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

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

WALZ: Lynne Walz, Legislative District 15, Dodge County.

ARCH: John Arch, District 14, Papillon, 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, Jennifer Carter, and our committee clerk, Sherry Shaffer, and our committee pages today are Nedhal and Angenita. OK. A few notes about our policies and procedures. Please turn off or silence your cell phones. This afternoon, we'll be hearing six bills-- six bills. All right. 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're planning to testify today. Please fill one out and hand it to Sherry when you come up to testify. This will help-- 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 handouts submitted by testifiers will also be included as part of the record as exhibits. We ask if you do have any handouts that you bring 10 copies and give them to a page. We use the light system for testifying. Each testifier will have five minutes to testify. When you begin, the light will be green. When the light turns yellow, that means you have one minute left and when the light turns red, it's time 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 very strict no prop policy in this committee, and with that we'll begin today's hearing with the Gubernatorial appointment of Michael Bailey to the Board of Emergency Medical Services. Welcome, Michael.

MICHAEL BAILEY: Thank you.

HOWARD: We'll have you state your name and spell it for the record.

MICHAEL BAILEY: All right. I'm Michael Bailey, M-i-c-h-a-e-l B-a-i-l-e-y.

HOWARD: And we're hoping you could just tell us a little bit about yourself and your interest in serving on this board.

MICHAEL BAILEY: All right. I'm from Westerville, Nebraska, live on a small family farm. I have a couple businesses in the town of Ansley where I there joined our local EMS volunteer fire and rescue department. I've served for about 16 years in that capacity. I've had the opportunity and the luxury during that time to serve as a first responder of EMT and also now a paramedic, which brings ALS to our area. I have worked for a critical access hospital in Ord, Nebraska, for I believe it's about three to four years as a paramedic, both in the ER and on an ambulance service. I've also got a chance right now where I'm currently working PRN for Good Samaritan at a Level 2 trauma center in Kearney, so I get to see EMS from quite a-- quite an aspect. I've served on this board since 2015, so this is a reappointment for me. I come in to fill a spot for somebody else. During that time, there's a little bit of a learning curve I think first getting on there so, but I really enjoyed the time that I've had there and the changes that we've really made probably in the last 15 years on that EMS board, so.

HOWARD: Tell us a little about the changes. I'm very curious.

MICHAEL BAILEY: So, I would say since when I first came into this board, it seemed like we did a lot more just looking in investigations and things like that. But as time went on, we wanted to make a

difference. We went out to the stakeholders and did a lot of those forums. I think you guys got to hear about those. I think I attended all but one of those forums. It was nice to hear from-- from everybody out there and then take those things and try to put them back into action. The frustrating part of that is that the process and the time it takes to get that back into action, you know, we had to make statutory changes, what you guys have helped us a lot with. And then we've had to make rules and regs changes. And we're currently in the process of now rewriting protocols. And I think the rules and regs are close to finally-- finally getting through, but just the process of seeing that all go through. And the downside, like I say, is going back out after you talk to everybody and we're going to-- we're going to try to fix this. But it's just that the patients have come back to them and tell them, we're-- we're getting there, it's getting closer.

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

WALZ: OK, I just want to say that I-- we all understand that frustration here. Thank you for coming. What would be one of your number one goals as far as the upcoming--

MICHAEL BAILEY: I think in the upcoming session, I think-- or not sessions but the time that we have going forward to the next group would be working with trying to build better work force out there. You know, we have a hard time getting volunteers and I don't know how that's-- we're really going to change that unless we figure out a way to either incentivize the businesses out there ,because we're taking a lot of these shops have one or two people there and you take them way to run these calls they lose that. There's got to be some type of incentive out there. But I think it's gonna be more than that. We're going to have to look at how we can bond together and work together. Currently in our area, some of our squads are starting to interlocal agreements and work together to where they work in two different towns. But now they're-- they're responding out to-- to the other town to help. And I can give you an example of Ansley and Mason City have signed an interlocal agreement. I think it's about four years ago to now, we just both respond to each other's calls. So that way we know somebody is coming for that-- that person that's out there. And I think you're starting to see that develop out into some of those smaller communities out there as well. But it takes that education and that-- that helping train them on how that can be done.

WALZ: Right. And I would imagine that that would allow somebody who has just come off a call to have a little bit of time off before they have to go back on another one. Does that help that situation at all?

MICHAEL BAILEY: It might. But it seems like in those small communities, you-- you've only got maybe two or three--

WALZ: Yeah.

MICHAEL BAILEY: --people available during the eight to nine hours stretch. So they're-- it's back to back. They're probably going to get-- have to go in two.

WALZ: Yeah, well, thank you for what you do.

MICHAEL BAILEY: Yeah.

WALZ: Appreciate it.

HOWARD: Senator Arch.

ARCH: Thank you. So I was-- I was interested that obviously this is quite a balancing act that you have to do to stay involved and-- and employment elsewhere. How-- how do most people do that on the-- on the volunteer basis while employed? What-- what's required to get that to work?

MICHAEL BAILEY: Well, I think if in my case, it's-- it's the luxury that I'm the-- I'm the owner. And so I can-- I can make those changes and I can-- I can step away and I can do that. And I think you also got to have the understanding of your-- your customer base, which for me, being a small community, I think most of the people support the fact that, oh, we show up and he's gone. But we know that's probably-- he's probably on call or helping with that, so it's-- it's-- that helps. But most people that work for somebody that gets to be tough. It takes maybe a couple of calls before they're allowed to leave. And, you know, like I say, if there's only one employee that somebody has and they're-- they're taking off and closing that shop, that's-- that's just not justibio-- justifiable for a business owner. So that-- that's a huge challenge and a huge juggling act.

ARCH: Yeah, I'm sure it takes a real commitment. Thank you for your commitment.

MICHAEL BAILEY: Thank you.

HOWARD: Thank you. Any other questions? Senator Williams.

WILLIAMS: Thank you, Chairwoman Howard. And thank you, Mike, for being here coming all the way from Ansley in Legislative District 36. We have a contest with this group and I have not been allowed to participate because I don't get too many people from Legislative District 36, so could you tell the group here which is the best Legislative District? [LAUGHTER]

MICHAEL BAILEY: 36, of course.

WILLIAMS: Right answer. We'll advance you.

HOWARD: Thank you so much for coming down and your willingness to serve on this board. We really do appreciate it.

MICHAEL BAILEY: Well, thank you.

HOWARD: All right. And the next step is we'll advance your confirmation to the floor and we'll debate it there. And we do really appreciate your time today.

MICHAEL BAILEY: All right. Thank you.

HOWARD: Thank you. All right. This will close the gubernatorial appointment for Michael Bailey to the board of-- the Board of Emergency Medical Services. And we will open the hearing for LB1037, Senator Hunt's bill, to change provisions relating to household eligibility for Supplemental Nutrition Assistance Program benefits. Welcome, Senator Hunt.

HUNT: Thank you very much, Chairwoman Howard. Which one is it? Good afternoon, Chair Howard, and members of the Health and Human Services Committee. My name is Megan Hunt, M-e-g-a-n H-u-n-t, and today I'm presenting LB1037, a bill that ensures that eligible children will not lose Supplemental Nutrition Assistance Program benefits if the head of household in a family is disqualified because of a failure to meet work requirements. Under current regulations, dependent children are ineligible for SNAP benefits unless the head of household satisfies federal work requirements under 7 CFR 273.7. LB1037 makes it a requirement that children in these households are still eligible for benefits. The intent of this bill is to address real needs of child

hunger in Nebraska and give the heads of households comfort in knowing that as they search for work, their children won't go hungry. According to the National Conference of State Legislatures, Nebraska is only one of six states that disqualifies the entire household from SNAP if the head of household becomes ineligible due to not meeting work requirements. We need to join the rest of the country in understanding that food security is of the utmost importance and there should not be punishment passed down to those who do not have the power to change the situation in their family in poverty. Nebraska's Department of Health and Human Services has recognized this problem and has taken steps to correct this issue. My office spoke with the department earlier this week, and we are aware that the department is taking necessary steps now to implement this policy regardless of LB1037, and we found that out after we introduced the bill. But this does not take away the need for this bill. According to our Legislative Research Office, using U.S. Census Bureau data from 2014 to 2018, roughly 16 percent of children in Nebraska are living in poverty. In my District, District 8, 25.2 percent of children live in poverty. It's over a quarter. The fiscal analysts found that on average, 82 households in Nebraska have been disqualified because of these federal requirements as I've mentioned in this bill. Maintaining the rest of the household on SNAP would not have a significant impact on the department's caseloads. This is a household disqualification policy that should never have been implemented. It should not be a discretionary policy either. We should be doing everything we can as lawmakers to ensure a healthy future for children in our communities, our districts and our state. Since DHHS says that they've made the decision to do this, I think that we should codify it into statute to make sure that that security is there for future families regardless of who's running DHHS or who's in the executive branch or what we're doing in Nebraska. Finally, I went to address that there's no fiscal note on this bill. All of the benefits are paid with federal funds. This is a commonsense bill, common sense policy. I'm glad to see the department supports this issue. So I would like to pass this bill in the Legislature so this policy won't change if there's ever a change in administration. And I would ask that the committee advance this and I hope we can find a great place for it. Thank you.

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

CAVANAUGH: Thank you. Thank you, Senator Hunt. I really just wanted to say thank you even though the department is moving forward with this on their own for highlighting children hunger, so thank you.

HUNT: Yeah. My feeling is like, I'm glad we all agree. Let's put it in statute and make sure the kids stay protected no matter what happens.

HOWARD: All right. Any final questions? Senator Murman.

MURMAN: Yes, thanks, Senator Howard, and thanks for coming in, Senator Hunt. Just to clarify, if-- you've mentioned you're open, if-- if the head of the household is looking for work, they do not qualify. Is that the case or-- or is it only-- if they have to be working.

HUNT: My understanding-- my understanding is that they have to meet federal work requirements. And if you're just looking for work, that's not a way to meet the requirements. But somebody behind me who has legal expertise on this issue can answer that more directly, but that's my understanding in terms of the federal law.

MURMAN: OK. Thank you.

HUNT: Uh-huh.

HOWARD: Seeing no further questions, will you be staying to close?

HUNT: I will. Thank you.

HOWARD: All right. Well, we'd like to invite our first proponent testifier up for LB1037.

JULIA ISAACS TSE: Good afternoon, Chair Howard and members of the Health and Human Services Committee. For the record, my name is Julia Isaacs Tse, J-u-l-i-a I-s-a-a-c-s T-s-e, and I'm here today on behalf of Voices for Children in Nebraska. Our state policy should support families in building a better future for their family. Voices for Children in Nebraska supports LB1037 because it would better ensure that Nebraska parents can meet one of the most basic needs for their children, food. Today, over 17 percent of Nebraska's children do not have reliable and adequate access to nutritious food. The Supplemental Nutrition Assistance Program, or SNAP, is one of the most effective anti-poverty programs in our nation's history, providing food assistance to nearly 85,000 Nebraska children. It is estimated that SNAP moved 86,000 Nebraska families out of poverty in a year. The

vast-- the vast majority of SNAP participants in Nebraska are working families who are struggling to make ends meet. Over half of SNAP recipients fall under that category, or families with household members that are unable to work due to age or disability, which are nearly a third of SNAP recipients. Benefits are calculated by need and benefits-- benefit amounts decrease as family income increases. As it stands, many Nebraska families receiving food assistance still struggle to make ends meet. The average SNAP benefit is estimated to only cover 43 to 60 percent of the actual cost of NLB diet. And families with growing teenagers may struggle in particular to put food on the dinner table. The average Nebraska family receives one dollar and 25 cents in SNAP benefits per meal for each family member. No child should be punished for circumstances that are beyond their control. Currently, when heads of households not exempt from work requirements fall out of compliance, the entire family, including children, is penalized and ineligible for anywhere from 30 days to 180 days. Most states do not disqualify the entire household when the head of household is out of compliance without good cause, and Nebraska is one of only 10 states that utilizes this harmful practice. And I would note that this diverges from Senator Hunt's figure of 7 states because the other-- the remaining states have a more punishing policy so they go above and beyond what's federally-- the federal minimum. So taking away food assistance from a household already struggling to pay the bills is a cruel and unnecessary policy that is harmful to the many Nebraska children that rely on SNAP benefits. LB1037 ensures that families can continue to receive food assistance if the head of household is not in compliance with work requirements. LB1037 would disqualify the noncompliant head of household alone and allow the family to continue receiving food assistance at a lower benefit amount. We thank Senator Hunt for her continued leadership in addressing food insecurity for Nebraska's children, and this committee for their time and consideration and would urge you to advance this bill. Thank you.

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

JULIA ISAACS TSE: Thank you.

HOWARD: Our next proponent testifier for LB1037. Good afternoon.

KEN SMITH: Good afternoon, Chairperson Howard and members of the Health and Human Services Committee. My name is Ken Smith. That's

spelled K-e-n S-m-i-t-h, and I'm the director of the Economic Justice Program at Nebraska Appleseed. Nebraska Appleseed is a nonprofit legal advocacy organization that fights for justice and opportunity for all Nebraskans. I appreciate the opportunity to testify today in support of LB1037. Just by way of context, the Supplemental Nutrition-- the Supplemental Nutrition Assistance Program, also known as SNAP, is the nation's most important anti-hunger program across our state. SNAP helps about a 155,000 Nebraskans put food on the table for themselves and their families. SNAP has a demonstrated track record of serving as a temporary source of nutrition assistance, significantly reducing food insecurity for participating households and alleviating the disastrous and well-documented short and long-term consequences of food insecurity and hunger. SNAP is a federal program, but by its design, Congress supported states broad discretion to structure and administer the program in ways that best fit the needs of each state. One of the areas of the program in which states can exercise that discretion is in how they choose to impose sanctions when and if a SNAP participant fails to meet their work requirements. The sanction of this type simply deems a person ineligible for SNAP for a certain period of time. Typically, the federal-- the federal minimum and the policy that state-- that the state Nebraska adheres to is one month for the first instance of noncompliance with work requirements, three months for the second and six months for the third. As has been stated today, some states, including Nebraska, have opted not only to disqualify an individual for noncompliance, but deem the entire household ineligible for SNAP if the person charged with noncompliance is the head of household. I think it's just worth noting that all household disqualifications can have disastrous effects on families that are already often living paycheck to paycheck and experiencing food insecurity. I think as both Senator Hunt and the testifier before me alluded to, one of the unintended consequences of whole household sanctions is the impact that it has on children. There is a growing awareness among researchers that the consequences of hunger in the early years of life can extend well beyond childhood and affect physical, mental and economic well-being as adults. Whole household sanctions increase food insecurity for families, and place Nebraska's children at risk of suffering the long-term consequences of childhood hunger. LB1037 would address this issue by eliminating all household sanctions and limiting the application of the sanction only to the individual thought to be out of compliance with work requirements. While that person would no longer be eligible, in households SNAP benefit allotment would likely decrease during the sanctions period,

it would not disappear entirely. So this would improve outcomes for Nebraska children and families who participate in the SNAP program. I think to add to the figure that a couple testifier-- that Senator Hunt and Julia before me shared of-- all of our neighboring states refrain from imposing whole household disqualifications. Prior to this hearing, we learned that DHHS is working to administratively change our sanction process to eliminate all household sanctions. We applaud DHHS for initiating this positive change that will help the families that they serve. However, even if the regulatory change proceeds as planned, there is still a need to amend our statutes as proposed by Senator Hunt in LB1037. As this committee well knows, agency practices and regulations can undergo frequent review and revision. Incorporating this change into statute increases the staying power of DHHS as commendable actions. There is no-- there is broad consensus that making this change will benefit Nebraska children and families. Amending the statutes accordingly is the right thing to do. So for those reasons, we thank Senator Hunt for bringing the bill and we would urge the committee to advance it to General File. I would just respond briefly to Senator Murman's earlier question. I think it's our understanding that looking for a job does not satisfy SNAP work requirements. There may be instances in which a person is participating in ADC and if they're fulfilling the requirements of that program, may also be eligible for SNAP. And we think job search is a component of ADC and can't-- can satisfy the requirements of that program. But just to be clear, it's our-- it's our belief that we're looking for work is not a SNAP work requirement complaint activity. With that, I'd answer any other questions.

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

MURMAN: Thank you, Senator Howard, and thanks for testifying. Being the only farmer, I think here on the board, I've got to ask this question. What federal department budget funds the most successful program, as you mentioned it?

KEN SMITH: That would be the United States Department of Agriculture.

MURMAN: Thank you very much.

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

KEN SMITH: Thank you.

HOWARD: Our next proponent testifier for LB1037? Seeing none, is there anyone wishing to testify in opposition? Good afternoon.

STEVEN GREENE: Good afternoon. Before I get started, I just want to say-- say thanks to Ken for answering questions ahead of me having to do that, so appreciate it. He's definitely an expert. Good afternoon, Chairperson Howard, and members of the Health and Human Services Committee. My name is Steven Greene, that's S-t-e-v-e-n G-r-e-e-n-e, and I'm a deputy director for the Division of Children and Family Services for the Nebraska Department of Health and Human Services. I'm here to testify in opposition to LB1037, which will change-- excuse me, which will change provisions relating to household eligibility for the Supplemental Nutrition Assistance Program. The USDA, Administration of Food and Nutrition Services, provides states the opportunity to take approximately 28 various policy options in administering their states SNAP program. The intent of SNAP options are to provide states, and this is a direct quote from the USDA-FNS website, with flexibility to adapt their programs to meet the needs of eligible low-income people in their states. This allows the states the ability-- ability to tailor their SNAP program to the various economic conditions program modernization and target benefits to those most in need. LB1037 elects a SNAP option through state statute rather than through state plan amendment and agency regulations. The USDA regularly makes changes to federal rules and regulations governing SNAP. One example is the recent proposed rule change to broad-based categorical eligibility. The department loses the ability to make necessary changes timely when a state statute dictates the details of the program. The department is already amending the state plan, as noted in previous testimony, and the agency regulations to elect the SNAP option that would be required by LB1037. This decision was made by the department as part of its annual review of its SNAP options. In light of historically low unemployment rate, coupled with the administration's focus on helping families move from poverty to self-sufficiency, we believe this SNAP option strikes the right balance between personal responsibility and also providing assistance to low-income families. To reador-- to reiterate, it is important for the committee to understand the department opposes electing SNAP options in state statute. The department wants to continue its flexibility in administering its program to meet the needs of Nebraskans. Thank you for the opportunity to testify before you today, and I'm happy to answer any questions you may have.

