. We are also a founding member of NEHII and believe that it holds great promise for the future of the health of our state. We support LB1184, which would restrict the Division of Medicaid and Long-Term Care of the Department of Health and Human Services from setting standards for psychiatric inpatient, and psychiatric residential treatment facilities that are more restrictive than national accreditation standards. There is one specific example of regulation that has a negative impact on recruitment of nurses and psychiatric technicians, and that's been explained earlier in the, in the testimony. There already is a significant work force challenge

within healthcare. This is especially true in our rural communities. There are no age requirements in any other medical specialty nor any national accreditation standards. However, there is an age limitation for psychiatric facilities in Nebraska. Currently, there's a shortage of over 4,000 nurses in Nebraska. This is projected to grow 34 percent to over 5,400 by 2025. Psychiatric nurses are even in more demand. Nationally, there was a 58 percent increase in psychiatric nurse open positions between 2014 and 2015 and that's expected to grow. CHI Health is currently recruiting 26 psychiatric nursing positions and 20 psychiatric technicians for our inpatient acute behavioral facilities, changes day by day, but that was the number yesterday. Twelve of those positions are located at Richard Young in Kearney. We currently are utilizing nurse travelers to meet some of these, these nursing demands, and that's usually national people that come in and provide services within our communities. One of our recruitment initiatives is working with nursing students and students in social work and psychology programs to work part-time as psychiatric technicians. We do not require a bachelor's degree, so there are opportunities for those under the age of 21 to work with patients in our acute psychiatric inpatient units under the supervision of licensed nurses. This experience supports future recruitment once the students complete their training. They are held to national training and competencies, the same as any staff member, and a lot of the, the-- that competency and training information will be elaborated on by one of our other NABHO members. A great example of this recruitment initiative that we have is a student nurse tech program. It's not specific just to psychiatry, but provides an opportunity for nursing students in their junior or senior year of a Bachelor RN program to be hired in on call positions. We offer very flexible hours to support their educational commitments. Especially in psychiatry, this serves as an excellent opportunity for nursing students to become familiar with working with psychiatric patients in the therapeutic milieu as psychiatric technicians. Nursing students have very limited exposure to psychiatric nursing in their clinical rotations. One of the programs in Kearney, the requirement for psychiatric clinical rotation is only 24 hours and all of their nursing training. The other program has an opportunity for 60 hours. Still, that's very limited for nursing students to be able to see what it's like to work with psychiatric patients. So the exposure of the student tech program really allows an exposure to nursing students to psychiatric nursing, and it's an excellent opportunity for many nursing students. So you can see the age requirement adds another barrier in meeting work force challenges,

especially in rural Nebraska. For these reasons, we urge you to advance LB1184 to the full Legislature for consideration. Please know that CHI Health is a resource and would be happy to answer any questions you have on the proposal.

HOWARD: Thank you. Are there questions? Seeing none, thank you for your testimony today. Our next proponent testifier for LB1184. Good afternoon.

DAVID MIERS: Good afternoon, Senator Howard and members of the committee. My name is David Miers, it's D-a-v-i-d M-i-e-r-s, and I am submitting this written testimony in support of LB1184 on behalf of Bryan Medical Center and would like to thank, Senator Arch, for proposing LB1184 and its amendment. For many years we have sought to reverse the Division of Medicaid and Long-Term Care's odd decision to require entry level mental healthcare technicians to be at least 20-years- old and actively pursuing education and human services or have prior experience or education. Most recently, during the long awaited rewrite of Chapters 20 and 32, we submitted written recommendations along with the rationale why the regulation should be rewritten and should be appropriately trained and competent without the additional age and education requirements. But then a letter from then Director Van Patton indicated that the regulation would stand as originally written. It's difficult to understand why our state would adopt regulations that are incongruous, myopic, and lacking strategic vision regarding the inadequate behavioral health labor force needed to care for Nebraskans. In looking at the myriad regulations for behavioral health and physical health services in Nebraska, we are unable to find that this higher standard is applied elsewhere. There are techs, aides, healthcare workers and many other entry level positions throughout healthcare. We cannot provide services without these individuals. They work in hospitals, nursing homes, assisted living, clinics, health departments, and many other places throughout the state, and we're perplexed why a specific class of worker that's employed at specific levels of care must be held to a different higher standard, especially when a hospital and residential levels of care have at least the same or higher requirements for licensed staff supervision than many other types of services. Organizations that provide inpatient and residential behavioral health services are required by regulation be accredited by a national accrediting organization. These organizations, such as the Joint Commission or Commission of the Accreditation of Rehabilitation Facilities, have numerous standards and requirements for organizations to ensure that

staff have the knowledge and competence to provide quality of care, treatment, and services. The outline of the relevant standards include orientation, supervision, education, and training, competence, and evaluation. And I've posted in my testimony here I won't read through these is just a small excerpt of the Joint Commission standards for training and competence. As you can see, they were held to a very high standard for training and competence to the Joint Commission. So these standards were created and constantly updated by nationally recognized experts. Accredited organizations go through rigorous on-site surveys at least every three years. Bryan Medical Center will be surveyed this summer for a full week with no less than seven surveyors. Given that Nebraska regulation requires programs to be nationally accredited and the rigor required to meet these nationally recognized standards, it continues to be a mystery as to why the Nebraska Department requires this oversight, yet feels it necessary to require a higher standard than these experts. Furthermore, I wanted to point out that the American Academy of Child and Adolescent Psychiatry, in their principles of care state that staff in addition to the supervisors, may be mental health aides with high school level education and additional training and skills necessary to provide safe and competent care. So other organizations will testify to the real obstacle this regulation poses to our behavioral health work force. Nebraska needs young people to become interested in caring for those with behavioral health needs. So do we fan the flame with opportunities as these young men and women leave high school or hope the fire doesn't go out as we wait two more years. I ask that you support LB1184 and its amendment, and I'm pleased and welcomed to answer any questions you might have.

HOWARD: Thank you. Are there questions? Seeing none-- oh, Senator Murman.

MURMAN: Thanks a lot, Senator Howard. And thanks for testifying. I'm not sure if you're the right one to ask this question, but we're talking a lot about age restrictions. Why is the two year older than the oldest resident in there? That's in the amendment. Maybe, maybe we can ask somebody later on.

DAVID MIERS: I'm not sure.

MURMAN: OK. Thanks.

HOWARD: All right, thank you for your testimony today.

DAVID MIERS: Thank you.

HOWARD: Our next proponent testifier for LB1184. Good afternoon.

DENNIS VOLLMER: Good afternoon. Good afternoon, Senator Howard and members of the committee. My name is Dennis Vollmer, D-e-n-n-i-s V-o-l-l-m-e-r, and I serve as the director of the Boys Town Psychiatric Residential Treatment Facility. Boys Town serves up to 96 youth and their families from across the state of Nebraska in our behavioral health programs comprised of 80 beds in the Psychiatric Residential Treatment Facility and 16 beds in the Child and Adolescent Psychiatric Inpatient Unit. These programs combined have employment opportunities for over 150 direct care staff working either full-time, part-time, or on call. Boys Town is in strong support of LB1184 and would like to thank, Senator Arch, for introducing it. Three aspects of the bill I'd like to highlight are: First, it will help increase the size of the mental health work force. We attend numerous career fairs recruiting candidates for positions within our program. Unfortunately, we cannot present the information about these positions to anyone under 21 as the current regulations prohibit hiring them. This takes away opportunities for juniors and some seniors to start their careers in the field while still in school. We recently attended a social work career fair at a local university and five of those students asked directly about current employment opportunities at the PRTF. Unfortunately, none of them were eligible as they were not 21-years-old. Secondly, Boys Town, as well as other mental healthcare providers, provide extensive training to all new direct care staff, including behavioral health technicians, nurses, teachers, and therapists. Direct supervision, frequent consultation, and ongoing competency- based trainings are also provided to all direct care staff as part of their continuous development. The attachment you have received illustrates the comprehensive training that occurs for our staff. We do this to ensure quality programing and consistency of treatment for the youth we serve while meeting all Joint Commission and state licensing standards. Finally, waiting to hire individuals who are 21 years of age puts our program at a significant disadvantage in retaining them. Typically, soon to be 21-year-olds and those already 21 years of age who have graduated from college are looking to secure higher level positions in the field versus a behavioral health technician, which is an entry level position. If they do start with us after college, they often leave after gaining a year's experience to do other things, being able to hire a 21-year-old who is still in school allows us to build relationships with them and to identify

potential future employment opportunities within Boys Town. And let me also add, we are currently struggling to have the necessary staff to maintain the program capacity that we desire. Fewer staff require that we limit our capacity in order to run a safe and effective treatment program. This limits access to serving-- access to services for children in the state of Nebraska. In summary, we thank, Senator Arch, again for introducing LB1184 and I stand ready to answer your questions.

HOWARD: Thank you.

DENNIS VOLLMER: Thank you.

HOWARD: Are there questions? Senator Williams.

WILLIAMS: Thank you, Senator Howard. And thank you, Mr. Vollmer, for being here. Just so that we understand this a little better, you talked about that this behavioral health technician is an entry level position. Can you describe a little bit what the duties and responsibilities--

DENNIS VOLLMER: Sure.

WILLIAMS: --that are around that job?

DENNIS VOLLMER: Yes. We, we hire behavior health technicians for day shift, evening shift, and overnight shift, so they're working roughly an eight-hour shift. They're working directly with the children teaching social skills. We, we use a psychoeducational model, which is a derivative of the family home model that Boys Town has been operating for some, some years from Kansas University. And so really, they are the, the heart and soul of our program, teaching skills, working very, very closely with the therapists and under the psychiatric adolescent psychiatrist involvement. So they are really the bread and butter teaching to those children each and every day, monitoring, helping them become better citizens, teaching social skills.

WILLIAMS: Do you see any distinction between being 20-years-old or 21-years-old and be able-- being able to fully fulfill those duties and responsibilities?

DENNIS VOLLMER: I do not. I see with our comprehensive training, pre-service orientation, ongoing consultation and oversight, as well

as the annual trainings that we are required to have for the-- for 20- or 21- year-old behavioral health technicians that they should be able to do a fine job in working with our children.

WILLIAMS: Thank you.

DENNIS VOLLMER: You're welcome.

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

DENNIS VOLLMER: Thank you.

HOWARD: All right, our next proponent testifier for LB1184. Seeing none, is there anyone wishing to testify in opposition? Seeing none, is there anyone wishing to testify in the neutral capacity? Seeing none, Senator Arch, you're welcome to close. We do have some letters: there's one letter in support from Andy Hale and David Slattery from the Nebraska Hospital Association; no letters in opposition; one letter in the neutral capacity, Jeremy Brunssen, from the Department of Health and Human Services. Welcome back.

ARCH: Thank you. Well, I think the, the testifiers I think laid it out pretty, pretty clearly that this is, this is an attempt at a resolution that's been ongoing for many, many years. And I think it brings reasonableness. It provides, it provides some distance between those that are being hired and the juveniles that are being cared for as far as age goes. And, and it provides opportunity and that is-- that's huge, opportunity both to the provider to adequately staff so that, so that they can maintain the census and, and take care of the juveniles, as well as to the individuals who may be considering human services in some capacity to be a, a career track. So I would encourage you to look favorably on LB1184 as amended with AM2479. And I would answer any questions if you might have any.

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

MURMAN: Yeah, thanks. So the two years is just to keep a little bit of distance between--

ARCH: Yeah, I, I think that's-- I think that is the intent because, because obviously working with, with these youth-- you are in very direct contact with these youth. This is unlike other perhaps medical, medical services where you're in and out and taking vitals and that

type of thing, you're, you're-- it-- you're, you're teaching lot of, lot of direct, lot of time spent and, and some, some age difference from the oldest there is probably appropriate.

MURMAN: OK. Thanks.

HOWARD: All right. Any other question? Seeing none, thank you, Senator Arch.

ARCH: Thank you.

HOWARD: This will close the hearing for LB1184, and we will open the hearing for LB1158, Senator Arch's bill to provide information on job-skills programs to applicants for medical assistance.

ARCH: Good afternoon, Senator Howard, members of the Health and Human Services Committee. For the record, my name is John Arch, J-o-h-n A-r-c-h, and I represent the 14th Legislative District in Sarpy County. I'm here today to introduce LB1158. As we are all very much aware, Medicaid expansion is scheduled to come on-line later this year. It is estimated approximately 90,000 Nebraskans will qualify for the program, some considered the working poor, for others perhaps unemployed due to certain unemployment barriers, including illness. We've had countless briefings on the expansion and the waiver process, and every time I keep thinking, in addition to providing access to healthcare, what more can we do with our existing state and federal resources to assist this particular constituency? How can we take advantage of the opportunity Medicaid expansion is presenting to further improve lives? I've shared my thoughts with many of you on the committee and I credit Senator Howard with alerting me to the SNAP reemployment pilot program. The program is a collaboration between the Department of Labor and the Department of Health and Human Services and it's existing today. SNAP recipients who may benefit from the federal Workforce Innovation and Opportunity Act, or WIOA, are identified and offered the chance to take part in the program, which includes help with job searches, resumes, interview preparation, job-skills training, as well as assistance with things such as childcare and transportation. The pilot program, and I would remind you this is, this is the SNAP program, the food, the food program, which began in 2016 in Grand Island, is heading into its fourth year and has been expanded to all of Hall County, Adams County, Platte County, Madison County, and I believe Scotts Bluff County. The program has been such a success, it is my understanding there are plans to

take it statewide. Upon learning of this program, I met with Department of Labor Commissioner, John Albin, and then director of Division of Medicaid and Long-Term Care, Matthew Van Patton, and asked if it was conceivable for a similar program to be offered to the Medicaid expansion applicants. And from those conversations, LB1158 was drafted. LB1158 requires the Department of Health and Human Services beginning in 2021 to inform each adult applicant for Medicaid, not just those who are later determined eligible, about the opportunity to participate in job-skills programs within the Department, the Department of Labor, or other programs in the community that can assist in improving employment opportunities. This is not a work requirement. This is entirely voluntary. They self-identify during the application process that they would like some assistance. Until I met with Commissioner Albin and Dr. Van Patton, I was not aware of all the various resources there are available to assist individuals beyond the programs we typically identify. And the only way somebody who may benefit from one of these programs would know about them is by providing that information. Under the bill, the Department is charged with following through and connecting those applicants who are interested with the appropriate program. And I assume most of this will be done by the MCOs at the time of application. I purposefully drafted the bill broadly so as to limit any fiscal impact and to give DHHS and the Department of Labor the flexibility to develop the collaboration as these departments see fit. Given the success of the SNAP reemployment program, which was done without legislative intervention, I have every confidence these agencies will develop a successful program. In fact, I'm so confident we can be successful in helping unemployed and underemployed Nebraskans that the offer for job-skills training is not limited to the expansion population. In other words, those who actually are determined to be eligible, but it's available to any Medicaid applicant if they so wish to take advantage of it. In addition, LB1158 contains some reporting requirements so we can determine if offering this extra service in the medication application process proves to be beneficial. Though there is no sunset date in LB1158, I'm treating it somewhat like a pilot program in that the reporting requirements are for two years only. We give the program some rollout time and then require the Department of Labor to report to DHHS quarterly the number of applicants who were referred to job-skills programs, the number of applicants who received help, and the type of services they received. Additionally, DHHS will be required to report that information to the Legislature every quarter. While mandated work requirements for the

Medicaid expansion population have resulted in lost coverage, lawsuits, and mixed results, voluntary employment betterment options show promise. According to the Kaiser Foundation, Montana, Louisiana, and Maine are three states that stand out with respect to proactive and targeted voluntary job-skills programs. In Montana, clients enrolled in work force development programs saw wage growth between 82 and 84 percent. With the expansion, the Medicaid Program, as we have traditionally known it has fundamentally changed and we're in a position to change with it. As we gain a better understanding of the needs of this newly covered constituency, perhaps we will find other ways to assist them to improve their lives. Perhaps we will discover some recipients who may for the first time feel well enough to enter the work force or move from part-time to full-time employment, or to seek a better job with a hand up from the state. I hope that at LB1158 is just a beginning to take a more holistic approach to helping Nebraskans through the Medicaid Program. If we are successful in helping those who are ready to find a new career track and improve their lives, everyone will benefit. I am seriously considering this bill as my priority and encourage you to advance LB1158 to General File. I'd be happy to answer any questions.

