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STINNER: Welcome to the Appropriations Committee hearing. My name is John Stinner. I'm from Gering and represent the 48th Legislative District. I serve as Chair of this committee. I'd like to start off by having members do self-introduction, starting with Senator Erdman.

ERDMAN: Thank you, Senator Stinner. Steve Erdman, I represent District 47; that's ten counties in the Panhandle.

CLEMENTS: Rob Clements, District 2: Cass County and parts of Sarpy and Otoe.

McDONNELL: Mike McDonnell, LD5: South Omaha.

HILKEMANN: Robert Hilkemann, District 4: West Omaha.

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

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

STINNER: Assisting the committee today is Brittany Sturek, our committee clerk. And to my left is our fiscal analyst-- analyst, Liz Hruska. For the safety of our committee members, staff, pages and the public, we ask that you-- those attending our hearing to abide by the following. Submission of written testimony will only be accepted between 8:30 and 9:30, in the respective hearing room where the bill will be heard later that day. Individuals must present their written testimony in person during this time frame, and sign and submit written testimony record-- for the record, at the time of submission. Individuals with disabilities can designate a person to submit their written testimony. Due to social distancing requirements, seating in the hearing room is limited. We ask that you only enter the hearing room when it is necessary for you to attend the bill hearing in progress. The bills will be taken up in order posted outside the hearing room. The list will be updated after each hearing to identify which bill is currently being heard. The committee will pause between each bill to allow time for the public to move in and out of the hearing room. We request that everyone utilize the identified entrance and exit doors to the hearing. We request that you wear a face covering while in the hearing room. Testifiers may remove their face covering during their testimony to assist the committee members and transcribers in clearly hearing and understanding the testimony. Pages

will sanitize the front table and chair between testifiers. Public hearings for which attendance reaches seating capacity or near capacity, the entrance door will be monitored by the sergeant at arms, who will allow people to enter the hearing room based upon seating availability. Persons waiting to enter a hearing room are asked to observe social distancing and wear a face covering while waiting in the hall-- hallway or outside the building. To better facilitate today's proceeding, I ask that you abide by the following procedures. Please silence or turn off your cell phone. Move to the front row when you are ready to testify. Order of testimony: introducer, proponents, opponents, neutral, closing. Testifiers' sign-in: hand your green sign-in sheets to the committee clerk when you come up to testify. We ask that you spell your name for the record before you testify. Be concise. It is my request that you limit your testimony to five minutes. We may change that as we go because we have a time constraint on us. We have to be out of here by 1:30. Obviously, the next hearing will start at that time. If you will not be testifying at the microphone, but want to go on the record as having a position on the bill being heard today, there are white sheets at the entrance where you may leave your name and other pertinent information. These sign-in sheets will become exhibits in the permanent record, at the end of today's hearings. We ask that you please limit or eliminate handouts. Written materials may be distributed to committee members as exhibits only while testimony is being offered. Hand them to the page for distribution to the committee and staff when you come up to testify. We need 12 copies. If you have written testimony but do not have 12 copies, please raise your hand now so the page can make copies for you. With that, we will begin today's hearings with Agency 025, Department of Health and Human Services. I guess the first one is medical long-term care, I believe is what's on my list. I don't know if that's the way you guys look at it, but we have today Public Health and Operations, also. So--

KEVIN BAGLEY: Good morning.

STINNER: Morning.

KEVIN BAGLEY: Chairman Stinner, members of the Appropriations Committee, my name is Kevin Bagley, Ke-v-i-n B-a-g-l-e-y. I'm the director of the Division of Medicaid and Long-Term Care in the Department of Health and Human Services. I'd like to begin today by thanking Chairman Stinner, the members of the committee, and your

staff for working together with us. Medicaid is a significant portion of the state's budget and has significant impacts on the more than 300,000 beneficiaries currently eligible for Medicaid coverage. Our division is committed to serving Nebraska's most vulnerable residents, and has worked with the Governor on a responsible budget to continue that work. Before I begin, I'd like to discuss some recent developments surrounding our Medicaid expansion 1115 waiver. It's become clear to us, in recent conversations with CMS, that they will not provide a decision on the waiver implementation plan we submitted in December 2020, in time to begin the wellness and personal responsibility requirements on April 1st, as previously planned. While the waiver itself was approved in October 2020, approval of the waiver implementation plan is required before we can put in place the mechanisms that would allow us to have those demonstration participants receive those prime benefits. We're working with our federal partners at CMS to resolve their outstanding concerns so that we can move forward as quickly as possible. The Governor has proposed a responsible budget for the Division of Medicaid and Long-Term Care. The Governor's budget recommendation for state fiscal year 2021-2022 totals approximately $2.8 billion, of which $911 million is state General Fund. For state fiscal year 2022-2023, the Governor's budget recommendation is $2.9 billion, of which $946 million is state General Fund. I would like to highlight a few adjustments to Medicaid's appropriation in our budget recommendation. The department requested approximately $2.7 million general-- in General Fund for the upcoming biennium to cover ongoing CHIP utilization costs, following the phase-out of enhanced Federal Medical Assistance Percentage, or FMAP, for Program 344. The enhanced rate was originally put in place through the Affordable Care Act and expires on September 30 of this year. Additionally, the budget recommendation includes a request for just under $39 million in General Fund for state fiscal year 2022-2023, for increases in the Medicaid Program 348 utilization. This utilization is the result of increased number of individuals eligible for Medicaid, a mix of membership, and resulting increases in the number of services utilized, as well as payments to our managed-care organizations covering those additional beneficiaries. The Medicaid Division also requested approximately $181,000 in General Fund in state fiscal year 2022-2023, to implement LB323, which was passed in August 2020, which changed the eligibility standards for the Medical Insurance for Workers with Disabilities program. Medicaid did not receive previous appropriations for this program, which has an effective date of

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October of this year. I also want to provide an update on the status of the temporary enhanced FMAP associated with the maintenance of effort requirements during the declaration of the COVID-19 public health emergency. The department has received an additional 6.2 percent of FMAP since January 2020, which is formally in place until at least June 30 of this year, though the new federal administration has signaled that they intend to continue that declaration of public health emergency through the end of this year, which would result in receiving that additional enhanced FMAP through December 31st of this year. Included in the Governor's budget recommendation was a reappropriation of General Funds generated from the enhanced FMAP in the current biennium, to fund the request in the first year of the upcoming biennium. The department would ask that the Appropriations Committee adopt this approach in the Appropriations budget rather than appropriating new funds. We understand this to be the case with one exception, where the committee appears to fund $117,000 for implementation of LB323 in state fiscal year 2021-2022, with a new appropriation rather than reappropriating the existing funds. Finally, we'd like to provide an update on provider rates Given the uncertain economic forecast amidst the COVID-19 pandemic and the uncertainty surrounding its impact to the Medicaid program budget, the department did not put forward a specified provider rate increase request. The department reviews existing rates against a variety of other state Medicaid programs, as well as other payor sources. Upon request, the department may even conduct a more in-depth rate study for specific services. In the event the department determines a given rate is not appropriate, we are able to take appropriate and responsible actions, and adjust those rates as needed. In conclusion, we support the Governor's budget recommendation, which provides the necessary resources to continue our focus on covering the healthcare needs of our Medicaid beneficiaries, with an eye on improving the experience and outcomes of our population served. Thank you for your consideration on these items. I'd be happy to answer any questions you have.

STINNER: Questions? Senator Hilkemann.

HILKEMANN: Thank you, Mr. Bagley. I'd like to go back on your third-- on the third paragraph of your testimony, just a little-- a little bit more on the Medicaid expansion waiver.

KEVIN BAGLEY: Yes.

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HILKEMANN: It was my understanding, from what-- just what I've read is-- is that-- that they aren't going to approve that waiver.

KEVIN BAGLEY: So it's been an interesting conversation, and that's a great question. So there-- there are a few elements that are all moving at the same time on that. The first is, we received that approval of the overall waiver request in October, and we've been working with CMS since then on our implementation plan. In addition, we received that letter from CMS on the 12th, outlining their concerns with the community engagement requirement, as well as some of the other requirements. We-- we believe those to be the wellness and personal responsibility requirements, though they weren't called out by name in that letter. Regardless of whether or not we received that letter, we were still waiting on that approval of the implementation plan, which appears to be on hold at this point, based on our conversations. So we aren't going to be able to move forward and hit that April 1 date. In addition, as we read that letter from the 12th, we believe CMS may have some concerns with those requirements that we'll need to discuss with them in order to move forward. So really, at-- at this point, I think we are going to need to resolve those questions with CMS before we figure out how we move forward.

HILKEMANN: So is your plan at the present time just to go with the Medicaid expansion program period and not try to put in the wellness program?

KEVIN BAGLEY: So right now, as it's currently set up, we have about three quarters of the members that have come in through that expansion program in that basic benefit tier. They would continue in that benefit tier until we reach a resolution on-- on the waiver.

HILKEMANN: So you're saying about 75 percent are already in-- into the program?

KEVIN BAGLEY: Yeah, and so--

HILKEMANN: It would be another 25 percent that might be able to be opted into the-- to the other.

KEVIN BAGLEY: So we have approximately 35,000. I'm going to give a pretty approximate number there. I haven't seen the numbers.

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HILKEMANN: So the optional services that were being taken-- that were going to be provided if people were part of the wellness program, are they going to be provided to everybody at this point now?

KEVIN BAGLEY: They will not. So about a quarter of the folks that have come in, of that 35,000 that we've seen coming through expansion, automatically qualify for those benefits. They're 19- and 20-year-olds, pregnant women, or they qualify as medically frail. In those cases, they automatically qualify for that prime package. And then the other 75 percent of those folks will remain in that basic benefit tier until we can resolve this with CMS.

HILKEMANN: That's another question I had. Thank you for saying you had 35,000 people. When we-- when this bill was being presented to us as a legislative process, we had members from about the-- I think the low number was 75,000 people that were going to be affected by this. And we had people like 125,000. Where'd they all go?

KEVIN BAGLEY: You know, that's a great question. One of the things that we've seen in a lot of other states, and in the conversations I've had with other states, and my experience in the state of Utah when I worked there, was that there is a little bit of a runway in terms of getting those folks to that number. A lot of other states we've seen that have--have started-- I'll say later in the process-- with expansion, have typically seen 15 to 18 months of build-up before they reach those final numbers. We anticipate that'll be the case here.

HILKEMANN: So you are saying, when you come before us next year, you'll be saying that we will be maybe closer to the 75,000 that we originally had talked about?

KEVIN BAGLEY: I believe so.

HILKEMANN: OK. Thank you, Mr. Chairman.

STINNER: Any additional questions? Senator Kolterman.

KOLTERMAN: Thank you, Senator Stinner. Thank you for being here today. I have-- it kind of plays along those same lines of what Senator Hilkemann was just asking about. When-- when the program was being developed, you came up with an eligibility and enrollment system. What's the status of that today? What are you utilizing to get that?

And where do we stand with-- I think originally there were some challenges with Wipro on that. Where does that all stand?

KEVIN BAGLEY: Yeah, there's a-- there were some-- some difficulties with Wipro, and there is continued work on that front. The system we currently--

WISHART: Can you explain what-- can you explain what Wipro is?

KEVIN BAGLEY: So that was-- and I'm going to have to refer to my notes just a little bit since that predates my tenure here. But I believe that was the vendor that was leveraged to do a lot of that system development previously. There were some difficulties in-- in getting that done. My understanding is that we've since moved on from that, and-- and we're working on doing some additional development to replace aspects of our, I would say, antiquated system that we currently use. It functions. It works. It's definitely end of life. So I guess the broad answer to your question, Senator, is there's continued work on that front. It's not impeding our ability to get people into services right now, but there are definitely efficiencies to be gained and increased levels of customer service to be had by moving in the direction of that improved system.

KOLTERMAN: So-- so in essence, when the Wipro situation failed and you cut ties with Wipro, you didn't go out for a new bid to get a different contractor. Is that what I'm hearing you say?

KEVIN BAGLEY: I may have to get back to you on the details on that, Senator. I don't think I'm quite well versed enough in that yet to be able to answer that accurately without potentially misstating anything.

KOLTERMAN: That's fine. Can I continue on?

STINNER: Please.

KOLTERMAN: The other side of that-- and again, it fits right in with-- with all these added people, where will we add on the Medicaid Management Information System?

KEVIN BAGLEY: That's another area where we're continuing to do some development. So in-- on that front, as we look at the future of the agency and where we would like to move to, most of our services are

done through a managed-care arrangement, which means that they-- the claims won't need to be processed through an MMIS system. As we look at the services that are not currently in that setup, one of those areas is our long-term services and supports, our long-term care. Many states have moved in the direction of managed long-term services and supports. We believe that that would be a good direction for us to move in. That being said, I think there's a lot of work that needs to be done in order to do that right. We've seen states who have done a poor job of that, and that's come back to hurt providers, and it's come back to hurt members, and we don't want to do that. But we believe it can be done well, and we think that's the direction to head.

KOLTERMAN: So-- so in essence, you're telling me that you haven't entered into any contracts for a new MMIS system?

KEVIN BAGLEY: We have. We've been doing some maintenance work on the existing one. And I may have to get back to you a little bit on the status of any contracts for that, but our hope is that we can move in a direction where all of our services are provided through a managed-care arrangement, which means we would not need to procure a new MMIS system.

KOLTERMAN: OK. And then, my last question. In-- in your testimony here today, you talked about not doing any provider ratings because-- my question to you is, did you have-- have the providers come to you with specific requests to increase their rates?

KEVIN BAGLEY: So we haven't seen specific requests come to us that I'm aware of. There were some rate increases from the previous session that have been implemented. In addition, there have been some temporary adjustments to provider payments, including additional add-ons for our long-term care residential settings or nursing facilities or assisted living facilities, as part of the pandemic and that kind of limited time response. I guess what I-- what I would say to that is that, while we haven't necessarily had a ton of requests come in, I don't think we are coming in opposition to those. When we looked at the budget request back in October, there was so much uncertainty around what the budget would look like, around what everything-- what the status of-- of all of those pieces would be. We didn't feel it would be appropriate to make certain requests at that point. That being said, as the committee looks at some of the requests

that-- that I'm aware are coming in, I don't think that we're coming necessarily in opposition to any of those. Rather, we would be happy to implement whatever-- whatever increases or appropriations are passed into law.

KOLTERMAN: So if we-- if we-- if we pass some rate increases for providers, you'll make sure that the money gets paid out to them right away. Right?

KEVIN BAGLEY: So I will-- I will say yes, and I'll add a caveat. Right away is always a little bit trickier. That being said,--

KOLTERMAN: The-- the reason for my question is, I just heard yesterday another one of my assisted-living facilities is--

KEVIN BAGLEY: Sure.

KOLTERMAN: --closing down in my district. I don't have a very big district. And I heard that it's along with two others. It's a three-person chain, so to speak.

KEVIN BAGLEY: Sure.

KOLTERMAN: And in the pandemic, the nursing homes and assisted-living facilities and the hospitals, they're having a hard time making things go. And for us to just turn our back on them and say: Hey, we're not going to give you any rate increase, that's bothersome to me. And we talked about that yesterday; I'm sure you know that. So I-- I think it's important that, if we do pass a rate increase and give some providers some help, that it gets taken care of as soon as possible, because we can't afford to continue to have these places shut down in the state of Nebraska.

KEVIN BAGLEY: Yeah, I think that's-- that's a great point, Senator. And I guess what I would say to that is, anything that gets passed during this session that applies to the upcoming biennium, we believe we have enough lead time at this point to have those new rates in place by July 1. If we needed to implement those prior to July 1, we'd love to have some conversation on how to do that.

KOLTERMAN: OK. Thank you very much. That's all.

STINNER: Senator Wishart.

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WISHART: Thank you for being here, Director, and thank you for answering Senator Kolterman's questions that way. That's, you know, it's music to my ears to hear that kind of response that, when we appropriate funds, that your team is going to work on making sure it gets those providers. Really quickly, just dovetailing off of what Senator Kolterman said, the funding for pandemic relief is one time.

KEVIN BAGLEY: Yes.

WISHART: Is that correct? OK.

KEVIN BAGLEY: For the most part.

WISHART: For the most part, OK. I wanted to go back to the conversation around Medicaid expansion.

KEVIN BAGLEY: Sure.

WISHART: And I'll preface this by saying, I recognize that you-- your tenure here has been short so far, you're new, and that the decisions that were made about this waiver were done by your predecessor. But when-- when we were having conversations about expanding Medicaid, multiple senators on this committee and multiple senators in the Health and Human Services Committee warned the department that this type of waiver may not cut it with the feds. So were you given a plan B to be prepared to get these-- this type of coverage to Nebraskans?

KEVIN BAGLEY: So I guess I'll say we always try to have a plan B or a C or a D. You're right, because the reality is, there's a lot of moving parts when it comes to these programs. And I guess the other thing I'll say is, Medicaid is an incredibly large ship to turn. And so once we've-- once we've turned in a direction, it takes a lot to reverse that course. And so one of the things that-- that I've tried to make sure we do here when it comes to this-- this expansion program and the 1115, is to try to be really purposeful and deliberate about the decisions we make. So as-- as we received that letter, as we've had some ongoing discussions around the implementation plan, as it's become clear that we're not going to get the approval in time to continue the implementation that we planned on, I think now it's really a-- we need to have a decision from the feds on which direction they need us to go. And as we have those discussions, once it becomes clear where it is we need to be, we'll move in that direction. But I

think the difficulty-- the reality is, any direction we take at this point probably adds months to the implementation.

WISHART: Do you believe that dental and vision care are critical components of somebody's overall health care?

KEVIN BAGLEY: You know, I would say the evidence definitely points in that direction. What-- what our hope is with the current implementation plan-- that is obviously still pending approval, right, by CMS-- is that we'll be able to help provide a pathway for people to leverage those benefits in a more responsible way. Our hope is that what that will actually do is bring down the cost of healthcare while also creating a better experience for the member. This would be similar to a lot of the wellness-type incentive programs we would see in a lot of commercial plans. The difference is, it doesn't change the cost structure for the beneficiaries. It just changes the behavior and incentive structure around that.