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

ARCH: Thank you. Thanks for your testimony today. Do you happen to know, have we done-- have we done this with other SNAP options? Have we put other SNAP options into statute?

STEVEN GREENE: We have. In fact, the statute that is being amended by this bill, there are actually several different SNAP options that it-- that the state is required to take. For instance, and I think I'll go-- if you don't mind, I'll just refer to the-- the bill itself.

ARCH: Sure.

STEVEN GREENE: And I'm not a legal expert, so if I'm making any-- any incorrect legal citations, let me know. But on page 4 of the bill, it does talk about the department shall create a TANF-funded program or policy and then lines 3 through 7 that actually-- I don't if that's the right section, but mandates a taking the broad-based categorical eligibility state option for the state of Nebraska. So that question speaks to the complexity of-- of state options, just like as it was noted certain administrations can change their state policies and the federal level state-- the federal government can make rule changes that could, in fact, could impact the state's current state options. And so our position is in order to stay compliant with both-- with federal government rule changes for this program, we want to have that flexibility outside of state statute. Does that make-- does that answer your question?

ARCH: It-- it does. I guess the question is if-- if administration, federal administration now makes-- makes those changes, do they simply provide the option to the state or you've seen options become requirements by the federal government?

STEVEN GREENE: That's-- that's a good-- that's a good question. I know part of how this conversation occurs at the federal level is every-- every time that the ag bill comes up for reauthorization and so sometimes Congress will take or pursue modifications to the food stamp per-- food stamp program through the reauthorization of that bill. Historically, I have not-- historically, there are changes to the rules related to the food stamp program or SNAP program, but not what I have seen and I could be wrong and I'll get clarity back with my team, is not related to the SNAP options. The SNAP options, though, are-- they are flet-- flexible in nature. And so it's not just policy

decisions related to-- in this case of waiving the work requirement for households. For instance, an example would be giving states the flexibility of what they even want to call their SNAP program itself. Does that-- is that helpful?

ARCH: Yes.

STEVEN GREENE: OK.

ARCH: Yes. Thank you.

HOWARD: Senator Murman.

MURMAN: Yes. Thanks, Senator Howard, and thanks for testifying. It was mentioned in earlier testimony there's-- I don't remember the specific number, but like seven or eight states haven't done this yet. So why-- why have other states done it if it's so risky?

STEVEN GREENE: Right. I can't speak for other states and why-- why they make their option. I think that does speak to the-- just the flexible, the nature of it being flexible from state to state. What-- what I can say is that, again, to the testimony when we-- when we were viewing our state options and especially with some of the-- the work for-- work for us or SNAP DOL pilot projects that we were-- we were doing where we wanted to help families as a whole. We really felt like this was the right thing to do to take that option to eliminate the whole household disqualification. But I can't speak to why other states would take that approach compared to Nebraska.

MURMAN: Thank you.

STEVEN GREENE: Um-hum.

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

STEVEN GREENE: Thank you.

HOWARD: Our next opponent testifier for LB1037? Seeing none, is there anyone wishing to testify in a neutral capacity? Seeing none. Senator Hunt, you are welcome to close. While she is coming up we do have some letters. Letters in support: Jacqueline Kehl, self; Mary Sullivan, National Association of Social Workers-Nebraska Chapter; Ingrid Kirst, Lincoln-Lancaster County Food Policy Council; Lisa Graff, Nebraska

Academy of Nutrition and Dietetics; Dr. Erin Feichtinger, Together, Inc.; Scott Young, Food Bank of Lincoln; Joey Adler, Holland Children's Movement; Amy Behnke, Health Center Association of Nebraska. No letters in opposition, no neutral letters. Welcome back.

HUNT: Thank you, Senator Howard. Thank you, members. I think it's appropriate for the Legislature to require regulations for SNAP, some regulations that the 49 of us decide are appropriate for Nebraskans because it's in the interest of our constituents and respectfully to DHHS, you know we're elected to fulfill the needs of our constituents and the Legislature is the body that has the power to make the policy to do that. And so, I understand wanting flexibility based on what's happening at the federal level, but those are things that we can always address again with legislation when those issues come up. So leaving some of these issues like child hunger and child poverty up to department regulations, when we have changing administrations, changing political motives in this partisan branch of government, which we are not, I think that that is why it's important that we codify these things in statute. And if there ever is a bridge to cross where the federal government is doing something that's preventing us from carrying these-- these laws and policies out, that's a bridge we can cross when we come to it. But today, in 2020, we're not there. But we know that our kids are there with-- you know, over a quarter of the kids in my district living in poverty. More-- more than that on free and reduced lunch. And this is a bigger problem in rural Nebraska than it is in urban Nebraska. District 46, District 35, District 17, District 19, huge farming communities. And we know that these are hardworking people and this is the breadbasket of America and these farmers are working and ranchers to feed the whole country, the whole world. But our own kids in these communities are going hungry. And for that reason, I think it's appropriate for the Legislature to codify in statute what DHHS thankfully plans to do, because we also pull down so few federal dollars compared to other states. And this is a zero cost way for Nebraska, in our budget, to address an urgent, immediate problem. Kids should not go hungry because their parent is looking for work. These are parents who are doing the right thing. And we cannot punish kids for circumstances that are not in their control. Household disqualification never should have been implemented, and LB1037 ensures that it won't happen in Nebraska again. As I said, I feel like we have a responsibility as legislators and as a state to make sure that every child can grow up healthy and have a chance to succeed, that they don't have marks against them that are going to stigmatize

their experience as they go into adulthood, and prohibiting a household's access to SNAP under the household disqualification regulation puts up a barrier that can impact a child far beyond their youth. So I ask this committee to advance this bill and I look forward to finding it on the floor and we'll figure that out. Thank you.

HOWARD: Are there questions? Senator Murman.

MURMAN: Thank you, Senator Howard, and thanks a lot, Senator Hunt.This isn't a trick question, but I'm just curious as to what percentage of the agricultural budget of the federal government goes to the SNAP program.

HUNT: This is knowable, but it's-- I don't know it right now. I don't have that in my notes, I don't think and I don't have that memorized.

MURMAN: That's fine. You don't have to answer.

HOWARD: Senator Murman, do you know the answer?

MURMAN: I think I've got a good idea, but I'm not going to guess at it either.

HUNT: Thank you.

MURMAN: Thank you.

HOWARD: Senator Williams, do you know the answer?

MURMAN: Yeah, that's what I was thinking.

WILLIAMS: The answer is about 80 percent of the federal ag budget goes to the SNAP program.

HUNT: Thank you.

HOWARD: All right. Any final questions for Senator Hunt? Seeing none, thank you, Senator Hunt. This will close the hearing for LB1037 and we will open the hearing for LB1038, Senator Hunts' bill to change provisions relating to eligibility for Supplemental Nutrition Assistance Program benefits. Welcome back, Senator Hunt.

HUNT: Thank you very much. Good afternoon, Chair Howard, and members of the Health and Human Services Committee. My name is Megan Hunt, M-e-g-a-n H-u-n-t, and I represent District 8 in midtown Omaha. Today,

I'm presenting you with LB1038, a bill that would increase access to Supplemental Nutrition Assistance Program, or SNAP benefits. Under the current statute, an individual with a conviction for drug distribution, or with three or more felony convictions for the possession or use of a controlled substance, is ineligible to receive SNAP benefits. LB1038 removes this lifetime ban. Additionally, the bill provides for individuals that have completed their sentences or are serving terms of parole, probation, or post-release supervision and are in compliance with the terms of that parole, probation, or post-release, that if they're eligible, they may apply for and receive SNAP benefits. The intent of this bill is to remove a major barrier to successful reintegration for formerly incarcerated people while also reducing hunger for affected people and their families. I brought this bill last year. I hope some of you recall voting it out unanimously last year for floor debate and I prioritized this the last year and I will continue to bring this bill every year until it passes, because I believe this is the right thing to do to modernize our SNAP policy in Nebraska. It's something we need to do if we care about recidivism, if we believe that the purpose of incarceration is to rehabilitate and that everyone deserves a second chance once they have served their time and paid their debt to society. I can share some data to issue-- on this issue to demonstrate that expanding SNAP access for formerly incarcerated people instead of pushing them toward reoffending will result in cost savings for the state. A person convicted of a drug felony spends an average of 1.6 years in jail and the average cost to incarcerate a person for a year in Nebraska is $35,950. So that's a total for that year and a half of $57,520. The fiscal analysts provided no fiscal note to this bill. There's no change to the state's budget. All SNAP benefits are federally funded and the state only has to share 50 percent of the costs of administration, and as illustrated in the fiscal note, the state feels that they can absorb that cost. So we can either provide SNAP benefits to assist folks to get back on their feet and support their families, or it sounds like we can spend $57,520 to incarcerate each repeat offender that did not have the proper resources to reenter their community. Over 600,000 individuals are released from state and federal prisons every year who face serious barriers to attaining employment and housing, barriers that are reinforced in Nebraska by the statute we currently have on the books. This makes it more difficult for formerly incarcerated people to access food, which perpetuates cycles of poverty. It negatively impacts the children who depend on these people and it increases rates of recidivism. The population of people in Nebraska that utilizes SNAP

benefits is diverse. In fact, I have turned to SNAP benefits and public assistance for a temporary hand up just as thousands of other parents in Nebraska have done for a variety of reasons, not out of their control. I, however, do not have any drug convictions on my record. But, you know, today I'm 33, but if I had had a conviction when I was 18 or 19, I would be prevented today and for the rest of my life from receiving any of those benefits that I would otherwise be eligible for. So how are parents supposed to concentrate on finding work and supporting their families if all they can think about is a hungry child or finding housing? This is why so many individuals who reoffend commit financially motivated crimes like theft or drug distribution. Often when we talk about these statistics about crime and drug use, we forget that there are families and children wrapped up in those statistics. We talk about people who are offenders as if they're individuals, and we don't think of them as mothers and fathers and grandparents and brothers and sisters and people who have dependents who rely on them. There should be a concern that 11.9 percent of our Nebraska population is food insecure. We should be concerned as the state that 16 percent of Nebraska children live in poverty, that 17.9 percent of Nebraska children are food insecure, and we reduce that number when we remove barriers like this to SNAP benefits which comes at no cost to the state. This was really interesting to me. There was a study in 2018 conducted at the University of Maryland that gives us an idea of how this could play out in Nebraska if you can kind of extrapolate the results a little bit to our own state. This study looked at individuals who committed drug-related crimes in Florida before and after Florida implemented a lifetime ban on SNAP benefits for people with drug-related crimes. This study found that people who were convicted of drug-related crimes after the SNAP restrictions were imposed were 9 percent more likely to return to prison, and that the crimes that resulted in recidivism were primarily spurred by financial need. So those crimes of theft, the crimes of drug distribution, the-- you know, we call them kind of the struggle crimes or the survival economy, the laws that you break just so that you can support your family and get by. So I would ask Nebraska, can we afford 9 percent of the people who come out of our carceral system for drug convictions to reoffend? Should we be paying for perhaps 9 percent of those people to go back into our system? We know how expensive that is and we know that as a state that's something that we're really trying to fight. We all want to make research-based policy decisions. So it's clear to me where this research is urging us to go. I want to promote the good life in

Nebraska. I think everybody deserves a second chance. Everyone deserves access to the good life, especially after they've already paid the penalty for their crime. They've paid their debt to society. They're out, they're supporting their families. Maybe this is even decades later and we want to make sure they can reintegrate and be part of society just like everybody else. So I would urge you to support this bill. And I think it's a simple bill. I don't want to make it more confusing by saying too much, but I'd be happy to answer any questions.

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

WILLIAMS: Thank you, Senator Howard, and thank you, Senator Hunt, for continuing to-- to bring this bill. Is-- has the language changed any this year from what the bill was. It appears to me there's some slight changes in the definition.

HUNT: Yeah. So, we, we-- you, the committee voted this bill out last year unanimously with the committee amendment that added that if a person has completed their sentence or is serving a term of parole, probation, or post-release supervision, so that committee amendment that-- that we had from last year, it just provides a little bit extra securities to make sure that the people who are receiving these benefits are on the road to recovery, and that they have--

WILLIAMS: And as I said--

HUNT: --paid-- paid the price for their crimes as-- as determined by the state.

WILLIAMS: So the language is what the committee amendment was last year.

HUNT: This is the committee amendment language, that's correct.

WILLIAMS: And remind us again, are there any other felonies that prevent a person from receiving SNAP benefits after they have served their time other than drug felons?

HUNT: Senator Williams, there are no other crimes in Nebraska that we use to impose this lifetime ban on SNAP benefits. If somebody has committed child molestation or aggravated assault, or grand theft auto-- I'm trying to think of crimes, like there is no ban on this

type of assistance. So some of the most heinous crimes that we see, those people are still allowed to reintegrate into society. But maybe somebody who did drug distribution, again as a survival thing for them when they were teens or in their early 20s, we have people come through here all the time who tell stories of their recovery and how they've moved on from that and been great contributors to society. But other things happen to people that they sometimes cannot control. And for the state to take away this support for them because of something that's arbitrary, in my opinion, especially when you compare the severity of a crime like drug possession with something like murder or rape, makes no sense to me, and I think that we need to take steps as a state to fix it.

WILLIAMS: You've thought about this issue for a lengthy period of time. Can you come up with any rational justification for denying SNAP benefits for a drug crime versus the other crimes that you were mentioning?

HUNT: No, Senator Williams.

WILLIAMS: Thank you.

HOWARD: Any other questions? Senator Walz.

WALZ: Thank you, Senator Hunt. I really appreciate you bringing this piece of legislation. You know, something I was thinking about, as you were talking about the bill, is the person who was incarcerated and now is able to receive SNAP benefits. Would they also benefit from participating in the employment and training program or having to maintain the-- the 30-hour week, work-- work week? I mean, is that something once you go back on the SNAP or are eligible again for SNAP, you automatically have to start participating in the employment and training program or work 30 hours, right?

HUNT: That's right. We still have, you know, able-bodied people without dependents and there's all kinds of different work requirements, 20 hours a week type things that people have to maintain in order to qualify for SNAP.

WALZ: Yeah, I just was thinking that would be such-- that's another big benefit of this program. Usually when you come out of jail, you do not have a job, so this is just another benefit in helping them find training or employment opportunities.

HUNT: Another part of my concern of the reason I brought this legislation is because a lot of times it's not really for the people who are just being released from prison. It's not, you know, something for the people who are just coming out. It's for the people who 15 or 20 years down the line fall on hard times. They go through a divorce, they lose a job, and then all of a sudden, surprise, you're not eligible for benefits. And when you were, you know, selling pot as a teenager or you got caught with possession in your 20s--

WALZ: Yeah.

HUNT: --these people didn't know that this was a potential consequence that when I'm 48 years old and I'm divorced and broke, I'll never be able to get assistance because of these choices I made. And as Senator Williams reminded us, we don't do that for any other crime in Nebraska. So it's not really-- that's not justice being served by our state.

WALZ: Yeah, I'm glad you had mentioned that too, because that wasn't something that I had thought of before, so thank you.

HOWARD: All right. Any other questions? Seeing none, thank you.

HUNT: Thank you.

HOWARD: Thank you, Senator Hunt. Will you be staying to close?

HUNT: Yes, sure. I think so.

HOWARD: OK. All right. Well, we'd like to invite our first proponent testifier up for LB1038. Good afternoon.

KAYLA WATKINS CRAWFORD: Hello. My name is Kayla Watkins Crawford, K-a-y-l-a W-a-t-k-i-n-s, and Crawford, C-r-a-w-f-o-r-d. I'm here just to kind of speak from my own personal testimony, my own personal experiences. I accumulated a drug felony about ten years ago. I did two years on the Douglas County Drug Court program, found that the program was not a good fit for me and the things that I was needing in my life. So I'm-- I dropped out of drug court and did two years on probation. Completed that successfully. In the midst of all-- all of that, I also did inpatient treatment, which I completed, and outpatient treatment, which I also completed. Upon completing my probation and trying to regain benefits for myself and my three children, I was told that because of the attempted possession with

intent charge that I had received, I would permanently be disqualified from ever receiving food stamps in Nebraska. I, however, am the only financial provider for myself and three kids. So it-- it weighed a lot on me to figure a way to financially support myself with three kids. I resorted to working a lot. I began working two jobs, sometimes 60 to 70 hours a week. I was never able to be a parent to my kids, and it left my kids to be raised by society and the things that they're seeing around them. The environment that I'm raised, that they were raised in, the poverty, the-- the neighborhoods, the kids. So for me, anytime that I'm at work, I'm not able to-- to teach my kids anything. I can't raise them. I can't teach them right from wrong. I can't give them answers to things that I don't understand myself. There's days where I would work for three or four days and I couldn't eat while I was at work because all I could think about was feeding my kids at home. And spending that kind of time at work doesn't allow me to take advantage of other opportunities like pantries and other organizations, which may be able to help, because I'm time-constricted to financially providing for my kids. That was 10 years ago. I've maintained employment since then. I've completed any type of requirements that I possibly could to be an upstanding member of society. And still to this day, I struggle. I have recently had to take time off of work, so now I have no financial income to provide to my kids, but my kids being raised by society started to cause them to go down the wrong paths. They started hanging out with the wrong kids and there was no one there to guide them. No one there to supervise them. And because I had to work two jobs, I was overqualified for daycare. I was overqualified for other benefits. So it became a catch-22. I felt stuck. I felt like there was nothing that I can do. There's no solution to this. I would spend hours on the phone with DHS caseworkers and supervisors and begging and pleading and telling them, you know, I'm $100 over budget, but I would have to cut my hours back down to 30 hours a week where 30 hours a week working and making only $14 an hour, I can't provide-- I can't afford rent. I can't afford the utilities. I can't afford household items. I can't afford gas to get them to and from school and me to and from work. So I had to work 70 hours a week and I became neglectful almost as a parent. And it's not a very fulfilling feeling knowing that you can't take care of your kids. You can provide one aspect, but you can't provide the other. And organizations like DHHS are there as an asset for us that struggle and putting this bill in place keeps us isolated. It keeps us feeling stuck and hopeless, and no matter how hard we work, that there's never a way out. And although it's-- it's the-- it may just be a portion of

assistance, that one portion eases that stress on a parent. It eases that stress on a kid. I can name countless times where my kids would call me at work and, mom, I'm so hungry, what can we eat? And I'm like, my kids are 13, 10 and 7. They don't know how to fight. You know, they don't know how to provide for themselves. They don't know how to cook a full-course meal. They don't know how to make sure they're in bed at 8:30, but when I'm off at 11 o'clock and I have to go home and I have to get them in bed by midnight, they're not getting enough sleep for the school the next-- the next day. They see the stress that the parents go through and that resonates with them, and it turns into lashing out at school that turns into conflicts with peers. Kids don't understand the struggles that we go through as adults, and they see how hard it is for us, though. And they don't know how to deal with that. And just giving-- being able to tell my kids that's one thing you don't have to worry about, she'll always have food on the table. You will always have something to eat. They go to school and they're able to eat, but when they come home, I don't usually have anything to be able to provide. I would work and make one meal at work and bring it home to split between my three kids just to sacrifice my meal for them so I knew that they could eat. So I appreciate you guys listening today and I'm open for any questions you may have.