HOWARD: Thank you. Are there questions? I, I have a language question, on your green copy.

ARCH: Sure.

HOWARD: You said in your opening that it's for each adult applicant for medical assistance, but on line 6, page 2, you say each applicant. I think maybe because each-- because kids apply for it and, and so I think maybe we need to--

ARCH: OK.

HOWARD: --nuance that language.

ARCH: That's page 2, line 6.

HOWARD: Um-hum.

ARCH: OK.

HOWARD: Just to say--

ARCH: Yeah.

HOWARD: --well, you want adults and you want adults who aren't disabled or something like that.

ARCH: Right.

HOWARD: Right. Yeah, absolutely. OK.

ARCH: OK.

HOWARD: Thank you.

ARCH: Thank you.

HOWARD: Any other questions? All right, seeing none, will you be staying to close?

ARCH: I will.

HOWARD: Wonderful. OK, our first proponent testifier for LB1158. Good afternoon.

JOHN ALBIN: Good afternoon, Chairperson Howard and members of the Health and Human Services Committee. For the record, my name is John Albin and I'm Commissioner of Labor and I'm here-- appearing here today before you in support of LB1158.

HOWARD: Commissioner, could you spell your name please?

JOHN ALBIN: Oh, I'm sorry, J-o-h-n A-l-b-i-n. LB1158 furthers existing efforts between the Nebraska Department of Labor and Nebraska Department of Health and Human Services. The two agencies have already been working together to help improve the lives of Nebraskans. In 2016, the SNAP Next Step Program was launched in Grand Island. The program is a partnership between NDOL and DHHS that provides individuals participating in a SNAP Next Step Program coordinated services between the two agencies to help individuals improve their skills and achieve the ultimate goal of self-sufficient employment. The program utilizes existing NDOL employment, training employees, and programs to help individuals, to help individuals with resumes and job training. SNAP Next Step has expanded from Grand Island to Hastings, Columbus, Norfolk, Scottsbluff, North Platte and Sidney. The program is helping participants reach employment goals and live better lives. The partnership has utilized existing strengths in both agencies. NDOL

already administers the Wagner-Peyser program, the Reemployment Services and Eligibility Assessments programs, and the Workforce Innovation and Opportunity Act. All of these programs are focused on helping individuals gain employment. As part of these programs, NDOL works with individuals on resume drafting, interview skills, and job searches. NDOL helps individuals enroll in job training programs and provides career guidance. SNAP Next Step is a natural coordination between the two agencies. SNAP Next Step helps Nebraskans enrolled in SNAP find more suitable jobs through job search and resume assistance, interview training, vouchers to buy clothing for interviews, and paying for childcare and similar services. Participants who have committed to the SNAP Next Step Program have realized an average increase of wages of more than $900 a month or $11,000 a year. DHHS will follow me and they will provide information on pilot program statistics. Ensuring that individuals participating in SNAP have access to these programs is critical. LB1158 helps to make sure that those currently without self-sufficient employment have access to existing programs to help them achieve financial independence. I have also included the latest quarterly report on the SNAP Next Step Program, which DHHS prepares every quarter, and I'd be happy to answer any questions on my testimony or the report.

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

MURMAN: Thank you, Senator Howard. And thank you, Commissioner Albin, for testifying. Just curious, you know, it sounds like the, the SNAP Next Step Program's been very successful and, and proud to see another thing that started in the, the heart of Nebraska in the Tri-Cities area. Could you give us some specific examples? I'm sure you have many persons that were helped by the program.

JOHN ALBIN: Yeah, I mean, at page 3 of the report, there's three of the new ones, which I found that out when I opened up the email yesterday. And I think they're a good illustration, but you can all read those. One of them that I think I am most the proud of was from our first, I believe it was our first cohort in Grant Island, we had a single mom who was working part-time as a waitress, waitressing has obviously erratic hours. It was hard to be a full-time mom and do a good job as a mom when she was working crazy hours and not-- and working weekends when the kids were home and were lacking in supervision, or at least a level of supervision she would like. She was one of our, our first cohort, she came through the program, she ended up not only with a full- time job, but if I remember right, it

was like a $20 an hour, the job had a pension program and it had health and it was a regular schedule, so it was like she could be home with the kids at night to help them with the homework and at weekends to do all the things that a single mom has to do on a weekend with her kids. So there are a lot of stories like that out there in the program. So yeah, we're real proud of it.

MURMAN: Thank you.

HOWARD: Any other questions? Senator Cavanaugh.

CAVANAUGH: Thank you. Thank you for being here, Director Albin. I was just looking at your supportive services on page 2, and I'm interested-- it looks like the highest utilized or financially utilized service is transportation. How did you administer that?

JOHN ALBIN: Transportation ends up being a lot of different things in the WIOA world. It can be anything from a set of tires to gas vouchers so that they can get to that first paycheck. Sometimes it's even a car repair. I mean, you know, transportation is huge. You know, there is public transportation in Lincoln and Omaha, which is kind of adequate. And in central and western Nebraska, it's just really not existent. So a lot of times we will be involved in these, sometimes that transportation will be if they need some classroom training, we'll give them gas vouchers so they get back and forth to class while they're doing-- finishing up their training, so. WIOA is kind of a flexible program in that sense as long as they meet the eligibility requirements coming in.

CAVANAUGH: It sounds really creative. Thank you.

HOWARD: All right, seeing no other questions, thank you for visiting with us today.

JOHN ALBIN: All right. Thank you.

HOWARD: I bet you were confused because we're not Business and Labor.

JOHN ALBIN: Yeah, you're starting to sound like Senator Lathrop, I was in front of Judiciary Committee the other day and he goes why are you here?

HOWARD: Thank you.

JOHN ALBIN: Thank you.

HOWARD: Our next proponent testifier for LB1158. Welcome back.

JEREMY BRUNSSEN: Good afternoon, again. Good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. My name is Jeremy Brunssen, J-e-r-e-m-y B-r-u-n-s-s-e-n, and I'm the interim director for the Division of Medicaid and Long-Term Care within the Department of Health and Human Services. I'm here to testify in support of LB1158, which would require DHHS to inform Medicaid applicants of optional third-party job skills, training, and other similar programs. We would like to thank, Senator Arch, for introducing this legislation. LB1158 recognizes the opportunities the Medicaid Program has to improve Nebraskans live-- lives in addition to providing health coverage. This bill would require the Department to refer Medicaid applicants to voluntary third-party job skills or training programs. These programs can give individuals job skills that may lead to better economic opportunities in their lives. With better skills and the jobs that come with them, it's possible that many of these individuals may no longer need Medicaid coverage. DHHS already refers applicants to job training programs in a manner similar to the bill. The only changes this bill imposes are reporting requirements by which DHHS would be required to submit quarterly reports to report-- submit a quarterly report to the Legislature detailing the number of applicants referred to these programs. The Department of Labor would similarly be, similarly be required to report how many applicants followed through with referrals and which programs they utilized. DHHS's report is the only change that would be necessary to implement this legislation, and we have no concerns with complying with this reporting requirement. The Department would again like to thank, Senator Arch, for bringing this bill forward, and we would share his priority of providing job training opportunities to Nebraskans who are interested in advancing their careers. We support our current referral practice being written into law, and we ask the committee to advance this bill to the full Legislature for the debate. Thank you for the opportunity to testify. I'd be happy to answer any questions.

HOWARD: Thank you. Are there questions? Seeing none-- isn't it more fun this way?

JEREMY BRUNSSEN: What's that?

HOWARD: Coming in in support? I'm just kidding.

JEREMY BRUNSSEN: Glad to be here.

HOWARD: Thank you. Our next proponent testifier for LB1158. All right, seeing none, is there anyone wishing to testify in opposition? Seeing none-- in opposition?

LARRY STORER: Well, kind of half and half.

HOWARD: Neutral? Do you think neutral is more appropriate? Do you want to go neutral? I'll call out neutral next.

LARRY STORER: No, I'm gonna swing to the positive,--

HOWARD: Oh, OK. Well, then we'll say--

LARRY STORER: --but I'd like to request-- I've got to leave so I'd like to do both bills on the same topic. I can tie them together.

HOWARD: LB1158?

LARRY STORER: And, and the next one, LB1204.

HOWARD: OK,--

LARRY STORER: I can tie them together.

HOWARD: --in support of LB1158?

LARRY STORER: In support of both.

HOWARD: All right, we'll stay on supporters then.

LARRY STORER: And then I'll be out of your hair.

HOWARD: Hey, you're not in our hair. All right.

LARRY STORER: Larry Storer, 5015 Lafayette Avenue, Omaha 68132.

HOWARD: Could you spell your name for us as well.

LARRY STORER: S-t-o-r-e-r.

HOWARD: Thank you.

LARRY STORER: The reason I'm here today is to be in favor of this, but also try to point out that words do matter, and, and all of your efforts are well-meaning. But in the execution of these, these laws and principles and ideals, there's a lot of things that fall between the cracks. And I would like to see amendments or tweaking to the language in these bills, too. From my perspective, I have a grandson that's about to age out of the transition system, if that still exists. So he's almost 21, what happens? Is he kicked out the door at age 21? Does he have to make his own application again for disability services? His mother now is a single, single mom and she's probably going to be disabled also, so I have some deep concern about his future. And I hear all of these programs for everybody, and I listen to a lot down in Omaha at both of the local bodies down there. I just shoot my mouth off, too. And I keep wondering, will-- I try to engage my grandson to find out what's going on with, with his program in his transitions. And it sounds like mostly he's sitting around, maybe learning how to wipe tables or crush boxes. But he's been there two or three years and it doesn't take that long to, to learn how to wash a table or crush a box. So I wonder the people that are directing these thing-- yeah, they talk about job training, and I've been to quite a few of the things they put on and, and quite a few of the meetings through his DD services and things. So I'm so to speak part of that team. But the big problem, once again, I think, is the misapplication, if you will, of the, the meaning of the privacy laws. People are afraid to disclose information about the program. Maybe it's human nature, maybe they're afraid of being sued because they might say something wrong because too many people sue for too many reasons, but there's not very much interchange. And as a grandparent that's been pretty active all along, that's very frustrating to not be able to offer and receive information. I get more of it here and down at Douglas County Board and City Council and out of The Reader magazine and the north Omaha Star than I do from people involved in the system. So I want to know if you're setting this up for people maybe now 22, he'll have another year before he's 22, a year from May, but he's just-- is he out in the cold? Who's helping him transition to the next phase? I'm not allowed to for lots of different reasons, but mostly law. So we have a work force shortage all over the place, they say, but here you have kids study for months, years at a college campus-- there's classrooms right next to them, they're there for hours in the afternoon all day, and all they're learning is wiping tables and cleaning-- crushing boxes. You don't need that much training for working with a restaurant or a hotel industry. So they are not being

trained, they are not being trained to be successful when they do a job. So all the well-meaning words go to waste at the people conducting the programs don't have their heart in it. And it's the people that are observing the programs, don't have a say in it. And I've been all the way up to the Ombudsman and the Attorney General's Office on some things over the last few years, quite a few of the last few years, things that, that aren't quite right in the Health and Human Services system that shouldn't get away-- that nobody should get away with, but they do. Well-meaning as I was, never allowed to really give input. Oh, no, you're not the guardian. Oh, privacy act, that does a hell of a lot more harm than it does good. Thank you.

HOWARD: Thank you. Let's see if there are any questions from the committee before you go. Are there questions? Seeing none, thank you for sharing your story with us.

LARRY STORER: Thank you.

HOWARD: Is there anyone else wishing to testify in support of LB1158? Seeing none, is there anyone wishing to testify in opposition? Seeing none, is there anyone wishing to testify in a neutral capacity for LB1158? Senator Arch, you're welcome the close. While he's coming up, we do have some letters in support: Annette Dubas, from the Nebraska Association of Behavioral Health Organizations; Kristen Hassebrook, Jennifer Creager, and Bruce Bohrer from the Nebraska Chamber of Commerce and Industry, Greater Omaha Chamber, and Lincoln Chamber of Commerce. No letters in opposition. One letter in the neutral capacity: Molly McCleery, from Nebraska Appleseed. Welcome back, Senator Arch.