WISHART: So you've got two options. You can battle it out with the feds and-- or, from my understanding, you could just not go down that waiver path, and right now just offer that premium tier to every person with, frankly, a lot less administrative overhead for dealing with that. Why not do that?

KEVIN BAGLEY: Well, like I mentioned, moving that Medicaid ship is a really, really difficult thing to turn. And so even if we were to take that direction, I think we would be realistically probably six months out to be able to make that happen.

WISHART: Why would it take six months to put somebody who has qualified for Medicaid expansion and is already enrolled, why would it take six months to put them in the same plan, except as a woman who's pregnant?

KEVIN BAGLEY: The reality is, the approvals that would need to go through a CMS, the-- the additional work that would need to be done on contracts with our managed-care plans, on rate changes with those plans, the actuarial studies that would need to be done. Medicaid is a cumbersome beast. And so the reality, I think, is, as we've looked at it, it would take several months to make anything happen, short of the path that we had already laid out. And so I think, even at this point, with CMS creating this additional delay, we're still talking about

several months, likely. Even if they were to approve the plan in, say, a month from now, I think we'd still be looking at several months to even restart the process that [INAUDIBLE].

WISHART: And again-- and I'll close here-- and again, I don't fault you, because you are new and didn't make a lot of the previous decisions. But when I hear that there is a plan B in place for a waiver that many advocates and senators said is very unlikely to go through-- however great it is, it's unlikely to go through and there's going to be a battle with the feds-- my goal and my understanding would be that plan B is, we're ready to put all these people who have voted to expand Medicaid onto the full Medicaid package; that's the plan B. And so it's frustrating to hear that there is now going to take six months to put somebody on a plan and expand their services to get vision, which, by the way, is critical for working, if somebody has vision issues. Dental is very important for somebody's overall health. And so that's frustrating. We heard this yesterday as well, that there's a plan B, we've got a plan B. Well, now is the time for the plan B, and it sounds like it hasn't been planned out. And so again, I don't fault you for this, but I-- I-- but moving forward, we need to make sure that, when people vote something in place, that they're not waiting four years for just half of that to happen. Thank you.

KEVIN BAGLEY: Thank you, Senator.

STINNER: Additional questions? Senator Clements.

CLEMENTS: Thank you, Mr. Chairman. Thank you, Mr. Bagley. My question is, in the-- let's see. In this program budget request for the next two years, how many Medicaid expansion people do you-- are you putting in here for us to fund?

KEVIN BAGLEY: So the-- the current request in the budget is roughly the same as it was in the original appropriation for Medicaid expansion. Right now, as we look at the-- as we look at the rate of buildup, we're adding 5,000-6,000, or so, new members each month, with some variation. So for example, we saw a significant amount of applications come in around the same time as the ACA open enrollment period that took place at the end of last year. The current administration has re-opened that open enrollment. Now, it's unclear to us if we'll see a similar spike in enrollment. We may or it may be

that-- that we don't see that, because all of the folks that-- that were going to be part of that have already come through in last year's open application period. It's unclear to us, but we'll continue to monitor that, and we'll come back to the committee if we see any significant changes.

CLEMENTS: You didn't give me a number.

KEVIN BAGLEY: I'm sorry. I don't have a good number to give you on that just because I don't recall what the number was last year. But I've heard 75,000 mentioned a couple of times, and-- and--

CLEMENTS: I recall 90,000 estimated, but that's fine. [INAUDIBLE].

KEVIN BAGLEY: And I'm happy to follow up with you on that, Senator. I--

CLEMENTS: Anyway--

KEVIN BAGLEY: I just don't have that in front of me.

CLEMENTS: Yeah. Well, I guess mainly that you didn't-- you did not decrease the amount because of the slow sign-up that we've seen.

KEVIN BAGLEY: No, we have-- we have not requested a decrease in the amount. I believe the initial amount funded only a portion of the year, and so we've continued with the amount that was previously appropriated in this-- this new budget.

CLEMENTS: All right. Thank you.

STINNER: Additional questions? Senator Dorn.

DORN: Thank you, Chairman Stinner. Thank you for being here, Director. I don't know what page you're-- you're on here, but this is the bottom of our second page, where in it-- with the provider rates--

KEVIN BAGLEY: Yes.

DORN: --and how you look at those. And you-- you commented that in the event the department determines a given rate is not appropriate-- well, I've sat on here over two years or whatever, and we've heard a lot about provider rates and so on. And-- and I'll particularly bring

up what Senator Kolterman brought up here with another nursing home closing, I think. And since I've been here, we've heard the number, about 15 have closed, and we've had a lot of discussion about their provider rates and-- and how that has affected them. I guess, can you explain what you mean by when the department determines a given rate is not appropriate and then you will increase it?

KEVIN BAGLEY: Sure. So we are always trying to make sure we're-- we're paying appropriately for services. And I guess that's a pretty vague term, so I'm going to try to be as specific as I can on it. But there's obviously a lot of nuance and variation when it comes to that. Specifically, when we look at long-term care, for example, we have a lot of discussions with the associations there to try and understand what the current outlay is for them. With our nursing homes, for example, we actually have some cost reporting that we evaluate on a regular basis. And so I'll-- I'll note here that I don't have the history here in Nebraska with that exercise. But one of the things that-- that I believe has been done-- and I would like to continue to do as the director here-- is really to make sure that we're monitoring those on a regular basis to really understand what those cost profiles look like. And if there are adjustments that need to be made that we have existing appropriation that we could leverage for, we could make that change. If we don't have that existing appropriation, then certainly we can include that in an upcoming budget request or in discussions here with the committee. So again, I guess we're always on the lookout, and we're always welcoming feedback from providers and others who have concerns on that front. And so I don't have a good specific example, aside from some of our COVID-specific, more time-limited things that we've done, for example, that the add-on for our nursing facilities and assisted living facilities.

DORN: No, I fully realize that, you know, this is-- this past year has been different than--

KEVIN BAGLEY: Sure.

DORN: --what many years are, and COVID is part of that and-- and how that funding has flowed in through here. But are-- are you looking at-- you said you-- I don't know-- do the evaluations, but are you looking at this compared to, I call it, other states? Or-- or-- or are you saying they're getting by and we don't need to fund them anymore, I guess? That-- to me, that's not appropriate.

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KEVIN BAGLEY: Yeah. I-- I think it depends on the service, and it'll depend on kind of the nature of where things are. When we look at those cost reports for our nursing facilities, one of the big questions is: Are we able to cover their costs? And if that's not the case, then that certainly raises a red flag. I want to be careful to-- to say, you know, Medicaid isn't the only funding source for our nursing facilities. And I don't want to suggest that it's the role of the Medicaid program to ensure their viability either. But at the same time, we are a big payer. And so it's in our interest to ensure that there is availability of that service. So I-- I think that's an example where we would want to make sure that we're covering their costs with our rate. And I-- I think we would also look at other states. We would look at other payers' nursing facilities. We are one of the primary payers. So we would probably look at other states, looking at those cost profiles, and try to identify, are we hitting the mark there.

DORN: Thank you.

KEVIN BAGLEY: Sure.

STINNER: Senator Kolterman.

KOLTERMAN: Thank you, Senator Stinner. This'll be my last question, I think. While we're talking about nursing homes, and assisted-living facilities, and things of that nature, what-- where are you at? Several years ago we looked at managed care for our nursing homes. Is that still on the horizon? Is it yet to come? Or are you-- obviously, you have your plate pretty full right now. And I would hope that doesn't just happen overnight, that there'd be a lot of input and participation from our providers in that. But where does that stand? Again, on HHS a couple of years ago, it was getting ready to implement, and then, all of a sudden, boom, it's gone.

KEVIN BAGLEY: Yeah, I see--

KOLTERMAN: And it stays that way for a while.

KEVIN BAGLEY: I think I will gladly and wholeheartedly agree with you. There's a lot on our plate right now. That being said, I think that is something we still look out on the horizon as we look at the future, as we talk about the need, potentially, to procure a new MMIS system.

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If we were to move in the direction of managed long-term services and supports, that large, one-time, and potentially significant ongoing cost, from an administrative standpoint, wouldn't be there. We believe that we can provide better care and better services to our members if we go the managed long-term services and supports route. But to your point as well, that is absolutely not something that can happen overnight. I mentioned earlier, in response to Senator Wishart's question, that Medicaid is a very big ship to turn. When it comes to managed long-term services and supports, it is a very big ship to turn, and it has a very significant impact on the lives of those individuals who are particularly vulnerable. And so we want to be extremely sensitive in how we roll that out. It will take, frankly, I think, years of planning to do right. And so that's something that we do believe is in the future. I would say it is not in the short-term future. It will take a considerable amount of discussion with stakeholders across the spectrum to do that.

KOLTERMAN: Well, I guess I'd like to say a couple of things. Thank you for being candid with us about that. I would also-- I know you're relatively new. I would encourage you to reach out to the providers that are here. I mean, just look around this room; there's a lot of providers. You're going to get a lot of input today, I'm sure. But at the same time, I would encourage you, as you move forward, to bring these people together and talk about it, 'cause-- 'cause they've got-- they've been in the field for years, and they've got a lot of experience in running some of these facilities. And if they have the input, they can help you put together a good MMI proposal and make it-- make it so it's a win-win for everyone. So thank you.

KEVIN BAGLEY: I-- thank you, Senator. I'd like to add to that. And I apologize, Senator Stinner, I know you'd like to move on, I think. But one of the things that we're definitely trying to do, as a division, is to have regular discussions. We're working on setting up quarterly meetings with our provider associations, and we're also working to reinstate a medical care advisory council that will bring stakeholders from our beneficiaries, as well as our providers, together to advise the agency on how we move forward better. So I look forward to those conversations and continuing those conversations.

KOLTERMAN: Thank you.

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STINNER: [INAUDIBLE] I-- interrupting Senator Hilkemann; I know he has another question. But we built our model on about a 90,000 participants to the Medicaid. We also did some cost analysis of what the prime would cost versus what the basic was. So now that we're not doing it for another six months, as your testimony is what I hear, we may have to start rightsizing some of the appropriations that we put in. I'm just throwing that out for you as a heads up. We need to do some recalculating and recalibrating. I happen to agree with Senator Wishart. It's hard for me to believe this is the implementation plan, the stuff that you were talking about, actuarial studies and all the rest of that had to be part of the waiver. So that should be set already. You don't have to do that. The implementation plan, I would suggest, to my mind, would be: OK, do you have problems with those two or three items? We're pulling them out and we're going to move ahead with the basic-- or with the next plan. That's how simplistically I look at it. It's logical to me. I guess I get the fact CMS is a different animal, but I would explore trying to get to the next tier as quickly as possible for all the reasons that were stated in this committee. And I think you'll-- you'll hear it from the Legislature. The other thing that caught my attention-- two things. You were talking about-- and Senator Kolterman really covered it pretty well-- in the enrollment and eligibility, we did have a group come in because the interface wasn't in place. We got some federal money for that. Obviously, we had jettisoned that program. And your testimony was that, because of the enrollment and eligibility still needs to be worked on to get it up to date-- I think you mentioned the fact that it was end-of-life technology. Are we working on a plan for that? Are we going to see something from-- from you, asking for appropriations, or is the fed going to contribute to that? Or how does that work?

KEVIN BAGLEY: So there's certainly a significant amount of federal money that comes in on those type of projects,-- excuse me-- typically to the range of 90 percent federal participation. So I'd be happy to-- to get back with you and the rest of the committee, Senator, on-- on the details of that.

STINNER: I just want to make sure that we have an efficient system, that when somebody makes an application, we can process it.

KEVIN BAGLEY: Yes.

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STINNER: And we-- you know, some of this 35,000, as opposed to the estimate of 90,000, I hope I don't find out that there's people on a waiting list that are not being processed for 30 days or 45 days. I haven't heard that, and I don't know if anybody else has. The other thing that really kind of caught my attention is, you made a statement about nursing homes: We-- we don't ensure their survivability-- or viability, excuse me. That kind of sets my hair on fire because I've got-- I'm going to say, outside of Lincoln and Omaha, when you go out and you take a look at the census, we've got nursing homes with 70, 80 percent Medicaid patients, you know. Based on the studies that we have, we're not even close to cost. We tried to get to a breakeven or a parity on cost. I think we're still $9 or $10 per-- per patient, per day away from that. So first of all, let's make up that gap and we'll end up talking about viability beyond that. And I'm going to say this: The location of a lot of those, it's absolutely critical that they stay in place. Now, they may have been designed initially for 100 nursing-- 100 patients. They may only have 60, but those 60 people in those beds in that nursing home, from an economic standpoint, is incredibly important to the small town. So when we talk about viability, yeah, we talk about just covering cost. There's no profitability, there's no excess in there for depreciation and all the rest of that stuff that you need to have. So you caught my attention on that. I just wanted to explain to you that there is a difference between rural and what, maybe, you're seeing in Lincoln in Omaha, where they can pick and choose whether they take Medicaid or not. That's not the case in-- in some places. The other thing, I want to thank you for the $20 dollars per day per person. And I'm going to ask this question. You obviously are seeing something impactful as it relates to COVID. And I'm talking about the fact that people aren't coming into the nursing homes. We have much more vacancy. We still have the fixed cost associated with it. This is a critical time. And I hear right now that one of the-- or one of the three nursing homes or assisted-living are possibly going to go out of business. What I'm asking is: Have you-- have you taken any time to take a look at that? And then, have you done any studies prospectively on how long it's going to take these nursing homes to build that-- build back from where they're at today on vacancies so that they can become more viable?

KEVIN BAGLEY: Yes, I'll say--

STINNER: Too many questions in that. I'm sorry.

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KEVIN BAGLEY: That's OK. I guess I-- I will say a couple of things in-- in response to some of those is, right now we aren't seeing any kind of a wait on individuals being able to have their eligibility determined, even-- even with the large influx of individuals coming in. We saw, over the holidays, a huge spike in applications, and we saw at that point an associated spike in the time it took. But even then, I think we were well under a month, certainly. And we're seeing pretty typical turnaround times right now, in terms of getting that eligibility determined. So I guess I want to say we aren't seeing any delays right now in that. And if we start to, I-- we are monitoring that very closely. When it comes to our nursing facilities, I guess I will clarify, it is absolutely in the best interest of the Medicaid program to continue to have that full spectrum of long-term care services from our facility-based care to our home- and community-based services. If we don't have that spectrum, then we're missing something, in terms of our opportunity to serve those individuals; and we don't want to have that. We are definitely seeing a lot of long-term trends as well as short-term trends in changes with nursing facilities. I don't want to speak for those facilities in-- in this setting, but we're definitely seeing, over the long-term, a trend in reduction in that census, where we have a larger facility that just is filling fewer and fewer beds. When we look at long-term trends and the fixed-cost nature of some of those-- those providers, then I think it does call into question, how do we make this work better? Now, I don't think it's the Medicaid's role to make those decisions. We can help provide incentive, and we can help structure our programs such that it assists in that front. But I want to be careful that we're not making those decisions for those facilities. But we are, in the short term as well, seeing a more pronounced decrease in that census, as fewer people want to be admitted to those nursing facilities, with concerns potentially over infection and other things. And I think-- I think we're also seeing a concern on individuals being able to visit their family members in those facilities, and so as vaccinations continue, as things continue to improve slowly but surely, we believe that-- that some of those short-term obstacles will be overcome, but they may have long-term ramifications. And so I think we're continuing to look at that. I mentioned the cost reports that we do. That's something we're continuing to look at. And these cost reports that we're just reviewing and beginning to review right now will include some of that time under the public health emergency. And so that will be

informative to us, in terms of what the short-term impacts may have been.

STINNER: Thank you for that. Senator Hilkemann.

HILKEMANN: I'll pass.

STINNER: I'm trying to manage the clock behind you, too, with all of this. So in any event, any additional quick questions by anybody?

WISHART: Can I have one quick question?

STINNER: Senator Wishart.

WISHART: Following up on M-- the-- it's MMIS, is the-- what, dollarwise-- why would we need, one-time funding, to get you to completely just overhauling, get that system where it needs to be?

KEVIN BAGLEY: I can tell you it would be large, but I don't have a good number that I could give you right now. I'd be happy to follow up.

WISHART: That would be great to know. And it would mainly be one-time funding.

KEVIN BAGLEY: So I can tell you from my experience in the state of Utah, I was part of our MMIS replacement project. Their one-time funding makes it sound like it's a quick turnaround. I worked on that project. I started working on that project nine years ago. It has not quite completed there in the state of Utah. And I can tell you it was significant, in terms of the total amount of dollars being spent.

WISHART: Yeah, OK.

KEVIN BAGLEY: So it-- there would be some one-time, as well as ongoing funding.

WISHART: OK.

KEVIN BAGLEY: I'd be happy to follow up with you on that.

WISHART: That would be happy to know, what the one-time cost is and then what the ongoing would be.

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KEVIN BAGLEY: Sure.

STINNER: Seeing no additional questions, or not allowing any additional questions, thank you for your testimony.

KEVIN BAGLEY: Thank you.

STINNER: We're going to run through Public Health and then Operations, in that order, and then we'll take proponents and opponents, and see where we're at with the clock. Good morning.