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

KAYLA WATKINS CRAWFORD: Thank you.

HOWARD: Our next proponent testifier for LB1038.

JEANETTE DORTCH: Hello Senators, nothing like that throwing me off, but I'm here to show support of the bill, L-- I mean, LB1038, because this is a situation that my family members, in particular, one family member had a drug conviction that was not able to get assistance from the state of Nebraska. He served his time for his charge. He took all the steps necessary to become a better member of his community and for his family. I support this with-- bill because it is a step into the right direction on helping our community, must feel supportive and take away that criminal mentality and barriers that most of time puts people to criminal behaviors. We, as parents, do our best to provide for our children. We, when we get up, get pushed in hard situations. There's a high chance of going back to criminal actions. I feel like snak-- SNAP benefits meet the nutritional standards. People are out

there struggling to provide, and if we had healthier options, it just better for our growing children. I know a lot of people that are trying to be good citizens and good parents. I appreciate your time for you listening to me. We have good people out here, yes, we do, that have made mistakes, but we have to bring back humanity and help each other become better and not just push other barriers. Thank you for your time. Any questions, I'm open if you have questions.

HOWARD: Thank you. Could I trouble you to spell your name for the record?

JEANETTE DORTCH: I'm sorry, I got so overwhelmed with her story. My name is Jeanette Dortch, J-e-a-n-e-t-t-e, Dortch, D-o-r-t-c-h.

HOWARD: Thank you.

JEANETTE DORTCH: Thank you.

HOWARD: All right. Any questions from the committee for Ms. Jeanette? All right. Thank you for visiting with us today. Our next proponent testifier for LB1038. Good afternoon.

Y'SHALL DAVIS: Good afternoon. Hello. My name is Y'Shall Davis. And Y'Shall is spelled, Y-'-S-h-a-l-l, Davis, D-a-v-i-s. First, I want to thank Senator Hunt for bringing forth LB1038. Very necessary, especially with so many other states lifting the ban on this. It would be great to see Nebraska follow suit. I work at the Nebraska Urban Indian Health Coalition as a case manager, is part of my role to-- it's an inpatient drug treatment center so the clients come in and I help them apply for SNAP benefits. Them-- by them being able to get SNAP benefits, it offsets our food costs and it has them already set up to when they complete the program and they transition back into their communities that they already have their SNAP benefits put in place. But I noticed that a lot of the individuals there wouldn't be approved for SNAP benefits because of drug possession charges. And being that this law goes back to '96, 1996, I mean, again, a lot of these people this happened 10, 20 years ago and they still can't get services. I think it's very discriminatory because I mean, just looking at the clients, the ones with SNAP benefits leave. They go and normally do fine. The ones without, they just fall into a deeper hopelessness. They-- they're the ones who contribute to recidivism, they go back and forth to jail. And, you know, it sounds, you know, like a small task, but, I mean, that's really major in a lot of

people's lives not being able to, you know, provide food to their families. I remember there was a lady there with 11 kids and they were like in a four or five different homes. And she was just like, man, if only I can get SNAP benefits, I can take food there. I could take food to each one of those homes and, you know, work toward, you know, better my relationship with the caretakers and the kids. And she's like, but I can't even do that, like, you know, so it made her feel like I just wanna use drugs again, you know, like I mean, something so simple as giving my kids food. And then she'd see other people who committed other crimes, you know, leave there with food in a position to help their families, but here she is that I've seen others that didn't qualify because drug possession charges just feel stuck in a-- it's-- it's just not fair because again, other criminals that do their time, you know, they get to do it. And then we have to sit back and wonder, is this a black and brown problem? I mean, because a lot of crimes, I mean, anybody could commit them, but drug possession charges, that's something that really people of color are dealing with. So therefore, those individuals in particular get back home and they can't even contribute to their households and their families because of this law. It's pretty antiquated, I think. It's been around since 1996. And then they say, oh, I heard that if I did drug treatment, then I can get my benefits. OK. We're in a drug treatment center. We watch you complete and they still can't get them, you know, so it's like-- I like this bill because it's more simple, OK. If you get on parole, when you're on probation, you can get your SNAP benefits back. I mean, we'll take what we can get, but I think that's a step in the right direction. And that's all I have. So if you guys have any questions, I'd love to answer them.

HOWARD: Thank you. Are there questions? Thank you for dealing with us today. Our next proponent testifier for LB1038.

MICHELLE DEVITT: Good afternoon, Chairwoman Howard, and the committee. My name is Michelle Devitt, that's M-i-c-h-e-l-l-e D-e-v-i-t-t, and I'm a labor attorney and working with the-- as the legal and policy coordinator at the Heartland Workers Center in Omaha, for a nonpartisan, nonprofit organization. Today, I'm here speaking on behalf-- on their behalf in support of LB1038 because in the experience of our organization the ban on SNAP for people with drug felonies poses both a cruel hardship and a needless barrier to reentry to the community. This needlessly increases the likelihood of recidivism at great cost to the state of Nebraska. For these reasons, we view LB1038 as both a humane and a sensible reform. Reentry after

incarceration presents many challenges from securing housing, rebuilding community ties, the difficulty of finding work with the drug felony conviction record is well-- well-documented and the recently incarcerated struggle to meet even their most basic needs for some time. In our view, getting enough food to survive should not be one of those barriers. Yet the existing ban on SNAP benefits to Nebraskans with drug felonies burdens these individuals just when they are trying to get on their feet. Moreover, it is worth noting as many have, that this ban does not just affect the person with the drug conviction, it impacts their whole family by reducing the official household size by one member. This impacts the benefit levels of elderly parents, children, disabled adults, spouses and others in the household indefinitely. We have experience with this at the Heartland Workers Center, where our leadership development organizers regularly work with the formerly incarcerated and their families. We hear them worry about the effects that lack of food is having on their children, including the stress of making ends weak with weekly trips to a food bank or relying on relatives who are themselves struggling with scarcity. Whether they have two children or 11, they all want the same thing to get back on their feet after incarceration. Instead, food insecurity makes it more likely that they'll be forced to resort to desperate means. Leaders from our community have testified on this issue in years past, and they worried then, as now, about falling back into old habits and old cycles when they have no other choices. The lived experiences of these individuals is consistent with research indicating that food insecurity substantially increases likelihood of recidivism. One study found that 91 percent of individuals who had recently been released from jail were experiencing food insecurity, with 37 percent of those having gone an entire day in the most recent month without eating. Of those, these individuals were much more likely to engage in high risk behaviors, including drug use and other criminal activity when compared with those who had even just gone, had that one day that they didn't have to go without food. Similarly, recent research on recidivism by Harvard's own center for law, economics and business found that 10-- there were 10 percent lower rates of recidivism in places where the recently released had fully-- full access to public benefits. That's both the lived experience and formerly-- of the formerly incarcerated, and research demonstrate the benefits of restoring SNAP. LB1038 is also fiscally responsible. The fiscal note for this bill estimates that the only cost will be the administrative cost of restoring benefits to households where someone is currently disqualified. Meanwhile, to reduce recidivism, is a

savings for obviously our law enforcement, our prisons and our courts. Restoring SNAP benefits for individuals with drug felonies is the right thing to do for families we believe and a sensible thing to address recidivism. So we are urging the committee to advance this bill to the floor and I'm prepared to take questions. Thank you for your time.

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

MURMAN: Thanks, Senator Howard, and thanks for testifying. I just want a clarification. There is an exception for the lifetime ban if-- if they-- they have been convicted of possession and use or possession, is that correct?

MICHELLE DEVITT: That is correct.

MURMAN: OK. So it's only for distributing--

MICHELLE DEVITT: For distributing.

MURMAN: --that they're having a lifetime ban.

MICHELLE DEVITT: Correct.

MURMAN: Thank you very much.

MICHELLE DEVITT: Yes.

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

MICHELLE DEVITT: Thank you.

HOWARD: Our next proponent testifier for LB1038.

KEN SMITH: Good afternoon, Chairperson Howard, and members of the Health and Human Services Committee. My name is Ken Smith, K-e-n S-m-i-t-h, and I'm the director of the Economic Justice Program at Nebraska Appleseed and appreciate the opportunity to testify today in support of LB1038. I think I will deviate from my written testimony. I know this is a conversation that we've been having for-- for many years. And the reasons why it is important have only become, I think, more clear throughout the time that we've been having this debate. So we really do appreciate Senator Hunt's persistence with this bill and are hopeful that this is the year that we can get it across the finish

line. You know, the testifiers that went before me, and Senator Hunt in her opening, I think covered most of, if not all, the issues that I had planned to talk about. But I just wanted to zero in on a couple of items for-- for your reference. One is that there are six states that since 2016 have implemented this change. And I know the efforts in this state to make these changes have been going on since at least that long, so it feels a little bit like we're being left behind. Just in the last two years, both the state of Mississippi and West Virginia made this change to increase access to food assistance for poor people who are reintegrating after a period of incarceration. So, you know, I don't know, you know, everybody's doing it is-- is the best policy reason, but everybody seems to be doing this and I think we should too. The other thing I wanted to talk about was the intersection between this and recidivism. Senator Hunt pointed to a study that was done in Florida that, you know, that really provided empirical kind of measurable data that shows the effect that this has on our recidivism rates. I think last year I crunched some numbers and it was kind of back of the napkin, admittedly, but if you look at the number of people that are transitioning out of prison for offenses, you know, relevant to this-- to this discussion, the number of people taken in conjunction with the amount of savings that the state has when somebody does not get-- come back into the prison, according to my estimations, would save the state over half a million dollars a year. So at a time when our prison system is in a state of crisis, when we have systemic overcrowding, you know, well over or about one and a half times the capacity of the system with some-- with some facilities closer to 300 percent capacity, you know-- you know, we should be looking high and low for ways to reduce that number. And this is a good way of doing that. And it's a-- and it's a way of doing it that has-- has no fiscal impact on the state. So I think we should be kind of sprinting to get this to the finish line, particularly this year. The last thing that I wanted to share was, Senator Walz, you had asked a question about the employment and training components of SNAP and whether that could be kind of brought to bear to even be kind of further, you know, present further opportunity for-- for people who need it. And I just want to point out that DHHS has over the last couple of years been undertaking a very concerted and so far very effective effort to restructure our SNAP employment and training program to expand its scope and its reach, to make it a very valuable resource for folks in Nebraska on SNAP to use to try to kind of take that next step. And as I'm saying that I'm realizing that I think they're branded that SNAP next step, which is appropriate. So at any

rate, I will close with that and would be happy to answer any questions you may have, but would certainly urge you to get the bill across the finish line this year.

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

MURMAN: Thanks a lot, Senator Howard, and thanks a lot for testifying, Mr. Smith. Just-- I want to just continue a little bit from the last question I asked. The family, including the kids of a former drug dealer, would receive SNAP benefits, is that correct? It wouldn't be just the individual that wouldn't that-- that now.

KEN SMITH: That's-- that's right. My understanding is that while the person who is subject to the ban would not be eligible, it is not a household sanction as we discussed under the last bill. But I think it's important to remember that-- that when-- when a household's eligibility is determined and when there's SNAP allotment is calculated, it's based on the number of people who are eligible. So it would still be taking resources away from families. And I also just wanted to follow up on a question you had posed before asking about the possession and use component to the current structure. So the modified ban does allow for SNAP access in certain cases when somebody has only one or two possession or use, a drug-related felony charges, or convictions rather. But there are kind of qualifications built into that in that they have-- they also need to have been participating in or have completed treatment. A lot of times those treatment options are not available. So it's a little bit more complicated than just, you know, people who have one or two of those types of convictions can access SNAP.

MURMAN: OK. Thank you. Just to continue a little bit on that. According to my information, it says two or more felonies, they are still eligible if they-- so more than two, if they are completing the program or have completed it-- the drug program.

KEN SMITH: That's correct. That's correct.

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

KEN SMITH: Thank you.

HOWARD: Our next proponent testifier for LB1038. All right, seeing none, is there anyone wishing to testify in opposition? Good afternoon.

STEVEN GREENE: Good afternoon. Good afternoon, Chairperson Howard, and members of the Health and Human Services Committee. My name is Steven Greene. That's S-t-e-v-e-n G-r-e-e-n-e, and I am a deputy director for the Division of Children and Family Services for the state of Nebraska Department in Health and Human Services. I'm here to testify in opposition to LB1038, which would change the Supplemental Nutrition Assistance Program, otherwise known as SNAP eligibility for drug felons. With this change, individuals with convictions for drug possession, use and distribution of drug-- or drug sales would now be eligible for SNAP if-- and this is important for us in our position, if they completed their sentence for such felony or are serving a term parole, probation or post-release supervision. And currently, individuals are ineligible for SNAP if they have received a conduct-- conviction for drug distribution or drug sales, or if they have three or more convictions for drug use or possession and have not completed treatment after conviction. In the last two years, the department has denied or closed an average of 692 SNAP participants related to drug felonies. Many times the person ineligible for SNAP due to a drug felony is part of an existing household, which was talked a little bit with other testifiers. The other members of this house-- of those households continue to be eligible for SNAP. Consistent with the department's position on similar legislation last year, we believe the current policy strikes the right balance between ensuring program integrity while giving those with substance abuse convictions a second chance in supporting a citizen striving to overcome drug addiction. And I would just point out that as a side, that's really where our opposition lands similar to last year is we really see the treatment component as an important tool that we want to see and continue to be able to use. And so that's-- that explains or is why we do not support this legislation, and I'm happy to answer any questions that you may have.

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

WALZ: Thank you. Thank you. Can you go over that last paragraph with me again?

STEVEN GREENE: Um-hum.

WALZ: With us again?

STEVEN GREENE: Yep, so we want to be consistent in our position so we, as you all know, we opposed the bill last year-- and Director Wallen at the time had testified that-- so current policy and I'll read it, strikes the balance between ensuring program integrity and giving those with substance abuse convictions a second chance. So for us, as a position last year and I went back to make sure that I was articulating that position well, is that we want to maintain the ability to provide drug treatment and that current requirement in order to receive SNAP it would-- is currently codified in state statute, and that's something that we'd want to continue to be able to provide.

WALZ: So they can't-- what-- are you saying that you can't provide drug treatment if they are receiving SNAP benefits? Is that what you're saying?

STEVEN GREENE: No, what we're saying is that-- that current statute requires for certain cases for them to complete treatment. And so we want to continue to be able to-- to support that as an option towards recovery. Does that make sense?

WALZ: Yeah.

STEVEN GREENE: OK. Yep.

WALZ: I guess I just-- I just am wondering why that can't be changed, that you could do all of it--

STEVEN GREENE: Right.

WALZ: --at the same time.

STEVEN GREENE: So-- so just can't speculate beyond what the bill says other than-- that our position is similar to what we had last year. So I don't want to say that that's not important, but we're going off of what is in statute. And I think last year it eliminated or it had that treatment component and in this bill it's completely eliminated in the treatment component in statute.

WALZ: OK. I guess-- all right. I get-- the other question I have and I think I know the answer. Shoot, I lost it. If-- oh, I did lose it. So

you were saying that the family members are still eligible for the SNAP benefits--

STEVEN GREENE: Correct.

WALZ: --but that does not give that-- the person who was incarcerated or-- they are not able to benefit from that job training or the employment training.

STEVEN GREENE: Correct.

WALZ: OK. All right.

HOWARD: Senator Arch.

ARCH: Thank you. But just one follow-up question. Is there a distinction between other family members and head of household as we heard with the last bill?

STEVEN GREENE: Yes. So other family members would be, for example, a child or somebody under the age of 18 would be a clear example of the difference between head of household and in that family as a unit. I-- I wish I knew the exact-- so if you're asking the question of what about a couple, is that sort of the root-- the root question about what about another adult living in the household that's not the head of household?

ARCH: Well, I guess that I don't understand, though, technical distinction. But-- but if-- if the individual that-- that was incarcerated and does not qualify is also head of household, is that an issue? We talk about other family members qualifying--

STEVEN GREENE: Yeah.

ARCH: --the fact that that person is head of household, does that-- will the change that now the department is already considering and Senator Hunt has brought, does that change any of the facts in this issue?

STEVEN GREENE: That is be-- I wish I had a good answer for that. And let me-- let me check with our eligibility, our SNAP program administrator, because I don't want to provide bad information on that. That's a good question and a valid question. I don't want to give you bad information.

ARCH: Thank you.

HOWARD: So I just have a question. Just to-- so I-- I worked on the original bill like this treatment issue is partially my fault because that was what we could get done at the time. And at the time, the department had been really opposed to treatment, to including treatment at all. And so it's kind of good to see that things have changed in that regard. And you know that I have a lot of experience with addiction in my family, right? My sister passed away from a drug overdose 11 years ago. And is withholding food benefits considered a best practice when we're considering helping somebody get over an addiction, or work through a substance use disorder?

STEVEN GREENE: Yeah, it's a fair question. I don't know, and I'm not going-- that would be a great question that I would-- I would like to take to my team. And as you know, the department is more than just the department of children, or Division of Children and Family Services. I think that's a good question for consideration especially with the Division of Behavioral Health. And I know there was a couple policy discussions or conversations that we had internally specific to this bill. I think that's a good question. I'd like to follow up on that. I don't I don't know the answer.