ARCH: Thank you. I'm really excited about this bill. And I, and I will tell you why, because I, I hope that it is the beginning of a much longer, broader conversation within the Legislature that takes a more holistic view of our services that we provide to those who find themselves in, in difficult situations in life. One that-- and, and you can, you can see-- I mean, I'm not the originator of this, but you see the Department of Health and Human Services and Department of Labor already collaborating and, and, and they're, they're working at getting outside that silo of the department and, and, and seeing these-- all of these services that cut across the various departments, and, and I, I really welcome that. I think that is-- I think that's the only way we're gonna be able to answer the question, and that is, are, are we really helping in these sit-- I know we're providing

services and the types of things that we, that we identify and quality measures are how many services we provide and how fast did we answer the phone and are the recipients of those services satisfied with the, with the, with the care or whatever that's been provided, whatever that service may be? But are we really helping people? And I think we're only going to be able to answer that as we, as we go across the departments. And that's difficult in, in the departments for-- to, to do that because they have-- they are specifically tasked with certain things, and I think it's the role of the Legislature to ask that question, and perhaps provide that enabling legislation that would allow them to go outside and, and cut across as well. So I'm, I'm hoping that it's the beginning of more discussions. And, and also I would say that, you know, the other day we had, we had discussions regarding NEHII, and we-- and, and our-- in our information systems, and, and one of the, one of the comments that was brought up during that discussion was this, this whole concept of social determinants of health. And we're learning a lot about that, we're learning that, that, that healthcare is much more than a doctor-patient interaction or any of that, it is, it is, it is, it is impacted by many things in an individual's life. And if we were able to identify those things, and this is through the health information system, if we were able to identify those things and change that and help that in the environment, perhaps we would find a very different outcome in health. And so, and so this is a broader discussion, it requires data, it requires coordination across departments. But I-- this to me, this was a first step to engage in that conversation, and I hope that there will be, I hope that there will be more, because one of the, one of the challenges that we will have with our Medicaid expansion program is, is this, this perhaps could identify those people that are, are ready to change that, say, oh, I want a better place in life, I want a better career, I want a better-- I want better health, I want-- I, I-- I'm ready to change. But then we will find others within, I think, our Medicaid expansion, constituency who, who maybe need to be shown a different, a different life that's possible, hope that, that could be encouraged. And in some cases incented, but, but certainly encouraged to find a better life for them and their family and their children. And that will be more challenging, so we start with identifying those who are saying, help me, I'm, I'm ready, and we'll tackle some of the bigger questions later. But thank you, and I would encourage you to support LB1158, answer any questions you may have.

HOWARD: Thank you. Are there any final questions? All right, seeing none, thank you, Senator Arch.

ARCH: Thank you.

HOWARD: This will close the hearing for LB1158. OK, we will open the hearing for LB1204, Senator Cavanaugh's bill to require a family support waiver under the Medical Assistance Act and provide for a pilot family support program under the Disabled Persons and Family Support Act. Welcome, Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman Howard and members of the Health and Human Services Committee. I am Machaela Cavanaugh, M-a-c-h-a-e-l-a C-a-v-a-n-a-u-g-h, and I represent the best district, District 6 in west central Omaha. I'm here today to introduce LB1204, which directs the Department of Health and Human Services to apply for a family support waiver under Medicaid and to create a pilot program with the aim of supporting disabled children and their families. In January of 2019, the Nebraska Department of Health and Human Services began assessing the eligibility of children for aged and disabled waiver eligibility using more restrictive criteria, which we all are very familiar with. This led to children being taken off of the aged and disabled waiver, and the changes came as a result of promulgating new rules. So we all kind of as a, as a-- as the best committee with some of the best districts represented went, went on a, on a journey together over this past year and learned quite a bit about our A&D waiver and the effects it had on the children across the state from changing this eligibility. We now have the developmental disability waiver, which we were thankfully able to work with the Department and get children back on with high needs. This waiver, which we heard about in the Olmstead hearing that we had, and we've heard about from Arc of Nebraska several times, this waiver is an opportunity for us to do something that's a lower cost and innovative and helps families keep their family member in the home without them having to also make a sacrifice of, of leaving a job or getting a divorce to qualify for services. This is something that we really can do to help families. It of course, it does cost money, but it's a low cost. This is one of the lowest cost waivers and we really can determine how much we want to spend on this waiver. This particular bill has a self-directed annual budget of $12,000 to eligible families. It would allow disabled children to access essential services while keeping their caregivers in the work force, which we're, we're constantly talking about the need to keep people in the work force. So I want to go to the fiscal

note-- as you can see, I skipped some of the things in my, my, my testimony because we know it, we've been it, it's, it's here, so the fiscal note from the Department-- and I haven't had a chance to talk to-- through with the Department, we'll hear today from them what they think about this bill, but I just want to address some of these issues in advance. So under their fiscal note, on the, the second page of it, it says, 7)-- that's the last line of the first sentence, moves the Disabled Persons and Family Support program from the Division of Children and Family Services to the Division of Developmental Disabilities. Now that, on its surface, doesn't really indicate anything, but the Department did send out a, a statement today about concerns over the funding of this and that it is through the Developmental Persons Family Support program [SIC], which we previously funded at $910,000 and $800,000. Those, those dollars have been clawed back because the department didn't utilize them. And so they currently are utilizing $185,000 for that particular program. My bill does not ask or require that they utilize that $185,000 for this waiver. It is not going to impact whatever they are using the $185,000 for currently. My bill allows for the Appropriations Committee to appropriate new funds to support this waiver, and it does not have a dollar amount. I would work with the Appropriations Committee to see if there are funds available and how many funds there are. This is a pilot program, so whether we can help 1 family in this pilot program or 10 or 20 families, whatever funds we, as a state, have available, it's disappointing that we-- that the Department no longer is utilizing those previous $800,000. But this is not intended to cut into that programming that they're currently doing, and I just wanted to make that clear from the outset. And I apologize, I probably should have gotten a copy of this, it's all marked up. For the committee, I will get one before my closing for you all so that you can have it. Yeah, so I'll make sure I hit that note, and I think for now that's it, I'll take your questions. Thank you.

HOWARD: All right, thank you. Are there questions? So did I hear you say that this would move-- so we already have a family support waiver or it's that they would need to apply for a waiver certificate?

CAVANAUGH: Oh, sorry, yes, the, the, the crux of this bill requires us to apply for the waiver.

HOWARD: OK.

CAVANAUGH: The opposition-- well, I shouldn't say opposition, the statement in the fiscal note is concerns over if the waiver isn't approved that it would be General Funds. If the waiver isn't approved, then I don't believe that this bill requires us to fund anything from General Funds beyond what we would have appropriated. So it-- it's just requiring seeking the waiver and that the Appropriations Committee would then appropriate whatever funds they deemed-- I'm saying appropriate a lot, but whatever they've deemed appropriate. So it's really just a-- to move forward us applying for that waiver, and then it would help alleviate some of the waiting lists for some of our other waivers.

HOWARD: Thank you. Any other questions? All right, seeing none, will you staying to close?

CAVANAUGH: Yes, I will.

HOWARD: Thank you. We'd like to invite our first proponent testifier up for LB1204.

EDISON McDONALD: I have the presents for you.

HOWARD: Great.

EDISON McDONALD: OK. Hi. My name's Edison McDonald, E-d-i-s-o-n M-c-D-o-n-a-l-d, the executive director for the ARC of Nebraska, and glad to be back talking about this issue again. I know that we have talked about this issue previously, and we've talked about kind of how the Arc went and undertook a collaborative study going and working with a wide variety of disability organizations, experts, leaders, parents, to go and figure out how we can go and address three significant key system issues: the developmental disabilities waiting list that we have been working on for 30 years with no solutions; the vocational rehabilitation waiting list, 3,000 people; and the aged and disabled waiver, that while affecting a smaller amount of people, it still had a tremendously detrimental impact on a great many families. In order to address this, we held town halls around the state, collected data, gathered input from stakeholders, and compiled a report with analysis, analysis and guidance about key policy opportunities. We've brought several of these bills to this committee's attention. This report was then sent to thousands, presented to this committee, provided to the Department, and discussed with hundreds in a variety of community meetings. Our hope was to

provide information and guidance in a comprehensive fashion that would provide guidance for the Legislature and for the Department of ways to overcome these difficult situations. One key proposal of this was a family support waiver, which Senator Cavanaugh has taken leadership on. We understand the Department plans to come in opposition to this, which is disappointing, considering we have asked them for comments and amendments, however, none have been provided. I believe that if the Department or anyone doesn't think that this is the answer that they should provide to you in detail how they plan to address these issues. Currently, the only guidance we have is the Olmsted plan, which has fallen below our expectations in hopes, in particular, in the fact that it fails to keep up with inflation and will lead to an increased waiting list. If we don't act now, this continual-- this crisis-- these crises will continue to grow, the state will lose lawsuits, families will suffer, and the fiscal impact will continue to snowball. You will hear from families directly that are in crisis later. But for now, I wanted to talk about the family support waiver and I would encourage you to keep your mind open for any potential amendments suggested. This bill keeps family caregivers in the work force, keeps children with disabilities in their family home, supplements their family health insurance coverage, provides support for therapies and medical needs not covered by the health insurance and also offers access to long-term services and supports such as specialized child care respite and home and vehicle modifications as examples. I wanted to quickly go through a few of the handouts that I gave you. Number one, probably the most important one for this hearing is this orange one, this really goes and breaks down how the family support waiver is supposed to work. This has been done in a variety of other states with a very similar structure to Tennessee's, and so I know that there's been some concern stated that this might not go and meet CMS's standards, however, clearly it has in Tennessee and in other states. This kind of walks through what this is supposed to cover and make sure that, number one, we're going and protecting those families who have received those cuts to the aged and disabled waiver. Number two, we are going and working on developing some solutions for those families that have-- were in unique conditions that have not previously had access to the supports and services that they need. If you look through our nice big waiver study, you can see almost every other state has more waivers. They have more tools in their tool belt to deal with these issues, which is part of why we don't see them. We don't see them in quite the same way. And then number three, is to go and work on addressing folks in those two groups, but also other folks

who are on the developmental disabilities waiting list. This is a 2,300 person waiting list that we have had for decades. And the Department has had opportunities to go and address this issue, find solutions, and has failed to provide those answers. We brought this in the hope that we would have some potential answers and some answers where it's not just about going and appropriating more money. It's about appropriating the right amount of money that we can save people, save value for the state, and ensure that we're protecting the families who need that help. With that, I would open up to questions.

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

WALZ: I have a couple questions.

EDISON McDONALD: Yeah.

WALZ: One of them I'm not really familiar with is, Edison, is the--

EDISON McDONALD: Um-hum.

WALZ: --you're taking money from the Disabled Persons and Family Support. What, what is that?

EDISON McDONALD: Yeah. So it, it was a program, and I think there are a lot of programs out there that aren't utilized properly or as well as we would hope. Ultimately, it was designed to kind of help support some families that would be generally in this kind of area. What we ended up with as we were looking through for potential funding, you know, we'd, we'd like to see this go across the state and, you know, have a broader capacity eventually. But we wanted to start off testing it and finding kind of a way that we could move forward and finding a, a limited and targeted appropriation. So that was really kind of where we were first looking, as Senator Cavanaugh said that was the fund that was significantly underused due to lack of education of families, and then also due to the more restrictive requirements.

WALZ: And then I think it calls for up to, up to $12,000-- or annually,--

EDISON McDONALD: Um-hum, yes.

WALZ: --$12,000 a year. Does that money go directly to providing care to the person,--

EDISON McDONALD: Yep, and--

WALZ: --so no overhead or administrative cost?

EDISON McDONALD: --you can go and look on the back side and it shows kind of what that can-- what sort of options you have there, making sure to provide things like physical therapy, behavioral health, applied behavioral analysis, specialized formulas, occupational therapy, durable medical equipment, and making sure that they, they have those options. Basically, families undertake a tremendous value for all those who are sitting out there who have-- who aren't getting waiver services, whether they're on the waitlist or they don't know that they have services available, this goes and helps to ensure that they have at least some support for some of those key things. And in particular, I think some of the ones we really need to focus on are physical therapy and occupational therapy and specialized formulas, which has been one of the most dire. And then number three is the, the access to Medicaid and providing a different pathway. Ultimately, Medicaid is a federal program that's designed to cover both the scope of age and the breadth of disability. However, our system was one of the first systems really designed and we haven't made that many modifications and updates. And so what we've done is we've left out a whole bunch of folks that should be there. We have these other tools that are available to us under federal guidelines that we're not taking advantage of.

WALZ: Um-hum. OK. I think that's all I have for now. Thanks.

HOWARD: Thank you. Other questions? Do you want to tell us what this list is?

EDISON McDONALD: Oh, yeah, thank you. That, that list is the list of 1,600 Nebraskans who signed onto our petition who wanted to see action to go and end the waiting list and saw these ideas and liked them. Ultimately, these families are out there, they're struggling, they're trying to find these solutions. And previous legislatures have promised that, we're still waiting, and they're still hoping for that. And I just wanted to make sure that-- some of those 1,600 families will be here today, but for the others, I wanted to make sure that their names at least were included in the record.

HOWARD: Thank you. All right, other questions? Seeing none, thank you for your testimony today. Our next proponent testifier for LB1204.

ANNE CONSTANTINO: Chairwoman Howard and members of the Health and Human Services Committee, good afternoon. My name is Anne Constantino, A-n-n-e C-o-n-s-t-a-n-t-i-n-o, and I'm the president and CEO of CRCC, a nonprofit in Omaha, formerly known as Children's Respite Care Center. I'm here to today to testify in support of LB1204. I want to thank my senator from Omaha, Senator Cavanaugh, for offering this bill and for her passionate advocacy on behalf of Nebraska children and families. We'd like to say that CRCC is the place where children find a world of possibilities and where parents find peace of mind. We help children with special needs from birth to age 21 reach their potential by providing comprehensive educational, nursing and therapeutic care through our behavioral health day and weekend programs. Our licensed nurses, therapists, and teachers, and also our care staff combine their skills and experience to assist children whose needs cannot be met in a traditional childcare setting. It is no overstatement to say that the children we serve have among the most medically complex care needs in the region. Caring for the children we serve often represents a full-time job on the parts of their parents and guardians. For our parents and guardians, the stressors of attempting to maintain full-time employment, which is a necessity for many Nebraska families desiring access to affordable healthcare options while balancing the demands of frequent medical appointments and daily care needs are immense and ever-present. LB1204, the family support waiver represents a lifeline to the parents and guardians of those in our care. The provisions in this bill help to keep family caregivers in the work force, support family cohesion, and expand family and consumer control over healthcare decisions. LB1204 is undoubtedly a pro-family bill. In order to illustrate the potential impact of this bill, I would like to share a story of a child we have served at CRCC and that has been directly impacted by the lack of funding and support from the state of Nebraska. Tony has a primary diagnosis of a developmental delay and a secondary diagnosis of autism. In addition, he is legally blind, has hearing loss, and is also nonverbal. He also receives 100 percent of his nutrition through a feeding tube and needs constant supervision. At the end of 2019, he lost his primary funding because of the change in eligibility requirements that the state instituted. His mother appealed the decision and was denied, so she had to stop working to stay home with Tony. The burden of 24/7 care has been incredibly difficult on the family, both financially in addition to the well-being of everyone in that household. Without the ability to work, the whole family has had to be supported with public assistance. An increase in respite support would have been able to mitigate the

entire situation for this family. As the CEO of a nonprofit receiving state support, good stewardship of public resources is a principal focus of ours. In addition to being pro-family, LB1204 represents fiscal responsibility in policymaking. LB1204 seeks to maximize existing state funding and support of proven cost-saving care approaches. For instance, expanding family access to specialized childcare services such as those provided at CRCC in turn supports access to cost effective, preventative, and fully-integrated healthcare services. Furthermore, LB1204 allows for something often uncommon in Medicaid programming, budget predictability through a per-family maximum annual budget for the services. And support for independent living skills and vocational training as provided by LB1204 can help ensure that the clients we serve have access to the tools they need to reach their maximum potential and share their considerable talents as active members of our state's communities. LB1204 represents pro-family and fiscally prudent policy making. I ask that you please advance this bill out of committee. Thank you for the opportunity to testify, and I welcome any questions at this time.