GARY ANTHONE: Good morning, Senator Stinner and members of the Appropriations Committee. My name is Dr. Gary Anthone, G-a-r-y A-n-t-h-o-n-e. I'm the director of the Division of Public Health and chief medical officer for the Department of Health and Human Services. The Division of Public Health serves the entire population of the state of Nebraska. Public health's critical societal role has become clearer over the past year as we've come together as a state to respond to the COVID-19 pandemic. From testing to contact tracing, and now vaccination, Nebraska Public Health delivers the DHHS mission to help people live better lives. The budget proposed by Governor Ricketts will enable us to continue to prioritize efficient, effective, and customer-focused state government. I would like to thank the members of the Appropriations Committee for including the Governor's recommendation to include funding to implement LB963, which will provide for reimbursement for resiliency training for first responder and frontline state employees. Last year, I asked the committee to support an increase in cash spending authority to allow DHHS to replace its Licensure Information System, which reached the end of vendor support in June 2020. I would like to provide this committee with some updates on that process. Last year, our licensure team issued a request for a proposal that sought to achieve four primary goals: automate the initial license application and the renewal process; improve public access to licensee information; maximize DHHS staff productivity; and improve and modernize the computer system for licensing. After reviewing bids from a variety of potential vend-- vendors, DHHS entered into an agreement in October 2020, with VisualVault, to replace the obsolete Licensure Information System. This replacement has been branded Nebraska LANCE, L-A-N-C-E, or the Licensing and Certification Environment. Since October, the DHHS team has been hard at work with VisualVault in pursuing an aggressive implementation timeline. Project planning and design are in

full swing, and with data conversion and testing coming soon. The first project to go live is slated for September 2021, at which point Uniform Credentialing Act professions and occupations, as well as childcare programs, will transition from the old Licensure Information System to LANCE. Two subsequent phases will incorporate community-based services and healthcare facilities and services into LANCE. As of today, this project is on time and meeting budget expectations, with all milestones on track for success. I'd like to thank the Appropriations Committee for including this recommendation last year. Finally, I'd like to thank the Appropriations Committee for supporting Governor Ricketts' budget proposal. This will enable the Division of Public Health to be effective stewards of taxpayer dollars while supporting our mission to help people live better lives. I'm happy to answer any questions.

STINNER: Thank you. Questions? Questions? Senator Hilkemann.

HILKEMANN: Doctor, thank you for your work during this last year, this tough time. and I think that the decisions that over all that have been made, I-- and I've been in contact with the Governor. I think that our state has handled it about as well as any state that I'm aware of. And I thank you for your leadership in that.

GARY ANTHONE: Thank you. And it's been an honor and a privilege.

HILKEMANN: I-- are we-- are we-- are there-- I'm aware that there are a lot of scams now that are occurring, particularly for our senior citizens, threatening [INAUDIBLE]. Have you had a lot of these reported to your department?

GARY ANTHONE: I have not.

HILKEMANN: OK.

GARY ANTHONE: No, I don't really have any information on that right now at all, Senator.

HILKEMANN: OK, great.

STINNER: Additional questions? Seeing none, thank you. The next thing on my list was Operations, DHHS Operations. Morning.

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LARRY KAHL: Good morning, sir. Chairperson Stinner, members of the Appropriations Committee, my name is Larry W. Kahl, L-a-r-r-y, middle initial W, last name K-a-h-l. I am the chief operating officer for the Department of Health and Human Services. The DHHS provides 24-hour care for adult patients at the Norfolk, Lincoln Regional Centers, and residents at the Beatrice State Developmental Center. We also provide 24-hour care to youth committed to the Youth Rehabilitation and Treatment Centers in Kearney, Geneva, at the Lincoln Youth Facility, and to youth receiving services at Whitehall Psychiatric Residential Treatment Facility. The Youth Rehabilitation and Treatment Center in Kearney serves high-risk male and female juveniles who were committed to the facility by the juvenile court system. The administrative team continues to strive for improvements in maintaining a safe environment for these juveniles and for the employees. Phase Program Model has been in place since May 2019. It includes the objective daily scoring system, whereby juveniles are rated on their interactions with adults, interactions with their peers, and overall compliance. In July 2020, the Missouri Youth Services Institute, MYSI, added their MYSI Model to the clinical array of treatment tools. This is a unit-based best practice rooted in the engagement of youth by staff at every available, teachable moment, throughout all waking hours of the youths placement. The Youth Rehab and Treatment Center in Geneva is no longer serving female juveniles that we're preparing for reentry. Given the absence of the availability of key programmatic components-- predominantly staff-- the program is currently dormant. The youth facility in Lincoln serves as-- serves the high-acuity male and female juveniles who have been committed by the juvenile court system. This population of juveniles has the opportunity for more intensive, individual-based treatment services, including greater access to psychiatric and psychological services, as well as higher to staff-resident ratios. The treatment program is designed to be short-term so the juveniles can return to the community or a lower level of care. The Whitehall Psychiatric Residential Treatment Facility, a PRTF, is a 16-bed behavioral health facility which provides intensive, individualized treatment for juveniles who sexually harm. It serves youth ages 13 to 18. The program, in collaboration with Lincoln Regional Center, has enjoyed joint commission accreditation since September 2019. The program has man-- maintained an average census of six youth over the last year. Whitehall is also now home to the Substance Use Disorders Treatment Program. The two programs do not mix. The housing-- they're housed

separately in separate facilities. The youth previously served in Hastings successfully moved to this location, to Whitehall, in the fall of 2020. With the adult facilities, the Lincoln Regional Center is a 285-bed psychiatric hospital that provides highly structured treatment for individuals suffering from mental illness. In September '19, LRC underwent the triannual Joint Commission Accreditation Survey for both the hospital and behavioral health programs. The hospital program was determined to have one conditional finding related to national patient safety goals of 15-10.01, which states the hospital reduces the risk for suicide. This led to a $5.6 million request for funds to make facility structural upgrades for ligature mitigation. The conditional finding required LRC to create a mitigation plan that consisted of increased staffing, placing all patients on 10-minute safety checks, continuous bathroom door locking, and observations while the patient is in the bathroom. In order to sustain this temporary mitigation plan, LRC had to increase the number of staff within a 24-hour period by an additional 21 staff. The project is on budget and on target to meet the anticipated completion date. The Norfolk Regional Center, NRC, is a 111-bed psychiatric hospital, consisting of one male psychiatric medical support unit and four sex offender treatment units. NRC provides treatment for individuals that have been adjudicated under the Nebraska Sex Offender Commitment Act or have been committed to inpatient treatment by a county mental health board, for treatment of a sexual disorder. NRC has a new interim leader and is focused on improving a number of quality-of-care metrics in standardized fashion with the Lincoln Regional Center. Beatrice State Development Center is an intermediate care facility, for individuals with developmental disabilities, that provides residential, vocational, and recreational services. BSDC offers both long-term care and short-term care units for the residents. I would like to thank you, the Appropriations Committee and the Legislative Fiscal Office team for your work on the preliminary budget recommendations and for supporting the Governor's biennium recommendations as it relates to the facilities. We are in support of the Governors and the committee's budget recommendations. I'd be happy to answer any questions at this time.

STINNER: Questions? I have a question. This rehabilitation in Geneva is no longer serving female juveniles. What are we using the facility for?

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LARRY KAHL: At this time, the facility is not being used. It-- we're keeping the power on. We don't want any burst pipes. The facility is being maintained, but it is-- it is dormant. It's empty at this time.

STINNER: Do you have it up for sale?

LARRY KAHL: It is not. We're walking through the discussion process right now. We're looking at a new term that I've learned with-- through the Department of Administrative Services-- VBEL, and looking at that process in terms of how that we might continue to be good stewards of the taxpayers' resources and reduce our overall cost profile.

STINNER: How many youths are now occupying this high-acute facility that we have in Lincoln?

LARRY KAHL: The Lincoln Youth Facility?

STINNER: Yeah.

LARRY KAHL: We currently have six youth, three males and three females,

STINNER: Three males and three females.

LARRY KAHL: Yes, sir.

STINNER: So you've got six. You have 16 beds. Is that what I saw?

LARRY KAHL: At that particular facility. I think that we can house as many as 20. We have 16-bed capacity at the White Hall.

STINNER: My understanding is, this is a leased facility from the county.

LARRY KAHL: Yes, sir, it is.

STINNER: And you're paying how much a year in lease payments?

LARRY KAHL: I would have to get back to you on that, sir. I don't have that off the top of my head.

STINNER: My recollection, it was about $400,000.

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LARRY KAHL: Sounds [INAUDIBLE].

STINNER: So doing the math, it's an expensive facility for--

LARRY KAHL: It is.

STINNER: --what we have, but we've abandoned Geneva and we're looking at viability. And I've always wondered, is it because you can get the specialists in Lincoln as opposed to somebody in Geneva to-- to do this high-acuity?

LARRY KAHL: It's-- your point is-- you're exactly correct. In my relatively short tenure here, I've been utilizing a three-legged-stool approach. Facility is-- is very important and critical, updated appropriate facilities to the type of care that we're trying to provide, appropriate number of staff and appropriately trained staff, another key vital component, and the third component is the programing. We are moving across all of our facilities to much more of a treatment-based care than a corrections-based system that it perhaps was in the past, which is true of youth facilities across the country. So all three of those components need to be in place. And the more robust I can make each of those three, the more appropriate the fit is, the better likelihood of us being able to be successful in providing the care to youth. And so, to your point, sir, you're exactly correct. One of those legs of the stool was absent-- the Geneva program. Actually, several were--were absent. The one that was great was the facility, based on an investment made a few years back that really shored up that building. It's a wonderful building. I'd love to put it on a truck and move it to where I can have the other two resources widely available. Staffing is the primary issue.

STINNER: Overall, the YRTC is supposed to come up with a facility planner and an overall plan for it. And what is that date? Is that April?

LARRY KAHL: Yes, sir. We're due, I think, by the end of March,--

STINNER: End of March.

LARRY KAHL: --that we present that to the Health and Human Services Committee, and it is substantially complete and under review. And so we'll hit our target.

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STINNER: So you can't disclose anything to us. Is there an appropriations that's going to be attached to that? Or--

LARRY KAHL: The goal of that-- that statement of work was twofold. One was to respond to LB1140 and to make sure that we were meeting the requirements that were spelled out in that piece of legislation. And the second was to create a five-year plan and to map a course, going forward. And what I am pleased to be able to-- to share is that we've incorporated both of those into the singular document, and that the five-year planning tool, by design, is a living document. So my primary focus, I guess, to be-- to try to kind of summarize it, has been learning the history, doing a thorough evaluation, and providing stabilization. And with those three things under our belt, I think we can begin to do the fine tuning. And that's actually underway now, what we're trying to enhance what we have. But we're not looking at rapid growth, we're not trying to take over the world. We want to make sure that we can sustain what we're doing and that we're doing it in the most cost-efficient way possible. The five-year plan starts to map the course for: Where would we like to be two years from now? Where would we like to be three years from now? And what does that look like? What does it include? And so that's-- would be some of the nature of what's in that five-year planning document.

STINNER: The Whitehall facility, the 16-bed behavioral health-- I got that we got that mixed up with that other one-- but how many children are in that right now?

LARRY KAHL: Today's census, we've got 14.

STINNER: OK. Thank you.

LARRY KAHL: Yeah.

STINNER: Any additional questions? Senator Clements.

CLEMENTS: Thank you, Mr. Chairman. Thank you, sir. Regarding the Whitehall movement from Hastings, what is the Hastings facility being used for now?

LARRY KAHL: The-- the Hastings facility, where the youth were actually housed in Building 3, is scheduled for demolition for this fall. It was a-- while a beautiful, historic building, extremely dated and beyond its meaningful life. And so the Department of Administrative

Services has it scheduled to be demolished. The Hastings campus did have good foresight and built additional cottages on-site, and additional facilities for being able to provide schooling, dining, group-- family therapy. And those buildings are currently not being utilized, but we anticipate to be able to use them later this spring.

CLEMENTS: For what purpose?

LARRY KAHL: My understanding is that we have a legislative mandate that we're not to blend the girls and boys at Kearney. And so we would need to move the girls off of that campus. And so we would look at the Hastings center-- facility as being the most appropriate location for us to be able to relocate those girls and meet those legislative requirements.

CLEMENTS: All right. Thank you.

LARRY KAHL: You bet.

STINNER: Thank you. Additional questions? Senator Kolterman.

KOLTERMAN: Thank you, Senator Stinner. I just have an observation, and I know you're new. But I have to say it. If you look at this committee, five of us are from rural Nebraska. County-- the state line doesn't end at the Lancaster County line, going west. You closed up Geneva, you're working on Hastings. Everything shouldn't be moved to Lincoln and Omaha. We have the capability in Geneva of hiring people that could work there. It worked for years. We need to continue to look at rural Nebraska. If we expect the state to grow, we can't think everything is going to happen in eastern Nebraska. Just an observation, but what I'm seeing, what I'm hearing doesn't cut it with me. Thank you.

LARRY KAHL: Thank you for your observations, Senator.

STINNER: Additional questions?

DORN: Yeah.

STINNER: Senator Dorn.

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DORN: Thank you, Chairman Stinner. Thank you, Director, for being here. I guess my-- you made the comment about three things you look at, and one of them is staffing or whatever.

LARRY KAHL: Um-hum.

DORN: How-- you're-- you're more facilities. But how-- how does that-- or who reports to you or how does that come up with-- or how is that determination made? Because Geneva was staffing, that we hear that the reason that-- and I-- I know we're having issues and I call it-- other departments within the state is staffing. So how is that related to you? Or what kind of those conversations go on? Or how do you make that determination on staffing? And--

LARRY KAHL: I guess, you know, relative to staffing at-- at any of the-- any of the facilities that we have open positions, we continue to work closely with our human resource partners to actively recruit, and being as creative as we can be to actively recruit-- getting out into the schools. They've tried some things that have surprisingly been pretty effective, drive-in recruitment sessions, which are kind of a foreign thing, kind of a COVID-related thing. But they've had some success. In Beatrice, in particular, we've had some success with that. Folks come, interview, learn about the jobs, and actually follow through with applications. So far, what I'm seeing overall, sir, is that we're-- at each of our existing operating facilities, our absentee rate, if you will, or our vacancy rate, is-- is pretty much on par with what most of the other industries in the area are experiencing. We do end up trying to hire, especially when we get into specialty staff, licensed staff are much more difficult to recruit, not as difficult to recruit entry level positions for, you know, hand-- some hands-on care or housekeeping or nutritional services. Some of those things are a little bit easier to recruit for. But when we get into licensed professionals, licensed social workers, licensed mental health workers or psychologists and psychiatrists, much more difficult in the rural areas. And I'm-- I completely understand and am very sensitive to what Senator Kolterman is-- is speaking to. And I'm dedicated to continue to look at ways in which that we can, you know, try to make that more viable-- share resources. Technology has been-- through COVID, we've learned some things about technology, that it can actually be useful in ways to us that maybe we hadn't thought about in the past. So looking at telemedicine. So there are-- we're continuing to try to staff where we can and meet those needs. And I think our

human resources department, overall, is doing a pretty, pretty good job. I'm looking at about an 80 percent turn rate-- from when we post, they get about 80 percent of them filled in a timely fashion, within acceptable fashion. So it's not been-- not been bad.

DORN: Thank you.

LARRY KAHL: One market I will share-- volunteering maybe too much-- the Kearney marketplace. We have a staffing issue there, but it's because they have such high employment. Their unemployment is next to nothing. And so we're competing for anybody that we get at that location, and we're competing with all the other folks in the-- in the community for the limited number of folks that are there. So we-- we see it on both ends.

DORN: Thank you.

STINNER: Senator Erdman.

ERDMAN: Thank you, Senator Stinner. Thank you for coming today. I've been to the Hastings facility there, and I've also been to the Kearney one. It seems that, since Kearney put that overhang on the fence, they haven't had as many people escape. Then in Hastings, I don't think there's any fencing at all there. Is there?

LARRY KAHL: You're correct, sir. There is not.

ERDMAN: How do you propose to make that work, if you put people there that you want to remain there and not let them get away? How do you do that?

LARRY KAHL: Well, there's-- there's a way that I hope to be able to do it, and there's a way that I may ultimately end up having to do it. What we're hoping to do, in a large extent through the-- the MYSI Treatment Model, is that the staff-to-resident ratios are adequate and appropriate, and that the staff are trained, not so much from a check-the-box corrections kind of a mindset, but from a therapeutic mindset where they engage with the youth, they know the youth, they know the youths' behavior, they know their attitude changes. They can preemptively work with-- hopefully prevent youth from acting out in a way that would-- that would result in them eloping. That's the hope. It may be kind of a high hope. And in all reality, we're also having ongoing conversations right now about looking at what it would take

for us to fence an appropriate section of the Hastings campus, because unfortunately, the reality may be that, as as much as we try to to engage the youth, their hearts, their minds, and keep them actively involved in that treatment process and not wanting to go anywhere, the reality is, fear is a strong motivator. And sometimes for kids, rather than change, they like to bolt, that they like to try to escape it. So I think that may be something that will be in our future.

ERDMAN: Well, looking at and remembering how long it took to get a fence in Kearney, you and I both-- both will be gone from this job before we get a fence in Hastings.

LARRY KAHL: I've been learning about the capital appropriations process, and I think it would be of a size that would require us to go through that process. And so that will likely be the process that I'll have the opportunity to learn more about.

ERDMAN: Thank you.

STINNER: I'm going to ask a last question, and I was involved in this decision of moving the maintenance budget to DAS, and apparently that was a big problem as it related to Geneva. Has that been worked out so that we're getting the appropriate maintenance, appropriate and timely-- timely decision-making at ground level to maintain those facilities?

LARRY KAHL: It's a unique relationship.

STINNER: That-- that-- that says a lot.

LARRY KAHL: It's-- it's-- I've just recently begun having regular meetings with DAS staff. I think the gentlemen that are at our facilities are tremendous. I've had the opportunity to meet with some of them and visit with them. Their heart is in what they're doing. They care about those buildings and facilities, and want to maintain them. I think it requires an active partnership. It requires us to come to the table to let them know, in a timely fashion, of what we're-- we see the needs are and what our anticipated needs are going to be. And then on their end, they see themselves as a service organization, and so they need to be responsive. And I have no long-term history of any kind of difficulties with that relationship yet. It's one that is unique in-- in-- by its nature. But I'm hopeful

that we'll be able to continue to move forward in a-- in a dynamic partnership that allows us to keep some very nice historical buildings in operational condition.

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

LARRY KAHL: Thank you. Thank you all.

STINNER: I do want to enter into the record written submitted testimony by the agency of Public Health proponent Julie Erickson, American Cancer Society. Letters for the record: the Health Center Association supports Program 502; AARP supports Programs 571 and 347. We have 81 letters in opposition to Program 348. And with that, we'll take additional proponents. Any proponent of any of the agencies?