HOWARD: Thank you.

STEVEN GREENE: Um-hum.

HOWARD: Any other questions? Senator Walz.

WALZ: I have a question. Senator Murman asked the question before. The only-- the only thing that's been added in to this, oh, how do I want to say it-- exempting the lifetime ban is distribution.

STEVEN GREENE: Um-hum.

WALZ: Is that correct?

STEVEN GREENE: Can you repeat that one more time?

WALZ: So under the new language, a person convicted of a felony involving possession use or distribution. I was thinking-- I was thinking that-- Senator Murman, can you help me? [LAUGHTER]

MURMAN: Yeah, I think you're heading--

WALZ: So we're just adding distribution, or we're taking out distribution.

STEVEN GREENE: Right. Yes.

WALZ: We're just exempting distribution.

STEVEN GREENE: Right. Right. Correct.

WALZ: So right now, if the felony involves possession or use--

STEVEN GREENE: Right, that's the--

WALZ: You receive--

STEVEN GREENE: Correct.

WALZ: --effect of it.

STEVEN GREENE: Up to three-- three times and as long as they've completed their substance abuse treatment and if they have a felony for distribution, it is currently a--

WALZ: Lifetime ban.

STEVEN GREENE: --lifetime ban, correct.

WALZ: OK. I just wanted to make sure you are understanding that too. OK. All right. Thank you.

STEVEN GREENE: Thank you.

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

STEVEN GREENE: Thank you.

HOWARD: All right. Our next opponent testifier for LB1038? Seeing none, is there anyone wishing to testify in a neutral capacity? Seeing none, Senator Hunt, you are welcome to close. While she is coming up, we do have some letters for the record. Letters in support: Tessa Foreman, Nebraskans for Peace; Jacqueline Kehl, self; Mary Sullivan, National Association of Social Workers-Nebraska Chapter; Ingrid Kirst, Lincoln-Lancaster County Food Policy Council; Jasmine Harris, RISE; Dr. Erin Feichtinger, Together, Inc.; Julia Isaacs Tse, Voices for

Children in Nebraska; Scott Young, Food Bank of Lincoln; Joey Adler, Holland Children's Movement; Amy Behnke, Health Center Association of Nebraska. No letters in opposition. No neutral letters. Welcome back, Senator Hunt.

HUNT: Thank you, Senator Howard. That's excellent to hear because I did not solicit any letters of support for this bill and I-- I didn't put in, honestly, the usual work I do for my bills in like whipping up testimony and stuff like that. So I want to thank the testifiers behind me for taking the time to come engage with us. Mr. Greene from DHHS said that this would remove the requirement for treatment, and that seemed to be a basis of a lot of their opposition to the bill. So I would like to explain this because he said that he can't speculate beyond what the bill says. So let me explain what the bill says. The new matter of the bill, that's the important stuff, pretty much the whole bill, it says a person convicted of a felony involving the possession, use or distribution of a controlled substance shall only be eligible for Supplemental Nutrition Assistance Program benefits if such person, one, has completed such person's sentence. So they're-- they've complete their sentence, they've paid their debt to society or, two, is serving a term of parole, probation or post-release supervision for such felony. What-- the reason what Mr. Green said is incorrect is because if someone is serving a term of parole, probation or post-release supervision, in statute, Chapter 29-2262, which divines the condition of probation. It says that in order to be in compliance with probation, you have to refrain from unlawful conduct, so that would include drug use. It also says that the-- the offender must pay for tests to determine the presence of drugs or alcohol, psychological evaluations, offender assessment screens or rehabilitative services. And most importantly, it says in all cases in which the offender is guilty of violating Section 28-416, which is the section of our code which deals with drug offenses. So specifically talking about drug offenses, when the offender is guilty of a drug offense, a condition of probation, shall be mandatory treatment and counseling as provided by said section. So in this bill, we were very deliberate and very careful to avoid this opposition from DHHS that, well, now we're gonna be taking people out of treatment. Now we're gonna have people that are not getting rehabilitation for drug addiction. That is not true, because if you are serving a term of parole, probation or post-release supervision, that is terms of your parole. In order to be serving that term, you have to be in compliance with it, and if you are out of compliance, you would not be eligible

for SNAP under this bill. Another thing, I-- in my time sitting over there and listening, I looked up, Senator Williams and Senator Murman, the question that we had about the farm bill, the farm bill spending. So for 2019 to 2028, the 10-year budget for the farm bill is $867 billion. The budget for nutrition in that bill, the block is called nutrition, is 664 billion and the budget for SNAP is projected to be $68 billion. So that is 10 percent of the budget for nutrition in the farm bill goes to SNAP. So it wouldn't be accurate to characterize that as 80 percent of the costs of the farm bill going to SNAP. It's really only 10 percent of the small portion for nutrition, which also includes food distribution program on Indian reservations, the Emergency Food Assistance Program, Commodity Supplemental Food Program, Community Food Projects, Senior Farmers Market Nutrition Program and Food Insecurity Nutrition Incentive. All of those programs are included in the nutrition component of the farm bill, but SNAP is only 10 percent of that. And so I want to reiterate, this bill has no fiscal note, but we're not dumb, we all know that we pay for everything somehow, whether that's with our federal taxes or our state taxes. But I just want to emphasize that the value that this bill and this policy will bring to Nebraska in terms of reducing recidivism, in terms of keeping people from reoffending based on those survival crimes that we know they're committing to-- that end them back up in jail. You know, for less than 10 percent of 30 percent of the entire farm bill, I-- I hope that we can agree that that's a worthwhile expenditure. Another thing that excites me about the potential for this bill is that there's interest from researchers at the University of Nebraska-Lincoln in doing a little bit like what the Maryland study did on the law in Florida. People are interested to see if we pass this law in Nebraska, what happens to our offenders? Does our recidivist rate go down? And if we pass this bill, we will have the opportunity to see Nebraska as a experimental field and get that data to possibly push better legislation around the whole country. For that reason, we should be leaders on this. We have-- we have a lot of resources that we could be giving to people that we are withholding for no good reason. And now we know we have opportunities for research, for better policy down the road if we pass this. So thank you for your time. Happy to answer questions.

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

MURMAN: Thank you, Senator Howard. Thanks a lot, Senator Hunt. On page 5 of the bill, the part that you were referring to, line 4, first word in that line, shouldn't that be an "and" rather than an "or"?

HUNT: Let me search my mind for a minute. We had this conversation last year. There was a reason that we said or instead of and. I think it may be because if they have completed their sentence, it means they have already served a term of parole, probation or post-release. So in that case, those people already would have received the drug treatment, etcetera, that I-- that I outlined when I came back up for my closing.

MURMAN: OK. Yeah, it says has completed such person sentence for such felony, or is serving a term of parole.

HUNT: It could also be because sometimes for a drug conviction, you are sentenced to parole, probation or post-release, or parole or probation instead of incarceration. And so it would include those people who were not incarcerated.

MURMAN: But if it's an or, they wouldn't had to taken the drug program because they would-- may do that on parole, probation or post-release.

HUNT: Well, completing their sentence would also include that drug treatment.

MURMAN: Pardon me?

HUNT: Completing the sentence would also-- the terms of completing a sentence would also include that drug treatment for a drug crime as outlined in the statute that I explained.

MURMAN: OK, well, we can talk about that later. Thank you.

HUNT: Yeah, I would be happy to.

HOWARD: Well, let me ask the question in a different way. Let's see if I can get to where we're going. So--

HUNT: Maybe you can help me too.

HOWARD: --because, so it's an or because you can have one or the other. You could have completed your felony sentence. Right? And you

could be in your 40s and you would have done it in your 20s and you finished all of your probation and parole.

HUNT: That is right.

HOWARD: You've done all of that and you finished it, but you're 40 now and you're broke as heck and you need SNAP, so if it's "and", then you would also be in your 40s and you would need to complete your felony, your-- your sentence and be serving parole, but you might have already graduated from parole because it was 20 years ago when you committed your felony. And so it's an "or" because you could have completed your sentence or you're serving probation and parole. So it fits both of those. And the probation and parole is really so when you get out, I think, and you'll confirm this for me because this is a question, when you get out, you're serving that parole, probation and that's there as the safeguard to ensure that there is that substance use disorder treatment.

HUNT: That's right.

HOWARD: OK. Yes, Senator Murman.

MURMAN: OK. Yeah, just to continue a little bit on that. I'm thinking the drug program would often be during parole, probation or post-release. So if they're on the program, I assume they're being tested for drugs. So my preference would be an "and" so they would have to complete that program or at least be taking it--

HOWARD: Right.

MURMAN: --to-- to be eligible for SNAP.

HOWARD: That's a good question. I think-- I think it reaches into the question of whether or not we want to help people who may have committed their crimes quite a long time ago and completed their treatment program and have fallen on hard times, or if we require it only for people who are newly released. And Senator Hunt, do you want to tell us what your preference is if it's only for newly released or if it's people who--

HUNT: Sure. The intention is that this law would reach to both people who are newly released and who maybe-- may have served their sentence 30 years ago. And if this is someone who has served their sentence 30 years ago, they've fallen on hard times, whatever, they need SNAP. To

require them, I mean, how would that work? In effect, you require them to go through parole again or something like-- so that's why we need that "or" because it's just not legally feasible to have the "and".

MURMAN: Well, I would prefer to require them to take the drug program.

HUNT: I-- I hear that your preference is that drug treatment be part of the eligibility for SNAP. If this is someone who's newly released or someone who's been released in the last several years in modern history, you know--

MURMAN: Right.

HUNT: --they will have gone through parole, post-release supervision or probation. And as I explained in that statute and I can-- it's probably on here the date when that was passed, they will have already gone through that. Not only that, they've paid for that treatment themselves out of pocket. They've had to go through an accredited, you know, drug treatment program. So these things are already in statute in the chapter that specifically deals with drug offenses. So your concern is already addressed by Nebraska law.

MURMAN: OK, yeah, thank you. Yeah. I think it was 1996 it was passed.

HUNT: Thank you.

MURMAN: Thank you.

HOWARD: All right.

HUNT: So anyone before '96, I would say we should not require them to go through parole or probation because they no longer have those challenges, perhaps, with drugs.

HOWARD: That's a good question. And I'm glad we kind of took the time to sort it out. All right. Any final questions for Senator Hunt? All right. Seeing none, thank you, Senator Hunt. This will close the hearing for LB1038 and the committee will take a brief five-minute break.

[BREAK]

HOWARD: LB783, Senator Lowe's bill to change the definition of ambulatory surgical center. Welcome, Senator Lowe.

LOWE: Thank you, Chairwoman Howard, and members of the Health and Human Services Committee. My name is John Lowe. That's J-o-h-n L-o-w-e, and I represent the 37th District. I'm here to present LB783. LB783 is designed to benefit patients throughout Nebraska. Current law prevents patients at ambulatory surgical centers from staying at the facility overnight. This is not beneficial for patients and it does not match well the language in most states. LB783 was originally written and would have allowed anyone who was at these facilities and goes under anesthesia to remain at the facility for 24 hours once the anesthesia-- anesthesia is applied. The Department of Health and Human Services expressed concern with this language. I met with them and we came up with AM2474. This changed the language to stay within federal guidelines, but remain fla-- but maintains flexibility in patient care. AM2474 changes the length of stay to 23 hours and 59 minutes after the patient is admitted into the surgical center. Nebraska is one of only 13 states that prevents overnight stays at ambulatory surgical centers. In total, there are 37 states, if my math is right, and Washington, D.C., that offer patients at ambulatory surgical centers more flexibility. I believe it is important for Nebraska to follow the lead of most other states and offer more options and better care for patients that attend these surgical centers. Thank you. And I would be happy to answer any questions that you may have.

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

ARCH: Thank you. Thank you, Senator Lowe. And we've had some discussions in anticipation of this. This technically doesn't allow overnight stay, does it? And maybe somebody that follows maybe would have a little more technical understanding of that.

LOWE: It's--

ARCH: Because if you have-- if you have anesthesia administered at 2:00 in the afternoon, you would-- well, I guess, yeah, OK.

LOWE: Well, and it's-- and with the amendment, it's on admittance.

ARCH: Oh, on admittance. OK. All right. Thank you.

LOWE: Yeah.

HOWARD: So just-- I want to make sure I understand. So then if you were admitted at 2:00 p.m., you could stay until 1:59?

ARCH: Next day.

HOWARD: The next day. OK. Senator Murman.

MURMAN: Oh, I wasn't raising my hand, but I do have a question.

[LAUGHTER]

MURMAN: So if you were there 23 hours and 59 minutes and still weren't doing as well as everyone had hoped, that doesn't happen very often, I'm sure, but when it does happen, I assume you would-- they would take-- the ambulance would take you to the hospital, but not the hospital.

LOWE: It would be just as it is today. And right now, because the statute says the same working day, so right now, if you were admitted at 12:01 in the morning for your surgery, you could still have that full day. But I don't believe any patients want to come in at 12:01 in the morning. And most doctors would rather have their day ending at that time, too, I believe.

MURMAN: But-- excuse me. If they weren't doing well, they would just be transferred to a hospital at that time.

LOWE: They would be transferred to a hospital at that time.

MURMAN: Thank you.

HOWARD: All right. Any other questions? Will you be staying to close?

LOWE: Yes, I will.

HOWARD: Wonderful. Thank you, Senator Lowe.

LOWE: I like this committee.

HOWARD: We're-- I mean, we're the best one, I mean, in the Legislature. We'd like to invite our first proponent testifier up for LB783. Good afternoon.

DAVID McCONNELL: Good afternoon, Chair Howard, and the committee members. I'm Dr. McConnell. Dr. David McConnell. D-a-v-i-d M-c-C-o-n-n-e-l-l. I'm here to support the amendment of the length of stay at outpatient surgery centers to 23 hours and 59 minutes. I've been a medical director at an outpatient surgery center in Kearney,

Nebraska for over 10 years. I'm an anesthesiologist and over the last five to 10 years we have seen such an increase and influx of more complex cases come to our center. These cases include spine cases, total needs, total hips and total shoulders. And this 23 hours and 59 minutes actually allows us to have enhanced recovery. And what I mean by enhanced recovery is allowing those patients to have medical care to help them with pain control during that post-operatively, and then also to regroup from anesthesia. And these patients, I want to make clear that we're not looking to increase the complexity of the patient, we still have guidelines of who is admitted to an outpatient facility. This is just strictly to help with the-- enhance the recovery for it. And so patients that have significant heart disease or lung disease, these patients still need to be in an inpatient facility and they would never have come to our facility to begin with. So I wanted to make sure that that was clear. Our facility, outpatient surgery centers throughout the United States are seeing-- it's not only Nebraska and our center that seen these bigger cases. CMS is allowing more and more cases to be brought into centers like ours. The latest one in 2020 is total knee arthroplasties. And we anticipate that in 2021 that total hips will be approved by CMS and we'll begin doing those. The map that was handed out to you, the yellow shows the 13 states that Senator Lowe talked about that do not allow overnight stay. And you could see that we're right in the middle of states that do-- the surrounding states do allow the 24-hour stay or they don't have a requirement for the timing of it. With-- with outpatient surgery, we have high quality. We provide a safe environment. We have a high patient satisfaction and we have low infection, and we definitely do it at a lower cost. And so in a community like Kearney, where I'm at, I work at both the inpatient hospital and the ambulatory surgery center and so do our surgeons. And so if a patient is having a total knee, they could have the same surgeon, the same anesthesiologist doing the same case, and we would like to be able to provide an option for our patients, especially when we have the quality and the-- for our situation, it's the same staff and it's at a lower cost.

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

ARCH: Thank you. Do you anticipate that as a res-- if-- if this bill passes, do you anticipate that regulations will change regarding ambulatory surgery centers for overnight stays, services available, the type of-- the type of requirements to keep a patient in overnight?

DAVID McCONNELL: Well, what we-- if a patient is requiring ancillary care such as respiratory treatments, or needed an intensive care unit where IV medications are needed to support the heart, that's not going to be added to our outpatient. That's not the intent. This-- this is for patients that need our requirements already. We do knee scopes at our facility. Not everybody that gets a knee scope is allowed to have it in our outpatient surgery center. They might have significant heart failure or lung disease or on oxygen at home. Those are not candidates for an outpatient surgery center. So that would not change. So I know there will not be added. There's regulations out there for outpatient surgery centers with 24-hour stays, but we're not going to be adding the ancillary care. Did I answer your question?

ARCH: Yes, yes. Thank you.

HOWARD: Senator Walz.

WALZ: A quick question. Thanks for being here. So are you doing total knee procedures right now?

DAVID McCONNELL: Yes.

WALZ: And at this point, how much time are they allowed to stay?

DAVID McCONNELL: Well, we have to time-- both right now, the private insurance, we've done total knees and total hips and total shoulders at our facility. And we bring them in early in the morning at 7, do the case and we have to have them discharged by the evening. At this point, we have to be super selective at this point because we don't have 23 hours stay. The patients have to be-- qualify from a medical standpoint to be admitted to our facility, but they also have to be motivated to want to go home.

WALZ: Uh-huh.

DAVID McCONNELL: And so-- and we've been-- the patient satisfaction is just fantastic.

WALZ: I would really want to at least spend the night if I was having that done-- at least.

DAVID McCONNELL: It would-- CMS wanting, providing-- adding this to our list. They need that extra time.

WALZ: Absolutely.

DAVID McCONNELL: They just need the time.

WALZ: Thank you.

HOWARD: Senator Arch.

ARCH: Thank you. Another question. So if you-- let's say a total joint and-- and you come-- you come to the end of that, and for whatever reason the patient needs more observation. I'll call it observation. What-- what will be your-- what will be your option at an ASC?

DAVID McCONNELL: We have agreements with inpatient facilities, Good Samaritan Hospital, and also our other hospital in Kearney to transfer the patient. And we-- if a patient has a dysrhythmia that was not there preoperatively, and postoperative they do and were concerned about it, that patient at that point is transferred by ambulance to the center. And when CMS or Triple A, HSC comes in to give us their okay or credentials for it, they look at our transfer rate and our readmissions. They have to be low. We can't be bringing patients in and then just transfer them at the end of the case. They look at our transfer rate, our ER visits, and our admissions.

ARCH: Thank you.

HOWARD: Senator Walz.