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

ANNE CONSTANTINO: Thank you.

HOWARD: Our next proponent testifier for LB1204. Good afternoon.

SHERRI HARNISCH: Thank you, Chairwoman. Thank you to, Senator Machaela Cavanaugh, for introducing this piece of legislation. And thank you for this committee for taking the time to listen to issues that are meaningful to my family. My name is Sherri Harnisch, S-h-e-r-r-i H-a-r-n-i-s-c-h. I urge you to support LB1204, an important piece of legislation that would provide a small fraction of funding to support and provide very basic needs to working families like ours. As the parent of a young child with Down syndrome, I'm an active member of the Down Syndrome Alliance of the Midlands. I serve as a Nebraska state ambassador for National Down Syndrome Society and a member of the National Down Syndrome Congress Advocacy Coalition. Most importantly, I sit before you today as a mom. We fell unconditionally in love with our daughter the moment she was born, and despite our initial fears due to unknowns regarding her diagnosis, we promised that we would always unapologetically advocate for her rights. This is precisely why I am here today, fighting for her right to receive services that are promised to her under federal law. While navigating

the world of special needs can certainly be overwhelming at times, please rest assured it is not my child's disability that has me overwhelmed, it is the very thought of finding our way through our state's complicated and confusing system of winding roads. This system of transition in adult services and locating funding to provide important services for our child is daunting to say the least. I think everyone in this room can collectively agree our current process could improve. Similar to many families in our shoes, we began investing in our daughter's future early on in the form of school-based and private therapies to ensure that she has as bright and productive a future as possible. Macy is in the fourth grade, and because of proper supports she is doing really well alongside typical developing peers in the general education classroom. She is not afraid to speak her mind and has done so here in Lincoln as well as many times before members of Congress in our Nation's Capital. Macy is active in her local community. She loves ballet classes each week, she goes to gymnastics and cheerleading classes every week. She participates in Special Olympics track and swimming and participates in weekly education classes at her church. I know that these specific enrichment opportunities are helping to ensure a promising future for Macy, but the only-- and the reason I sit here today, the only reason why she has been able to participate in typical everyday activities provided in our community is because of expensive OT, PT, and speech therapy services. We have been fortunate enough to provide for her at an early age. It is only with these necessary supports that she will continue to, to develop skills and build connections to achieve and maintain employment. Macy, just like the next person, deserves to work and earn a fair wage. But she can't do it alone. She will need programs that teach her independent living skills, academics, and social services. I recognize that this process of getting Macy to and through the system here in Nebraska is going to be challenging. And again, not because of her cognitive disability, but because of the lack of funding and supports for the complicated and involved process of accessing services that will help her transition from being a student to being a productive, contributing, working, taxpaying adult. My daughter Macy has a lifelong intellectual disability, and yet in the eyes of this Legislature, she is not disabled enough. Macy has a lifelong physical disability, and yet in the eyes of this Legislature, she is not disabled enough. Macy struggles with day-to-day tasks that her typical developing peers take for granted. And yet, in the eyes of this Legislature, she is not disabled enough. As she grows, this ability gap continues to wide-- widen at a pace that scares me to death. Macy

and friends like her, however, do not fit into the extremely stringent bubble of criteria that our Nebraska lawmakers would consider her to be eligible for any sort of medical assistance program. If passage of LB124 [SIC] happens, Macy has a chance to finally get a much deserved, albeit small, piece of the pie, then I'm all for it. Something is better than nothing, and anything will go a long way in helping assure as promising as independent a future for her as possible. Our family, yes, has been fortunate to have decent health coverage through companies we have worked for. Over the years, we've been able to utilize our high deductible HSA account to provide our child with OT, PT, and speech services. We never asked for a handout, but it sure would be nice to finally receive some sort of supplemental funding from our state, whom I believe has a fundamental duty to ensure that all children have similar access to critical services and much needed therapy supports. We're not asking for a lot, we're just asking for you to throw us a bone. Despite our public school system's robust programs, our kids deserve so much more than this and you know it, and I think we can do better. And I'm sure, as you are all aware, Nebraska is light-years behind so many other states who are already doing the right thing by providing support to families in similar situations as ours. It's mind-blowing, it's wrong, it's unacceptable, and it's reckless. Passage of this bill is a vital step forward for parents and children with disabilities. It will correct an imbalance and make more consistent the availability of much needed funding to set our kids up for any type of success. Our daughter Macy is 10-years-old, she has never qualified for assistance, but she has still 11 years before she becomes eligible to hop on that long waitlist of-- that currently sits at 7 years. At this point, she will be 28-years-old. That is quite a gap. If you do the math, my husband and I will be nearing our retirement years before our daughter will have received any sort of therapy support from our state. Tell me how that is Nebraskan Nice? Thank you.

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

WALZ: I don't have a question but I have a comment, I, you know, follow Macy all the time, she's one of my favorite people in the whole world.

SHERRI HARNISCH: Thank you.

WALZ: And she is so fortunate, so fortunate, you guys are all fortunate in your family to be able to support her. And I just wanted

to tell you, thank you for being an advocate, not only for her, but I know that you're here to be an advocate for every child that needs support, so just wanted to thank you for that. You're doing a great job.

SHERRI HARNISCH: Thank you.

HOWARD: Any other questions? Seeing none, thank you for visiting with us today.

SHERRI HARNISCH: Thanks.

HOWARD: Our next proponent testifier for LB1204.

DONNA SABATA: It's been a long day. My name is Donna Sabata, D-o-n-n-a S-a-b-a-t-a.

HOWARD: It's OK.

DONNA SABATA: I am here on behalf of my son and daughter-in-law, and as a concerned grandparent of three beautiful grandchildren. My grandchildren were micro-preemies. The oldest of the three was born at 24 weeks and weighed 1 pound, 7 ounces. The twins I have it with me were born at 27 weeks and weighed 1 pound, 14 ounces and 2 pounds 2 ounces. They were all in the NICU for four months. Thank God, I got it together. All of them suffered from oral aversion and failure to thrive through the NICU. So in order to bring them home, they had to surgically place a G-button which would allow the parents and the grandparents to feed them when they got home. Please know that their G-buttons are their lifeline. They are only gaining weight due to the nutrition provided to them through their G-buttons. In fact, Knox is still struggling to gain weight despite the fact that he is tube fed. He has recently seen a new GE doctor and a dietitian at Children's in Omaha. They have made a switch to a higher calorie specialty formula to increase his weight. The parents did, at one time, try to gradually wean the seven-year-old off her G-button feedings, which in turn caused her to become very sick and her hair fell out. And they say vegans go through that. So we had to add fat and her formula back to her diet. They struggle with day-to-day things such as brushing their teeth as it immediately causes gagging and retching. They do not get hunger pains like you and I do, so as you, as you seen them [INAUDIBLE] throughout the whole entire day, they never tell me they're thirsty or hungry unless we make sure they get their feedings and their snacks. They all require special care as they too-- they're

too young to hook themselves up to their feeding pumps overnight, unhook them in the morning, and do their bolus feeds throughout the day. They require someone who has been trained to administer their feedings to replace their G- buttons if they come out as there is a short window of time that can be-- that they can be replaced before the stoma closes and it has to be dilated again. I am only one voice speaking, not only for my grandchildren, but for all the children throughout Nebraska who are disabled and in need of help. I was born in Nebraska. I was raised in Nebraska. And I am one of many that is disappointed in Nebraska and Health and Human Services. On January 7, my son and daughter-in-law received notification that the State Review Team denied their A&D waiver, kicking the kids off of Medicaid at the end of January. They were never notified of a policy change from their caseworker or anyone. Private insurance does not cover the enteral feeding formula, the specialty formula, which costs over $1,000 a month per child, and they have three. So in order for them to properly feed their children, they are going to have to come up with an extra $3,000 a month. And that only include-- that only includes the formula, not, not the feeding tubes, the bags, everything that goes along with it. My grandchildren did not choose to be born with this disability. Their parents and all parents of children, healthy or not, pray for the best for their children and to have healthy children. With both parents working, they are at a loss of what to do, as they cannot afford the extra $3,000 a month to feed their children. Their dad is now becoming a state patrolman, so he's going through the academy. So these children are not seeing their dad Monday through Friday. They have contemplated getting a divorce to fall below income guidelines for Medicaid, but would also fall behind in a life's journey. They are working on selling their house and looking into taking an early retirement to buy some time and to have money to feed their children. They have appealed the decision and are awaiting their appeal hearing at the end of this month. Please take into consideration all of these families here who live in the state of Nebraska who are needing some assistance for their children to be able to grow and thrive. Our family is praying for help that LB1204, family support waiver, would provide for our family and many Nebraska families. Many medical necessities needed cannot wait and families to be put on a waiting list of over 2,300 would be detrimental to the children and their families. How do you explain to a child you can't afford their formula to feed them? These families should not be forced to make these difficult choices the state of Nebraska and Health and Human Services is forcing them to make: selling homes, staying

married, or worrying how they will be able to afford the next box of, box of formula, food, or supplies when there are so many medical choices they are having to make already. The state of Nebraska and Health and Human Services needs to take immediate action to make changes to support these children and their families with LB1204. The state of Nebraska and Health and Human Services needs to hear the pleas of these children and their families. Please give them all a chance to grow, thrive, and be proud of our state of Nebraska. Thank you. Thanks for putting up with the tears.

HOWARD: I've, I've been there myself. All right, let's see if there are any questions from the committee. Are there questions? Senator Walz.

WALZ: I don't have a question. Again, I just want thank you for coming down and advocating and being such a great grandma for those girls.

DONNA SABATA: Well, I don't, I don't really know that the caseworkers at DHHS know what these families are going through. I really don't think they know. You know, and then just take everything away when they're 100 percent tube fed. These children are 100 percent tube fed. They don't eat food.

WALZ: Right. How, how has--

DONNA SABATA: Do I wish they would eat food? Of course, we all wish they would eat food. I strive every day to get them to eat food.

WALZ: Right. How have they survived without--

DONNA SABATA: That G-button?

WALZ: No, I mean, financially, I mean, $3,000--

DONNA SABATA: Well, they, they were approved of the A&D waiver--

WALZ: Right.

DONNA SABATA: --up until January.

WALZ: Right.

DONNA SABATA: And then they got cut off completely--

WALZ: In January.

DONNA SABATA: --and said we're not helping you anymore. Even though they have a G-button, doesn't mean they need to be covered. And my daughter-in-law mailed the HHS over 180 pages of documentation. And I did include their pediatrician paperwork for all three kids--

WALZ: Um-hum.

DONNA SABATA: --stating they're 100 percent tube fed. But you know, they would end up in the hospital if they didn't have it. And I just, I just don't understand why they're putting all these people through this. I don't, I don't understand it. Both parents are working, they have insurance, it's not like-- these parents aren't trying to live off the system, they're trying to get their kids to grow up and be healthy, so.

WALZ: Thank you.

HOWARD: Well, thank you so much for your testimony today.

DONNA SABATA: Thank you. Thank you for putting up with me.

HOWARD: All right, our next proponent testifier for LB1204. Good afternoon.

LEAH JANKE: Hi. My name is Leah Janke, L-e-a-h J-a-n-k-e. And I didn't think I was gonna cry, but I might after that. Good afternoon and thank you in advance for your time and consideration. I am here today to testify and to ask you to vote in favor of LB1204. I am the mother of three children and my youngest, Clay, has Down syndrome. I am also the executive director of the Down Syndrome Alliance of the Midlands located in Omaha, and here to represent the more than 500 families we support. I often encounter people who assume that children born with Down syndrome qualify for some sort of government assistance, but this is not the case in Nebraska. Unless your family falls below the income threshold, and most two income households do not, or your child requires nursing level of care along with several other new guidelines mandated by the waiver, having a Down syndrome diagnosis does not qualify a child for any of the current waiver programs in Nebraska. My son required open heart surgery at six weeks of age. We were able to bring him home from the NICU before his surgery with frequent cardiology appointments, and were told we would know when he was in heart failure when he would be too tired to eat, and his face would

start to turn blue, both of which happened when he was six-weeks-old. I was told by nurses and our Early Intervention social worker to apply for SSI/Medicaid, given his complex medical needs only to get a denial letter stating that he was too healthy to qualify because he did not need any at-home medical devices to keep him alive. And we are not alone in this, nearly 50 percent of babies born with Down syndrome are born with a heart defect. Clay has had at least one surgery every year of his eight years of life, and every year we pay our $7,000 deductible to cover these expenses. We pay our $60 deductibles at his frequent appointments and multiple times a week to cover his speech, occupational, and physical therapies that allow him to be a thriving second grader. Unfortunately, our health insurance plan recently changed and now he is limited to only 20 therapies per year. Private health insurance is not designed to cater to individuals with intellectual or developmental disabilities. They want to know what the problem is and how quickly and efficiently it can be fixed. This is not the way that our world with Clay works. I'm not here to gain sympathy or give you a sob story, I actually feel quite lucky with our situation in comparison to other families who have a child with an intellectual or developmental disability. I have known families who have been forced to surrender their parenting rights, quit their jobs, become a single-parent home, or uproot their family and move to another state just to qualify for Medicaid. This bill will keep parents like me in the work force, keep children like Clay in their homes, supplement family health insurance coverage, and provide support for therapies and medical needs not covered by health insurance. Thank you for your consideration. I urge you to please move this bill out of committee.