MARTY FATTIG: Good morning. Good morning, Senator Stinner and members of the Appropriations Committee. My name is Marty Fattig, M-a-r-t-y F-- as in Frank-- a-t-t-i-g. And I'm the CEO of Nemaha County Hospital in Auburn, Nebraska. I am testifying on behalf of my facility and the Nebraska Hospital Association, and I support a provider rate increase for Medicaid providers. Nemaha County Hospital is a county-owned, 16-bed critical access hospital serving southeast Nebraska. Hospitals receive reimbursement from the government that is less than the cost incurred to provide medical care to Medicaid and Medicare patients. On average, Nebraska hospital-- hospitals experience negative margins of 12.5 percent for Medicare and 17 percent for Medicaid in hospitals that have a disproportionate share hospital payment, or 27 percent without that disproportionate share hospital payment. Disproportionate hospital share payments is a governmental payment-- federal government payment-- and is an additional payment received by hospitals that have a disproportionately large number of low-income patients. Nebraska hospitals-- hospitals lost more than $640 million dollars in 2019, because of the shortfall in Medicare, Medicaid, and other public health programs. Our rural hospitals and critical access hospitals in Nebraska provide for the foundation for health services in rural Nebraska. They provide vital care to the most-- almost 670,000 residents who live in rural Nebraska. Rural areas tend to be-- have an older, poorer, and sicker population. That means that they have a higher percentage of patients covered by Medicare and Medicaid, and almost half of all children living in small towns in rural Nebraska receive their healthcare coverage through Medicaid. 50 percent of

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Nebraska's critical access hospitals are facing financial stress. Even our large rural and urban hospitals struggle with increasing levels of bad debt and charity care, as well. When hospitals are not compensated at a reasonable rate, they must make difficult choices. They may need to consider discontinuing services, reducing staff, or even-- or even closing. The loss of a hospital immediately reduces local employment and income, and the community has a devastating impact on the prospect for the future of the local economic development. When a hospital closes, the physicians, nurses, administrators, and the entire staff have gone, along with the community's healthcare infrastructure. Local businesses will be the next to leave, and the schools will suffer. The whole town will suffer. There is a whole multiplier effect that could be the death knell of the community. Hospitals are substantial contributors to the state's economy, as well, providing essential jobs throughout the state, employing over 49,000 Nebraskans and creating a demand for an additional 51,000 local businesses-- new-- I'm sorry-- 51,000 jobs in Nebraska due to the hospitals buying goods and services from local businesses. Nearly 10 percent of Nebraska's entire workforce either works for, or is supported by, hospitals. Nebraska hospitals are directly responsible for nearly $7.4 billion in hospital expenditures, including $3.5 billion in salaries and benefits. And important to note, every dollar spent by a hospital in Nebraska produces another $1.91 in economic activity. Nebraska hospitals welcome all patients and provide the same quality of care to everyone, regardless of their ability to pay. I would like to thank the committee for allowing this testimony, and I ask that they support an increase in the rates paid to all Medicaid providers. Thank you.

STINNER: Questions? I-- I need to unpack this $640 million. Your testimony is that the hospital's normal rate would-- for-- for a procedure is X amount of money.

MARTY FATTIG: Exactly.

STINNER: And what you're getting reimbursed from Medicare and Medicaid does not cover what you project your cost is,--

MARTY FATTIG: That-- that's-- that's correct.

STINNER: --and that across the board, for--

MARTY FATTIG: Across the board.

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STINNER: --all hospitals,--

MARTY FATTIG: All hospitals.

STINNER: --it's $640 million.

MARTY FATTIG: Yes.

STINNER: OK. You know, when I was covered under Blue Cross Blue Shield, they had a rate schedule too, that if you accept Blue Cross Blue Shield, they'll reimburse you at that rate. And I noticed on my bill many times, I'd get the bill, and normally it would be $2,000 for this procedure, but Blue Cross Blue Shield's rate was $1,000. So in essence, the hospital said they were charging off $1,000 on that bill. Is that kind of the same analysis here?

MARTY FATTIG: It is the same. Yeah, some of it's the same. It depends on if you get-- as I've heard it said several times here, it gets complicated when you start trying to determine cost about, you know, what comes off your-- your chargemaster and what you get paid. So I mean, there's people playing funny numbers, you know, playing games with-- with some of the numbers, but in reality--

STINNER: So I'm-- I'm going to ask this question. If I had Medicaid stacked up against Medicare, stacked up against, you know, Blue Cross or whoever,--

MARTY FATTIG: Um-hum.

STINNER: --is there a significant difference between what Blue Cross pays and reimburses the hospital versus-- and what-- what do you think that gap is?

MARTY FATTIG: Yes, the gap is-- first of all, it's commercial insurance and Blue Cross are the-- pay-- pay us the best, and then the next is Medicare, and then-- and then below that is Medicaid.

STINNER: OK. And that probably gets back to my-- my question is: How far is Medicaid out of step with what-- what Medicare pays?

MARTY FATTIG: Yeah, and I honestly don't have that information.

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STINNER: OK. I'm trying to mine some of that data. And the other thing that I always hear about. You're a county hospital, so you have-- in order to keep your not-for-profit status, how much do you have to do in charity cases? Or that may be a bad word for it. You may have a-- the appropriate name for it, but don't you have to do a certain amount of--?

MARTY FATTIG: We used to. We used to have a certain amount that was set, and that came through the Hill-Burton program, that they required a certain amount. Right now, we essentially have to approve all charity care that comes to us. You know, if people will apply for financial assistance-- we like to call it-- we have-- you know, we're obligated to provide that financial assistance to these people.

STINNER: So what was your experience at your hospital, as it relates to COVID and the extra costs that you incurred versus how much you were reimbursed by the CARES Act? Is there a-- what I call-- a COVID gap between you ended up having $100,000 of extra costs get reimbursed at $80,000, and so you have a gap there?

MARTY FATTIG: In our facility, no. We-- first of all, though, we do not care for the extremely ill COVID patients. So those-- those patients are-- are transferred to some-- a higher level of care. So that did not happen. We did receive, of course, some federal funding that-- that offset some of those lack of reimbursement-- shall we say-- or or gaps between what we were predicting, because our volumes went down dramatically when COVID was at its highest. So we did receive some federal funding to help some of us-- some of the critical access hospitals through those things. And it really depended on your financial strength as you went into the-- into the COVID pandemic as how-- it determined a lot about how you came out of that pandemic.

STINNER: OK. Additional questions? Senator Kolterman.

KOLTERMAN: Thank you, Senator Stinner. Marty, thanks for coming.

MARTY FATTIG: Thank you.

KOLTERMAN: Critical access hospitals--

MARTY FATTIG: [INAUDIBLE].

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KOLTERMAN: --there's an abundant amount of those throughout the state. They-- they get-- do they get reimbursed at a higher level for Medicare than any other hospital? Do you get a little bit of a bump because you're critical access?

MARTY FATTIG: What-- what-- what the medic-- what the critical access hospital program allows is for the hospital to get reimbursed their allowable costs for taking care of Medicare and Medicaid patients. So if it was assumed that all costs are allowable, then of course, what you do, essentially, is break even on Medicare and Medicaid from a critical access hospital point of view.

KOLTERMAN: Right.

MARTY FATTIG: But of course, not all the costs are allowable. There's a lot of things that the federal government does not allow. So we do well. What I'm really concerned about, and the reason I'm sitting in this chair, is because we require the larger hospitals to be very viable because there's a lot of things we can't care for. So we need them to be very, very-- in a very good state. So when our patients need to go somewhere else, they can go and have the services available to take care of that patient. You know, these large hospitals many times have a book of business, and-- and some of the things lose and some of them gain, as you know, just like every business does. Well, when-- when things start getting tight, some of those services that may not be carrying their own weight, they may-- they may cease to exist, and those might be services that we really need to have those hospitals provide.

KOLTERMAN: The point-- the question is kind of getting to is, is there a difference though? I know Medicare is a federal program.

MARTY FATTIG: Um-hum.

KOLTERMAN: Medicaid is a state program, but a lot of that money comes from the federal government. Do you get reimbursed differently as a critical access hospital than, say, Bryan or St. Elizabeth's?

MARTY FATTIG: Absolutely.

KOLTERMAN: So-- so you get a little bit of a higher rate?

MARTY FATTIG: We do.

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KOLTERMAN: That helps you out as a critical access, but it doesn't do any good for them.

MARTY FATTIG: Doesn't do a thing for them.

KOLTERMAN: OK, and then-- that-- that's all. Thank you

MARTY FATTIG: OK.

STINNER: Additional questions? Senator Erdman.

ERDMAN: Thank you, Senator Stinner. Thank you for coming today. So you're a county-owned hospital. Do you get tax dollars from the county?

MARTY FATTIG: We do not.

ERDMAN: How long has it been since you did?

MARTY FATTIG: The late '60s.

ERDMAN: OK, so you're standing on your own?

MARTY FATTIG: We are.

ERDMAN: I appreciate that. So how did CARES Act money treat you? You don't [INAUDIBLE].

MARTY FATTIG: CARES Act treated us very well. I have to admit, they treated us very well.

ERDMAN: So if your hospital is like the one in my county, it's vital for that hospital to remain viable.

MARTY FATTIG: Absolutely.

ERDMAN: And I appreciate that. I appreciate what you do.

MARTY FATTIG: Yep.

ERDMAN: Thank you.

MARTY FATTIG: You're more than welcome.

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

MARTY FATTIG: See you this afternoon.

STINNER: Good morning.

HEATH BODDY: Good morning. Good morning, Chairman Stinner, members of the Appropriations Committee. My name is Heath Boddy; that's H-e-a-t-h B-o-d-d-y. I'm the chairman-- excuse me-- I'm the president and CEO of the Nebraska Health Care Association. And on behalf of our 423 nonprofit and proprietary nursing and assisted-living facility members, I'm here today to testify in opposition to the Medicaid budget because it does not include a provider rate increase. I've been--

STINNER: Heath, we're on proponent's still.

HEATH BODDY: Oh, excuse me, Senator.

STINNER: Yes.

HEATH BODDY: I apologize.

STINNER: That's OK. We are on proponents still. I'm sorry about that. Any additional proponents? Any opponents? Thank you [LAUGHTER]. Transcriber would go crazy; I would.

HEATH BODDY: My sincere apologies; I should pay better attention. So I've been in front of you before and talked about facilities struggling to serve a growing Medicaid population with rates that are significantly below the cost of care. You also might recall that in 2018, Nebraska experienced 12 nursing and assisted-living facility closures, which then jumped to 22 closures in 2019, and thankfully only saw two closures in 2020. The last budget included increases for Medicaid providers, and I want to thank you for that support. The reality is, like any business, facility costs increase every single year. However, unlike other businesses, providers cannot just raise their prices to pass on these cost increases to consumers when Medicaid is the primary payer for 55 percent of the nursing facility care in our state. According to our accounting consultant, in 2008, the gap between the average cost and the average Medicaid nursing facility reimbursement was about $20 a day. For 2020, the gap is

estimated to be over $30 dollars a day, and you're going to hear some examples today of specific facilities and what that-- what that number looks like. Data for assisted living is limited, but an example of that would be a provider with 22 percent of their residents reliant on Medicaid. Their private-pay residents must pay an average of $938 more each month in order to make up the Medicaid shortfall. Recently, we learned that Medicaid plans to implement a temporary COVID-related rate add-on for facilities through June 2021. And while we're extremely grateful for this, what we're asking of you today is an increase in funding to continue to close the gap between Medicaid rates and the cost of care. That funding, the funding that we're talking about today, would begin after the temporary funding would end. A business model based on serving a high percentage of Nebraskans reliant on Medicaid that requires a few individuals paying privately to supplement the shortfall is just not sustainable. We owe it to Nebraskans to ensure there's continued access to nursing and assisted-living services by continuing the effort you undertook two years ago to get Medicaid rates closer to the cost of care. You may have heard me say before that we take our responsibility seriously, not just to ask for funding, but to work toward solutions. In the past couple of years, we worked together with Medicaid team and members of the Legislature to develop and implement a new nursing facility reimbursement methodology that's cost efficient, incentivizes quality, and sustains access. We're committed to continuing these efforts. If you're wondering what it would take to fix this shortfall, historically, facility costs have increased between 2.5 and 3 percent per year. So if we think about a 4 percent annual increase, we would at least get ahead of the yearly increases, and take a little bit more out of that gap, and get us closer to the cost of care. Therefore, I urge you to include an increase for Medicaid providers in the budget with the nursing facility appropriation identified as a dollar amount. And be happy to answer some questions.

STINNER: Thank you. Question? Senator Erdman.

ERDMAN: Thank you, Senator Stinner. Thank you for being here. So in the CARES Act, did you-- those nursing homes receive some CARES Act money?

HEATH BODDY: They did, Senator.

ERDMAN: Did it make them whole?

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HEATH BODDY: The CARES Act money would have been for COVID-specific expenses. And I think the experience, based on the facility, would matter on what that facility experienced. So said differently, if facilities had higher levels of COVID outbreak, that would have-- the dollars would have a different effect than facilities that had lower levels of COVID outbreak.

ERDMAN: So let me ask it a different way then. Generally speaking, did it bring them up to breaking even with what they were experiencing?

HEATH BODDY: I don't have that data specifically. I would say the CO-- the CARES Act dollars were critical to help in the increased costs for COVID, which would not necessarily get at the gap that we're speaking of here.

ERDMAN: So then there's talk of another contribution from the federal government, and that one is significant as well. Have you reviewed that to see if you'd be eligible, that nursing homes would be eligible for any of that?

HEATH BODDY: Senator, I'm not sure which gap. If we're talking about the next stimulus package, my understanding is, Nebraska would receive a substantial amount of money. How that would manifest into individual facilities, I don't think is clear. I would like to think that we would have some discussion, as a state, in how we can channel some of those dollars to that.

ERDMAN: Yeah, thank you. Appreciate it.

STINNER: Senator Kolterman.

KOLTERMAN: Thank you, Senator Stinner. Heath, welcome.

HEATH BODDY: Thank you.

KOLTERMAN: I just heard yesterday that three more assisted living facilities are closing in the state. Are you aware of that?

HEATH BODDY: Senator, I understand one of them. But if they're of the same ownership, I'm aware. I think they have five in the state.

KOLTERMAN: OK. Well, when that happens-- So as an example, that's happened in York, Nebraska.

HEATH BODDY: Um-hum.

KOLTERMAN: There's only one other facility in York. If they can't take care of them, do you just move wherever you can find a facility? Or how does that work?

HEATH BODDY: Thanks for the question. And it's an incredibly important question, as we look at some of these closures, as we know, over the last years have been in rural markets. I think you're going to hear some testimony behind me that will speak to that a little bit, but let me say this. If there's-- the other options, if assisted living goes away in this example, the other options would be more costly levels of care. And often our-- our colleagues in the hospital environment, depending on what the care scenario is, would end up having some of those Nebraskans reside there. I think the other part that we have to acknowledge, maybe not quite as brilliant of an example in the York market, but when we talk-- [INAUDIBLE] about some of these greater areas-- Senator, you referenced, you know, Mitchell and Bayard before-- we get out on some of these expansive part of the states and a facility goes away, we're talking about extreme levels of distance that families will need to go to participate in their loved one's life and their loved one's care. So I-- it, of course, has an economic impact. It, of course, has a family and a social impact with them, as well.

KOLTERMAN: When Senator Murman did a lot of work to keep Red Cloud open, helped facilitate that a couple of years ago, I believe. And that was privately-owned. And that's-- that's, I think, working out well. But you're right, that's a challenge. And we need to continue to at least fund so they're-- so at least they'd break even because when you-- you're right, when we close down these facilities in a small town, it-- and not-- it places a big impact on the economy of that community.

HEATH BODDY: I completely agree, Senator, I appreciate your thought there. One good thing about this part of healthcare is, we-- we know what the costs look like. We have the ability to-- these costs are audited. They're capped, so they're only allowable costs. We have an ability as a state to understand what we're looking at as those changes happen. And so if these costs continue to increase between 2.5 and 3 percent, we can look at that, we can audit that, we can-- we can

understand what our responsibility would be from the state's perspective to care for those Nebraskans.

KOLTERMAN: Thank you for being here.

STINNER: Could you give the committee some kind of understanding about what's happening in the nursing homes, as it relates to vacancies, and just what that trend looks like, and predominantly how long it's going to be for the nursing facilities to get their population or their census back up?

HEATH BODDY: Thank you, Senator Stinner, for the question. And certainly we've seen in the news that, from a COVID perspective, nursing facilities and assisted-living facilities have been hit incredibly hard, which means that the family members, the residents across the state also, were more-- were more impacted. So from an occupancy perspective, we saw some decline early in COVID, but where it really hit was in the fourth quarter of 2020. And so what we see now, we see, anecdotally, 15 to 17 percent occupancy declines as people have been affected or the life cycle has taken its course. And now consumer confidence is down, based on restricted access, restricted visitations, family members saying: Boy, it's really hard for me to want to take my loved one to a congregate care facility when I'm not sure I'm going to be able to see them, touch them, hug them, kiss them for a while. And so it's had a detrimental impact. When I talk to the experts nationally, my guess is, nobody's certain. But I'm hearing 12, 14, 18 months to make significant climbs out of these occupancy issues. And as-- as we've talked in this committee before, the extreme concern I have for the-- especially these rural facilities is to say the reserves likely aren't there for that kind of-- of a cash loss or-- or the lack of revenue for that long. And what's that going to look like to the fabric of post-acute care, for long-term care across our state? I think we are in for a real challenge here, from a-- from a business model perspective, over the next 12 to 18 months. It really emphasizes again-- and I-- I appreciated Director Bagley's point about, you know, he was trying to process, is this-- is the viability of those facilities Medicaid's purview or their lift? But I think to-- to whether it was Senator Kolterman or you, Senator Stinner, that made the point, so many Nebraskans rely on Medicaid for their financial support to live in those facilities. That's the commitment we've made to them as a state. It certainly is part of our responsibility, in my mind, as the state of Nebraska, to say we've got

to find a way to to close that gap, to make sure that Nebraskans who use their own funds to pay for care aren't picking up the difference of what we're not covering between care and the reimbursement for care.