WALZ: I'm just curious, you know, one of the things I-- I really am concerned about, so I'm glad that you're bringing this bill, is people who are older and really need some overnight supervision. But one of the questions I have is, if somebody is in a nursing home, would they still-- would they still be OK spending-- would they qualify to spend the night, I guess? Or do they have to be transferred immediately back?

DAVID McCONNELL: I would-- each case is individual.

WALZ: Sure.

DAVID McCONNELL: And there are limited cases that we do that are from a nursing home and they're usually minor cases. This is probably not the support that they-- they don't have the support at home, even after-- on the 25th hour to do a major case like that. So we would

have to-- that would be selected not to be done at an outpatient center.

WALZ: OK. All right. Thank you.

HOWARD: Senator Murman.

MURMAN: Thanks, Senator Howard, and thanks a lot for testifying. I-- this map has confused me. I thought I understood what we're trying to do until I got this map. It shows Nebraska not requiring an overnight stay, but then, like South Dakota, no requirement. Right now, there'd be no requirement, correct, in Nebraska?

DAVID McCONNELL: Well, we have to dismiss a patient from our facility at 11:59 p.m. on the same day. And the-- South Dakota, having no requirement they just don't have requirements on how long a patient is to stay in allocation. So-- so they at that point they could keep the patient 23 or 26 hours. They don't have it that specific. We are required to have the patient dismissed or transferred by 11:59.

MURMAN: OK, I think I understand it. Thank you.

DAVID McCONNELL: And we-- we're changing. We don't want to just say overnight. It's 23 hours because we can't start everybody at, you know, different times of the day for operations.

HOWARD: Are there questions? Senator Murman.

MURMAN: Yeah, I just want a follow up after I thought about that a while. Wouldn't-- wouldn't it be to-- what-- what we're trying to do with this bill is to allow an overnight stay.

DAVID McCONNELL: We're allowing-- yes, it more or less is an overnight stay. But by definition, it needs to be 23 hours and 59 minutes, because that's in compliance with CMS. So we would want to-- that's the wording of it. But logistically, they all end up technically overnight.

MURMAN: The-- the blue ones on here say less than 24 hours, so that's what we would be moving--

DAVID McCONNELL: That's the 23, 59.

MURMAN: --to allow less than 24 hours.

DAVID McCONNELL: Yeah, we just can't go over the 24-- the hours.

MURMAN: Thank you.

HOWARD: Do you know why the overnight rule was put in place in the first place?

DAVID McCONNELL: No.

HOWARD: OK.

DAVID McCONNELL: I don't.

HOWARD: That's a good answer. All right. Any other questions? All right. Seeing none, thank you for your testimony today.

DAVID McCONNELL: Thank you.

HOWARD: Our next proponent testifier for LB783?

KENT ROGERT: Senator Howard, members of the Health and Human Services Committee, my name is Kent Rogert, K-e-n-t R-o-g-e-r-t, and I jumped in line a little bit because I'm going to go take a conference call, but I represent a couple of organizations that do a lot of stuff in ambulatory surgical centers. I represent the Nurse Anesthetists and the Podiatric Medical Association, the podiatrists in the state. So this would be-- this would be a helpful item for patient care and patient safety. And I'll give you example of myself. I have a procedure that I have to undergo once a year where I have to go under-- under anesthesia and I need a driver and I live alone. So this would be-- it's an easy procedure so it's not a big deal, but for someone like me who lives alone, this is-- this would be helpful because you would be able to go and stay and then you're assured, you're not be home alone where something bad can happen. You know, when you're wandering around the house with your new knee, you know, fall down and can't get up, so I think it would be helpful for a lot of reasons.

HOWARD: OK. Thank you. Are there questions? All right. Seeing none.

KENT ROGERT: Thank you.

HOWARD: Thank you for your testimony today. Our next proponent testifier for LB783. Good afternoon.

DOUGLAS RAMOS: Good afternoon. Thank you, Senator Howard, and members of the committee. My name is Dr. Douglas Ramos. I live in midtown Omaha and practice in central Omaha. And that's D-o-u-g-l-a-s R-a-m-o-s. I am board certified in general surgery and plastic surgery, which makes up the majority of my practice. I'm independent, so I have no affiliation with any healthcare entity or ownership in any ambulatory surgical care facility at this time. And I guess I'm here as much-- mostly as a patient advocate, arguably being someone that's performed amb-- more ambulatory surgeries than anyone in this room today having done that in my last-- little under two decades in Omaha and prior to that at Stanford University Medical Center and prior to that at Harvard University School of Medicine. In answer to your previous question, very quickly, the readmission rates after discharge from ambulatory surgical care facilities is somewhere between the order point one and one percent to the best that we can tell. We're now approaching 50 years of ambulatory surgical care facilities. They're not going away. They're here to stay. They're complementary to hospitals. I work at all of them, including hospital-based inpatient operating rooms, ambulatory facilities that are hospital-based and freestanding ambulatory care facilities throughout the greater Omah-- Omaha area and some other areas at hospitals throughout Nebraska. And will at other ambulatory care facilities, with the exception of Boys Town, Senator Arch, I've not ever have been out there, so I know-- where you been? Anyway, just-- you know, we're-- we're at a stage now where the number of cases done at ambulatory surgical procedures, either medical or surgical procedures have increased, so we're now at about 60 percent of those in our country performing in those kind of facilities. And again, it's not going away. But what I'm here as a patient advocate for, and it's been alluded to previously, is that as we now go to this 23 hour and 59 minute amendment and this-- this bill before-- for you, it basically sets a rolling clock, and I think provides for additional patient safety and not to mention comfort. A couple of things. Number one is if you take a patient that has exactly the same surgery on day one, and one of those patients get good pain control, post-operatively and the other one doesn't, how they're doing on post-op day seven is dramatically different. And the incidence of pain that you have in the acute surgical post-operative period on day one and day two directly correlates with the incidence of chronic pain later on, and so a higher proportion of those patients that have unmanaged acute pain in the perioperative period will have increased pain long term. And that's a significant issue. I don't want to get too tangential here

with the opioid crisis and everything else. Opioids are still a mainstay of treatment of the perioperative period, and they also that we're going to different modalities and nonopioid treatments for care in the post-operative setting, opioids have a much narrower therapeutic window. So the danger zone, per se, with opioids is much narrower. And so I think that allows us to provide better pain control for the patients post-operatively with this amendment and rule that is going forward, not to mention it's more compassionate. And I think the people of Nebraska deserve to have that. As it plays out, as-- as governments take a greater role in the involvement and provision and costs related to healthcare, we're looking at-- at acute pain that turns to chronic pain. And if that occurs, occurs at a cost of approximately $1 million for patient with chronic pain. And now the estimates for chronic pain problems in this country are close to three quarters of a trillion dollars. That's trillion dollars, not billion dollars. So I think the management of early acute pain can only be enhanced in this setting where you can manage that pain. And in essence, you're creating two different classes of surgical patients, that patient that comes in the morning gets a little better, perhaps post-operative management, as opposed to the patient that's having surgery for whatever reason at 3:00 or 4:00 in the afternoon and now he's being pushed out the door. And personally, having had a wife who's tough as nails undergo total knee and go home the same day, I can tell you, she clearly would have benefited from a day in the hospital. The office of the Inspector General currently says that Medicare has been saved $15 billion a year, and that's only with about 50 percent utilization of ambulatory surgical facilities when they could be. So we double that. We're now talking about a $30 billion savings for this country. So it's a significant issue. Again, as you look at this, I don't see any reason why you wouldn't do this from a compassion, from a safety standpoint. It makes good common sense. It makes good care sense. It could-- it's a safety issue that I think is only enhanced with the good care provided by the nurses that we have in this state. And the decision for who's chosen won't change. Certainly in my practice, it will not change. It just means that some of those patients are going to get better care if they can stay overnight. I'd like to thank the committee. Thank you, Senator Howard, for allowing me to speak.

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

DOUGLAS RAMOS: Thank you.

HOWARD: Our next proponent testifier for LB783. Good afternoon.

DANIEL LAROSE: Chairwoman Howard, members of the committee, my name is Dr. Daniel Larose, D-a-n-i-e-l L-a-r-o-s-e. I'm an orthopedic surgeon and the medical director of Advance Surgery Center in Omaha. Since the opening of our center in 2005, we've safely performed more than 30,000 procedures and I support LB783 and I'll briefly give you my opinion on why I-- I'm a proponent of that. With the progress of minimally invasive surgeries as well as the advance in anesthesia and pain control, more and more major and complex surgeries are performed as outpatient. When I started my practice in 19-- 1988, patients would come to the hospital for a knee replacement with a small suitcase expecting to stay from four to seven days. Now this procedure is commonly done outpatient. We were the first outpatient center in Omaha to do outpatient knee replacement and so far we've done more than 200. Our readmission rate, transfer rate is zero. We have not transferred one single patient to the hospital after a total knee replacement or total hip replacement at our facility. In my opinion, there's three main ways that our fellow Nebraskan benefit from surgery centers. The first is convenience and comfort. People really appreciate the efficiency of the surgery center. They come and they park 50 feet from the entrance. It is less intimidating if you need to have an elective procedure than being at the hospital. They also get their procedure usually more on time and they go home and sleep in their own bed and they eat their familiar food and they're surrounded by friends and family. The second one is the infection rate, mainly because we do not treat patient with chronic infections and abscess. Our infection rate is usually significantly lower than at the community hospital and this is particularly important for joint replacement. Our current rate is less than half of our community hospital. Our last meeting that we had last night, our rate is below half of 1 percent. Each joint replacement that is infected is very costly to treat. Studies are showing cost between $100,000, which is low. It's usually more than that, to half a million dollars in medical and economic costs for every single joint infection that we get. So far, center saves two joint infections, it's hundreds of thousands of dollars saved. And for every patient that gets an infection, it's usually a life changing event. They can't work. They need multiple operation. They have failures. It's a-- it's a catastrophe. The third factor, of course, is the costs. ASCs are paid yearly 58 percent of the hospital for the same service, which means that we can replace two hips on a patient

for a price of one at the hospital. With our aging population, the need for joint replacement significantly increasing, these are going to be enormous savings. Those monies could be used elsewhere. There's many ways to reduce costs in healthcare and the one that I'm more interested in, and when I go to meetings this is discussed, all over the country, is to change the equity setting of a procedure, which means basically what we used to do at the hospital, do at the ESC, and what we now do at DSC, find ways to do it at the office. And this will have a significant impact on healthcare costs over the next decade. The advance in technology are allowing to do all that, but the laws needs to evolve also. I mean, I'm not sure why this law was passed, but it was a long time ago. Now maybe we need to readjust and-- and-- and allow things to-- to-- to evolve. Now the question that you may ask is if you're able to do all those procedure outpatient, why do we need this law? If you're already doing it, then we don't have any transfers. So in my opinion, the change will be the selection. Right now we have to be very, very selective. So currently when a physician decides that somebody is a candidate for a knee replacement as an outpatient, for instance, we have to be absolutely sure that they will be able to go home right away. Now, if we could keep them 23 hours, in my opinion the majority of them will still go home and won't stay overnight or 23 hours. We'll still send him home, but we'll be able to offer the service to a greater-- a greater number simply because our selection process won't be so-- so strict. So, I respectfully ask that you support the bill and I thank you for your time. And if you have any questions, I'm happy to answer.

HOWARD: Thank you. Are there questions? Doctor, I just have a question. Will you have to modify or maybe how will you have to modify your staffing structure for overnight stays?

DANIEL LAROSE: That's a good question. And-- and really for-- for our centers right now, we would probably do it if we know that somebody will stay overnight. I think our center is doing mainly musculoskeletal. We don't do GY and we don't do abdominal cases. So I think it's gonna be still rare for us to keep people-- people overnight. But we won't have to be so strict so that we cannot offer it to somebody. It's interesting, until this year Medicare did not allow those cases to be done at DSC and we had patient that would come that were on their Medicare and say, hey, I heard you're doing outpatient, that's what I want to do. I want to go outpatient and we couldn't do it. So-- so there's a demand for that. But maybe for this group we'll have a safety net in other words of saying, well, Mrs.

so-and-so is not able to-- to go home, we'll be able to keep her overnight. But I think the staffing won't be a full-time overnight stay. But maybe my administrator has a different opinion so.

HOWARD: Thank you. Any other question? Seeing none, thank you for visiting us today.

DANIEL LAROSE: Thank you.

HOWARD: Our next proponent testifier for LB783. Good afternoon.

VISH BHOOPALAM: Good afternoon, Chairwoman Howard, and members of the committee. My name is Vish Bhoopalam. I'm an interventional cardiologist with Pioneer Heart Institute. Spelling, V-i-s-h, Bhoopalam, B-h-o-o-p-a-l-a-m. I practice interventional cardiology for 25 years in multitude of settings, university hospitals, community hospitals, and as a founder of-- founding member of Pioneer Heart Hospital. I'm here to testify on behalf of the Nebraska Medical Association and the Nebraska Chapter of the American College of Cardiology in support of LB783. LB783 will have a positive impact on patient outcomes, lower costs and provide greater patient satisfaction. The Nebraska Medical Association and the American College of Cardiology, Nebraska Chapter, supports LB783 because the proposed bill changes-- proposed changes in the bill will help reduce costs for patients who do not necessarily need to stay in a traditional hospital setting following a surgical procedure that requires anesthesia. This will allow us to provide care for higher acuity patients without having to admit them to a hospital. In the end, this has the potential impact of reducing costs on the healthcare system as a whole as costs are approximately 40 percent lower in the ASC than in the hospital setting. In the specialty that I practice, this bill will have a positive impact on patient outcomes. Many believe that cardiovascular procedures require long hospital stays and are complex. However, this is typically not the case. Over the years with a refinement of technique and tools that have been-- that we have, we can perform these procedures safely in an outpatient setting. And as a matter of fact, CMS recognized this and approved this in November-- of last November or 9 codes for cardiology procedures to be performed in an ASC setting. This not only allows for better cost and better outcomes and allows for better patient satisfaction. Under the benefit of having the initial recovery take place in an ambulatory surgical center is that the patients have reduced risk of being exposed to infections when compared to traditional hospitals. Multiple

studies done in the past have shown that infections rates are 20 to 50 percent lower than hospital settings. Multiple factors have been attributed to the lower incidence of infections. Finally, LB783 would allow patients to be closer to their home, where the bulk of recovery is to take place. Patients in greater Nebraska will be able to go to the nearest ambulatory surgical center for procedures and return home within 24 hours, whereas currently these same patients could potentially have to make trips to Omaha or Lincoln and pay-- and face long trips back home. And even for patients-- patients who require specialized care in Lincoln or Omaha, they can recover in an ASC rather than transferring to a hospital where overnight stay-- spend overnight stay is possible. Despite these clear benefits of an ASC, only 48 percent of the procedures approved to be performed in an ASC are performed in an ASC leading to a large increase in costs estimated to be to the tune of $414 billion nationally. One of such barriers to care in an ASC is the inability to hold the patient overnight forcing many patients to be treated in the hospital setting. This effectively limits the procedure and surgery times to mornings and late afternoons, especially for patients coming from far away because if they have a procedure at two o'clock and they need-- or three o'clock and they need six hour wait time, then you're getting into the wee hours of night or early morning where you really cannot send the patients back home. So they end up getting scheduled in a hospital. In summary, allowing 24-hour stay allows care for patients at lower costs and better outcomes on a convenient, friendly ASC setting. For these reasons, the Nebraska Medical Association and the American-- and Nebraska Chapter of the American College of Cardiology would ask the committee's support and advancement of LB783. I'll be happy to answer any questions.

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

VISH BHOOPALAM: Thank you.

HOWARD: Our next proponent testifier.

LEE HILKA: My name is Lee Hilka, and I am the chief executive officer of Riverview Surgical Center.

HOWARD: Please spell your name.

LEE HILKA: Thank you, Dr. Howard. H-i-l-k-a.

HOWARD: Dr. Howard-- go on. [LAUGHTER]

LEE HILKA: Thank you. I just got approval. Thank you and committee members for inviting me.

HOWARD: Did you spell your name? I'm so sorry.

LEE HILKA: H-i-l-k-a.

HOWARD: Okay. Thank you.

LEE HILKA: I have to apologize, I don't have the brain power as all my predecessors. We have some very intelligent people that preceded me, some very intelligent doctors. But I wanted to let you know that surgical procedures are moving to outpatient at lightning speed and that's because of medical technology. Every year, I see a mass producers list called the Inpatient List, and that's surgical procedures that can only be done in the hospital setting. And every two years that list is shrinking. It gets smaller and smaller, like now the total knees could only be done in a hospital setting, now they can be done in an outpatient setting. And people ask me, why is CMS doing it? Well, California has been doing total knees and total joints for 20 years on the commercial side, not the Medicare side and not the state side. And they produced this encounter data to CMS, and these are the six things they found. Little to zero infection rate as opposed to a hospital which is sometimes high. It's the same physician. It's the same physician that performs your case at the hospital and he walks across the street and does it at the surgery center. Same physician. Superior equipment in technology. Environment. Most of the people like our surgery center, I'm biased, you know, our surgery center is like a five-star hotel and we treat our patients that way. So if you're ever up in South Sioux, come and we'll give you a tour. Patient satisfaction rate. Of 63,000 surgical cases, this group in California did over seven years, they had a 98.2 satisfaction rate. They asked them, would you rather have the same procedure in the hospital or in the surg-- surgery center? And they all-- 98.2 percent said surgery center. So that's huge. And finally, all the above for 30 to 50 percent less than a bill from a hospital. And that's huge. And that's one of the reasons why I see immensely decided to move some of these patients to an outpatient surgery. So I want to tell you briefly my situation. I had, unfortunately, I had hip surgery in December of '18. My bill from the hospital, because Riverview wasn't built at the time, was $36,000. My insurance company paid thirty. I got a bill for

six and I paid that bill. If Riverview is the lot review surgery center in Nebraska is allowed to do overnight stay, because I was overnight and I got discharged in the morning, we're going to do the same procedure for 19,000 and not a penny is going to be billed to the patient. So there will be-- they won't get the $6,000 bill. So to me, you know, it's-- it's about choice. I live in South Dakota and I can sit down with my surgeons, and they can say, Lee, you have to have this procedure and they can tell me the pros and cons of the hospital, and the pros and cons of a surgery center. From my friends who live in Iowa, same thing. They have a choice. Nebraskans don't. So if you're-- you're a resident of Nebraska and you want to have a certain-- if you want to have my hip surgery, you're going to get that $36,000 bill because they don't have the choice. So that's all I have to say about the subject. I'm open to any questions that you may have.