HOWARD: Thank you.

LEAH JANKE: Sorry.

HOWARD: Those are what they're there for. All right, are there questions from the committee? Seeing none, thank you so much for your testimony today. Our next proponent testifier for LB1204.

BRIDGET ASCHOFF: Hello. I apologize in advance, I had some trouble with the copy machine. It was operator error. Apparently it printed front and back, but I only copied the front of one page on this page, so you'll just have to listen to me as I read this page and pretend like you see it on your paper. Senator Cavanaugh and HHS committee, thank you for your time this afternoon. My name is Bridget Aschoff,

B-r-i-d-g-e-t A-s-c-h-o-f-f. Thank you for the opportunity to share with you today. It's kind of crazy to sit back and reflect on the past 12 to 14 months and see how far we've come. I vividly remember sitting down with you this time last year to discuss very troubling issues we are facing with the A&D waiver. It was myself and several other moms and a few advocates as we sat around a big table right here in the Capitol. I'm pretty sure it was the first time I stepped foot in the Capitol since my class field trip in the fourth grade. Since that day, I know I personally have felt so heard and supported by your committee. Not only have you listened, but you've asked questions, you've followed up with my family specifically, and you followed through. And for that, I'm so, so grateful. I sit here today to testify in support of LB1204, the family support waiver. When the conversation started last year, it was really just the beginning of a broader and more complex situation than I think anybody truly understood at the time. We knew our Medicaid system and our waivers had room for improvement and what started as looking at eligibility criteria for children under the A&D waiver has really sparked a broader scope of what our state offers for support, how we compare to neighboring states, and how we can help make improvements for those in our state living with or raising children with disabilities. It's no secret that there are gaps in our waivers. There is a significant population of children and adults who need and require services who are falling through the cracks and who have been left in a state of panic and desperation as they try to figure out how they're going to afford the mounting pile of medical bills they have stacking up on their kitchen counter. Last--since last year, I have been to countless stakeholder meetings in Lincoln listening to and having conversations with the Department of Health and Human Services about this very, this very issue of lack of supports for children with disabilities and their families. There have been some very fruitful conversations and some great changes that the Department has made. I have to commend Courtney Miller, who I feel has made herself available for conversations, even on Husker game days and who helped implement the waiver to waiver transfer that my family and several others have benefited from tremendously. She has reached out to many of the families personally and has been the only consistent presence from the Department on this issue, who is willing to help make positive change. So thank you, Courtney, for all of your hard work. While forward progress has been made in general, we still have a lot of room for growth. We have hundreds of families who are in crisis right now because their disabled children who once had access to Medicaid and

other supports like respite care and specialized child care are now not eligible for either of the waiver options available in our state. I'm not talking about children who may need a little extra support in school, like small modifications on homework, I am talking about children who have severe and profound disabilities like spina bifida, Down syndrome, and cerebral palsy, children who are wheelchair bound and 100 percent tube fed who are being denied. Our state sees the most disabled, just not disabled enough to receive support. In our current system, these families are left with nothing, zero help. Just a year ago, they were receiving the help and support their child needed-- needs. As a parent of a child with disabilities, this past year has been one of the most overwhelming as I have been forced to figure out how to best advocate for the changes that are necessary, not just for my own child, but for the hundreds across our state. This is brand new territory for me. Lots of new jargon to learn and understand, lots of rules and regulations to try and figure out, lots of tears shed, lots of sleepless nights. A year in and and I still feel like I've barely scratched the surface. The Arc of Nebraska has been the only advocacy group that consistently reached out to those of us with younger children with disabilities to help understand what we are experiencing and trying to find ways to help us. The Arc has kept me as a parent informed and has worked tirelessly to implement changes. I want to thank, Edison McDonald, and the Arc of Nebraska for championing this issue with us as we seek to find better solutions. A family support waiver is a viable option for our state to support children with disabilities, their families and help bridge the gap in coverage for children that lost eligibility under the A&D waiver. As it is written, the bill does need some changes in order for it to be effective. I have heard time and time again the Department wants to hear from parents and advocates and to work together. Here we are. Our children and our families in the disability community deserve better than what we are offering. A response of, we're sorry, there is nothing we can do is not acceptable. There are things we can do, a family support waiver is one of them. We need to show those who are falling between the cracks that their lives matter, that we value the dignity of their human life, and we want to support them so that they can not only survive, but thrive. When I obtained my Masters in Education, I focused heavily on children's behavior and brain development, research supports early intervention with children to give them the best shot at achieving their highest potential. Our most vulnerable children cannot afford to wait six to seven years on the DD waitlist for access to services they need now. If the Department really wants to

collaborate with families that have children with disabilities that have fallen in the gaps, I've discussed before, then I hope they will offer language to Senator Cavanaugh so that this bill can be moved forward and a program can be created that fills the gaps we have in our system, and that it's done in a manner that will allow for CMS approval. Thank you again for your time and your consideration.

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

BRIDGET ASCHOFF: Thank you.

HOWARD: Our next proponent testifier for LB1204. Good afternoon.

JENNIFER HANSEN: Good afternoon. My name is Jennifer Hansen, J-e-n-n-i-f-e-r H-a-n-s-e-n. I am testifying in support of LB1204. I support the passage of a family support waiver as I understand the dire necessity of one. I have three children and my middle daughter has disabilities and is currently on the aged and disabled waiver. I do not represent any organization or committee or board. I represent only my family and hope to serve as the voice of other Nebraska families who are in need of LB1204, but who are unable to provide their testimony in person. I have extensive interaction with numerous families across the state with children with disabilities. As such, I understand the impact for not having appropriate systems of support for families who are dealing with so much already. When the eligibility criteria of the aged and disabled waiver changed, those families suddenly no longer qualified for that waiver. Overnight, they lost Medicaid, resulting in the inability to provide their children with medically necessary and sometimes life sustaining treatments and medication, as well as the loss of childcare and respite subsidies. These Nebraska families were put into an immediate crisis situation with nowhere to turn for help. As a tax paying citizen, I find it extremely disturbing, and as a mother, extremely frustrating that our state has no system set up to help families and their children with disabilities. If you drive just a couple of miles east across the border, every single one of our children would have comprehensive waiver services with the wait of just eight months. A mom of a child autism who moved to Nebraska not long ago from Iowa told me she never even considered to check into waiver services before she moved here. She thought that since her son was on the waiver from the time of his diagnosis in Iowa, they would have the same access to needed supports and services in Nebraska, only to be told they had a seven and a half

year waitlist to receive those supports and services. How can it be that we are one of the highest tax states and yet we have no help for children with disabilities? As a state, we have to do better for our families. We have to find a way to provide families the systems of support they need to provide intervention earlier than the juvenile justice system or foster care. Quoting from the 2017 Nebraska Voices for Children Report, quote, Children with disabilities and their families experience barriers to their basic human rights and inclusion in our society. Their abilities are frequently overlooked and underestimated, while simultaneously their needs are given low priority. The barriers these children and their families face are more frequently the result of their environment and public policies rather than their impairment. Nebraska ranked 49th in state expenditures for families with a child with an intellectual or developmental disability. I'm gonna let that that sink in, 49th, end quote. That was three years ago. Where have we gone from there? What have we done to address this? What have we done to help those families besides kick them off this waiver? I would like to take this moment to thank, Edison, and the Arc of Nebraska for understanding the enormity as well as the urgency of this situation for families in Nebraska and the willingness to take a stand with us families on this issue. Also, I'd like to express my extreme gratitude to this committee for holding the state to task for taking years to adjust the age and disabled waiver eligibility criteria and promulgate those regulations following the lawsuit but cutting all of these children from the waiver services basically overnight while not putting into place another safety net for them. I urge you, I urge you to prioritize this bill for those families. Thank you.

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

JENNIFER HANSEN: Thank you.

HOWARD: Our next proponent testifier for LB1204. Just by a show of hands, how many folks are still wishing to testify? We might take a little, we might take a little break after this one just to go to the bathroom.

LISA RHODES: Sounds like a great idea.

HOWARD: I'm telling you. OK.

LISA RHODES: Thank you for that.

HOWARD: All right. Good evening.

LISA RHODES: Good evening. My name is Lisa Rhodes, L-i-s-a R-h-o-d-e-s, and I'm testifying today in support of LB1204, the family support waiver. My husband, Wes, and I are both lifelong residents of Nebraska, were born and raised on our family farms. We have an eight-year-old son, Layne, who has Duchenne Muscular Dystrophy. Layne also has a sister, Olivia, a brother, Wyatt, and another sibling arriving next month. To kind of tell you about Duchenne, also known as DMD. DMD is a rare progressive genetic muscle wasting disorder that affects every muscle in the body and it robs young boys of the muscle strength that it takes to complete activities of daily living. Something as simple as scratching an itchy nose, turning over in bed, getting up off the floor, climbing stairs, or even hugging their mom all rapidly become impossible to do. DMD is 100 percent fatal and primarily affects boys. There can be cognitive deficits, but not always. The boys are diagnosed between the ages of two to five. They're in a power wheelchair full-time by the age of 8 to 12, and they have a life expectancy of 27 years. We don't have time to wait for services because most boys aren't diagnosed until they're between the ages of two to five, and then we have to wait for services. Layne is fortunate enough to be eligible for the Comprehensive Developmental Disability Waiver this year, but we were informed that he barely qualifies cognitively and he may lose coverage next year when he is reassessed for eligibility when he turns nine. Layne was born perfectly healthy. He hit milestones on time. We had no reason to believe that there was anything going on. We had no family history of Duchenne at all. When Layne was about 2, he went to the doctor-- we took him to the doctor for a few concerns about some minor delays. A couple of months and one genetic test later, we had the grim diagnosis of Duchenne Muscular Dystrophy, that was in 2014. And in the grief of this earth- shattering diagnosis, navigating the state waiver programs was not on our radar. We had the rug ripped out from under us and our lives turned upside down. Families like ours need help soon after diagnosis to ensure that our children get access to the quality healthcare necessary to keep them on their feet and enjoying their life longer. Activities like walking longer distances are hard on muscles and if overdone it can cause further muscle damage. To preserve the muscle function and conserve energy, our son utilizes a scooter for those longer distances when at school. Scooters are not covered for pediatrics by our insurance and we paid for the scooter

out of our own pocket, which was around $2,000 dollars. We had to move to a home that was more accessible to help minimize costs of home modifications as those become necessary. And we are doing everything that we can to give Layne the best quality of life and to keep him on his feet doing things he loves and as independently as possible. I currently work part-time, my husband works full-time. Even with the benefits we are provided through his employer, it is still a struggle to keep ahead and budget for the things he needs. The specialty medications for Duchenne have copays that we would not be able to afford. The equipment Layne needs to stay healthy, out of the hospital, and active include a cough assist, which is roughly $6,000, night splints to prevent muscle tightening, $4,000 to $5,000, medications upwards of $400,000 per year, as well as a whole team of doctors that we see twice a year with costs over $10,000 for physician and procedure costs at each visit, and those figures are all prior to insurance coverage. If we didn't have the insurance coverage, I don't see-- I don't know any family that would be able to handle that kind of costs. The copays and the coinsurance that we would be responsible for would be stifling. How does a family like ours budget for, you know, meeting our $10,000 out-of-pocket max every year? So what options do we have if we have no access to services in Nebraska? Do we divorce? Do I quit my part-time job so that the entire family would qualify for state assistance? We've even contemplated moving out of state for better opportunities for our family, even though our roots are here in Nebraska. We don't want to leave, this is home to us. LB1204 will help to provide a pathway to Medicaid insurance for Layne only to supplement our primary coverage. The budgeted amount would help with home modifications or specialized childcare along with other expenses related to Layne's disability. LB1204 makes sense for our family and for Nebraskans. We aren't looking for a handout, we need a hand up. Please help us to help disabled children and their families in Nebraska by moving LB1204 out of committee. Thank you.

HOWARD: Thank you. Are there questions? Seeing none, thank you for visiting with us today.

LISA RHODES: Thank you.

HOWARD: All right, the committee will take a brief five-minute break and we'll reconvene at 5:15.

[BREAK]

HOWARD: [RECORDER MALFUNCTION]. Our next testifier in support.

PEGGY STONE: My apologies in advance, this is kind of an impromptu testimony, so I don't have handouts for you guys. Are you ready?

HOWARD: Ready.

PEGGY STONE: OK. Senator Howard and HHS Committee, my name is Peggy Stone, P-e-g-g-y S-t-o-n-e, and I am here to advocate for LB1204. By 18 months, the majority of toddlers have a vocabulary of about 20 words; by 2, most can use around 200 words and start joining them together in 2's and 3's. It is true these milestones matter. My son Paul did not start talking by the age of 2. In fact, my son has not been able to communicate for roughly 2,190 days. My son is 8-years-old and still cannot functionally communicate. He has been diagnosed with autism and has an intellectual disability. Over a year ago my son, along with hundreds of other children were deemed ineligible for the aged and disabled waiver. This waiver provided necessary supports for my son's medical needs, therapies, childcare if I return to work full-time, and respite care for our family. I have stayed home with my children, only working part-time so that we did not need to find specialized care for Paul. We would need to hire someone before and after school, on school breaks, and over the summer. Based on this, our family sacrificed in many areas for me to be his primary caregiver. Kids Connection is offered through the school district, however, based on Paul's supervision needs, they cannot provide care for him as he requires one-on-one attention. Paul does not require a nurse to care for him. However, he does require specialized care as his needs-- he needs hands-on assistance with all of his activities of daily living. He's unable to follow more than a single-step instruction. He doesn't have the ability to identify dangerous situations. This is a huge risk if he should ever become lost, as he cannot communicate with others. There are many more children like Paul in our state and many more families like ours. According to the World-Herald, more than 2,300 Nebraskans with developmental disabilities are on waiting lists for services. This does not fit with our moral standard of helping our neighbors, and being Nebraska Strong, Nebraska Strong. The average resident of Nebraska can make a huge difference and can find satisfaction by just getting involved, that's why I'm here today. And by choosing to support this bill, you can find a way for those with disabilities to stay in their homes rather than being placed in a state or private institution. You can ensure that they get specialized care and the necessary supervision

they need to ensure their safety. Both of these advancements will help save the taxpayers of our state millions of dollars in the long run. This bill will provide therapies to improve the quality of life for disabled-- the disabled, which will transcend to all of those around them. This bill allows for individuals to enhance their abilities so that they can be productive members of society. This bill also allows parents like me to be able to find trusted individuals to care for my son while being able to reenter the work force. This bill means so much to so many in our community. This is truly a matter of life or death for some, and that is why we need to come together to find an answer on behalf of them. Imagine these families will not have to choose to become divorced in order to drop their income below poverty level in order to get services for their loved ones. Imagine these families will not have to leave their child in the care of someone who isn't qualified. Imagine these families will be able to get their child the medical treatment they deserve in order to keep them alive. Just imagine of how many possible lives you will be improving by advancing this bill. I am here to encourage this committee to do just that.