STINNER: And that gets a little bit back to what Senator Erdman was asking about, is the COVID gap that maybe was incurred initially. And then obviously, there's some funds from the federal government that will come in, probably get-- the nursing homes will get to participate in that, as well. And we're trying to measure that as well, but I think, based on your testimony, $9, $10 is a gap we're dealing with starting out, pre-COVID. So we've got that to deal with. We've got the COVID to get our arms around and what-- what the status is of the nursing homes and then, prospectively, where we go with this. And the federal government, I think, will probably close some of that gap as it relates to COVID, but I don't think it's going to cover all of it. My understanding was-- and several-- depending on where you were located, you had to test your people sometimes once a week, sometimes once a month, sometimes even more so. And that was an extra heavy cost to a lot of the nursing homes.

HEATH BODDY: That's absolutely right, Senator. In fact, at one point, I think three quarters of the counties in Nebraska were red counties, meaning they were higher than 10 percent COVID positivity in the county, which meant, based on Centers for Medicare and Medicaid Services requirements, facilities are required to test their team members two times a week with what I call the old brain scrub, the PC-- the PCR test. And so you can imagine as a team member, one, it's a high cost. And Nebraska did a brilliant job. Governor Ricketts did a great job trying to help us with-- get those tests and have those out there. But from a-- from a quality of life perspective, residents and team members getting these tests ongoing really got to be problematic. So we have the cost perspective, but we also have this-- you know, I'd like to capture consumer confidence, but this desirability aspect that if you're going to be in an environment, if you go home, you don't have to deal with those things. And so it really makes it a tough equation.

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

HEATH BODDY: And I apologize again for the error.

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STINNER: No, that's all right.

DARCIE BRINK: Good morning.

STINNER: Good morning.

DARCIE BRINK: Or is it still morning?

STINNER: It is still.

DARCIE BRINK: OK, good. Senator Stinner and members of the committee, my name is Darcie Brink, D-a-r-c-i-e-- c-i-e B-r-i-n-k. I'm going to take this off, sorry. It's probably easier.

STINNER: Please.

DARCIE BRINK: I'm so used to wearing it. I'm vice president of finance at Tabitha, here in Lincoln, Nebraska. Thank you for the opportunity to be here today to speak on behalf of this. Tabitha has been a Medicaid-certified provider since 1972. We operate three skilled nursing facilities and two assisted-living facilities here in Lincoln and also in Crete, Nebraska. In 2020, Tabitha provided care for 200 Medicaid beneficiaries. As you know, the proposed biennial budget does not include an increase for Medicaid providers. As a provider who works diligently to protect the health and safety of Nebraska's most frail and vulnerable citizens, we are devastated by this failure to recognize the precarious state of our industry. Genworth's most recent "Cost of Care Trends" report, which includes the impacts of COVID-19, identifies the following key factors contributing to the rising cost of healthcare: labor shortages; wage pressures; employee recruitment and retention challenges; regulatory changes; and of course, personal protective and equipment costs. Three of these factors are directly attributable to the unprecedented labor shortages we are living through. For nursing facilities, approximately 75 percent of our operating cost is labor. With Nebraska's unemployment rates remaining very low and substantial growth projected in the senior age cohort for another decade, labor costs will continue to rise and providers will be forced to offer more pay and higher benefits to fill positions. Under normal conditions, nursing is considered one of the most stressful careers. Under COVID, direct hands-on caregiving became an extremely dangerous job. Layoffs in the restaurant and other hospitality industries did not create a surplus of candidates turning

to long-term care facilities for jobs. Although Tabitha recruited aggressively in this impacted sector throughout 2020, very few hires resulted from this. Competition for healthcare workers also increased. In 2020, Tabitha experienced an uptick in employees recruited by hospitals. Certified nursing assistants making more than $15 per hour in our communities were left-- they left to pursue $20 and higher wages offered by local hospitals. Current Medicaid reimbursement falls short of what is needed for Medicaid providers to remain competitive. Even before the worst pandemic in generations, Nebraska's long-term care facilities have been struggling to stay afloat and provide quality care. Now, with COVID-necessitated requirements, Tabitha is spending an additional $2,300 per day for personal protective gear, and the cost of staffing resources allocated exclusively for COVID activity is estimated at $6,400 a day. We, today, ask for no less than a 3 percent increase in provider rates. Thank you for the opportunity to be here with you today, and I'm glad to answer any questions that you may have.

STINNER: Thank you. So you incurred up to $6,400 estimated COVID activity cost. How much was your reimbursement? Do you-- have you quantified that?

DARCIE BRINK: So we received CARES money, as was spoke about earlier with Heath, and what we're seeing right-- we don't have a gap currently in what we receive from CARES money in comparison to what we're spending. But our-- as he spoke also-- our census has declined, starting in the fourth quarter. And we continue to see that even currently today. And so we're expecting that by, you know, June or going on throughout the rest of this year that those monies will deplete, and we won't have enough reimbursement to cover the costs.

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

DARCIE BRINK: Yeah, thank you.

JANET SEELHOFF: Good morning, Senator--

STINNER: Morning.

JANET SEELHOFF: --Stinner and Appropriations Committee members. I am Janet Seelhoff, J-a-n-e-t S-e-e-l-h-o-f-f. I'm the executive director

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for the Nebraska Association for Home Healthcare and Hospice, representing our home health, hospice agencies, and personal care private duty companies across the state of Nebraska. I'm here to testify on behalf of our members to respectfully ask for adjustments in the Medicaid home health and waiver reimbursement rates. We know that has been at least ten years since we've come before you and asked for an adjustment. And I have distributed a couple of documents to help give you some data around that. One is, first of all, that we engaged Roger Thompson from Seim Johnson to do a study for us. And he looked at an analysis of what the current Medicaid reimbursement rates are, published on the state's Medicaid fee schedule, compared to what the actual costs are to deliver healthcare services in the home for Nebraskans. And he also analyzed the rates for waiver. And he looked at 12 agencies across the state, both urban and rural settings, with home health visits ranging anywhere from 3,600 to 65,000. And that was done over the end of eight-- 2018 through June 2019. And as you looked at that, we looked at staffing salaries, travel costs, cost per visit and overhead, and also factored in a 3 percent inflation rate. It's important to note that some of our home health patients have been longtime patients. These are individuals that have been getting care for 10, 15, even 20 years. And then we have many patients who get what we would call intermittent services. So for example, someone who's recovering from knee replacement surgery that needs just a few in-home therapy visits. The overall findings concluded that for home health agencies, adjustments are definitely needed in direct skilled nursing. That would be RN and LPN services, as well as our home health aides, physical therapy, occupational therapy, and speech therapy services. And for waiver clients, it would be adjustments in the hourly rate for RNs and LPNs. And we've given some recommended numbers on the spreadsheets to help get to where we need to be to cover our members' costs. We have had numerous discussions with DHHS about this, in particular with Jeremy Brunssen, deputy director of finance, and he was kind enough to share with us the utilization rates from 2018 through 2020, and that's also there for you to look at. And what the department has identified is that there is about an $11.1 million gap of where we need to be to cover services. We are asking for that adjustment because we feel like this cost study clearly shows what's required and overdue to serve Nebraskans. We do recognize that this committee has very difficult decisions to make, competing priorities with many healthcare providers, and we know there's limited funding. So we would entertain a phased-in approach that would help us to get

to that target over a certain period. For example, perhaps 25 percent each of the next two years to help address that gap. We also understand that DHHS has not preferred-- performed an internal study or analysis of the services or rates, and we are committed to continuing working with them on that. And in talking with DHHS, I think it's their plan to get back with us in March with at least a high-level look at an assessment, and continue that conversation. Most importantly, this is about access to care for Nebraskans. Home healthcare is the low-cost option for delivery of care in the home. We are seeing an uptick of services across the state; there's no question about that. More and more Nebraskans needing the services, our agencies have higher censuses than they've ever had. So it's a little bit different than what you've heard from some other testifiers. And we are absolutely committed to keeping people independent and safe in the comfort of their homes for as long as it makes sense to do that. And I've got a couple members behind me that will share more specific examples of the impacts on their agencies, serving everyone from children to the elderly. And I'll be happy to answer any questions that you might have.

STINNER: Thank you for that. Questions? Senator Wishart.

WISHART: Well, thank you for being here. And I really appreciate the work that your association has done in preparation for this. And this is very helpful. Quickly, you mentioned that the department is going to be looking at doing, potentially, a rate study. Wouldn't that be duplicative to the work that you've already done here?

JANET SEELHOFF: I think that it will be helpful because we honestly have a lot of questions about the utilization rates that they've shared with us, and we want to have a clear picture of-- does this really encompass everything in home health? And if they can also help us forecast what they think the growth will look like over the next several years, that would be very helpful.

WISHART: OK. When did you come to the department with this information?

JANET SEELHOFF: We first met with them October 23 of last year.

WISHART: OK. So what was their reasoning if they believed that an adjusting of the $11 million would be needed to address the gaps

between the actual costs and the state's current reimbursement rate? What was their explanation for not asking for those dollars this year?

JANET SEELHOFF: They've simply said they've had a full plate with other priorities.

WISHART: OK. And then one other question I have is, when we met you mentioned that there may be legislation that's working on this. There have been some issues with requiring like nursing certification for giving somebody a bath that have caused additional costs. I-- I don't know if you wanted to go into that or somebody can talk a little more to that. But I-- my understanding is that some of the requirements for home healthcare agencies are-- are troublesome for-- for staff who have done services in the past, because they require a certain level of expertise or certification for something that-- am I-- am I tracking?

JANET SEELHOFF: I think you might be referring to our personal care home care companies that are not required to be licensed for services.

WISHART: Yes.

JANET SEELHOFF: And they're very restricted in what they can do in the home,

WISHART: OK.

JANET SEELHOFF: Bathing and some other-- what we would call activities of daily living--

WISHART: OK.

JANET SEELHOFF: --are things they're able to do.

WISHART: OK.

JANET SEELHOFF: There has been some discussion with the Public Health Division on whether they may want to move towards licensure requirements for those providers in the future. And we're in the middle of that conversation. As far as home health, licensure is very strict. And so anything that's deemed skilled care has very stringent requirements.

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WISHART: OK, thank you.

STINNER: Additional questions? Seeing none, thank you.

JANET SEELHOFF: Thank you.

SEAN BALKE: Senator Stinner--

STINNER: Morning.

SEAN BALKE: --and committee, thank you so much for having me today. My name is Sean Balke, spelled S-e-a-n B-a-l-k-e, and I am president and CEO with a company called Craig HomeCare. And I'm here in opposition today of the preliminary Medicaid budget, and in support instead of the reimbursement rate adjustment proposal that the Nebraska Association for Home Care and Hospice has recommended. And really, instead of reading to you, you're going to have my testimony. My, really, position here today is to speak with you to illustrate the-- some examples in the kind of critical nature of the access-to-care crisis that exists today for really a specific subset of the Medicaid population. My organization, Craig HomeCare, has been providing services, hourly nursing services in Nebraska since 2006. And we specialize in pediatric, very medically complex, very medically fragile cases. We also serve some adults that have similar conditions. Those are typically the aged-out cases. They were pediatric cases that we moved to adult cases. And in addition to that specialty, my organization is the only one that focuses on serving rural Nebraska in addition to the urban areas. We certainly provide services in Omaha/Lincoln areas, but we serve every inch of Nebraska. We have cases in Sidney. We have cases, I mean, in very hard to reach, remote places. And our organization has struggled considerably to try to make this model work with that mission of making sure that children that are extremely medically complex, that, as my testimony illustrates, very sick children, very sick adults in some cases, that are on medical technology to stay alive. They're on ventilators, they're on-- they have tracheostomies, they have feeding tubes. Think of it as a, for pediatric cases, a neonatal intensive care unit in a hospital. Right? You look at what that type of level of care is. We're replicating that type of an environment in a home setting, so that children that are medically ready-- they're stable enough to be able to come home-- that they can actually make a transition back to the home- and community-based setting where they can be cared for at a

much more affordable level than what it costs to keep a patient in an acute-care or rehabilitation hospital. And in addition to those benefits to the-- to the child, in that sense, there's tremendous benefits to the family by not having their child in a long-term-care, acute-care hospital or an institution of some sort, but having them in the community. You can see a list of some of the services that we provide. We-- we only hire and employ RNs and LPNs in our business. So it's-- it's a licensed, skilled, certified level of care. And the crisis that exists is at the bottom of my first page that I'm going to start with, to give you some statistics on what we're facing right now. On average right now, because of the reimbursement rate. It simply has not kept pace, and it's-- it's not even with like what other states are doing; it's market conditions that have been-- been talked about already by some other conferees. Market conditions are difficult in the state of Nebraska, and the rates have not kept pace. Competition is very intense. And yet these areas that need service, especially some of the rural areas, simply cannot compete with even the other entities that are out there today that are-- that are looking to-- to hire nurses, as well. So as a result, only about 51 percent of the medically necessary and approved authorized service hours-- those are hours that the physician says they need, the state says is OK, the managed-care organizations authorized and approve, say this is what they need to be able to come home. Right now, on average, about 51 percent of those are able to be provided. Now that's across the state. You look rural, and rural families are even more impacted. Those numbers drop to 42 percent or less of the medically-authorized services for those patients that are able to be provided. Consequences of that are we have children-- and I say children, because this is the most often initial transition from an acute-care hospital-- they may sit, they're-- they're ready to come home, family's been trained to care for them when we can't, because that's part of the deal when they come home. Ready to come home but, because we can't have enough nursing to cover what's needed, they stay there for-- we've seen days, we've seen weeks, we've seen months, and we've seen years where the child sits in an acute-care hospital or a rehab hospital ready to come home, but they can't because there's no ability to hire nurses for that service. So that obviously increases tremendous cost to the Medicaid system when those children are sitting in those types of institutions rather than a home care setting. And they also utilize-- the emergency department utilization goes way up because the families don't have help. They're-- they're tired. They have to choose between

sleeping, eating, caring for other kids. And they-- maybe they miss a medication dose, they miss a care. These children then have issues. They escalate. They don't notice that there's a symptom of pneumonia potentially creeping in there. And there's kids that are on ventilators. They don't notice it. Child escalates, goes to a hospital. When they go to a hospital, they don't go for a day or two. They're there for weeks or months sometimes with those conditions. So it's tremendous cost to the system. So the cost savings on my-- on the second page of my testimony, I indicate some examples. We've done some work to under--understand what the DRG or daily--

STINNER: Sean, we have-- the red light's on.

SEAN BALKE: Oh, it is. I'm so sorry.

STINNER: Can you close?

SEAN BALKE: I'll wrap up. Gives you an idea of some of the cost differences between $2,600 to $4,800 a day for a hospital-- us about $550-- huge difference in cost savings there. When you get to the impact on families and so forth below, it's just-- it's just-- you know, if you go to our Web site, craighomecare.com, there's a video called "Kelly's Letter," written by a Nebraska mother who receives these services, tells and shows everything about what she-- her and her family experienced related to caring for a very medically complex child at home. And so thank you for hearing my testimony, and I'll be happy to stand for any questions.

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

SEAN BALKE: OK. Thank you.

STINNER: Just for my-- I'm trying to keep a head count here. How many people have yet to testify or want to testify? How many do we have? I've got this girl--

_____: We have seven-- seven.

STINNER: Seven? OK, we're OK still.

WISHART: Can we go through lunch? Can we go through lunch?

STINNER: Yeah.

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WISHART: OK.

KARI WOCKENFUSS: Good morning. Chairman Stinner and members of the Appropriations Committee, my name is Kari Wockenfuss; that's K-a-r-i W-o-c-k-e-n-f-u-s-s. I'm the administrator of the Louisville Care Center and a board member of the Nebraska Health Care Association. I am entering my 29th year as a long-term care administrator-- 17 years of those have been at the Louisville Care Community. I am here to testify in opposition of the proposed Medicaid aid budget recommendation. Louisville Care Community is a not-for-profit, city-owned nursing facility located in Louisville, which is 15 miles south of Omaha. In 2020, Louisville Care Center had 12,164 Medicaid census days in our nursing facility. Louisville Care Center's actual cost, per Medicaid resident day, was $215, but we were only reimbursed $189. Therefore, we experienced a shortfall of $26 per Medicaid day, for a total shortfall of over $316,000. Currently 68 percent of my residents in the nursing facility and 22 percent in our assisted-living facility qualify to receive the Medicaid benefits. We currently have 73 members on our staff, with a total annual payroll of $2.5 million. But in addition, last year we spent well over $500,000 on contract labor that we are forced to use to fill our professional nurse and certified nurse aide open shifts. In addition to staffing shortages, rural communities such as ours are competing with urban wages and hospitals that can further-- that further impacts our staffing. We do not receive any supplemental funding from the city of Louisville. While we are supported and very appreciative of the $20 per day increase to help with the COVID-related expenses, this is also temporary. Approximately 70-- or 65 percent of our referrals come to us that's already qualified for Medicaid funding. Louisville is one of the few facilities that will accept a Medicaid participant without an obligation for the potential resident to pay privately for a set number of months or even years. If Louisville cannot financially afford to take Medicaid-eligible people, where will they go? Facilities such as ours must be available to meet the needs of the underserved. While we believe in serving all who need care, regardless of the payer source, we are also a business and we need to maintain our operations. I strongly encourage you to include a provider rate increase for both nursing facilities and assisted-living facilities in the next biennial budget. Thank you for your time and consideration, and I will answer any questions if you have any.

STINNER: Questions? Senator Clements.

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CLEMENTS: Thank you, Mr. Chairman. Thank you, Mrs. Wockenfuss. Appreciate your good work that you do in Louisville, in my district.

KARI WOCKENFUSS: Thank you.

CLEMENTS: Could you say again what your current ratio is of Medicaid patients?

KARI WOCKENFUSS: We have 68 percent currently, and that's been low. We've ran as high as 80 percent.

CLEMENTS: During the last year you've been that [INAUDIBLE]?

KARI WOCKENFUSS: We've been right about 68 to 73 percent.

CLEMENTS: All right. And how did the COVID affect you? Did you get funding for your extra expense?

KARI WOCKENFUSS: We did. We actually were one of the-- up until last week, we did not have a COVID resident, but last week we received our first one. So-- but going forward, that CARES money is going to help what we're experiencing right now.