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

LEE HILKA: Thank you, Doctor.

HOWARD: Upgrade. Good afternoon.

MAGGIE SUMMERFELT: Hello, committee. If I say Senator Howard, will I be dissing you now since he called you physician? Senator Howard, members of the committee, my name is Maggie Summerfelt, M-a-g-g-i-e S-u-m-m-e-r-f-e-l-t. I'm the administrator at Advanced Surgery Center in Omaha. And I'm here to testify in favor of LB783. This is not a radical change for us at all. But does allow the surgery centers here in Nebraska the flexibility of keeping patients 23 hours, 59 minutes from admission. That's an important thing to understand, if it's necessary for the patient's care and safety. In 2009, actually, CMS changed its regulation to allow this stay. So it's been around even with Medicare patients for quite some time. So the way CMS said they wanted this policy to create a 24-hour rolling clock that will allow ASCs the flexibility to perform those procedures that require more lengthy patient recovery times. And many states prior to this had already changed their language to provide 23 hour, 59 minutes stays for their nonMedicare population. As you've already heard, there's only 13 states, including us, that that language is used to prohibit-- prohibit overnight care. I happened to live in the state of Nevada before I moved here and this was over 15 years ago and I managed surgery centers for five years. And during that time, I managed a center that routinely provided 23 hour, 59 minute stays. At that time,

it was before people were doing total joints in an outpatient center. So most of our cases were bariatric or gynecological. And we, like I said, we did it routinely. It was a great opportunity for our surgeons to schedule certain cases at our facility rather than the hospital, and it's because mostly they loved it because the patients could recover in a very quiet, safe environment with direct patient care. They weren't going to be sitting in a hospital and dinging a bell to get care because the person that was taking care of them was looking at them. We-- we actually did quite a few, as I said, overnight cares. We never had any-- any issues. Patients absolutely loved it, and we had very good outcomes. So I think it's-- I feel very confident in supporting this legislation because I've actually had firsthand knowledge. And to answer your question about staffing, generally what we did at that time was we had a pool of nurses that were able to do overnight care. And so they were pretty much on call when we knew that we had patients scheduled that we're gonna be staying overnight, we called them, they came in. And so they specifically only came in for that. So they were wide awake and ready to go. Again, this is not a radical change. CMS and a majority of the states already have the language. It seems apprais-- appropriate that the Nebraska facilities could do this, and we do total joints, and Senator Walz. If you ever want to come and see us and if you ever want to follow a patient that has a total knee--

WALZ: Ooh--

MAGGIE SUMMERFELT: --that goes home by six o'clock at night, I would be glad to show you how that works. But we also welcome the opportunity to have the flexibility to keep that patient overnight if that happens to be the case. So thank you for your time.

HOWARD: Thank you. Are there-- Senator Arch.

ARCH: Thank you. Just-- just a question. I was looking at the language-- the rest of the language in this paragraph here. Is the licensure for an ambulatory surgery center a health clinic.

MAGGIE SUMMERFELT: Yes.

ARCH: So there is no ASC licensure within the-- if that's the state of Nebraska.

MAGGIE SUMMERFELT: I believe I'm correct. I'm correct, right? It says it's under the health clinic.

ARCH: It's under the health clinic. OK. OK.

MAGGIE SUMMERFELT: And we were licensed as an ASC. I mean, our license is an ASC plus a number, but it isn't a health clinic.

ARCH: But it's under health clinic.

MAGGIE SUMMERFELT: Yes.

ARCH: OK. And I notice there's reference to the Health Care Financing Administration, which has been gone for some time in language. But anyway, OK, thank you.

MAGGIE SUMMERFELT: Uh-huh.

HOWARD: Senator WIlliams.

WILLIAMS: Thank you, Senator Howard, and thank you for being here. Who owns most of our ambulatory surgical centers?

MAGGIE SUMMERFELT: There's a variety of choices. Some are completely physician-owned. Many have a corporate partner and some have a corporate partner or hospital partner and physician.

WILLIAMS: A combination of a lot.

MAGGIE SUMMERFELT: A combination, yes.

WILLIAMS: Thank you.

HOWARD: Senator Walz.

WALZ: I have a really quick question. I don't know, Senator Murman, did you ask the question, the thing that's always on my mind? So if you spend the night, do you get breakfast in the morning?

MAGGIE SUMMERFELT: Yes, ma'am.

WALZ: I will come follow you around.

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

MAGGIE SUMMERFELT: Thank you.

HOWARD: Nice to see you.

MAGGIE SUMMERFELT: Good to see you.

HOWARD: Our next proponent testifier for LB783. Good afternoon.

TRACY HOEFT-HOFFMAN: Good afternoon, Senator. My name is Tracy Hoeft-Hoffman, T-r-a-c-y H-o-e-f-t-H-o-f-f-m-a-n, and a long name, wait till you see my email. Thank you for the opportunity to address you. I'm in support of LB783. Senator Walz, when you have your tour at Heartland, you get your choice of lunch even.

WALZ: Oh.

TRACY HOEFT-HOFFMAN: We let you pick from wherever we can either run and pick it up or deliver it in Kearney.

WALZ: Nice.

TRACY HOEFT-HOFFMAN: So, but I gotta admit Panera is probably usually top of the list for people so you can get a super nice sandwich there after anesthesia. So addressing the staffing question that you asked earlier and Maggie addressed it a little bit, Heartland would plan on not doing this every night of the week. We would limit it to a couple nights and we plan to hire additional staff that are dedicated just to recovering our patients overnight, because they actually our staff are a little bit spoiled and having Monday through Friday day shift, why would they want to work nights, right? So we-- we are looking at that. We also have plans to add additional space at our center so that these patients would have a very comfortable private room with a private restroom. That's kind of almost a separate-- separation from the-- from where we have the bulk of our activity during the day, which also means we'd add a couple ORs because we anticipate we're going to get busier. So we've been doing total knees since November of 2017 at Heartland Surgery Center and hips and shoulders, a little bit of spine before that. We do keep the total joints a little bit longer in the day, but that gives me a little bit of heart palpitation as an administrator, because I know I have to have them out of my building by 11:59 p.m. So if they're lagging a little bit with pain control, I have to put them in an ambulance and send them to one of the two hospitals in Kearney and now they're-- my cost effective care that I gave them all day just went out the window because now they have an

ambulance charge and now a hospital charge. So allowing us to have a rolling clock, as Senator Lowe said, you could come in at 12:01 a.m. and get admitted and have your surgery. Now, obviously, I don't think I have ever-- I shouldn't say I don't have any surgeons that would do that, I have one that texts me or emails me in the middle of the night but majority don't want to do that. Certainly that's not the best time for staff or a patient or a surgeon. So this bill would address that and give us that rolling clock so that if you are admitted at 2:00 in the afternoon for your surgery compared to the same surgery at 8:00 in the morning, you don't have a shorter recovery time, you can stay longer. And unfortunately, right now, I can't do that for you and because we are very busy-- we are a very busy, multi-specialty center in Kearney. We do over 400 cases a month and over 50 percent of them orthopedics. I want to be able to provide that same recovery period of time for every single patient we have. So, again, I ask you to support this and move it on to the Legislature for a vote, because this will give patients in Nebraska the opportunity to be in ambulatory surgery. For all the reasons all my colleagues have told you and I won't repeat them, but there's a lot of good reasons to be in the ambulatory surgery study.

HOWARD: OK. Great. Let's see if there are questions. Any final questions? Seeing none, thank you for your testimony today.

TRACY HOEFT-HOFFMAN: Thank you.

HOWARD: Our next proponent testifier for LB783. Seeing none, is there anyone wishing to testify in opposition? Seeing none, is there anyone wishing to testify in a neutral capacity? Seeing none, Senator Lowe, you're welcome to close. While he's coming up, we have one letter in support, Kris Rode-- Rohde from the Nebraska Association of Nurse Anesthetists. Welcome back. Senator Lowe.

LOWE: Thank you, Chairwoman Howard, and Health and Human Services Committee. I'm humbled to be here today with all this knowledge that has just spoke in front of me and behind my opening. They took time off today to come here. They could have been doing surgeries themself. It's that important to them and we are not trying to infringe on the hospitals. They're-- the CMS is allowing them to do these surgeries now. Hospitals are great. Matter of fact, I used one last year when I smashed my foot and Good Samaritan Hospital did a great job in repairing that. This is all about patient care and making sure that they're able to go home when they need to go home, not when they have

to go home by kicking them out at 11:59, and they weren't quite ready and they weren't expecting to go to a hospital and add the extra cost to that. It's totally about care and safety of our patients. When I spoke with Tracy Hoeft last year, I wasn't planning on making this a priority bill. I didn't think it would probably go very far because I thought the hospital association may come in and oppose to this. They're coming in neutral because they see the value of this. I'm going to make this bill my priority bill, so if you could kick this bill out as soon as possible, I will be grateful for that. Thank you very much.

HOWARD: Thank you. Any final questions for Senator Lowe? Seeing none, thank you, Senator Lowe. This will close the hearing for LB783.

LOWE: Thank you.

HOWARD: All right. We will open the hearing for LB1011, Senator Arch's bill to require certain hospitals to accept reimbursement from the Medicare program. Welcome, Senator Arch.

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. I represent the 14th Legislative District in Sarpy County and I'm here today to introduce LB1011. LB1011 would mandate that all hospitals, those who are licensed as a hospital in Nebraska, other than rehabilitation hospitals, long-term care hospitals, critical access hospitals, psychiatric hospitals, that they would participate in the Medicare program. It seemed like a given that any hospital would automatically participate in Medicare and almost all Nebraska hospitals do. However, there is currently no such requirement for licensure. And a quick look at CMSs, the Center for Medicare and Medicaid Services, Medicare website or the-- or the Nebraska Department of Health and Human Services roster of hospitals will reveal that not hospitals, in fact, do participate in Medicare. So why should we mandate this participation? I think as a policy, we need to set a standard level of requirements and expectations of care when it comes to hospital licensure in the state. By requiring Medicare participation, we automatically align with the federal regulations, which is far more efficient than promulgating various rules and regulations as standards of care change. Medicare regulations, and they're called conditions of participation, do not compute-- completely crosswalk to the state rules and regulations for hospitals in Nebraska. Most importantly, these standards provide basic

protections for Nebraskans and anyone needing hospital services in the state. For example, as a participant in the Medicare program, a hospital must comply with the Emergency Medical Treatment and Labor Act, or EMTALA, if the hospital has an emergency department. EMTALA regulations require that an emergency department must stabilize and treat anyone coming in for care regardless of their insurance or ability to pay. A hospital that doesn't participate in Medicare does not have to comply with EMTALA given the current state regulations. And while compliance with EMTALA is one of the more obvious reasons to mandate Medicare participation, CMS conditions and participation provide regulations governing such things as patient rights, notice of those rights, privacy and safety, confidentiality of records, food and dietary services, medical staff organization, building specifications, infection control, and the list goes on. Additionally, Medicare participation also triggers compliance surveys and transparent quality reporting requirements to incentivize improvements to the quality of care provided to all patients. Another requirement that comes with participation in Medicare is the acceptance of a fee schedule that dictates how much the hospital can charge for a service. Prior to this bill, I had a-- I have a bill-- had a bill in the Insurance Committee and it talked about this-- this concept of we accept all insurance. When a patient walks in and particularly those now we're talking about with Medicare participation, 65 and older, when a patient walks in to an emergency room or to a hospital anticipating services, they're not understanding that perhaps that hospital doesn't participate in Medicare. The ability of that hospital to bill and to balance bill is very different than those who participate in Medicare. That would be a surprise to a senior citizen if they are not participating in Medicare. This has significant financial impact on patients receiving care. Again, most hospitals already do participate in Medicare because those hospitals agree to certain standards each must follow. While I'm generally not a fan of more regulation by the government, we're talking about that basic level of care and transparencies-- transparency Nebraskans should be able to expect from all hospitals licensed in this state. And that concludes my testimony. I encourage this committee to give serious consideration to LB1011 and I'd be happy to answer any questions.

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

WILLIAMS: Thank you, Senator Howard, and thank you, Senator Arch. A couple of questions just so I'm on the same page. Won't-- won't affect

a lot of hospitals, but do you know how many in the state it might affect?

ARCH: I don't-- I don't know that number offhand. I am-- I am aware that there-- there is at least one that does not participate in Medicare to my knowledge.

WILLIAMS: OK.

ARCH: And-- and so this is again, this is what I would say is kind of just setting that-- setting the standard that there is a basic transparency, basic-- basic quality reporting, basic all of that, that we could come to expect from hospitals.

WILLIAMS: So your assumption at least would be a vast majority of the hospitals already are doing this.

ARCH: Oh, definitely.

WILLIAMS: OK. In the definition, critical access hospitals are not included in this?

ARCH: Right. We chose to-- we chose to not include the specialty hospitals of rehabilitation, long-term care, critical access hospitals, psychiatric hospitals, those have special-- special licensure. So this would be an acute care. This would be a general acute care hospital that would be included in this.

WILLIAMS: OK. Thank you.

ARCH: Yeah.

HOWARD: Are there questions? Senator Hansen.

B. HANSEN: I got to ask it.

ARCH: Sure.

B. HANSEN: Wouldn't most of these hospitals already provide basic care if they don't take Medicare? Otherwise, they'll get sued, or they won't have maybe good patient compliance or that, you know, like you're saying, if we put hospitals on Medicare, now we're forcing them Medicare, now they're going to start taking care of their patients better.

ARCH: No, I wouldn't say that.

B. HANSEN: OK.

ARCH: I would say that that-- that the-- that the reason for this, I would say, is transparency. More than anything else, it's transparency. So when you're in medic-- when you're participating in Medicare, you have certain reporting requirements to the federal government that is public information. You don't have that if you're not participating. There is no requirement for that transparency. And so that's-- would they be providing care? Oh, I'm not-- I'm not saying that they're poor providers or low care or anything like that. I-- but this-- but this is, again, kind of setting that standard that would provide that transparency so that you can go out and you can pull up hospitals and you can see quality of care standards and those are only increasing. Year after year, there's more requirements for those kinds of reporting, more transparency. Everybody-- everybody is moving and pushing that direction because patients have a right to know.

B. HANSEN: OK. Thank you.

HOWARD: OK. Any other questions? Senator Murman.

MURMAN: Thank you, Senator Howard. So you're exempting rehabilitation hospitals, long-term care, critical access hospitals, psychiatric, mental. What-- what's left? It seems like to me, that's about everybody.

ARCH: Yeah. So these are-- these are specialty hospitals and so what is-- what is left is general acute care hospitals. And so that-- that is-- typically that's what people think of when they think of a what would be considered a full service hospital, something to that effect. But that's-- but that's-- that's what you're talking about in this category that would not be excluded.

MURMAN: I would-- I thought those general care hospitals like we're talking about would also be a critical access hospital.

ARCH: No, the critic-- the critical access hospital is a special designation, federal government. That's a-- that's a federal designation. But those would be your-- those would be your small rural hospitals that-- that have certain regulations. They're reimbursed differently by the federal government than your general acute care hospitals. So they are-- they are typically smaller. They are limited

on the services they can provide. There's a certain mileage that they can't be as close in distance and so forth, and so it's-- they're a different category of hospital.

MURMAN: OK. Thank you.

HOWARD: All right. Seeing no further questions, will you be staying to close?

ARCH: I will.

HOWARD: Thank you. All right. We'd like to invite our first proponent testfier up for LB1011.

MARGARET WOEPPEL: Good afternoon, Chairwoman Howard, and members of the Health and Human Services Committee. My name is Margaret Woeppel, M-a-r-g-a-r-e-t W-o-e-p-p-e-l, and I'm the vice president of quality and data with the Nebraska Hospital Association. I am here to testify in support of LB1011. Congress passed the Emergency Medical Treatment and Labor Act, or EMTALA, in 1986 and that requires that Medicare participating hospitals with emergency departments to screen and treat emergency medical conditions of patients in a nondiscriminatory matter to anyone regardless of their ability to pay, insurance status, national origin, race, creed or color. Referred to as the anti dum--dumping law, it was designed to prevent hospitals from transferring uninsured or Medicaid patients to other hospitals without at least a minimum providing a medical screening examination to ensure that they were stable for transfer. EMTALA is important as it assures that Nebraska citizens will always be given life sustaining treatment they have a right to when they show at an emergency department. As the vice president of quality for the Nebraska Hospital Association, I work in collaboration with all of our members in our mutual dedication to drive quality and safe patient care. The NHA supports our hospitals in their tireless drive to assure Nebraskans are receiving the safest patient care possible. To lead our quality patient safety work we depend on the direction of state and federal agencies such as the Centers for Medicare and Medicaid Services or CMS and our Nebraska state Medicare condition, a partic-- of participation surveyors. Medicare conditions of participation for acute care hospitals gives us expanded and comprehensive regulations intended to assure the quality and patient's-- safe patient care. Nebraska hospitals participating in the Medicare program are then surveyed on a four-year rotation to assure compliance with the conditions of participation. In 2019, for

example, the Nebraska Hospital Association worked with our members at the direction of CMS to improve upon decreasing hospital acquired infections, decreasing patient falls during their hospitalization, improving care transitions and therefore increasing unnecessary-- or decreasing unnecessary readmissions. Additionally, CMS has directed their hospitals to evaluate for health disparities both within their walls and in the community it cares for, and to examine how hospitals can improve their patient and family engagement. Participating in Medicare and CMS not only provides evidence-based guidelines, it also provides hospitals with benchmarking standards. Participation in this program drives quality, performance improvement, and patient safety standards at all Nebraska hospitals. I would like to thank Senator Arch for introducing this legislation and ask of the committee to advance the bill. I would be happy to answer any questions.

HOWARD: OK. Are there questions? Senator Hansen.

B. HANSEN: Thank you. I'd kind of like to ask the same question that Senator Williams asked about how many, if you know, how many hospitals are in Nebraska that do not provide Medicare? Do you know?

MARGARET WOEPPEL: I don't know that number. I know that all that Nebraska's hospitals that are members of the Nebraska Hospital Association do provide-- are Medicare.

B. HANSEN: So your organization does not represent any hospitals that do not provide Medicare?

MARGARET WOEPPEL: Not at this time.