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

PEGGY STONE: Thanks.

HOWARD: Our next proponent testifier for LB1204. Good afternoon.

MAKAYLA LAUBY: Hello. I'm Makayla Lauby, M-a-k-a-y-l-a, Lauby is L-a-u-b as in boy -y. I'm a former teacher from Omaha who is now blessed to stay at home to spend all my time calling hospitals, doctors, nurses, and our insurance company. And recently, four different phone numbers for five different people making sure the Medicaid application went to the correct people to assure my son is on the waiver list for-- because there is a six- to seven-year wait. Our three boys are constantly put in front of PBS to keep quiet while mom is on the phone. My son, Ashton, is 8 and is quickly losing the ability to walk thanks to Duchenne Muscular Dystrophy. We've been told he will most likely need a wheelchair within the next two years. And that we should begin shopping for the $60,000 power chair. We will need to spend thousands of dollars to make our home handicapped accessible and getting a $27,000 conversion for our van so that we can take our son with a 600 pound chair to school or to church or Walmart. He was diagnosed at three when getting up off the ground was tricky,

but possible. Flash forward to today and he's not always able to get up off the ground. We carry him up and down stairs. We are rarely able to leave with family-- leave him with family because it's difficult for him to shower, get dressed, and make it to the bathroom without falling. We are fortunate to have a scooter on loan from the MDA so that he is able to get around school. We know this disease is progressing and could really take our son far too early in his life. My husband and I were raised in rural Nebraska with rural Nebraska values. Scott has been working at his job for 24 years and I taught in north Omaha for 6 years, both jobs requiring good ole Nebraska grit. We hate asking for help, but our bills are becoming astronomical. I started babysitting and selling Thirty-One to help afford our $5,800 deductible each year. We worry that I wouldn't be able to go back to teaching because I need to spend too much time on essential phone calls and putting-- and appointments. However, we work hard and we make things work to get our bills paid. We travel four hours to a Duchenne clinic for a six- hour appointment, that can cost anywhere from $2,000 to upwards of $,5000 depending on what they monitor at this point in our journey. His night splints to help keep his leg stretched cost $5,000. They're covered by insurance and MDA pays a portion that bill. We've been so fortunate to have good health, yet we still meet our high deductible from 2016 to 2019. How many times can you say that your family had good health and still met their deductible? After year-- after getting a blow of learning what Duchenne was and finding out that our life-- that our son's life expectancy was, we knew we needed to make each day count and hated focusing on the cost of the doctors and testing. We've come to the point where we started to stress about the bills. We don't want Ashton's days to be consumed with calling and waiting on-line while we negotiate bills that mount up each year. The FDA just approved a medication that will cost us $300,000 and is covered-- isn't covered completely by our insurance. We've talked about moving out of Nebraska to a state that will help us possibly by-- possibly with a buy-in secondary insurance because there is absolutely no way we can afford the medication on top of the bills that we already have. This bill would help our family to be able to afford the therapies to keep our little boy walking a little bit longer so that he doesn't need the medical assistance. It is possible that with a little help now, we can save on long-term healthcare costs in our future. This would be a win-win for Nebraska families just like ours. Thank you so much for today for listening to us.

HOWARD: Thank you. Are there questions? Seeing none, thank you for visiting with us today. Our next proponent testifier for LB1204.

BRAD MEURRENS: Good afternoon. Good evening, Senator Howard and members of the committee. For the record, my name is Brad, B-r-a-d, Meurrens, M-e-u-r-r-e-n-s, and I am the public policy director at Disability Rights Nebraska. We are the designated protection and advocacy organization for persons with disabilities in Nebraska, and I'm here today in strong support of LB1204. I'll be brief because I don't think I really have much to add from the families that spoke before, except for developing a waiver which is proposed in LB1204 is a step in the right direction, even if it requires additional tweaking. This bill is at least a starting point for the necessary larger discussion about how Nebraska can further support families who have children with disabilities. We would be happy to work with the Department of Health and Human Services, the Division of Developmental Disabilities, the Legislature, and all pertinent stakeholders to develop a mechanism to provide families the supports and services that they need. And well, we would recommend that the bill be advanced. That is my statement. I'd be happy to answer any questions if you have any.

HOWARD: Thank you. Are there questions? Seeing none, thank you for your testimony today. Our next proponent testifier for LB1204. All right, seeing none, is there anyone wishing to testify in opposition to LB1204?

COURTNEY MILLER: So before I start, I'm not gonna read the testimony line for line, I'm gonna paraphrase to be respectful of the five-minute clock, so.

HOWARD: Oh, sure. If you go over, that's OK.

COURTNEY MILLER: OK, thank you. Good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. My name is Courtney Miller, C-o-u-r-t-n-e-y M-i-l-l-e-r, and I am the director of the Division of Developmental Disabilities within the Department of Health and Human Services. I am here to testify in opposition to LB1204. LB1204 mandates that the Division of Developmental Disabilities apply for a Medicaid family support waiver under the Medical Assistance Program to maximize state and federal funds, establish a pilot family support program to serve children with disabilities, which includes eligibility criteria that disregards

parental income and with a definition of disabled that creates a lower threshold than the disability criteria for children as defined by the Social Security Administration, and move the administration of the Disabled Persons and Family Support program from the Division of Children and Family Services to the Division of Developmental Disabilities. The Department has three major areas of concern about this bill. The first area of concern is Medicaid eligibility. The intent language in LB1204 for these children to participate in Heritage Health through a new Medicaid eligibility group to maximize federal matching funds. Federal law requires states to cover certain groups of individuals. The mandatory categorical pathway to eligibility for Medicaid is comprised of three broad groups of low income individuals: families including children, parents, and pregnant women; individuals age 65 and older; and individuals under age 65 with disabilities as defined by the Social Security Administration. These mandatory eligibility groups must meet financial criteria based on the income and assets of the applicant's family. The income and assets criteria can vary both by eligibility category and by state. The federal government sets minimum thresholds, often based on the federal poverty level, but states can choose to cover these eligibility groups at higher income levels. There are a number of optional eligibility pathways that have been added to federal law over the years to give states the ability to cover additional individuals who may not otherwise be eligible if they choose to do so. State adoption of the optional eligibility pathways to cover children with disabilities varies considerably. States can choose to provide a medically needy pathway which covers medically needy individuals that would be categoric-- categorically eligible except for their incomes. This allows coverage to individuals with high medical expenses where the expenses occurred on a monthly basis are deducted from household income for purposes of determining month-to-month eligibility, also referred to as spend-down. States have two options available to specifically cover children with disabilities receiving services in the community. Both options require the child must be disabled according to the Social Security Administration definition of disability, but only one allows for the disregard of parental income. So the first under the Tax Equity and Fiscal Responsibility Act, or TEFRA, optional Medicaid category of coverage, states can cover children under age 19 who are disabled while living at home and would be eligible for Medicaid if they were in an institution. TEFRA, also known as the Katie Beckett Option after the child whose plight inspired Congress to enact this option into Medicaid law, allows

children with disabilities whose family has income that is too high to qualify for Medicaid so to gain Medicaid eligibility based on the income and resources of the child. The second option is the Family Opportunity Act, this allows children with disabilities and family incomes below 300 percent of the federal poverty level to buy into Medicaid. The bill establishes a pilot family support program to serve children with disabilities under criteria that does not meet the Social Security Administration definition of disabled and eligibility is based on the income and resources of the child. Based on these reasons, a state plan amendment is not likely to be approved by the Centers for Medicare and Medicaid Services, or CMS, to serve these children in Heritage Health. The second area of concern of this bill is Medicaid waiver authority. The bill requires the Department to submit a waiver application to provide nontraditional medical services under a pilot family support program. Medicaid grants states autonomy in how they run their programs. Under Section 1115 of the Social Security Act, the U.S. Secretary of Health and Human Services can waive certain federal guidelines on Medicaid to allow states to pilot and evaluate innovative approaches to serving beneficiaries. States seek 1115 waivers to test the effects of changes within a Medicaid program, both in coverage and in how care is delivered to patients. CMS reviews each waiver application to ensure that the proposed demonstration does not require the federal government to spend more on the state's Medicaid program than it otherwise would. For example, Arkansas opted to cover children under the optional TEFRA coverage category under the Medicaid state plan. While this Medicaid state plan coverage allows children with disabilities who meet institutional level of care to remain in their homes, it placed an unsustainable financial burden on the state. To address the financial viability of the program while maintaining coverage of this population of children, the state chose to transition coverage of the TEFRA population from the Medicaid state plan to a Section 1115 demonstration program under which the state charges premiums for the TEFRA child's coverage based on family income and implement-- and they implemented a lockout period for nonpayment of premiums. Many of the children who would be eligible to participate in the pilot family support program are not current beneficiaries of Heritage Health. The bill establishes a pilot program available statewide to provide home and community-based services traditionally available to individuals with disabilities that meet institutional level of care with an annual budget capitation per month. The proposed pilot program description does not align with the purpose of a pilot to evaluate feasibility, duration, cost, adverse

events, and improve upon the study design on a smaller scale prior to a larger implementation. Based on these reasons, an 1115 demonstration waiver application is not likely to be approved by CMS to serve these children in Heritage Health. The third area of concern is Medicaid funding. The bill mandates the Department to apply for a Medicaid family support waiver under the Medical Assistance Program to maximize state and federal funds and establish a pilot family support program to serve children with disabilities. If this program becomes law without an approved waiver application by CMS, the established pilot family support program must be funded with 100 percent state general funds. In 2017, CMS advised that prioritization of participants to receive state entitlement day services as the first priority for funding would not be approved within our Medicaid-funded Home and Community-Based Waiver Services application. The Department worked collaboratively with this committee to update Nebraska law to outline the priorities for serving Nebraskans who meet institutional level of care on the Medicaid Home and Community-Based Waivers. The Department is committed to prioritization based upon the severity of the participant's needs and/or other qualifying circumstances based on funding availability within the Division's budget appropriations. A concern I continue to hear year after year is how the Department is going to serve individuals on the waitlist with aging parents or caregivers who are unable to care for themselves. If this program becomes law and 100 percent state general, and 100 percent state general funded, it will prioritize funding for children who do not meet institutional level of care over the highest priority group defined in law. These children and adults are also waiting for funding. Prioritizing services for a group of children over others that meet institutional level of care criteria is another competing demand for Nebraska's finite resources. Thank you for the opportunity to testify before you today. I'm happy to answer any questions you may have.

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

WALZ: I guess. So Courtney, what's the plan then? How do we fix this bill so we can-- what do we do?

COURTNEY MILLER: That's a great question, Senator Walz. What I would say is that we as a state with the, with the Legislature need to determine what problems that we're trying to solve with the disability population and which ones we want to tackle first to allocate funding. What I can tell you is I have a deficit request this year for my 424

Budget of $8.6 million for fiscal year '21. And that is due to two things: one is to serve individuals with the ICAPs or evaluations. So that's the current population I'm, I'm currently serving in Services, and then we've seen a pretty significant increase or jump in Priority One funding. And so in order to serve Priority Ones along with Priorities Two, Three, Four, and Five, we needed a total of $8.6 million to accomplish that. That was in the Governor's proposed budget modifications and it was in the Appropriations' preliminary recommendations. And you know, I, I had a conversation with Senator Stinner, Senator Wishart, and Senator Bolz prior to coming to this hearing today talking about the exact same thing about funding. It's, it's-- we have a lot on our table, right? We have provider rates, the new rate methodology. We have a waitlist and we have provider capacity and the shortage of direct care staff across the nation.

WALZ: Right.

COURTNEY MILLER: And so we're looking at which, which should we tackle and in what way.

WALZ: Um-hum.

COURTNEY MILLER: And I think that's a, that's a partnership and a collaborative effort to determine that.

WALZ: I, I probably asked the wrong question, the wrong way. So just specifically to the things that you had areas-- major areas of concern regarding the bill,--

COURTNEY MILLER: Um-hum.

WALZ: --are those things that can be worked on with Makayla to make this bill better?

COURTNEY MILLER: So--

WALZ: And I know-- I understand all the other things, the other priorities, but just, just in regards to this bill.

COURTNEY MILLER: OK. I, I did misunderstand your question, I'm sorry.

WALZ: Yeah.

COURTNEY MILLER: So with the bill, 1915(c) waivers and a waiver authority under CMS, not the 1115 demonstration, but the other home

and community-based waivers are available to serve and, and to, to provide, many states have family support waivers, but they-- but the requirement is that they meet institutional level of care. What, what this bill is asking is to serve families with children who have a different definition of disability. And so if they do not meet the Social Security definition of disabled, then Medicaid Heritage Health Plan isn't, isn't available. And so you have-- that's your first step in the front door of Medicaid.

WALZ: I thought there was something in here that said something about ability-- financial criteria minus the expenses that they have to pay, medical expenses, things like that. Is there something--

COURTNEY MILLER: That spend-down is available today. We do have a medically needy category within our state plan. But again, the-- you have to meet the threshold for disability determination by the Social Security Administration.

WALZ: OK.

COURTNEY MILLER: So many of these children don't, don't rise to the level of institutional level of care. There is a need, there's a level of care, it's not institutional level of care.

WALZ: All right. So I'm just gonna ask it again, because that was a little over my head. Is there, is there something that we can do with the wording to make this bill better? I mean, are there things that we can do in here to provide services to some kids?

COURTNEY MILLER: Yes.

WALZ: OK, that's good answer. And is that something that the Department would be willing to work with Senator Cavanaugh on?

COURTNEY MILLER: I have an open door. I, I collaborate with anyone that wants to have a discussion about authorities and, and opportunities that are available to us. Absolutely.

WALZ: I know you do. The other question that I have just-- do you know where we're at, we were reevaluating the tool kit for the A&D waiver,--

COURTNEY MILLER: Um-hum.

WALZ: --where are we at with that?