CLEMENTS: And how is the gap that you said you have a $26 per day loss on Medicaid-- has that been the last several years about the same number?

KARI WOCKENFUSS: No. We're-- that's actually low for us. We've been as high as about $50 per person per day. I'm not sure, at this moment, where that loss is derived from.

CLEMENTS: OK. And did you have a decrease in population that other people have mentioned?

KARI WOCKENFUSS: Yeah. Right now our population is like sixty 67 percent. So we're down 23 percent.

CLEMENTS: 33 percent of the beds are--

KARI WOCKENFUSS: Thirty-three, yep.

CLEMENTS: --vacant.

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KARI WOCKENFUSS: Correct. We have six apartments right now, which usually we're full in our assisted living.

CLEMENTS: Oh, very good. Thank you for being here,

STINNER: Senator Erdman.

ERDMAN: Thank you. Senator Stinner. Thank you for coming today. So where do the people go?

KARI WOCKENFUSS: I'm not sure. Right now maybe Omaha area-- I-- but I can't. I don't know that for sure.

ERDMAN: Do you think they went to other facilities or just went home?

KARI WOCKENFUSS: I think there's a little bit of both, but I know probably a lot of it went home right now because they cannot see their loved one.

ERDMAN: I don't blame them. That'd be exactly what I would do, too.

KARI WOCKENFUSS: Yeah.

ERDMAN: Yeah. Thank you.

STINNER: Questions? Seeing none, thank you.

KARI WOCKENFUSS: Thanks.

LANA WOOD: Good morning, Senator Stinner and fellow members of the Appropriations Committee. My name is Lana Wood, L-a-n-a W-o-o-d. I'm the administrator of Home Nursing with Heart in Ralston. My agency provides Medicare and Medicaid skilled services in the Omaha/Fremont/Blair surrounding area. And piggybacking on Janet and Sean, we do mainly adults where Sean does the children. So I'm not going to repeat some of the things they said, just tell you a little bit about the patients we're seeing. In the last 27 years, I've been providing home healthcare services to Nebraska, and a majority of them, Medicaid recipients. Some of these patients I have taken care of for 23 years. These patients or the Nebraskans you see out in the community, they go to work every day. They're in our stores, our schools, our churches. Many are there because a Medicaid home healthcare agency went to their homes and got them up out of bed that

morning. They transferred them, they gave medications, they fed them. They got him in their mobility devices, and we got them up out of the house for the day. We go back and see these clients again at noon, in their workplaces or at their schools, and help them with their toileting. We make sure they get their new medications, that they get fed, that they're repositioned to prevent any pressure ulcers. We see these patients again at bedtime to bathe them, to get them back into bed, to make sure all their personal care needs are met. We administer IV antibiotics, we change complicated dressings, we provide strength training, we help them with safe transferring. And we also help them with their mental health issues when they may not otherwise follow through with proper treatment. We teach them how to be more independent in their own settings. We facilitate appropriate communication with their healthcare providers, which may not happen otherwise, and we prevent inappropriate uses of emergency room and hospitalizations by having a 24-hour on-call RN, who can troubleshoot any concerns. Because of our home healthcare agencies, these citizens have the freedom to live outside the confinements of facilities. The gaps are increasing between what home health services are costing us and what we're being reimbursed. Our skilled providers that we have, have a lot of options out there, and we want to continue to ensure that home health can provide qualified professionals to our Nebraskans. That's all I'm going to talk about right now. If anyone has any questions, if you have questions about the home health agent-- home health aides, I can see if I can answer those.

STINNER: Any questions? Seeing none, thank you.

LANA WOOD: Thank you.

STINNER: Morning.

JEREMY NORDQUIST: Good morning, Chairman Stinner and members of the Appropriations Committee. Thank you for your service on this highly esteemed committee. I am Jeremy Nordquist, N-o-- J-e-r-e-m-y N-o-r-d-q-u-i-s-t, government affairs director for Nebraska Medicine. Nebraska Medicine is a nonprofit, integrated healthcare system affiliated with the University of Nebraska Medical Center. We have over 9,000 employees and 1,000 affiliated physicians, and our providers perform over 1 million outpatient visits annually, and about 100,000 emergency room visits every year. Nebraska Medicine opposes the current budget recommendation to keep provider rates flat, and

asks the committee to reconsider this appropriation. Medicaid is a critical program for Nebraskans and an equally important revenue stream to sustain our healthcare system across our state. While Medicaid is an important revenue stream, it is not a profit generator, and our uncompensated care from Medicaid continues to grow. Federal disproportionate share hospital audits for Nebraska Medicine show that in 2016, our Medicaid shortfall was $23 million. That grew to $31.5 million, and 2018 is projected to be over $35 million this year. These are actual audited numbers of the costs to provide the care versus what Medicaid reimburses us. Mr. Chairman and members-- I know Mr. Chairman likes numbers, so I brought a few specific examples to some of the questions he had earlier. An average MRI for a Medicaid patient costs Nebraska Medicine $560. Medicaid reimburses $458 on average. An endo-- endoscopy costs about $1,400, and Medicaid reimburses $1,270. An average emergency room visit for Medicaid, a Medicaid patient costs $711; Medicaid reimburses $382. And the average vaginal delivery for Medicaid-- a Medicaid patient-- costs $5,272; Medicaid reimburses about $2,800. So it really-- you hear-- you hear a top-line number of, you know, Medicaid's, you know, only reimbursing. at 70 percent. It really varies by services. Those-- you know, the MRI and endoscopy, you know, they're reimbursed at 80-85 percent. But on something high-cost, like a delivery, they're reimbursing, you know, 55 percent. As Medicaid reimbursements fall farther behind, it makes it difficult for health systems like ours to keep our talented healthcare providers and attract new providers. This committee knows very well, with the efforts you've done in the past, that Nebraska is facing a nursing shortage. And having the revenue to provide, at minimum, cost of living salary increases is essential to keep those employees with our systems in our state. Especially post-COVID now, it's been highly competitive to-- to keep nurses staffed. We've also seen in other states that have provider rates deteriorate too far, large numbers of providers will refuse to participate in the Medicaid program, placing a larger financial burden on the remaining health systems. In closing, I know you have very many, many difficult decisions prioritizing the needs of our state. I'll just say that, you know-- you know-- and you know this well. The state dollars you invest in Medicaid provider rates are matched one to one, two to one, or more by the federal dollars. And those dollars are then invested in our communities, paying our providers, our nurses, our medical assistants, and all of our healthcare heroes. So we appreciate your consideration of

increasing Medicaid provider rates in the biennial budget. Happy to take any questions.

STINNER: It's good to see you came back to Nebraska.

JEREMY NORDQUIST: Yes. Great to see you.

STINNER: I have two empty seats here, if you want--

JEREMY NORDQUIST: I'm retired from being on that side.

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

JEREMY NORDQUIST: Thank you.

STINNER: Good morning.

JEFF FRITZEN: Good morning, Chairman, Stinner and members of the Appropriations Committee. My name is Jeff Fritzen, J-e-f-f Fr-i-t-z-e-n. I'm the executive director at Gold Crest Retirement Center and a member of the-- a board member of the Nebraska Health Care Association. I'm entering my 11th year as a long-term care nursing home administrator at Gold Crest. I'm here to testify in opposition of the proposed Medicaid aid budget recommendation. Gold Coast Retirement Center is located in Adams, Nebraska, 30 miles south of Lincoln and considered rural. On April 1, our facility was one of the first facilities in Nebraska to have a COVID outbreak. And we were able to see, in a short amount of time, what a COVID outbreak can do in a facility. At that time, PPE was harder to come by. Testing was still a challenge in the state. There was a lot of challenges that we have overcome today that we were not able to overcome In April. We saw large census drops from residents being sent to the hospital, a lot of negative media coverage, increased expenses, and drops in revenue or decreases in revenue. During our COVID outbreak that spanned over three months, our facility saw a $300,000 loss in revenue. Some of the conversation today has been about CARES Act money. In that same quarter, our CARES Act money was about $242,000. So it kind of shows in that particular month where our CARES Act went to and how it kind of helped with the facility and the de-- and the loss of revenue that we saw during that quarter. And then, talking about the census, some people were questioning kind of where census had gone in the facility at that quarter. We saw a lot of fear with our residents. So the ones that didn't get COVID, we saw families pulling them out of the

facility at that time. And then we also saw, you know, just over general lifespan, you know, you're just going to have that natural volution of residents passing away, so that census decrease, on top of people leaving, you know, created obviously a census challenge. We're a stand-alone nonprofit facility with 52 nursing home beds, 20 assisted-living apartments, 18 independent living rentals, and we also do a child daycare, which at the same time of the outbreak, we decided that we should close the child daycare until the outbreak was kind of under control and contained. So I think we closed the daycare for about 30 days. And we have-- we serve an occupancy of 76 children. 41 percent of our nursing home residents are currently utilizing Medicaid funding. And on our assisted living, we currently have 40 percent of our residents using Medicaid funding. Last year we had around 6,881 days of Medicaid census on the nursing facility side, and 1,813 of Medicaid census on the assisted living side. We lost, on average, $40 a day per Medicaid beneficiary, for a total of $315,000. And this data came from our 2019/2020 fiscal year, which is July to June. So facilities have seen a large increase in expenses due to price increases in general supplies, increases in wages to retain and recruit staff, pandemic supply costs, increase in contract labor prices and usage to fill staff shortages. As we continue to get more upside down with the current $40 a day on Medicaid funding, I'm concerned that there will be a placement issue when it comes to vulnerable Nebraskans on Medicaid. Many operators are already having to limit Medicaid admissions in order to try to keep their business profitable. We're the-- the closest facility to us is 30 miles away, so, you know, if we would limit Medicaid funding, they would at least have to travel 30 miles to the nearest facility, and sometimes further than that, obviously, as a Medicaid person has challenges trying to find a bed. Gold Crest employs about 100 employees, or a payroll of $2.3 million in wages. The biggest thing I've seen over the last years, we're no longer competing with hospitals and schools as we had in the past for staff. We're competing with Walmart, Target, HyVee, all those places that have seen, from what I'm hearing, revenue increases during the pandemic, so I see them offering higher wage-- base wages, offering bonuses to their employees, and offering all those different things that are making it challenging to-- to ask our staff to risk themselves, to care for our elders instead of maybe going to a Target and making the same or similar money. So that's been a challenge to the business. And like those businesses, they can raise their cost of goods and services. We are unable to do that with our

Medicaid residents' rates. And so Medicaid resident-- Medicaid rates are not paying for the entire [INAUDIBLE]. Residents' expenses during the middle of a pandemic has made it a challenge to recruit and retain staff, cover operating expenses, and still operate in the black. While we appreciate the least-- the latest $20 Medicaid add-on to help cover our current costs, a future increase in Medicaid rates is needed to help offset future cost increases in wages and benefits, staffing challenges, census and census jobs to avoid facility closures, and provide access to care for all Medicaid residents. I'd be happy to answer any questions at this time.

STINNER: Any questions? Senator Erdman.

ERDMAN: Thank you, Senator Stinner. Thank you for coming today. So those residents that went home or went somewhere else, did any of those return?

JEFF FRITZEN: If they have returned, it hasn't been by their choice. Most of those have not. We really saw it a lot in the assisted living. I wouldn't say as much on the nursing home side-- a little bit. But most of those nursing home residents, it's harder for them, for the family members to care for them at home. But assisted living was where I really saw the dramatic census changes at that time of our outbreak.

ERDMAN: Just an observation that seems kind of peculiar to me. I have several friends who have people in those facilities. They can't go see them. They can't visit them. But yet all the employees go home at night and come back the next day. When they call me and we talk about that and they ask if, in fact, the employees go home and return the next day, why couldn't I go see my family member? So if I had someone in those facilities, I'd take them out, too.

JEFF FRITZEN: Yeah.

ERDMAN: You have-- you have an opportunity there that you can't overcome an obstacle. It's just impossible for people to continue to put their loved ones in facilities like that that you have no control over how they can visit. That-- it's absurd.

JEFF FRITZEN: Yeah, I think that's been one of the hardest challenges with the pandemic is, where's the line of protecting the elder and the seniors, but then still making it enticing to have a family member

there for care? I think that's been a hard line we've tried to walk for the last year to figure out where the protection is and where and how to keep them safe, but then, also, allow them opportunities to interact with family and be a part of the community. I think that's been some of the things I've seen, too, is-- not only just families, but they feel isolated from the community.

ERDMAN: Right.

JEFF FRITZEN: In a center like ours, we had 100-130 volunteers, through pastors, through bingo, through music groups, through all sorts of things that essentially ceased in April. And I-- you know, that's one of my biggest questions I posed to my team is: Will we be able to get those volunteers back? If we can, how many of them will we get back to come back into the facility and make it the place that our residents enjoyed being at, you know?

ERDMAN: This conversation usually goes like this. If I have to make this decision again, I'm not sending my loved ones there or anyone else--

JEFF FRITZEN: Yeah.

ERDMAN: --'cause if that can happen to me once, it could happen to me again.

JEFF FRITZEN: Yeah

ERDMAN: We have a problem. Thank you for coming.

JEFF FRITZEN: Yep.

STINNER: Senator Dorn.

DORN: Thank you, Chairman Stinner. Thank you, Jeff. You and I have visited regularly, I think, through this, from the first COVID patient you had down there, which was one of the earliest ones in the-- I call it the nursing home care business-- in the state. And now I-- the conversation earlier there from Louisville that they just finally had one. I just find that-- I'm very, very thankful-- but amazing. What-- how-- how is your capacity, or what-- what are-- what is the future looking like? Or do you see that-- how long for rebounding?

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JEFF FRITZEN: Yeah, I think we've seen a lot of ups and downs in census in our building, so it's really hard to trend line. In June and July, I was at the lowest census I'd seen in 10 years that I'd been at the facility. But then I also-- there was a portion in the fall here-- winter-- that I saw some of the highest census we've had. So it has really fluctuated. And I have no idea how we've gone months where we've had a lot of people to care for, and then we've had months where we've been wondering if, like, I'm like: OK, how is this going to go in the long term? So since this has definitely fluctuated for our building, but that's not been the norm for other facilities in our area, I think some of that is due to a local facility nearby that has had some challenges. I think that has driven some census to us that we normally wouldn't have seen. I think that's part of why we see that increase at our facility in the last three months or so. But I don't-- I don't know that that's going to sustain. And that's, like I said, all in six months time. I've seen the lowest census, and I've seen some of the highest census in six month's time at our facility.

DORN: OK.

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

JEFF FRITZEN: Thank you.

MARK SROCZYNSKI: Good afternoon, Chairman Stinner and the rest of the Appropriations Committee. My name is Mark Scroczynski, M-a-r-k S-r-o-c-z-y-n-s-k-i. I am the vice president of Emerald Healthcare. We have buildings in Cozad, Columbus, Grand Island, and Omaha. Our patient population right now is 50 percent Medicaid. We're asking for a four percent increase in that Medicaid provider rate. As it stands, that 49 percent equals about 162 patients per day that we have. It's really a difficult situation. You've heard about the care, you've had some good questions with family members out there, and it's it is it is the most challenging. I have been in these nursing homes all the time. Quite frankly, why I haven't caught COVID, I have no idea-- none whatsoever. Our occupancy in all these four buildings ranges from sixty four to sixty seven percent. If I were a betting man, I would say that it's going to be longer than 12 months or 18 months before we get back to normal. If I could guess, and if I knew in 12 months, that would be the case, we could weather the storm. And yes, we have received Cares Act funds, but the federal government's questions about what is COVID- related is-- is difficult and questionable. Things like

when we have a COVID unit, in its own separate unit, we have to staff that with its own separate staff. We struggle just to staff it with what we have, and then you throw in a COVID unit, your own dedicated RN, your own dedicated housekeeper, your own dedicated CNAs, Compassionate Caregivers Act was one of the best things that Nebraska has come out with, credit to Heath Boddy and other people. That 4 percent is going to help us and, yes, we have a $20 Medicaid rate that's going to, in the short term, help us as well. But that's not sustainable. You've heard from my other colleagues on these same matters. Everything else I would say is be redundant at this point, but I'm in these nursing homes. I may have the title vice president, but I assure you I'm in these nursing homes and I see what goes on. So I'll end up with that. Are there any questions I can answer for you?

STINNER: Questions? Seeing none, thank you--

MARK SROCZYNSKI: Thank you

STINNER: --for being here.

ERDMAN: Thank you.

MATT ROSS: All right. Good morning, Chairman Stinner and committee members. My name is Matt Ross, M-a-t-t R-o-s-s. I'm the vice president of Rural Health Development. Our company has been helping nursing homes in small rural communities in Nebraska for 31 years. We are currently managing nursing homes in the following Nebraska communities: Beemer; Benkelman; Bertrand; Callaway; Crawford; David City; Humboldt; McCook; Mitchell; Stuart; Verdigre; Wauneta; Whiteclay; and Wilber. While these communities represent a diverse geography across our state, the nursing homes we serve in them are all nonprofit, stand-alone facilities, doing their best to care for the frail and the elderly in their small towns. I come here today to advocate on their behalf. It's well known that the Medicaid rate paid to nursing homes to care for residents receiving Medicaid does not cover the cost of their care. In order to stay open, therefore, many nursing homes are put in the position of needing to charge private-pay residents more than their fair share of the cost. This problem is compounded by the increasing percentage of nursing home residents who are on Medicaid, especially in small rural towns. Many of our facilities consider it their mission to care for their community elders, regardless of payer source. In order to keep homes like this

alive, we need to push for proper funding. I would be remiss to not mention COVID-19 and how it has disrupted all life as we know it. That becomes an understatement when we talk about the nursing home industry. Nearly every aspect of caring for our elderly has been impacted, and this hardly touches upon the psychosocial impact on our residents. We are so grateful for the provider relief funds and CARES Act money that has been allocated to the facilities. But we cannot rely on this money to continue to flow in to offset lost revenue and increasing expenses. In order for Nebraska nursing homes to be viable into the future, we need our Medicaid rates to come closer to matching the cost of caring for those elders. The cost of providing care continues to rise, so a Medicaid funding that remains flat digs us deeper into a hole. In parting, I'd like to reflect on some advice I've received over the years from my dad. Many of you know my father, Ron Ross, president of Rural Health Development. In between starting our RHD in the early 1990s and now, he took some time away from the company when Mike Johanns asked him to be the director of Health and Human Services for five years. Whether he was working for the state or with RHD, his philosophy has remained the same: Do what you can to put others in a position to succeed. I hope that our efforts today are impactful towards that goal. Thank you for having me. If you have any questions, I'd be honored to have the conversation.