B. HANSEN: OK. So, do you think that's kind of odd, how your organization all of them provide Medicare, now you want the old ones you do not represent to provide Medicare for the reason that you stated, by participating in these programs drives quality, performance improvements and patient safety standards at all Nebraska hospitals. So the hospitals that do not provide Medicare, are they unsafe currently? Do you-- are there issues in these hospitals that do not provide Medicare that would then force the government to tell them, we need you to provide Medicare because we think that makes patients more safe.

MARGARET WOEPPEL: I am not aware of any issues. All the hospitals in Nebraska are licensed, and to be licensed, you have to provide the most basic of quality standards. It essentially says, as I interpret

it, I'll read it as-- you must have a quality program. By participating in Medicare, you then expand on what is required for having that quality program and it directs how you run your quality program. A certain metrics that you need to be working on that are being worked on nationally, and then it assesses that. So it is-- it is the second step of quality, but still the very kind of basic. On top of that, hospitals can choose to be certified by other regulatory bodies.

B. HANSEN: OK. I think-- I think I understand some trans-- transparency points that Senator Arch was making.

MARGARET WOEPPEL: Um-hum.

B. HANSEN: What if you just made hospitals take Medicare in just their emergency settings. Because I think that's one of the concerns that you have here, right, is like someone goes to the emergency room in a nonMedicare provided hospital and then all of a sudden they're hit with this huge bill because it didn't provide Medicare. Whereas, if they go in there for maybe a routine checkup or some other, they would actually sit down and talk to somebody about their insurance, say, we don't take Medicare you have to go to this hospital. Would that be reasonable at all or--

MARGARET WOEPPEL: I don't know if that's allowed. I don't know.

B. HANSEN: OK. I was just curious, but I kind of thought from that--

MARGARET WOEPPEL: Yeah, I don't know.

B. HANSEN: --I just didn't know for sure. OK.

MARGARET WOEPPEL: Yeah, it's a good question.

B. HANSEN: All right. Thank you.

HOWARD: OK. Other questions? Senator Murman.

MURMAN: Thank you. I didn't really think about it till this last line of questioning. So according to Senator Arch, he only knows of one hospital doesn't take Medicare. Is-- is that true of Medicaid also? Do all hospitals take Medicaid-- or most.

MARGARET WOEPPEL: I am not the finance person. You know, I'd have to defer to my finance person, but I believe that most take both Medicare and Medicaid.

MURMAN: OK, so as far as you know, there probably aren't any or very few at least.

MARGARET WOEPPEL: Correct.

MURMAN: OK. Thank you.

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

MARGARET WOEPPEL: Thank you.

HOWARD: Our next proponent testifier for LB1011.

ERIC DUNNING: Good afternoon, Madam Chair, members of the Health and Human Services Committee. My name is Eric Dunning, E-r-i-c D-u-n-n-i-n-g. I'm here today as a registered lobbyist for Blue Cross and Blue Shield of Nebraska, and in addition the Nebraska State Chamber of Commerce and Industry has asked me to extend my remarks to them as well. We're here in support of Senator Arch's bill. The hour is a bit late, so I-- I would like to piggyback on some of the observations that Senator Arch has made in terms of the things that Medicare qualification brings to the table for hospitals, as well as EMTALA, the duty to treat and stabilize people in the event that they show up and they're in trouble. Because of those additional quality standards, our medical team asked me to share with you that when we're doing credentialing of healthcare facilities, Medicare qualification is one of the things that we really look very closely at and would be a little concerned about credentialing someone who was not Medicare qualified. So with that, I would be happy to answer any questions from the committee.

HOWARD: All right. Are there questions? Seeing none, thank you for visiting with us today. Our next proponent testifier for LB1011? Seeing none, is there anyone wishing to testify in opposition? Seeing none, is there anyone wishing to testify in a neutral capacity? Seeing none, Senator Arch, you're welcome to close. While he's coming up, we have two letters in support. Dr. Todd Hlavaty from the Nebraska

Medical Association, Todd Stubbendieck from AARP Nebraska. No letters in opposition, no neutral letters. Welcome back, Senator Arch.

ARCH: Thank you. One of the-- one of the issues that while we do-- while we discuss quality, we discussed EMTALA. I want to talk for a second about what happens when a patient walks into a facility, assuming that they're Medicare and they are not enrolled. They are not part-- they are not participating. And by the way, I would say that there-- it is not a federal regulation that all hospitals participate in Medicare. You-- you have that. You have that choice. And-- and when a patient walks in and this-- I can't begin to tell you how difficult some-- well, I could speak to banking regulations, and I think somebody would understand. But Medicare regulations are-- are extremely difficult. But if a patient walks in and you are not-- and you are not participating, the ability of that-- of that facility to bill Medicare is very difficult and complex. So there-- there is the ability to bill, but if you do bill and-- and you get caught into the Medicare, you-- you have to specifically opt out. I only say that to say that to a patient that's caught in that type of a situation, a senior 65 or older walks in and there's-- there's this assumption. Well, I just walked into a hospital and I have a Medicare card and-- and-- but-- but you can't assume anymore. And so if that-- if that elderly person is-- is not correct in the assumption that they participate in Medicare, the opportunity to bill at whatever rate, whatever charge is available to that hospital, whatever they decide to charge, not-- and-- and then chooses not to bill Medicare because they have opted out of Medicare, that individual would be responsible for the entire bill, because that's what we all sign when we walk in. We'll be happy to bill, but if we-- if the-- if the insurance company or whatever it is doesn't pay, the patient is always responsible. So with Medicare, you can't-- this is kind of technical, but you can't balance bill. You-- you have a-- you have a limit as to how much you can bill. And then they-- then they know that they're 20 percent responsible, whatever, whatever it might be. But all-- all of that goes away if you're not participating in Medicare. So this is what I would call a patient protection bill. It is-- it is-- it is to take away a lot of the surprise, particularly for those that would be enrolled in Medicare, where they could walk in, they would assume correctly and understand that-- that the Medicare billing responsibility and all of those regulations are being followed. Plus, to anybody that wants to understand the quality issues related to that particular hospital, that's available because those reporting

requirements are being followed. So, again, trying to set a base line of, this is the transparency that's expected of all hospitals. This is-- this is-- and for that particular Medicare population, no surprises. So with that, I would answer any questions, encourage you to consider LB1011 seriously.

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

WALZ: I have a quick question. I'm sorry that I missed your opening. You probably talked about this. Requires certain hospitals, I see there's a number of hospitals that are exempt. So what-- what hospitals would we--

ARCH: Right. We did-- we did talk about that because that's-- that's a very good question. These-- the list here are what would be considered specialty hospital, rehabilitation, psychiatric those types of hospitals, critical access hospitals. So what we have are, would be considered general acute care hospitals.

WALZ: OK.

ARCH: Right. You want to get technical, probably PPS hospitals, Prospective Payment System hospitals, but we won't get into that. But these are-- these are general acute care hospitals.

HOWARD: I just have a question. Have other states enacted something similar to us?

ARCH: I'm not aware that we've-- I'm not aware of that, but I can certainly research that.

HOWARD: OK. Thank you.

ARCH: That's a good question.

HOWARD: OK. All right. Any other questions? All right. Thank you, Senator Arch. This will close the hearing for LB1011. All right, this will open the hearing for LB1043, Senator Hansen's bill to change provisions relating to regulation of health care facilities. Welcome, Senator Hansen. You won't need those?

B. HANSEN: I won't be needing those, no. Hope not. Good afternoon, Madam Chair, and members of the committee. I think it's still afternoon. My name is Ben Hansen, B-e-n H-a-n-s-e-n. I represent

District 16. I'm here today to ask for your favorable consideration of LB1043, a bill that I am happy to sponsor at the request of the Department of Health and Human Services. The bill makes several changes to the statutes governing receiverships of health care facilities. Such health care facilities can include hospitals, assisted living facilities, nursing and skilled nursing facilities and ambulatory surgical centers. I will let a representative from the department explain in greater detail what a receivership is and how LB1043 would change the Nebraska laws regarding receiverships. Instead, I'd like to highlight why these changes are important, and as an example, in the spring of 2018, Skyline Healthcare began its collapse. At its height, this New Jersey based chain is reported to have owned or operated more than 100 nursing homes and assisted living facilities in seven states and cared for more than 7,000 senior citizens. Thirty-two of these facilities were in Nebraska and the department had to seek a receiver for them when the collapse began. Other states, including Kansas, South Dakota and Pennsylvania, had to do likewise. Although 2019 brought no new receiverships in Nebraska, this is a good moment to consider the lessons learned from recent events and make changes so that Nebraska can better handle any future receiverships. Doing so will help protect Nebraska residents, many of them vulnerable seniors who rely on various health care facilities for their well-being. I appreciate your time and would be happy to answer any questions I can. However, I would like to defer most of questions to the department. Their testimony will follow mine. Thank you.

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

CAVANAUGH: Thank you. Thank you, Senator Hansen. You might want bring those tissues closer for this question. I just see that we're changing in this bill the timeframe from 12 months to six months for the court ordered closure. I just wanted to make sure that-- I'm assuming because there's nothing in here yet about the court's, they're-- did you work with them on that timeline? Is that an acceptable timeline?

B. HANSEN: I would have to defer that question to the department.

CAVANAUGH: OK. Thank you.

B. HANSEN: Yep.

HOWARD: Other questions? So, Senator Hansen, I'm gonna give you a preview of my questions so that the person behind you can, like, prep for that.

B. HANSEN: Sounds good.

HOWARD: Yeah, good one. Because when I read this bill, I was like, oh, my gosh, this went to the wrong committee because this is very much outside of our wheelhouse, right? So, OK, my questions are things like, why are we filing in Lancaster or why are we mentioning Lancaster County. Right? OK. The bottom of page 5 talks about that financial analysis being done within the first 30 days. It's just sort of the mindset or the thought process behind it. And then I'm hoping someone will walk us through the last two pages overall on the Attorney General's role.

B. HANSEN: That makes complete sense.

HOWARD: Cool.

B. HANSEN: I've always wanted to say something. I can never confirm or deny these allegations. I never got a chance to ever say that ever. And so, I will defer those questions to the department.

HOWARD: Yes. And yes, OK. And we will-- we will need some help from our colleagues on Judiciary with this one. All right. Seeing no further questions for Senator Hansen, will you be staying to close?

B. HANSEN: Yes.

HOWARD: Wonderful. All right. We'd like to invite our first proponent testifier up for LB1043.

GARY ANTHONE: Chairwoman Howard, and members of the Health and Human Services Committee. My name is Dr. Gary Anthone, G-a-r-y A-n-t-h-o-n-e, and I am chief medical officer for the Division of Public Health within the Department of Health and Human Services, DHHS. I am here to testify in support of LB1043, which amends the statutes governing receiverships of health care facilities to improve the process for everyone involved. DHHS would like to thank Senator Hansen for sponsoring this legislation. A receivership is created by a court at the request of DHHS when one or more of five conditions prescribed in statute exist. The most common reason for a receivership is that an emergency exists that places the health, safety or welfare

of facility residents at immediate risk. Receiverships, particularly receiverships involving nursing homes, have become increasingly common in recent years. This is true not just in Nebraska, but throughout the United States. A total of 22 nursing homes and 11 assisted living facilities were in receivership in 2018 in Nebraska. Twenty-one of these nursing homes and 11 assisted living facilities were part of a chain of 100-plus facilities operating in 11 states, and caring for 7,000 persons, that failed. These receiverships are in the process of winding up the financial accounting to the numerous courts overseeing the receiverships. Based on the current statutory requirements, each facility is a separate receivership. There are no new receiverships in 2019, but additional receiverships could occur in the future. Receiverships involve ensuring care is provided to residents of the affected facilities, paying staff and vendors, collecting funds owed to the facilities, and complying with both operational and financial requirements. Each one is different, but all involve complex financial and care issues that need to be dealt with in a timely manner to protect all the residents and others involved. LB1043 is intended to address some of these issues that have arisen in the operation of the receiverships. LB1043 does this in a number of ways. The first is to shorten the duration of a receivership, lessening the uncertainty that patients and residents, their families, employees, vendors in the community experience when a health care facility is in receivership. Currently, a receiver has 12 months to terminate the receivership before the court is required to hold a hearing to determine whether the facility should be closed or sold. The bill shortens this timeframe to six months. The bill also requires that the closure or sale of the facility occurs within 60 days of the court order unless the court mandates otherwise. LB1043 increases the amount of information that the court and the department receive to oversee the receiver and the facility respectively during the receivership. Currently, receivers are required to perform regular accountings and make periodic reports. The bill specifies in greater detail the timing and content of these submissions. It requires the receiver to conduct a thorough analysis of the facilities financial records within the first 30 days of the receivership and then provide monthly reports on the financial status. The bill also requires monthly reports about the receivers plans for the continued operation or sale of the facility. In addition, LB1043 limits the number of facilities for which a person may serve as a receiver to five unless otherwise approved by the court. This is to ensure that the receivers can adequately focus on the individual facilities involved. Currently, there is no such limit

and a single receiver has been appointed for 32 facilities in the past. LB1043 also permits receiverships petitions involving multiple facilities within the same ownership to be-- to be brought in a single district court and makes other, more technical changes. This will permit one court to respond to issues that are interrelated among facilities and help to simplify the financial and operational items that need to be addressed by the facility. We respectively request that the committee support this legislation and move it to the floor for full debate. Thank you for the opportunity to testify today. I'd be happy to answer any questions.

HOWARD: Thank you. Do you want to start with some of my questions that you heard?

GARY ANTHONE: Thank you.

HOWARD: OK. And is anybody coming from like the Attorney General's Office behind you? Yes, OK, perfect. So if you can't answer them, we can send them over. Can you tell me why Lancaster County is-- is named?

GARY ANTHONE: To my knowledge, it is because it's local and this is where the Attorney General is and it will-- will make it easier for them rather than going to all the jurisdictions of Nebraska where these facilities were closed. Simplify that process, or to make it so that if there's multiple facilities owned by the same owner, that they can all be consolidated into one district court.

HOWARD: And then I'm going to keep going if that's OK. OK, so how did you land on the five health care facilities?

GARY ANTHONE: I-- I'm not certain why five was chosen, except that we knew that the 32 was in excess.

HOWARD: Went too high, right.

GARY ANTHONE: And it was thought that five would be an easy number for a receiver to handle.

HOWARD: OK. Perfect. I wasn't sure if there'd been an adverse event that led you to five. And then when-- on the bottom of page five, so right now what's happening is that they don't-- do they-- when a

receiver takes over, right now, they don't have any timeframe for going over the financial records.

GARY ANTHONE: There was no-- nothing in statute that said how they-- what time they made their reports or how often they made them. So this would put it in statutes that they have to do the first financial report within 30 days of receiving that receivership and then to make monthly reports after that.

HOWARD: OK. Thank you. OK, and then since the last two pages relate to the Attorney General, I should save that question for them.

GARY ANTHONE: That would be fine with me.

HOWARD: OK. All right. Other questions from the committee? All right. Seeing none, thank you for visiting with us today. All right, our next proponent testifier for LB1043.

DANIELLE ROWLEY: Good afternoon, Senator Howard. My name is Danielle Rowley. I'm Assistant Attorney General. Danielle is D-a-n-i-e-l-l-e, Rowley is R-o-w-l-e-y. I am the Assistant Attorney General who handled the 32 receiverships with Skyline. I also handled one in 2018 up in Dakota City. I handled the two that we had back in 2015 to the-- so to the extent that you have questions about how a receivership works, I'm probably the best person to answer those questions. I was going to read through testimony, but I think maybe focusing on your questions might be a little bit easier. Why Lancaster County? So when we have the 32 facilities at the same time, essentially what happened is I got a call from HHS late on a Friday afternoon. These facilities range from as far east as Omaha and as far west as Scottsbluff, and so file 32 pleadings and get an emergency order from a judge and it was 10 different judicial districts, on a Friday evening was pretty much impossible. So we were able to get permission from the Chief Justice to actually have a judge here in Lancaster County, just the judge on duty sign those orders so that we could get a receiver in place over the weekend. And then by Monday, we were able to go to all of those judicial districts and get an order from those judges. So even if we start in Lancaster County, it doesn't have to remain there, especially if the facility is out in Scottsbluff that doesn't necessarily make sense, but it was just to help us in an emergency situation like that so that we can get a receiver appointed, you know, within a matter of hours rather than waiting over a weekend, especially when we're dealing with employees who were not getting paid. And Senator

Cavanaugh, you asked a question about the six-month timeframe and why. So we have the the Skyline receiverships, 32 at the same time. Those cases are still open. And it's been almost two years since we started the receivership. Fortunately, the situation right now is those facilities have either closed, they're operating with a new operator, or even operating with the receiver but outside of the receivership. But we haven't closed the cases because ultimately before we can do so, the receiver has to finish paying bills and file a final accounting paperwork, because in this case, we ran out of money for the receiverships. That's-- that process is taking a lot longer than anyone anticipated. In the Dakota City receiverships, that also started in 2018. We got through those in about a six-month period and ended up selling the facility just as that was the best option. I think between the two different circumstances, it is a lot easier if we can get a receiver in the door. And in the first 30 days do a financial analysis of the facility and ultimately determine whether or not it's gonna be financially viable, which we didn't necessarily do in the case with the 32 Skyline facilities. It's-- it'll move things along faster. It can be very frustrating especially as an employee or even as a patient to be working at a facility that's under receivership and not know whether it's going to close tomorrow or six months from now or years from now. So if we can shorten that timeframe and, of course, there is discretion for the judge to extend it if necessary. But if we can shorten it, it gives people a little bit more certainty about what their future is going to be like, which I think is helpful. And it should help prevent the issue of us running out of money, which is what happened again with the Skyline receiverships. And then the last two pages. Good question, by the way. So the change in the statutory language in 71-2094 is very similar to how the Attorney General's Office actually handles civil cases when a state employee gets sued. Right now, the receiver is considered a state employee for purposes of getting sued. And so what our office would do, just like we do with any state employee when they get sued, is they have the opportunity to ask us to represent them if they don't want to go out and pay for their own attorney, to the extent that they have not committed any wrongdoing or-- I want to use the exact language from the statute too. It's intentional wrongdoing, or gross-- gross negligence, then we would continue to represent them. The big difference is here, if the case is unsuccessful, we lose, we settle, whatever, the judgment gets paid out of receivership assets and we're not dealing with state funds here. So that's sort of the difference between how we handle normal civil cases versus this. But the statute

was not really clear initially and we've had some issues with the 32 Skyline facilities now with the receiver being sued and there's a question of whether my office steps in to handle those lawsuits. And then how judgments would be paid or settled, and so hopefully the changes here clarify that. And I'm happy to answer any other questions that anyone has about receivership, even just in general.