COURTNEY MILLER: So we have-- CEO Smith has directed the standardized assessment tool. So we will move away from our home grown tools. And we have chosen the interRAI suite of home care for adults and the interRAI pediatric tool for children. And then the TBI, or the Traumatic Brain Injury, Waiver would also use the, the interRAI home care tool. And so now we're assessing what-- how does that align with the current criteria that we have. And so we are anticipating having regulation changes to the criteria because the wording, it doesn't show a direct alignment from the criteria to the tool. And so we are working on what that regulation would look like, what those changes would look like, and then who administers the tool, what's best practice,--

WALZ: Um-hum.

COURTNEY MILLER: --is it all doctors, is it at all nurses, is it social workers? And then figure out that, that budget impact to implementation of that tool and deciding what IT system to, to put the module in.

WALZ: How much time do you think that's gonna take?

COURTNEY MILLER: I would say until we know the, the budget impact and we have a little bit of more information. I'm just not comfortable putting out an exact timeline. I don't want to give false hope of, of when that would be in place.

WALZ: OK. I think that's it. Thank you

HOWARD: Senator Arch.

ARCH: Thank you. And thanks. This is hard to get the details, so thank you for being patient with us here. In your testimony, you talk about the third area of concern,--

COURTNEY MILLER: Um-hum.

ARCH: --that the bill mandates the Department to apply for a Medicaid family support waiver under the Medical Assistance Program to maximize state and federal funds.

COURTNEY MILLER: Um-hum.

ARCH: So the request is within Medicaid, but the definition of disability, did I understand you correctly to say that it is an institutional level of care required under Medicaid, so that we're, so that we're-- that we're wanting to apply for something, but we, we maybe won't be able to help the population of our families that we're wanting to serve? Do you understand the question?

COURTNEY MILLER: And, and I apologize. I, I have hearing aids and I heard wrestling so I didn't catch all the question, I'm sorry. Can you kind of repeat the beginning,--

ARCH: OK.

COURTNEY MILLER: --I caught the last of it.

ARCH: Your, your testimony says that this particular bill seeks a support waiver, a family support waiver, but that's within Medicaid, correct?

COURTNEY MILLER: I-- the Division of Developmental Disabilities administers two Medicaid waivers now.

ARCH: OK. Is this, is this family support waiver a Medicaid waiver within the Medicaid, CMS Medicaid program?

COURTNEY MILLER: Yes, the bill is asking us to apply for a waiver to get the federal matching funds to administer the pilot program that's being established, but they are not-- it's a, it's a and, it's not-- it, it doesn't say start the pilot program upon CMS approval of a waiver,--

ARCH: Right, right, I under--

COURTNEY MILLER: --it just says, do those two things.

ARCH: --I understand that, but it's a Medicaid waiver that we're seeking.

COURTNEY MILLER: Yes.

ARCH: OK. So-- and within the Medicaid program then the definition of disability is, is an institutional level of care?

COURTNEY MILLER: No.

ARCH: OK.

COURTNEY MILLER: The-- that's a great question, thank you. So the-- there's two-- there's a two-step process to be a waiver participant. The first is you have to be Medicaid eligible in your own right through the Medicaid criteria. And so there's, there's income resource based and there's disability. That disability threshold is federally mandated to meet the Social Security criteria. So if you're an SSI recipient or Supplemental Security Income recipient, you've got that. But there are some families that don't have that SSI because they're over income themselves, so they don't get that disability determination. Then we can-- we have a, we have a state medical review team that then can use the Social Security Administration criteria to do it as if they, they were the Social Security Administration. And so that's your front door, Medicaid state plan, your, your pharmacy, physical health, behavioral health, those services. To, to be a part of the waiver, you can be determined disabled by Social Security, but not necessarily meet institutional level of care. So that's the next step, is, is the evaluation for a level of care. And if you meet institutional level of care and you have that disability determination, then you can receive waiver services.

ARCH: OK. Thank you.

HOWARD: Other questions? Can you tell me a little bit about the Disabled Persons and Family Support program?

COURTNEY MILLER: Um-hum.

HOWARD: It, it sounds like it's got about $100-- $800,000, and, and tell me what it's used for and where those funds are going?

COURTNEY MILLER: Um-hum. So the Disabled Persons and Family Support Program is administered through the Division of Children and Family Services. And so I was able to get some information from them on the program. I'm not an expert on the program, but I'll tell you what I know. So the program is designed to encourage three things: employable-- this is straight from the regulation, employable disabled people who live independently to remain or become employed, families living with disabled family members to preserve the family unit, and disabled adults who resided in independent living situation to maintain their maximum level of independence. So the program services are intended to supplement other publicly funded programs available,

not replace, such as Medicaid and the Social Services Block Grant programs. So the eligibility is they must meet income and disability criteria in state law in, in this section that we're looking to-- we're discussing to amend, services include personal care, purchased lease of adaptive equipment, home modification, disability related counseling or training, medical mileage, and some-- a [INAUDIBLE] of services. The funding cap, the maximum assistance is $300 per month or $3,600 per year. And so in fiscal year '17 and fiscal year '18, it looks like we had an appropriated budget for that program of $910,000 and we had an, an annual cost or utilization spend of around $90 to $94,000. And so it's-- that was based on how many applicants they had. So we served 47 and 45 respectively in '17 and '18. So in 2019 under LB944, which was a mid- biennium adjustment, the Department did a alignment of expenditures versus the appropriation and did a reduction based on lower than budgeted spending, and so that budget was then reduced to $135,000. So for fiscal year 2019, they served 69 people and the annual cost or utilization was $124,000. So it's, it's aligned now with the number of applicants that they have. And so, so far, to date, there are 73 people served.

HOWARD: OK.

COURTNEY MILLER: Um-hum.

HOWARD: OK. All right, I-- do-- how long was it at $800,000? How long have we had the, the DPFS?

COURTNEY MILLER: Oh, I couldn't speak to that.

HOWARD: OK.

COURTNEY MILLER: It, it, it was established in statutes, so I'd have to go back to look to see when it was established in statute.

HOWARD: OK. I just have a concern where the Legislature appropriated $800,000 and then I don't understand why people weren't using these funds, especially when it's through CFS to preserve a family unit when we know we have some challenges in that area,--

COURTNEY MILLER: Um-hum.

HOWARD: --which is obviously not in your agency. So I'm, I'm not upset with you, but it just seems really strange that there was so much money directed to this support waiver, which is not the bill at hand.

So do you-- so the, the bill as written would require a waiver to be submitted, I think what I'm struggling with is I hear it as a pilot program, I hear it as-- there's an issue of our Medicaid eligibility within the waiver that we'd be applying for. And so I go back to Senator Walz's question, which is there any waiver, is there anything that we could put into statute or encourage you to do that would help some of these families with these specific issues?

COURTNEY MILLER: Um-hum. So I think that, as I said in my testimony, the, the concern is that you're, you're talking about a, a subset of the disability population, children that do not meet institutional level of care. And so there, there is no Medicaid eligibility category for anything for a disability related category that is under the Social Security definition of disabled. And so I, I don't have a solution necessarily with Medicaid funding that would result in serving or allowing them to be Medicaid eligible other than having a category of disregarding all parental income, which would-- we would become the health insurance for children in Nebraska. So that's, that's--

HOWARD: And we kind of already are.

COURTNEY MILLER: --the issue, that's the issue. You know, as, as a state, we, we always have the option to create 100 percent state general funded programs within any parameters that we choose. And so it, it appears to me the, the, the solution, if there is one that's going to be placed into statute and a new program created would be 100 percent state general funded to serve children with, with a total disregard of parental income and to allow the eligibility criteria as it's defined in this bill.

HOWARD: OK. All right. OK. Thank you.

WALZ: I have another--

HOWARD: Senator Walz.

WALZ: Thanks. I'm, I'm just trying to understand. I'm sorry.

COURTNEY MILLER: Yeah, no.

WALZ: The Social Security definition where children have to meet the levels of institution. Well, isn't that what you said? Can you repeat that?

COURTNEY MILLER: That's OK. I'm gonna look for my-- it-- sometimes the regulations actually read it a little bit better than I say. OK. So in the 4-- the 477 Medicaid Eligibility Nebraska Administrative Code regulations--

WALZ: So this is Nebraska, not federal?

COURTNEY MILLER: This, this is, this is across the board. This is federally mandated.

WALZ: Federal?

COURTNEY MILLER: Yep. So it-- the, the federal law, this repeats the federal law. All applicants for aid to the blind or aid to the disabled after January 1, 1974, must meet the medical definitions of blindness or disability of the Retirement, Survivors, and Disability Insurance, RSDI/SSI programs as admitted by the Social Security Administration. The determination by SSA that an individual is disabled or blind must be accepted for eligibility for ABD. In some cases, the state review team may make the determination of blindness or disability based on the SSA criteria.

WALZ: OK, so we could make that determination. Is that what you just said?

COURTNEY MILLER: We can--

WALZ: No?

COURTNEY MILLER: --when, when SSI is not present for whatever reason, we can apply the Social Security Administration criteria as if they were receiving that disability determination from the Social Security Administration. But, but we cannot change the criteria. So if the, if the, if the family was over income, SSI is not going to provide a determination. So they don't have a piece of paper that says a child's been determined disabled. And so we can make that determination using their criteria.

WALZ: I'm glad your door's open because I-- [LAUGHTER].

HOWARD: May I ask? Relative to children who have a disability, would they need institutional level of care in the absence of their caregivers?

COURTNEY MILLER: For children?

HOWARD: Um-hum.

COURTNEY MILLER: Children by nature must have caregivers, so I'd say for supervision, that would be a concern. I don't know that it would rise to institutional level of care.

HOWARD: So it would probably be more like a specialized foster placement or something like that.

COURTNEY MILLER: Right, if the-- I mean, for, for any parent that cannot meet the needs of their child for, for whatever reason, yes, that would be-- we have a system for that of the child welfare system.

HOWARD: OK. But we wouldn't necessarily say that they were at an institutional level in the absence of their caregiver.

COURTNEY MILLER: No.

HOWARD: OK.

WALZ: OK. I just have one more question.

HOWARD: Yeah, sure.

WALZ: I'm sorry. I know it's 6:00. I'm sorry, Courtney.

COURTNEY MILLER: It's fine.

WALZ: So I think Pennsylvania and Tennessee are two states that have done this.

COURTNEY MILLER: Um-hum.

WALZ: How did they do this?

COURTNEY MILLER: So I'm gonna clarify, when you say this, you mean--

WALZ: Is family--

COURTNEY MILLER: --what is, what is present in the bill?

WALZ: Right. Well,--

COURTNEY MILLER: They don't have what's present--

WALZ: --the bill.

COURTNEY MILLER: --in the bill. They have a Medicaid--

WALZ: The idea of the bill.

COURTNEY MILLER: --1915(c) waiver that's home and community based. And the basis of that waiver is alternative to institutional placement. So they-- all those children meet institutional level of care.

WALZ: OK.

COURTNEY MILLER: And because of the waiver slot, they-- we, we choose to disregard the parental income so that-- those states do have-- many states have family support waivers and, and many states have multiple waivers, but they are all institutional level of care.

ARCH: Be-- I'm sorry.

HOWARD: Senator Arch.

ARCH: Because it's Medicaid funded.

COURTNEY MILLER: Yep.

ARCH: Got it. Thank you.

HOWARD: You've got it?

ARCH: No, but I have that, I have that part.

HOWARD: OK. Other questions? Senator Murman.

MURMAN: Yeah, so some-- someone testified that they didn't have the services here that they had in Iowa. So that was a state program in Iowa that wasn't federally funded?

COURTNEY MILLER: That, that-- that's a, a generalized question that I, that I, I couldn't answer not knowing Iowa's-- the depth of Iowa's programs. Many states have, have state-funded programs, as we do the

Disabled and Families Support Program. That's 100 percent state general funded.

MURMAN: OK. Thank you.

HOWARD: Any other questions? All right.

WALZ: So you are gonna work with--

HOWARD: Senator Walz.

WALZ: --Senator Cavanaugh, right? No, that's it. I'm done.

HOWARD: OK. All right.

COURTNEY MILLER: Absolutely.

WALZ: I know you will.

HOWARD: Thank you for your testimony today.

COURTNEY MILLER: Thank you.

HOWARD: We really appreciate it. All right. Our next opponent testifier for LB1204? Seeing none, is there anyone wishing to testify in a neutral capacity for LB1204? Neutral? OK. Good evening.