STINNER: Questions? Seeing none, thank you very much for coming.

MATT ROSS: Thank you.

ANDY FUSTON: It looks like you made it to the end of the line

STINNER: It's after 12:00, so it is the afternoon.

ANDY FUSTON: Yes.

STINNER: Good afternoon.

ANDY FUSTON: Yes. So good afternoon, Chairman Stinner and members of the Appropriations Committee. My name is Andy Fuston, A-n-d-y F-u-s-t-o-n. I'm a director of facility operations for Vetter Health Services. I am also-- I have also served as mayor of the city of Lyons, Nebraska, for the last 14 years. I'm here to testify in opposition to the proposed Medicaid aid budget recommendation. In May 2015, the Lyons Nursing Home closed its doors. As mayor, I instantly

felt many things, but surprise wasn't one of them. The facility had been through six owners, and each time it sold, you felt more nervous about its future. It wasn't, however, until the last company, Deseret, took over that I felt the end was near; and that end came quickly. The state had to step in so that residents and employees were taken care of. In the end, our nursing home had an unceremonious demise. Two years later, an attempt to resurrect the nursing home ended unsuccessfully. It was awful, and I was angry because I knew what it meant for my little town. The loss of our second largest employer had ramifications beyond our community's ability to care for our own elderly. The nursing home was a good utility customer. When they closed, the city instantly lost a revenue source that helped pay for projects the city couldn't otherwise necessarily afford to do. Also gone was the sales tax revenue the city received in the business provided to the local business owners. What we gained, however, was a sense of uncertainty about the future-- the future of the property, the care of our elderly, and the uncertainty of not knowing how much Lyons would suffer from this loss. Now many factors went into the decline of my nursing home, but one must question the role insufficient Medicaid funding played in its story. Had there been adequate Medicaid funding support, would the facility been able to stand financially on its own, or been more attractive to a financially stable, high quality buyer? Could higher Medicaid reimbursement have helped the company that tried to breathe new life into the building succeed? I would have to say "yes" to all of the above. Sufficient Medicaid reimbursement may have helped the Lyons nursing home survive and continue to help our community thrive, as well. We have better health services provide care to approximately 10 percent of Nebraska's Medicaid long-term care seniors. That care is provided in facilities which are also considered part of the fabric of their community-- communities like Lyons. Sufficient Medicaid funding will help those facilities remain anchors in their community and help prevent what Lyons went through with the closing of its nursing home. So my ask of you today is to please consider an increase in Medicaid provider rates for each of the next two years. Without it, Nebraska could experience more stories, as we've already heard today, and like the one I've just told you; and I don't think anybody wants that. Thank you for your time and consideration. If you have questions, I'd be more than happy to answer them.

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

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ANDY FUSTON: You betcha.

STINNER: Any additional opponents? Seeing none, anyone in the neutral capacity? Seeing none, that ends our hearing on Agency 25.

[BREAK]

STINNER: Love getting started on time. So welcome to the Appropriations Committee hearing. My name is John Stinner. I am the-- I'm from Gering and I represent the 48th District. I also serve as Chair of the committee. I'd like to start off by having members do self-introductions, starting with Senator Erdman.

ERDMAN: Thank you, Senator Stinner. Steve Erdman, District 47, 10 counties in the Panhandle.

HILKEMANN: Robert Hilkemann, District 4, west Omaha.

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

WISHART: Anna Wishart, District 27, west Lincoln.

STINNER: Assisting the committee today is Brittany Sturek, our committee clerk. And to my left is our fiscal analyst, Liz Hruska. For the safety of our committee members, staff, pages, and public, we ask that you attend our hearings-- those attending our hearings to abide by the following. Submission of written testimony will only be accepted between 8:30 a.m. and 9:30 a.m. in the respective hearing room where the bill will be heard later that day. Individuals must present their written testimony in person during this time frame and sign the submitted written testimony record at the time of submission on the date of the hearing on the bill. An individual with disabilities can define a substitute to sign in on their behalf. Due to social distancing requirements, seating in the hearing room is limited. We ask that you only enter the hearing room when it is necessary for you to attend the bill hearing in progress. The bills to be taken up in the order posted outside the hearing room. The list will be updated after each hearing to identify which bill is currently being heard. The committee will pause between each bill to allow time for the public to move in and out of the hearing room. We request that everyone utilize the identified entrance and exit doors in the hearing. We request that you wear a face mask covering while in the hearing room. Testifiers may remove their face covering during

testimony to assist committee members and Transcribers in clearly hearing and understanding the testimony. Pages will sanitize the front table and chairs between testifiers. Public hearings for which attendance reaches seating capacity or near capacity, the entrance door will be monitored by a Sergeant at Arms who will allow people to enter the hearing room based upon the seating availability. Persons waiting to enter a hearing room are asked to observe social distancing and wear a face covering while waiting in the hall or outside the building. To better facilitate today's proceedings, I ask that you abide by the following. Please silence or turn off your cell phone, Senator Kolterman. Move to the front row when you are ready to testify. Order of testimony: introducer, proponents, opponents, neutral, closing. Testifiers sign in, hand your green sign-in sheet to the committee clerk when you come up to testify. We ask that you please spell your name for the record before you testify. Be concise. It is my request that you limit your testimony to five minutes. If you will not be testifying at the microphone but want to go on the record as having a position on a bill being heard today, there are white sheets at the entrance where you may leave your name and other pertinent information. These sign-in sheets will become exhibits in the permanent record at the end of today's hearings. We ask that you please limit or eliminate handouts. Written materials may be distributed to committee members as exhibits only while testimony is being offered. Hand them to the page for distribution to the committee and staff when you come up to testify. We need 12 copies. If you have written testimony, but do not have the 12 copies, please raise your hand now so a page can make copies for you. With that, we will begin today's testimony with LB426, Health and Human Services Committee, Senator Arch.

ARCH: Good afternoon.

STINNER: Afternoon.

ARCH: Chairman Stinner, members of the Appropriations Committee, my name is John Arch, J-o-h-n A-r-c-h. I'm here to open on LB426, which was introduced by the Health and Human Services Committee. LB426 would require the Department of Health and Human Services to contract for the completion of a cost analysis for necessary capital improvements and structural changes to the facilities of the Youth Rehabilitation Treatment Center-Kearney and to report on the results of the cost analysis to the Legislature. This bill arises from the recommendations

of the YRTC Special Oversight Committee in its December 15, 2020, report and before that from the recommendations of the Health and Human Services Committee in its January 2020 report on the YRTCs after the committee toured YRTC-Kearney in October 2019. Last February, Senator Howard was before you to open on LB1146, a bill that would have appropriated $3 million from the Nebraska Capital Construction Fund to the Department of Health and Human Services, specifically for the purpose of constructing dormitories at the YRTC-Kearney that would allow each youth residing there to have a private bedroom and to upgrade the shower and bathroom facilities to allow for more privacy. At the time she introduced it, I believe Senator Howard intended the bill to be a conversation starter and an educational opportunity for this committee. Additionally, there was some uncertainty regarding how much-- how much such improvements would cost and what exactly the $3 million would get us. However, the Health and Human Services Committee, as well as the to YRTC Special Oversight Committee, continue to feel that the state needs to invest in upgrading the facilities at YRTC-Kearney. As background, YRTC-Kearney was established in 1879. These aren't original buildings, by the way, 1879 and historically has been used to serve male youth. As many of you might recall after the crisis at YRTC-Geneva in August 2019, the Department of Health and Human Services moved some of the girls to Kearney. However, under the YRTC reforms we made last session, the Kearney campus will return to serving male youth exclusively by July of this year, except in the case of an emergency. Currently, there are five housing units on the YRTC-Kearney campus. One of these units, the Morton Building, has individual bedrooms, which I understand accommodates up to 30 youth in private rooms. The majority of the population at YRTC-Kearney, however, are housed in the four other units: Bryant, Creighton, Lincoln, and Washington where the youth sleep in open barracks style dormitories. Each of these units accommodate up to 25 youths in a single room. Additionally, these facilities lack private bathing areas. I've handed out some color photographs of the dormitories and bathing areas we're talking about, and I think you can see that we're talking about the bare essentials here. These housing units were built between 1945 and 1955. There's no privacy and it's far from a therapeutic rehabilitative setting. There are really two very specific concerns with the structure of these facilities. First, the barracks style dormitories and lack of privacy are simply not conducive to good treatment. In 2007, the Nebraska Juvenile Correctional Facilities Master Plan update was prepared, and

it found that dormitory style living arrangements at the YRTC-Kearney are not best practice. Rather, best practice includes creating facilities with a normative environmental character and small housing units. Additionally, in the assessment completed by the Missouri Youth Services Institute in April 2020, that report noted that the antiquated correctional physical environment has not been conducive to a youth-friendly treatment facility, specifically noting that the barracks style sleeping arrangements are not conducive to a safe therapeutic environment. Second, the structure of these facilities is a safety risk for youth and staff at the facilities I passed out, in addition, an Omaha World-Herald article for February 7 of last year, which gives you a picture of some of the problems that are exacerbated by the dorm style housing. Early that Friday, at about 1:30 in the morning, four boys who were committed to the YRTC-Kearney took apart those metal bed frames that you see in the pictures and used them to assault staff members, three of whom had to be taken to the hospital. I've also circulated a hand-drawn diagram that Senator Howard handed out last year. One of the challenges with the dorms at Kearney is that the staff is stationed in between two separate dorms so that the only way for the staff to get in and out of-- out of that area is to go through the dorms and down a set of stairs. If a staff member wanted to leave, if there was an altercation like the one last February, they would have to walk through the altercation in the dorms in order to get out. So when we're talking about restructuring the facilities, we're not only talking about what's appropriate for the youth who are committed to YRTC-Kearney, but also the safety of the working conditions for staff. I will mention that the Department of Health and Human Services is currently finalizing a five-year operational plan for the YRTCs, which was required by LB1140, which passed last session. In fact, they'll be presenting that plan to members of the Health and Human Services Committee and the YRTC Special Oversight Committee on March 9. That plan is required to include a facility plan as well as a capital improvements budget. I think this bill is a complement to that planning process that we required and will allow the department to really assess what improvements we can make in the near future to better serve the youth who are committed to YRTC-Kearney. With that, I appreciate your time and I'm happy to answer any questions you may have.

STINNER: So is it your testimony that we wait till the Health and Human Services has a chance to look at the five-year plan?

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ARCH: I would-- I would recommend that we-- that we wait. However, we, you know, what we may discover in the five-year plan and I've-- I have not been briefed yet on that five-year plan. But what we may discover is that there is a long-term issue that may require new construction or something like that, and we may have short-term issues that need to be addressed now. And that being the privacy, that being these are-- these are communal showers, you know, that that make it very difficult to control. So we may have some short-term issues that need to be addressed that-- that-- that may not wait so.

STINNER: And the range of age in these dormitories is from--

ARCH: The range of age?

STINNER: Age of the--

ARCH: You know, I've got I think somebody is coming after me to testify that will give you-- that will give you the exact-- the exact ages.

STINNER: OK, Senator Erdman.

ERDMAN: Thank you, Senator Stinner. Thank you, Senator Arch. So, Senator, this analysis that you're asking for may not be part of the solution, what you just described as the necessary things we need to do now. Is that correct?

ARCH: This-- this request for this analysis would be to address the issues today. In other words-- in other words, this would-- this would-- this would raise the issues of what do we need to do now for-- for both the privacy of those showers, private rooms, how do we handle a dorm, that dorm style condition that's out there right now?

ERDMAN: Didn't you say one of those buildings has individual bedrooms now?

ARCH: There are. It's not large enough to accommodate all of the-- all of the youth there at the YRTC, but one of those do have individual rooms.

ERDMAN: Would that building be retrofitted to be what you need?

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ARCH: That's why we need to do the study. I don't know the answer to that question.

ERDMAN: It's $125,000 just for the study.

ARCH: That was the department's estimate for what the study would cost. That number came from the department.

ERDMAN: Any idea what building the buildings that will be necessary are going to cost?

ARCH: No, I do not.

STINNER: Additional questions? Senator Clements.

CLEMENTS: Thank you, Mr. Chairman. Thank you, Chairman Arch. I was looking at this. I was wondering if the current layout of the buildings meets code for corrections of juveniles or-- or does it even meet code right now?

ARCH: They have had-- they have had that accreditation. And I believe it was in 2019. Again, somebody behind me could testify to the exact date of that. But, yes, they-- they did pass that accreditation.

CLEMENTS: All right. Thank you.

STINNER: Additional questions? Seeing none, thank you.

JENNIFER CARTER: Good afternoon, Chairman Stinner, members of the Appropriations Committee. My name is Jennifer Carter, J-e-n-n-i-f-e-r C-a-r-t-e-r, and I serve as your Inspector General for Child Welfare. The Office of Inspector General provides oversight and accountability for the child welfare and juvenile justice systems through investigations, identification of systemic issues, and recommendations for improvement. On January 5 of this year, we released a special investigation into the deterioration and closure of Geneva Youth Rehabilitation and Treatment Center. And in that report, we found that the Department of Health and Human Services, the Office of Juvenile Services and the leadership at the YRTC in Geneva failed to ensure the necessary and required management, staffing, programming, treatment, and facilities to care for youth in its custody. The issues with leadership and staffing and then programming and treatment led to an increase in frequency and duration of negative behaviors by those

youth, and then that those behaviors caused a lot of damage to the facility. Facilities are really integral to the programming in these-- and at these programs, and they can have a profound effect on the youth that are served. They should be and usually are tried to be built to serve and maintain the-- the needs of the youth that they are serving. The deterioration of the cottages at YRTC-Geneva had a really profound effect on the well-being of the youth in care there. And in fact, even the OJS director at the time emailed the DHHS facilities director noting that there was a real psychological effect to the state of the facilities. And I quote, he said, If the girls continue to live in areas that look damaged and look rough, they act how their surroundings act-- how their surroundings look. So we came in, in support today because LB426 aligns with our conclusion that the facilities at the YRTCs are really integral to programming, safety, and well-being of the youth in their care. And I think an evaluation of whether the physical plant supports that at any of our juvenile facilities is really helpful and necessary and could ward off problems in the future. So and I appreciate Senator Arch's focus on the barracks style dormitories, because that was just one thing we were going to bring up that I think that is a real area for focus because it has been an issue with staff safety. And I think it's just an issue in general for the boys. And in the last year or so, more actually now I'd note, right now the female youth are in Morton with the individual rooms, but that was a place that was often used for youth with higher mental health needs that were there, or frankly, smaller boys who were going to maybe be more subject to aggression by some of the older boys. And so they've lost that tool. But I think it's something that really any of the boys would probably benefit from having individual spaces. And the communal showering is-- was a real issue for the girls, continues to be and can be for the boys as well. To answer your question, Senator Stinner, that ages statutorily, you can't be younger than 14 to be in a YRTC and you can be there up to your 19th birthday. So through your 18th year. And I'm-- I'm actually going to-- I could happily get back to you on the date of the last time they passed the American Correctional Association accreditation. But they-- they did pass that last time. So I believe their buildings are up to code at least to meet that accreditation. And I'm happy to answer any questions.

STINNER: Any questions? Senator Wishart.

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WISHART: Well, thank you for being here. And thank you, Chairman Arch, for introducing this. Couple of questions. So with the Geneva facility, we ended up renovating that facility.

JENNIFER CARTER: One of the buildings.

WISHART: One of the buildings. How many more buildings would need to be renovated?

JENNIFER CARTER: At least three others--

WISHART: At least three.

JENNIFER CARTER: --for the cottages, for the living areas. They have an administrative building that's still in sort of working order and then LaFlesche, which was their building for higher needs youth, which kind of had been taken out of commission long before the crisis developed at YRTC, they renovated that as well.

WISHART: OK. So the Kearney facility, are-- why not have some of the youth who are at the Kearney facility, living in situations that may not be appropriate, in the newer renovated space in Geneva?

JENNIFER CARTER: I think that's a great question. And I think there was a time when I-- when we thought that the girls were going to move back to the renovated LaFlesche building and then, you know, the full use of Kearney for the male youth would be available. But I can only speak to what I've heard HHS testify to that they felt they couldn't staff it properly. And so that part of the plan never really got executed. There was a period of time where two to three girls would come as part of their transition back to the community, to Geneva. But never there's 20 rooms at LaFlesche, there-- it was never sort of used to the full census.

WISHART: OK, thank you.

STINNER: Additional questions? Senator Erdman.

ERDMAN: Thank you, Senator Stinner. So your comment about Geneva brings a question. Before they had the incident there with the girls, were they having trouble staffing?

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JENNIFER CARTER: Not to-- well, there was a slow decline is what we found in terms of being able to have enough staffing. So in the fall of 2018, there were maybe a few emails about that, but really by the beginning of 2019, they were pulling in staff from other facilities and largely the Hastings Regional Center. So at that point they were starting to have some real staffing problems. In their overall history of Geneva, there wasn't a lot of staffing problems that we are aware of, but there was sort of this fast decline around 2019.

ERDMAN: Do you have an opinion on what the intentions of the use of those buildings are going to be going forward in Geneva?

JENNIFER CARTER: I don't. I know that right now they're using a fair amount of space for, in the administrative building, for Medicaid and long-term care, kind of like a call center for Medicaid expansion. But since they have no longer been transferring the girls there for the transition out, I'm not sure if LaFlesche is being used at the moment. I think there's some conversations being had about what to do with those facilities right now.

ERDMAN: Are they having trouble finding staffing for that facility that they're doing the Medicare help with?

JENNIFER CARTER: I don't think so.

ERDMAN: OK, thank you.

JENNIFER CARTER: Certainly.