HOWARD: OK. Thank you. Are there-- Senator Walz.

WALZ: I'm going to take advantage of this, because you're doing a very good job of explaining this, so can you just finish from Friday night? Can you finish that story? So, just take us through the process of what you did, the process of-- just finish it.

DANIELLE ROWLEY: So to get a receiver in general, you have to have an appointment by an actual judge. The way the statute is written now, it has to be a judge who's in the same area where the facility is located. So essentially what we did was file a petition asking the court to appoint a receiver. You can do at ex parte in an emergency situation, meaning we're the only ones that have to show up in court. We don't have to have the nursing home come, for example. So we filed those along with an affidavit from a staff member of HHS that was aware of the financial issues of the facility. And then they were-- HHS, fortunately, was able to find a receiver who was willing to do so many facilities at the same time. The court appoints them and essentially they come in and stand in the shoes of the operators of the nursing home. They can hire and fire staff. They can move patients around if they want and they're essentially responsible for patient care at that point.

WALZ: OK. Thank you. That-- that's very good. Thanks.

HOWARD: Other questions? OK. Seeing none, thank you for visiting with us today.

DANIELLE ROWLEY: Thank you very much.

HOWARD: All right. Our next proponent testifier for LB1043. Good afternoon.

ABBIE WIDGER: Good afternoon. My name is Abbie Widger, A-b-b-i-e W-i-d-g-e-r. I'm general counsel for the Nebraska Health Care Association and we're thankful for the department for bringing forth LB1043, and thank you for the opportunity to comment in the proponent

position for this bill. As a representative of Nebraska Health Care Association, we represent long-term care providers, nursing homes and assisted living facilities in the state of Nebraska. And as you can imagine, our members were impacted by all the receiverships that were filed, not necessarily the receivership facilities, but all other facilities in the state have been impacted by this, as well as the vendors who provide services for the receivership facilities. And as a result of the interaction that the other facilities have had as well as the vendors, we recognize and support the department's efforts to revise the receivership statute. However, based on comments of some of our members, we do have some suggested language changes to what was proposed. And so in your handout attached to it, the red language is the language that's being proposed by the Nebraska Health Care Association. Generally, there are four categories that we're asking for language changes on. The first one is direct assistance from Medicaid. We don't think that licensure operates in a silo, and when you have something as big as a receivership going on, there needs to be communication between the whole department of Health and Human Services, not just the one silo, but the other part of it, and that's the payment part. So if Medicaid could be a more integral part of the team and work with the receivership and work with the receiver's team and contractor to assist in the more timely and accurate processing of Medicaid claims, I think that that would help. One example that I would like to share is that a lot of times when a receivership goes into a building, they may or may not know where all the documents are, and especially if you don't have the staff and if the administrator has left or the billing person has left because they haven't been paid, sometimes Medicaid has rejected a claim because there's a date of birth that's wrong or something simple along those lines. The facility may not at that point in time, right then and there, may not know exactly where that information is. Medicaid has that information and it seems to me like some flexibility with regard to Medicaid and assisting in processing those claims would also be beneficial. The second thing that we would like to see, based on comments from our members, is more transparency and accountability from the department to understand better what the criteria is for being a receiver. The application process, is there a list? What do we do to make this more of a public information so that we can get the best receivers possible? As far as the number five, I don't know that that's a magic number. We had one of our members tell us yesterday what about a range. And I think range based on demographics, resident census, geography within the state might be a more palatable solution. If you

have a Douglas County and you have two facilities that are-- that are large, that may be enough. But if you have northeast Nebraska and there's six facilities, but they're all kind of clustered in the same geographic region and you have two that are relatively small, it makes sense to do six instead of capita five. So that's just another suggestion. Also, paying vendors in a timely manner. When the receivership went into effect, a lot of the vendors immediately took up food, blankets, other things and then didn't even bill for that. But after the receivership was put in place, vendors continued to provide even though there were outstanding bills. So a process for getting vendors paid would be also beneficial. Also, we've added language regarding a new owner's ability to meet Medicaid certification criteria. The LB1043 requires the new owner to be able to be licensed. We would also like the new owner to be able to be certified for Medicaid and Medicare services, especially since Medicaid residents are a large part of our nursing facility population. So we really appreciate the improvement to the receivership statutes, and if you have any questions, I'd be happy to try an answer them. I'm kind of B-team here today, so.

HOWARD: Senator Arch.

ARCH: Thank you and thanks for your testimony. The question and I'm just not aware when-- when-- when a facility goes into receivership and somebody stands in the shoes, do they assume the Medicaid billing number and the licensure and everything of the previous owner for that period of time of receivership?

ABBIE WIDGER: For that period of time, it doesn't change. The license number that-- I'd say Skyline operated under is still the same license number that the receivership operated under. And if I have messed that, please correct me. But I-- looking at license page, it-- the license number on those facilities did not change until the ownership changed in March-- April of 19.

ARCH: Thank you.

HOWARD: Senator Cavanaugh.

CAVANAUGH: Thank you. Thank you for being here. I had asked previously about the-- moving the timeline from 12 months to six months. Is that something that impacts your constituency at all?

ABBIE WIDGER: Maybe.

CAVANAUGH: In a positive way?

ABBIE WIDGER: I'm going to-- well, I'm going to tell you a side story.

CAVANAUGH: OK.

ABBIE WIDGER: I have private practice and we represent-- my office represents one of the vendors that's involved in the Skyline matter. And so based on that, we do have some knowledge of the workings of the receivership. That receivership is still open--

CAVANAUGH: Right.

ABBIE WIDGER: --even though those facilities have been transferred. I-- I think it would be very, very beneficial to have-- if you have facilities that are in different judicial districts, to put them all under one judicial district, wherever that is. And maybe if the judiciary doesn't want to label Lancaster County, because if the Lancaster County judges say, gosh, we get all the administrative appeals, we don't want all the receivership, maybe what happens is if you apply for a receivership, it goes to the Supreme Court administrator and the Chief Justice pulls a name out of a hat and that's the judge that gets that. As far-- but with regard to the six months, if you are going to sell a facility, I know from experience it takes sometimes three or four months to sell a good facility. And so selling a facility that's in receivership, sometimes people have to process that a little bit more. I think what made this a very difficult transaction was nothing that the department did, nothing that the Attorney General's Office did, they've been wonderful. What made this difficult was the real estate was owned by the previous operator. And you had all this, not this-- all sorts of moving parts that nobody can really quite pin down. And it took the landowners some time to understand they needed to sell because nobody would lease the buildings from them. And that's what they wanted to do first, was they-- they contacted Nebraska Health Care and said, can you find anybody that would lease these buildings from us, they're in receivership? And everybody laughed. No, we're-- no, that's not going to happen.

CAVANAUGH: Thank you.

HOWARD: Are there questions? All right. I just want to make sure I understand what changes that you want Senator Hansen to consider.

ABBIE WIDGER: The ones in red are the ones that we had proposed.

HOWARD: Oh, in red in the copy.

ABBIE WIDGER: Yes.

HOWARD: And you've spoken with him about this already?

ABBIE WIDGER: Yes. Cindy Kennedy and Ashlee Fish have talked to him about it.

HOWARD: Okay. All right. Thank you.

ABBIE WIDGER: Thank you.

HOWARD: Our next proponent testifier for LB1043. Seeing none. Is there anyone wishing-- oh, proponent? Yes. OK. Wonderful.

SHARON COLLING: Good afternoon.

HOWARD: Good afternoon.

SHARON COLLING: Thank you very much, Senator Howard, and the rest of the committee. My name is Sharon Colling, S-h-a-r-o-n C-o-l-l-i-n-g. I'm President and CEO of Lantern Health Services, a Nebraska-based nursing home and assisted living management company, consulting company. I have 30 years of nursing home and experience, 25 of which as an administrator and since 2012 with my management company, I have been assisting nursing homes and assisted living across the state in a variety of capacities, including management, consulting, providing monitoring reports to DHHS for facilities under state monitoring. I most recently as a court appointed receiver for a nursing home and assisted living in northeast Nebraska, the one at Dakota City mentioned earlier. It is in my capacity in that last experience that I want to provide my support for LB1043 and offer a suggestion for a minor amendment. Upon review of LB1043, one sentence immediately came to my attention. It just jumped out and this on line 26 of page 2 where the bill states, unless otherwise approved by the court, no person shall be appointed as a receiver for more than five health care facilities at the same time. I have two concerns with that statement. First, is that in the state of Nebraska, many of our facilities,

especially in more rural areas, have a nursing home with an assisted living either attached to it or on the same campus. They are two separately licensed facilities and as an example, when I was in Dakota City, we had to get two separate court orders for the receivership, both to get the receivership and to end the receivership. One for the nursing home and one for the assisted living. So with the number of five, that would mean if-- if somebody were to pick up three entities, it's actually six facilities. So at the very least, I think the number need to-- needs to be changed to an even number because so many of our rural facilities have both a nursing home and assisted living on the same property. Second, my concern with that sentence is that there are a limited number of providers in Nebraska with the capacity to do receivership shers-- services for the long-term care profession. Facilities needing receivership have a lot of issues and a receiver must have an integrated team of individuals to address all those issues immediately under pressure and in the public eye. And usually you get less than 24 hours notice that a receivership is needed, and you've heard that from other people testifying, it was a Friday night. I'm also on a receiver list for a neighboring state when I get called for receiverships there, it is usually we want you across the state within four hours. And the facility might be six hours away from where my team is at, but that's sometimes how short of notice that you have when a receivership is needed. Keeping in mind that the department's ultimate responsibility is to ensure the health, safety and welfare of the residents in those facilities, so time is of the essence. So I am concerned that if we limit future receiverships to five or six facilities, given the number of entities in the state that are able to respond that quickly and with a team that could go out, that it might put us in a pickle if we get into a situation with a large number of facilities again and not enough receivers to-- to handle that. But that being said, given my experience as a receiver and having firsthand knowledge about the amount of oversight that was required by the Department of Health and Human Services, I still believe a limit on the number of facilities is very, very much needed. Although I think five facilities is perhaps not the correct number, I think if we had multiple facilities, so if-- if we used the 31 facilities of Skyline and put five per receiver, that would have been approximately, what, six different receivers involved. I can tell you as being one of those receivers, I had to call and speak with the department every single day, seven days a week, sometimes because of their workload with all of these receiverships, it would be 9:30 at night. Sometimes it was seven in the morning. It was on Saturday, it was on Sunday, it

was on the Fourth of July. It was on Labor Day. It was every single day. I got to experience first hand and I consider this a real privilege, some of the inner workings of the department just by being the receiver with the level of commitment, any amount of extra work that it took the entire department to deal with the number of receiverships that were in place at one time. And if they were trying, not only was-- was I doing that as a receiver, the other receiver was also having that level of interaction with the department as well. So if they simultaneous had to deal with five or six different receiver companies simultaneously, that would have, I think, exponentially increased their particular workload. My suggestion is a number of six, again, keeping it an even number and considering a nursing home and assisted living if they're on the same campus as-- as one. So that's basically 12 facilities, which is about a third of-- of what was handled with the Skyline. And I-- I am basing that just solely upon my own capacity.

HOWARD: Can I ask you to wrap up your final thought because you've got the red light.

SHARON COLLING: Yes, thank you. So I am in support of-- of this bill. I'm also in support of the automatic stays of action. Those court order clauses were very important during my receivership. I'm in support of the monthly rather than periodic reports to the court. I am support of the finite dates on closure or sale to a maximum of eight months. And I very much appreciate the opportunity to be here. I am fully in support of this bill.

HOWARD: Thank you. Are there questions? How does one become a receiver?

SHARON COLLING: Well, the process that I underwent several years ago, I had called to inquire. I received a form from the then head of the survey facility team. So I filled that out and it was just a simple little form, and then I was placed on the receiver list.

HOWARD: So anybody could do it.

SHARON COLLING: I'm-- I am not sure. I don't know if that process has changed. So I know that several years ago, when five facilities came up for receivership, I received that call. I was in Florida. I didn't feel I had enough team to take on five facilities at once so I declined at that point in time, because again, they needed somebody

that day. And I was in Florida and my team was scattered around the state, so.

HOWARD: OK. Have you spoken with Senator Hansen about these-- these changes or if--

SHARON COLLING: I have not. I did speak to the association and they were happy alluded to. At the very least, I think it needs to be an even number or-- because of the nursing home and assisted living is on the same campus. I would also suggest that maybe the definitions be actually included in the statute. I know the definitions are somewhere else. But again, when I was receiver, many of the vendors and some of the other entities wanted copies of the statutes and they certainly wanted copies of the court orders. We did send them out to all of the vendors, but I had a heart-- a large stack on my desk and would have to continue to send them out. Without those court orders, it would have been catastrophic. We had a lot of vendors trying to pull out. They'd already gotten damaged or kind of burned with the Skyline. The one I was with was after Skyline and insurance companies, vendors, life support system companies were all trying to pull out and we had to really play hardball with the court orders to make sure that those residents were safe.

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

SHARON COLLING: Thank you.

HOWARD: Our next proponent testifier for LB1043. Seeing none, is there anyone wishing to testify in opposition? Seeing none, is there anyone wishing to testify in a neutral capacity? Seeing none, welcome back, Senator Hansen. There are no letters for the record.

B. HANSEN: Thank you, Chairperson Howard, and the Judiciary Committee. Oh, I mean, the Health and Humars-- Human Services Committee. Love the input. It's great to hear from everybody. You know, when I agreed to take this bill, I appreciated the reasonable recommendations to make sure health care facilities and their residents are taken care of and receiverships are done in a timely and responsible manner, not just fiscally, but also personally. And so I appreciated this-- this bill and what it pertained to. So I am ready to work with the department and all stakeholders that came and testified. Should be some good fixes and some reasonable recommendations that they made. So with

that, I'll do my best to answer any questions if you have any of-- for me.

HOWARD: OK. Thank you. Are there any questions? No?

B. HANSEN: Good.

HOWARD: Thank you, Senator Hansen.

B. HANSEN: Thank you.

HOWARD: This will cause the hearing for LB1043. If you have to leave, please leave quietly. All right. We will open the hearing to LB1104, Senator Arch's bill to redefine a term under the Health Care Quality Improvement Act. Welcome back, Senator Arch.

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 LB1104. The purpose of this bill is to fix a gap in the Health Care Quality Improvement Act. The act provides employees of health care entities certain protections when an employee is part of a peer review committee. You may recall last session this committee heard LB119, which was subsequently passed and signed into law. That bill created the definition of, quote, professional health care service entity to ensure employees in physician run clinics are given the same protections as those in a hospital setting when they are members of a peer review committee. LB1104 would ensure that physician run clinics that are organized as nonprofits, not for profit, would also fall under this definition. I want to-- I want to, if you would, if you got the green copy in front of you, I think you can see it pretty clearly what we're trying to accomplish here. Because we delineate certain categories of-- of corporate organizational structures, you can see that-- that in this-- in the language already, you see Nebraska Professional Corporation Act or PCs, a lot of physician clinics are organized as a PC, Nebraska Uniform Limited Liability Company, LLCs, or the Uniform Partnership-- Partners Act of 1998 and so those are corporate structures. What isn't included in that list and it was inadvertent is what is underlined there and inserted, it's the Nebraska Nonprofit Corporation Act. So if a physician clinic is organized as Nebraska, not for profit, that wasn't enumerated. And because we enumerate the others, it was felt as though we need to make sure we include that. So as we discussed during

the LB119 hearing proceedings, records, reports of peer review committees are considered confidential. This confidentiality is important to ensure a thorough and comprehensive review and positive outcomes. It allows participants to be on-- open and honest without the fear of being subject to a lawsuit or held liable for actions taken within the scope of the peer review. This bill does absolutely nothing to change the established peer review process. LB1104 simply amends the definition of professional health care service entity to include medical clinics organized under the Nebraska Nonprofit Corporation Act. Those entities would still have to have written policies in place to govern peer review committees. Employees of nonprofit medical clinics deserve the same protections as any other entity and leaving out nonpro-- nonprofits was basically an oversight when we passed LB119. This bill, LB1104, corrects the inadvertent omission of nonprofit physician run clinics from the Health Care Quality Improvement Act. I ask you advance this measure to correct that error. Thank you, and I'd be open to any questions.

HOWARD: Thank you. Just out of curiosity. Do you know why the-- why the stricken section is stricken-- for purposes of rendering professional services?

ARCH: I'm not sure, but maybe somebody that follows me would be able to answer that question.

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

ARCH: I will.

HOWARD: Wonderful. All right. Our first proponent testifier for LB1104. Good afternoon.

MATT SCHAEFER: Good afternoon, Chairwoman Howard, members the committee. My name is Matt Schaefer, M-a-t-t S-c-h-a-e-f-e-r, testifying today in support of LB1104 on behalf of the Nebraska Medical Association. As Senator Arch mentioned in his opening, this bill is simply correcting an oversight from last year's LB119 or-- yeah. The Medical Association strongly supports the peer review process and extending that opportunity to nonprofit entities makes complete sense. As a reminder, the peer review process is the process where doctors evaluate the quality of their colleagues work in order to ensure the prevailing standards of care are being met. When

unanticipated outcomes happen, the peer review process can be a powerful tool to disseminate lessons learned and improve patient safety and the quality of care going forward. For those reasons, we urge you to adopt LB-- or advance LB1104 to the floor. Senator Howard, it's my strong guess that that stricken language is a term of art related to the Professional Corporations Act. And since we're expanding the list, it was probably Bill Drafters recommendation to simply strike that term of art.

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

MATT SCHAEFER: Thank you.

HOWARD: All right. Our next proponent testifier for LB1104. Seeing none, is there anyone wishing to testify in opposition? Seeing none, is there anyone wishing to testify in a neutral capacity? Seeing none, Senator Arch-- he waives closing. There are no letters. That closes the hearing for LB1104 and we are done for the day.