KRISTEN LARSEN: Yeah, good evening, Senators, not good afternoon. Isn't that funny? A few of us have our afternoon as a greeting, but good evening. My name is Kristen Larsen, K-r-i-s-t-e-n L-a-r-s-e-n, and I am here on behalf of the Nebraska Council on Developmental Disabilities to testify in a neutral capacity for LB1204. Although the council is appointed by the Governor and administrated by the Department of Health and Human Services, the council operates independently and our comments do not necessarily reflect the views of the Governor's administration or the department. We are a federally mandated independent council comprised of individuals and families of persons with developmental disabilities, community providers, and agency representatives who advocate for systems change and quality services. The council serves as a source of information and advice for state policymakers and senators. And when necessary, the council takes a nonpartisan approach to provide education and information on legislation that will impact individuals with DD. The council's taking the neutral position on LB1204. The bill acknowledges a gap in the system that has existed for many years. The council and other

disability advocates are aware that the lack of family supports is a barrier in Nebraska, and we support a solution to address this pressing issue. We recognize the advocacy of the Arc of Nebraska and the story shared by families, eight of whom you heard from today, who are experiencing systemic challenges to bring this issue to a-- to the forefront. However, we suggest that the solution might not necessarily be this bill as written. The council promotes collaboration and wants to foster an environment of cooperation and teamwork with stakeholders, family members, the Legislature, and representatives from the DD network, the Governor's DD Advisory Committee, DHHS, and the Arc of Nebraska. Through this collaboration, federal regulations within CMS, current state statute, rules, regulations, and limitations of the department can be worked through to create a bill that would provide needed services for families. We all basically need to get in a room and hash this out. It's very complex. People are being missed and kids are falling through the gaps. Families need more avenues to obtain services. We commend the efforts to incorporate innovative methods to support families and avoid out-of-home placements by providing in-home and long-term care supports such as specialized respite and child care. There are waiver models being used in other states, like you referenced, that could be adapted to Nebraska. These states, including Maryland, Tennessee and Indiana, are implementing the support waivers model to support families who would otherwise fall through the cracks. Their waiver programs fill a specific area of need not covered in an existing program or waiver. Maryland's Family Support Waiver addresses a wide ranging of supports, and I have a handout attached to my information. Currently, roughly 4,800 Nebraskans are being served with DD waivers. However, only 3 percent of those are children. So while 1,145 children are still waiting on the waitlists. The department must reduce the waitlist in a cost-effective manner. If Nebraska followed the Maryland model, a Family Supports Waiver could meet the needs of the children and families currently on the DD waitlist. Also on the waitlist, there are 430 minors on the waitlist who do not have Medicaid coverage because their parents are over income. Under the Tax Equity and Fiscal Responsibility Act, TEFRA, optional Medicaid coverage-- category of coverage states can cover children under age 19 who are disabled while living at home and would be eligible for Medicaid if they were in an institution. States have the flexibility to decide which institutional levels of care to cover. In Nebraska, my understanding is that right now we cover children who meet, I think, it's the hospital level of care. That could be changed. And I think Director Miller spoke about

that earlier. So according to information from the department, TEFRA could be expanded to meet the needs of the 430 children on the waitlist at a cost of $1.8 million state funds with a total federal match of $2.245 million. I provided a handout that is public information from the department that I received at the DD Governor's Advisory Committee last Thursday that shows that. OK. Based on the way LB1204 is written, the council has the following concerns. There are "nonimplementable" pieces with getting CMS waiver approval. It does not define what type of waiver DHHS should pursue. Is it the 1915(c) or 1115 demonstration waiver? The 1915(c) waivers require participants to meet that institutional level of care. So that disability criteria that you see in the bill as written is lower than the institutional level of care and could possibly create an additional waitlist. But it'd be a waitlist with state funding. Disability criteria does not mirror language in state statute or the federal definition of DD. That's another of our concerns. CMS will not approve a new waiver if there is a duplication of services within a current waiver. Demonstration waivers also have a robust research and reporting requirement, so more evaluators would be needed. Some states meet this requirement by contracting with their UCEDDs. And I would-- we would recommend that. Both waivers have specific reporting requirements that need to be developed with CMS. As written, the pilot program would require 100 percent state funds if approval from CMS was not given. And we have concerns that the DD Advisory Committee would have to understand all the CMS rules and regs and the council questions whether that's the appropriate entity for oversight. And finally, the bill proposes a time line that would be hard to achieve for CMS approval. And then I addressed the issue about the fiscal-- you know, we just learned today from the department that that-- what we thought was underutilized state-appropriate funding is no longer there. And so we'd have to kind of figure out where the money is gonna come from. But-- so that's all I have. I thank you for the opportunity. I thank the parents. I do thank Edison McDonald for-- he has sounded the alarm bell and it-- we just need to keep going.

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

WALZ: Yep. And I-- you know, I was trying to find your letter as it kind of peaked my interest, and then I lost half the stuff that--

KRISTEN LARSEN: No, that's OK.

WALZ: --you were saying. But I did hear you say that there's a possibility that we could mirror something like Maryland is doing. So are you saying that there is an avenue that we could use that--

KRISTEN LARSEN: I, I think that was the intention all along that there is an avenue to, to definitely get that Family Support Waiver. I just think that we-- perhaps that we needed to do a little bit more homework and sit down and understand how, how do we write that to get the approval. My understanding with Maryland, though, that those children that are receiving those supports, do meet institutional level of care.

WALZ: OK.

KRISTEN LARSEN: But some is better than none, you know.

WALZ: Um-hum.

KRISTEN LARSEN: It's so complex. And for-- I don't know how any of you folks that are serving as our senators even take on writing the bills, because I'm confused and I'm in the field and I still have questions. But you collaborty-- collaboratively, you get all these experts in one room, you bet we can figure out an answer. We're, we're Nebraska strong. We can do that. But unfortunately, our state just hasn't-- we just haven't had the opportunity to do that. There's many of us in here been echoing that our families really dropped-- our, our state has dropped the ball supporting families. There's a lot more we could do.

WALZ: Why don't you think we've gotten together to do that?

KRISTEN LARSEN: I think previous administrations might not have had the trust-- that there was a lack of trust between previous leadership and I, and I, and I totally get that. And maybe it's just as simple as just calling it out. Let's just-- maybe that's my role in this whole thing. You know, I'm representing 25 members of a council, all different personalities. Some of them are agency representatives, many of them-- 60 percent are family members and individuals with developmental disabilities. To get all those folks to get on one page is pretty difficult. That's the neutral testimony.

WALZ: Um-hum. But we haven't even come together.

KRISTEN LARSEN: But we've not come together.

WALZ: All right. Thank you.

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

KRISTEN LARSEN: Thank you.

HOWARD: Our next neutral testifier for LB1204.

JOE VALENTI: Senator Howard, Chairperson, committee, thank you for enduring a long day. I'm-- I come to you today strictly as chairperson of the Governor's Developmental Disability Advisory Committee. Currently, this committee, and this will be pretty elementary, and, I think, Kristen already covered part of it.

HOWARD: I know we know it, but would you tell us your name and spell it for us?

JOE VALENTI: Oh, Joe, J-o-e, Valenti, V-a-l-e-n-t-i. You have to know it by now. Sorry.

HOWARD: No worries.

JOE VALENTI: Currently, this committee is charged with the following: the Advisory Committee will show-- advise the department regarding all aspects-- the department being Department of Developmental Disabilities, Director Miller's Department, the Advisory Committee shall advise the department regarding all aspects of the funding and delivery of services to persons with developmental disabilities. The Advisory Committee, number two, shall provide oversight of the court order and custody act. Third, the department shall advise the committee to propose systemic changes to services. I think you've heard enough about the bill and, and, and some of the challenges with it, so I won't go into that again. But I would say that our committee as myself, as an individual, are very concerned about the needs of children. And as you listen to these parents, there's no doubt we've got to find some kind of solution. But it is mired, as Kristen just said, in, in very, very detail, which is very hard. Nothing against any of you here, but I do think they have to-- what we would suggest, we would encourage the individuals involved with this bill to meet with Director Miller and her staff to see if there's a way for this concept to be implemented and receive Medicaid approval. I would also

say that integrating the DD Advisory Council into this bill would be currently not within the scope of the responsibilities which are currently outlined in the regulations. Again, if appropriate, the committee would welcome more conversation of its potential and approved involvement. As Kristen just said, our skill set is not that detailed. So I would say it would take probably a revamping of that committee in significant amounts, and nothing against myself or anybody on a committee, but we just don't have that skill set. So it would take a-- you know take another-- education, a lot of education, and I'm too old for much education. So-- but I-- let me go to represent just myself and my wife Dee. Twenty years ago, give or take a couple days, we had to make Donny, our son, a ward of the state to get services. So I feel the pain of these individuals. It's very, very hard. It's not-- and I want to go back to a question you just asked. Why haven't we come together? It's-- you know, this Department of HHS and we look back at the, at the changes with CEOs. And, and I'm sorry, I just don't think they get the Governor's support. So that's my-- we, we got rid, rid of regional centers many years ago under Governor Thone. And, you know, that's just-- it's continued now. And I think Director Miller, and I'll say it again, has done an admirable job in four years and four years only. I mean, there's been a lot of changes, but it's gonna take money and coming together, as you just said, and we're all willing to do that. But we just-- we-- we've got to come together because this takes-- I'll be honest with you, it takes too much of your time, my time, Director Miller's time, Edison has good intentions. It's just-- we've got to come together to work on this stuff together versus throwing stuff out. It's just too hard to revamp. And, Senator Cavanaugh, I appreciate your efforts also. It's just-- it's very difficult. So-- questions?

HOWARD: Thank you. Are there questions?

JOE VALENTI: Thank you for enduring.

HOWARD: Thank you for visiting with us today.

JOE VALENTI: Now you're really getting an expert with Miss Swanson.

HOWARD: All right. Neutral testimony?

SARAH SWANSON: I'm think I'm the last one.

HOWARD: We'll find out.

SARAH SWANSON: All right. All right. Good-- it says good afternoon, but really good evening. Right. My name is Sarah Swanson, that is spelled S-a-r-a-h S-w-a-n-s-o-n. I'm here to testify as neutral for LB1204 and I don't represent any institution and organization but myself. I recently finished my Masters in Public Health and as part of my Capstone, I was a virtual fellow for the Association of University Centers for Disabilities in Washington, D.C., or we like to call it a AUCD. During this time, I worked with our policy team to create a policy brief on Innovations and Best Practices in Medicaid Managed Long-Term Services and Supports. After conducting an extensive literature review and interviewing policy wonks from across the United States, I learned that states are concerned about the burgeoning Medicaid budgets and that they are looking for new strategies to decrease Medicaid expenditures. One strategy that many states are taking is identifying ways to support family caregivers. The informal supports and daily care that family caregivers provide saves the state money because it deters more costly institutional placements. At one time, children with disabilities were placed in institutions. The belief at this time was that these settings allowed for all of the child's needs to be met. However, as time has progressed, we have learned that children, all children, do best when they can remain with their families and in their communities. Schools now provide special education supports, medicine has progressed, and children who are born with or who acquire disabilities are living longer. However, as these children's outcomes have improved, their long-term care is predominantly falling to their families. So as we've seen institutional settings close, the resource allocation has not followed. Children with disabilities have more needs than other children, including weekly therapies, more school meetings, and their families provide daily care such as administering medication, changing their diapers, and turning them over through the night, and cost a whole lot more than other children. Many families pick up extra jobs just to pay for the needed services or take on medical debt. Some families resort to dropping out of the work force or getting divorced because it would allow their child to have access to Medicaid. Only when they do so, not only does a child with disabilities become eligible for Medicaid, but their entire family as well as other social service programs. The bill as it currently stands, I believe, would benefit from modifications. For example, a specific institutional level of care criterion that would establish eligibility is not detailed in the bill. Additionally at this time, there isn't a fiscal note attached so there would need to be a discussion with the

department on how funding would be addressed. However, since this is a pilot, a small number of slots could be introduced as a beginning point, data collected which would drive further decisions. Although I am testifying in the neutral, I feel that a Family Support Waiver would offer a fiscally sound pathway for children with disabilities to gain access to Medicaid medical coverage and their families would receive supports needed to remain employed and able to meet their child's needs. While the Family Support Waiver is not likely the answer to all the barriers faced by families, it is one strategy that states are using to ensure that families get access to the supports needed to help them stay in their caregiving role as long as they can. I've included the link to the policy brief I mention, and if you look at page 24, you will see a chart that summarizes some states' use of Support Waivers. Thank you.

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

SARAH SWANSON: Yep.

HOWARD: Our next neutral testifier for LB1204? All right. Seeing none, Senator Cavanagh, you're welcome to close. We do have some letters for the record. Letter is in support: Kelsey Wilson, the National Association of Social Workers, Nebraska Chapter; Todd Stubbendieck, AARP Nebraska; Erin Phillips, People First of Nebraska; Judy Nichelson, Nebraska Brain Injury Advisory Council; Peggy Reisher, Brain Injury Alliance of Nebraska; Julia Keown, self. No letters in opposition, no neutral letters. Welcome back, Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman Howard and members of the Health and Human Services Committee. We are passing out-- I'm, I'm sorry, Ashton?

TAYLOR: Taylor.

CAVANAUGH: Taylor, Taylor, sorry. Taylor is passing out the letter that we all received previously. But I just wanted to make sure that we had it because it was referenced in the handout that Edison had given you all from Arc Nebraska. So I just wanted to make sure that that was readily available in your files for this bill. First of all, I want to thank-- profusely thank the parents that are here today. Thank you all for being here. I, I feel like you have become the subcommittee of HHS this year. We, we, we know-- we've gotten to know you and your children, and you are all an amazing inspiration and

advocates for your children. So thank you so much for being here and being part of the best committee in the Legislature. It's well documented that we are the best. I want to thank the committee as well. This past year has been quite a learning experience for myself on the Medicaid side of things, the waiver side of things, and what we as a state are doing and can be doing for those with developmental disabilities. And I am just humbled by all of this work and all of the people that are doing this work. And I want to thank Director Miller for her dedication to this issue. I, I don't even know where the state would be without her. So thank you, Director Miller, for your hard work on this issue. And I look forward to, as Senator Walz pointed out, working on this bill with Director Miller. And I will start with a note I had early on in the testimonies today and looking through the bill. So before we even got to Director Miller's testimony, I had a note to myself, work on language on page 5, line 19-23. So we were on the same wavelength, Director Miller. Because it was the exact thing that she brought up that doesn't say upon approval. And I was reading over this in Section 4 and I thought, oh, this like, it says and established a pilot, what if we don't get approval in my own head. So these are the kinds of things that we all know we've been working and especially in Executive Session, there are going to be those technical changes. I did not hear from the department until Friday that they were coming in opposition and the opposition that we heard today is not what was shared with me. I thought that their opposition was to concerns about adding more staffing and that this would create a waitlist-- a, a new waitlist. So I apologize that I did not have more of their issues addressed. I've only now been made aware of them. So I think that this is really important thing for us to be doing. It is a cost savings. I would like to direct you to page 23 on another handout that Edison had sent, sent out the Arc thing. It has the list of the states that are doing this and it, it kind of breaks it out, the type of waiver that they're doing, the budget, the name. So I think that's helpful as well to know that other states are doing this. And I know everyone in this state-- or everyone in the Legislature is trying to figure out how to be budget conscious. I think we can work together as a committee and with the department and with these families to find a path forward to offer something in the way of a waiver. The intention is not to dismantle Medicaid or lose federal funding, that is absolutely not my intention at all. My intention is to creatively solve a problem that we know we have. Just trying to see, I have a lot of notes to make sure that I'm just hitting all of them because it is end of the day. The reason that we've looked at the Disabled Persons

and Family Support Act is because it was being massively underutilized, because it was cumbersome in its process and its scope. And so it sat underutilized. And I thought this was an opportunity for us to do something good with those funds, though it is very unclear where those funds are. There's about $800,000 that was under-- unutilized in 2018, and Director Miller mentioned that those-- that they were a different appropriation in 2019, but that actually happened in 2018. So it's a little confusing and I think we've-- it warrants a conversation with Senator Stinner. So I think that's it. There's a lot. I'm sorry. Thank you all for your patience and your time today. And I look forward to working with this committee and with the department and our advocates on finding a solution for our families.

HOWARD: OK. Thank you. Are there questions for Senator Cavanaugh? All right. Seeing none, thank you, Senator Cavanaugh. This will--

CAVANAUGH: Thank you.

HOWARD: --close the hearing for LB1204. And it concludes our hearings for the day. Thank you.