STINNER: Additional questions? Seeing none, thank you.

JENNIFER CARTER: Thank you.

STINNER: Additional proponents? Seeing none, any opponents? Seeing none, anyone in the neutral capacity? Seeing none, would you like to close, Senator?

ARCH: Thank you. I-- I would-- I would comment that some of the questions that you've asked are very appropriate and they are questions that we hope to receive answers for with the five-year plan as it's presented to us. Regarding the use of Geneva, the-- yeah, the five-year-- the five-year plan, we hope, will answer some of that. I want to give you, though, just for a second, I want to give you a

little background of what's-- of what-- of what these facilities and what-- what has happened over the years to our understanding of what's the best care. As you know, this YRTC program is a DHHS-run program. So the youth comes in contact with the court system, juvenile-- juvenile justice, and they are sent then to Kearney or to the YRTC program. At that point, they move from corrections or I should say the judicial system to the DHHS, where there is what is called a rehabilitation program for these youth. Now, that's not per se treatment, as in medical care, as in a psychiatric residential treatment facility, but it is a rehabilitation program. And the Legislature determined that it was best served by DHHS for that rehabilitation. At the time that they complete that program, then they go back to probation, back to the court system again. So what happens here in the middle with the YRTC program is-- is not a correctional program per se. It is a rehabilitation program. However, when those facilities were built, it was definitely viewed as correctional. And so the facilities have that correctional look, the dorm style, the concrete walls, the-- the very, very strong facility. And so now as treatment and our understanding of what's, of how best to do rehabilitation and nobody's-- nobody's, I guess, surprised to learn that it is a difficult process to help some of these youth. But that understanding has moved from this correctional model to a rehabilitation model, but the facility remains a correctional facility. And that's some of what we're struggling with here with-- with the YRTC in Kearney. So with that, I would-- I would end and answer any questions you might have.

STINNER: Senator Kolterman.

KOLTERMAN: Thank you, Senator Stinner. Thank you for being here today. Do you know, John, was-- was it always under DHHS or when-- when did it transfer to DHHS from the courts?

ARCH: It--

KOLTERMAN: I'm talking about Geneva and Kearney now.

ARCH: Yeah. It certainly was before my time in the Legislature, but it was-- it was recent. That's all I could say. But I can get you the exact date when that-- when that occurred.

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KOLTERMAN: Is part of the oversight committee taking a look at where it really should be?

ARCH: Right. So the oversight-- the oversight committee addressed, wanted to investigate and understand-- by the way, this is-- this is the report. You should all have received a copy of that. But the oversight committee wanted to address the incident itself. What happened in Geneva, what led to that incident, and-- and now where-- where are we? And one of the things we looked at, we looked at program, we looked at staffing needs, we looked at facilities, we looked at all of that. And so some recommendations came out for that purpose.

KOLTERMAN: OK, thank you.

STINNER: Senator Erdman.

ERDMAN: Thank you, Senator Stinner. Senator Arch, as I go by YRTC in Kearney, probably once a month, my son doesn't live far from there, I've noticed that they put a curve at the top of the fence, and I haven't heard of anybody escaping for a long time. Did that solve that issue for them to escape over the fence?

ARCH: I don't believe so. I mean, over the fence--

ERDMAN: Right.

ARCH: --perhaps. Out of the facility? I don't think so. These are inventive youth.

ERDMAN: Yeah, I thought that was an intelligent move. That's what they should have done when they built the fence. Thank you.

STINNER: Additional questions? Seeing none, thank you.

ARCH: Thank you.

STINNER: We do have proponents written testimony: Jason Hayes is a proponent of LB426. Also letters for the record: Nebraska Children's Commission also in support. And that concludes our hearing on LB426. We'll now open with LB185, Senator Brewer. Welcome, Senator Brewer.

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BREWER: Thank you, Chairman Stinner. Good afternoon, fellow senators of the Appropriations Committee. I'm Senator Tom Brewer. For the record, that is T-o-m B-r-e-w-e-r, and I represent 13 counties of the 43rd Legislative District of western Nebraska. I am here today to introduce LB185. LB185 seeks an appropriation of $700,000 each year of the coming biennium to the Department of Health and Human Services to provide funding to the Fred LeRoy Health and Wellness Center in Omaha, which is a tribally owned, federally qualified health center. This health center was established in 1998 by the Ponca Tribe of Nebraska. It provides medical, dental, behavioral health, and public health services to American Indians and other eligible-- and other eligible Indian health services. The Fred LeRoy Indian Health Service Center is designated as a federally qualified health center, the term FQHC, that receives grants and contracted-- contract funding through Title V of Indian Health Care Improvement Act. They are qualified for Section 340A(4) of the Public Health Services Act. And this is defined by the Health Resources and Services Administration. Like other FQHCs in Nebraska, their federal grant funding is limited, which in turn limits the services they can provide. The purpose of LB185 is to provide adequate funding for the Fred LeRoy Health Center on the same level as this committee appropriates funds to the other FQHCs in Nebraska in every budget. Language in the mainline budget bill in 2019 for LB294 stated that funding-- the funds appropriated to the other seven FQHCs shall be used for the purpose of implementing a minority health initiative which may target but shall not be limited to infant mortality, cardiovascular disease, obesity, diabetes, and asthma. These health issues are of the utmost importance among the Native population in Nebraska, and we are here in need of funding to address them. It's my hope that this Legislature can treat the Fred LeRoy Indian Health Center the same as we do the other federally qualified health centers that we're currently providing funding to. Thank you for listening and I am available for questions.

STINNER: Any questions? Senator Wishart.

WISHART: Well, thank you, Senator Brewer, for bringing this bill. So there are seven qualified health centers. When we do public health aid, this goes out to them. But we have another federally qualified health center that exists in Nebraska, the one that you mentioned, that currently doesn't get that aid?

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BREWER: Well, they recently received the designation. So I think that's why it is just--

WISHART: OK.

BREWER: --now coming that they're in to receive the equal funding.

WISHART: OK.

BREWER: So before they didn't have the same level of qualification.

WISHART: OK.

STINNER: OK. Additional questions? Senator Hilkemann.

HILKEMANN: Senator Brewer, this is-- I just looked up where this is located. You're within about a mile of the OneWorld Health Center. Have they worked together previously or what-- what?

BREWER: Well, I didn't research this OneWorld healthcare facility you're looking at. When I researched the-- the Fred LeRoy Indian Health Center, one of the questions I had is, is it Ponca only, and it's not. Matter of fact, they serve 150 different tribal members. So, you know, whether or not there is a connection between the two, I don't know. But obviously, one is going to probably have the ability to work through Indian healthcare issues or Indian health services in a different way than the other would. So there will be folks that follow me, Judi, for one, that-- that will probably be able to have a better idea on that. But I would think that their missions are enough different that there may not be the ability to have lost-- a lot of cross-leveling there. But Chairman Wright's here, maybe another great person to talk to on that.

HILKEMANN: OK.

STINNER: Additional questions? Seeing none, thank you.

BREWER: Just so you know, I'm-- I'm in the middle of an Exec, so I'll probably waive close. I'll watch. If we can finish in Exec and I get back down, I will. But if I don't happen to be here, then I'll waive closure.

STINNER: Thank you.

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BREWER: All right. Thank you.

STINNER: Do we have proponents?

LARRY WRIGHT, JR.: Good afternoon.

STINNER: Good afternoon.

LARRY WRIGHT, JR.: My name is Larry Wright, Jr., L-a-r-r-y W-r-i-g-h-t, J-r. Good afternoon, Chairman Stinner, members of the committee. Again, my name is Larry Wright, Jr. I'm the tribal chairman for the Ponca Tribe in Nebraska. I'm here today to testify in support of LB185 and respectfully ask your support for this important legislation. Our first tribal clinic, the Fred LeRoy Health and Wellness Center, opened in operation in working to provide full services on January 1, 1997, under the federal Self-Determination Agreement Public Law 93-638. The Fred LeRoy Health and Wellness Center provides medical, dental, pharmaceutical, behavioral health, and public health services to American Indians and other eligible-- and others eligible for Indian health services. In our current capacity at the Fred LeRoy Health and Wellness Center alone, we serve over 6,000 tribal citizens and other qualifying individuals, tribal citizens from over 160 different tribal nations that live in Nebraska, that are Nebraskans have taken advantage of the services that we provide. The Fred LeRoy Health and Wellness Center is a designated federally qualified health center that receives grant and contract funding through Title V of the Indian Health Care Improvement Act. Like other FQHCs in Nebraska, our federal grant funding is limited, which in turn limits the services that we can provide. The purpose of LB185 is to provide funding parity for the Fred LeRoy Health and Wellness Center, as well as the other FQHCs in Nebraska that are funded through the federal Program 330, Public Law 104-299 and the Federal Health Centers Consolidation Act of 1996. The defining legislation for federally qualified health centers under the Consolidated Health Center Program is Section 1905(B)(2) of the Social Security Act. The Ponca Tribe of Nebraska is both a federally qualified health center under this program just referenced, and a tribal health center recognized by the Health Resources and Services Administration, or HRSA, also called 638 contract or compact. Since the health center is operated by a tribe providing outpatient healthcare programs that specialize in caring for American Indians and Alaska Natives operated under the Self-Determination Act, our outpatient healthcare facilities that are

operated by a tribe or tribal organization under the Indian Self-Determination Act are by definition FQHCs. Subsequently, the Fred LeRoy Health and Wellness Center is a registered FQHC with the state of Nebraska-- Nebraska, I'm sorry, the state of Nebraska Department of Health and Human Services. The Fred LeRoy Health and Wellness Center operates under the umbrella of our Ponca Health Services. The Fred LeRoy Health and Wellness Center is currently an expansion-- in expansion planning to increase our overall programs and services. We also have a clinic in Norfolk, Nebraska, and are currently renovating a building that was recently purchased here in Lincoln, and that will include a clinic as well. And in that project, we project to serve over 2,500 American Indians and staff and others in the Lincoln area. All of these things will in turn lead to the creation of over 300 jobs within the next two years, all in the healthcare field. The services we provide in our locations help provide preventative care, as well as helping those we serve who have chronic preexisting conditions and comorbidities. Many we serve are considered charity care, which in turn relieves other non-Native medical facilities and the costs associated. As a whole, more American Indians in Nebraska live in urban centers than live on reservations. As a tribe that was terminated in the 1960s and federally reinstated in 1990 with the condition of having service delivery areas in lieu of the reservation, the Ponca Tribe's service delivery areas in Nebraska include several of its largest cities: Omaha, Lincoln, Grand Island, Norfolk, and Columbus. We serve not only our own Ponca citizens but other American Indians in these locations. Like other FQHCs in Nebraska who rely on federal and state funding sources, the parity that this bill will afford the Ponca Tribe to carry out our mission to serve our tribal citizens, other American Indians, and our staff, who are all Nebraskans, is paramount to providing long-term preventative healthcare and minimizing the cost of healthcare that come with lack of access and neglect. And I'd be happy to answer any questions that you may have. And I want to, I'm sorry, just Senator Hilkemann, you asked a question earlier about OneWorld. Yes, we have relationships with all of those types of facilities in the Omaha area, especially in that proximity. We have partnerships with UNMC Medical Center, with Creighton University as well, to talk about the footprint that we have. The expansion project that we're talking about in Omaha is actually located. We're moving physically. That facility will be over by Ralston High School on a property that we bought several years ago are in the process. And that project and the expansion of the Fred

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LeRoy Health and Wellness Center will be an $80 million project if we can keep the construction and architect folks in line and not go any higher than that. But that's what we're projecting right now. So just to answer that question.

HILKEMANN: And--

STINNER: Go ahead, Senator.

HILKEMANN: So when-- so when is that-- when did you say that was projected to go over to Ralston?

LARRY WRIGHT, JR.: We own that facility now and we have-- we've been in the-- in the planning process for a couple of years now. It's a partnership with the Indian Health Service. This was a grant program that we applied for several years ago. And as you can imagine, there are 574 federally recognized tribes and they have a process where it's a competitive grant opportunity. And we were one of six that were awarded that-- that grant to move forward. And so this is a 20-year contract with the Indian Health Service and this facility, just to give you an idea of scope, the Fred LeRoy Health and Wellness Center is about 15,000 square feet in size. The facility that we're proposing will be about 125,000 square feet.

HILKEMANN: Well, my concern when I first thought about it was-- is the overlapping of the-- of the communities that you're serving.

LARRY WRIGHT, JR.: Correct.

HILKEMANN: OK.

STINNER: Senator Clements.

CLEMENTS: Thank you, Mr. Chairman. Thank you, Chairman Wright, for being here. On this funding request, does the state of Nebraska currently provide General Funds to the Fed LeRoy Center?

LARRY WRIGHT, JR.: We have different grants that we apply working with DHHS and other entities whenever those are applicable, and they fit programming that we work with. And so there are other grants that we work with, with the state.

CLEMENTS: But not a direct General Fund allocation.

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LARRY WRIGHT, JR.: No.

CLEMENTS: Just grants.

LARRY WRIGHT, JR.: Correct.

CLEMENTS: So this would be a new item from the state.

LARRY WRIGHT, JR.: Yes.

CLEMENTS: Thank you.

STINNER: Additional questions? Senator Erdman.

ERDMAN: Thank you, Senator Stinner. Thank you for coming. Did-- did your organization get any CARES Act money?

LARRY WRIGHT, JR.: We did.

ERDMAN: Do you know how much you got?

LARRY WRIGHT, JR.: We-- we received roughly $29 million.

ERDMAN: $29 million.

LARRY WRIGHT, JR.: Um-hum.

ERDMAN: What's your annual budget?

LARRY WRIGHT, JR.: For just the health-- health side?

ERDMAN: Your total budget?

LARRY WRIGHT, JR.: Our total budget within the tribe, we're about $40 million--

ERDMAN: Thank you.

LARRY WRIGHT, JR.: --for all of our services.

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

LARRY WRIGHT, JR.: Thank you.

STINNER: Good afternoon.

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JUDI GAIASHKIBOS: Good afternoon. Senator Stinner, Chairman, and all the members of the Appropriations Committee, I didn't testify on my agency budget this year, just sent in a letter. So today, I'm glad to see you all. And I'm here to testify in support of LB185. My name is Judi gaiashkibos. That is spelled J-u-d-i g-a-i-a-s-h-k-i-b-o-s. I am an enrolled member of the Ponca Tribe and I'm also Santee Sioux and I am the executive director of the Nebraska Commission on Indian Affairs, and I have been the director for 25 years. So our tribe was restored in 1990 and I became the director in 1995 to put it into historical perspective. As I was listening to LB426, there are a couple of things that struck me and I'm speaking in a holistic way to the history of Nebraska. And so often many of us weren't afforded the opportunity to learn about the first peoples, all of you and me as well, in the schools that we grew up in. So today I thought it was ironic to hear that the Kearney YRTC was built in 1879. And that was the year of the trial of Standing Bear. And Standing Bear had been forcibly marched to Oklahoma. At that time, we were not considered human beings. And his son dies, Bear Shield, 16-year-old, and on the way he is arrested and he ends up in a courtroom. And for the first time, we are human beings. And then another kind of a parallel that I thought about was one of the cottages is named the LaFlesche Cottage. And I don't know if all of you know, but America's first Native doctor was Dr. Susan La Flesche Picotte, who grew up in Walthill, Nebraska. And currently the Indian Commission is working to get that hospital restored. And we have raised $1 million and hope to raise $2 million more. So both a little bit of history that I think informs this bill today. For the Ponca people and for all Indian people, I am before you to support this bill, LB185, because Native Americans die at a much higher rate than any other people in America. Some of that's based on historic trauma. Some of that's based on lack of access to affordable healthcare. So over in Omaha, we have the Fred LeRoy Wellness Health Clinic and nearby is OneWorld. As an Indian person, I would not go to OneWorld. I would go to the tribal office because we're tribal people. And I want to say recently I was so thankful that my tribe could give me the COVID vaccination sooner than Lancaster County. And Chairman Wright informed me that we were doing 55- to 65-year-olds sooner. So I immediately got on the list because I haven't seen my daughters or my grandchildren for 13 months. So last week I got my first vaccination and I'll get my second March 18 and then in a couple of weeks I can go see my children. So I just wanted to say, Senator Hilkemann, OneWorld, you might say it does overlapping services. And what these FQHCs do is

they for-- give a one-stop shop that we can go to and be in a culturally competent setting. OneWorld isn't a tribal setting. And we are unique as dual citizens here in Nebraska. We are citizens of the state. And as far as what does DHHS currently do for our tribes? Some funding back in 1998. Since I've been here 25 years, I remember working on the bill to create the public-- the Native American Public Health Fund Act 25 years ago, only $100,000 per tribe and $100,000 for western Nebraska. That money has never increased. Now you know you can't run a health center on $100,000. And the Ponca Tribe has done so much as have the other tribes, the Winnebago Tribe, for instance. Wow. Isn't that great? So I don't think we should penalize the tribes for doing better. And what the tribe today is here before you to ask for money to build their sustainability and help them to be able to afford culturally competent healthcare for the first peoples of Nebraska. Therefore, I hope that you will find a way that you can do this, because those other entities, they're getting money out of the cash care fund. And there was language in there that wouldn't allow the tribe to do that. So, you know, during the COVID time, it's been very obvious nationally that there are high disparities for people of color in getting access to vaccinations, etcetera, healthcare in general. So with that, I would say I think it's time to honor the legacy of Standing Bear, Dr. Susan La Flesche. And this seven hundred thousand dollars would be something that going forward, you all can make a difference in the lives of Native American people. And I would be happy to answer any questions.

STINNER: Thank you. I wouldn't have guessed your age. I would have probably put you in the 30-year-old class-- classification. Any additional questions? Seeing none, thank you.

JUDI GAIASHKIBOS: No questions? OK.

***JASON HAYES:** Good afternoon, Senator Stinner and members of the Appropriations Committee. For the record, I am Jason Hayes, Director of Government Relations for the Nebraska State Education Association. NSEA supports LB426 and thanks Senator Arch and the members of the Health and Human Services Committee for introducing the bill. LB426 allows the Department of Health and Human Services to contract for the completion of a cost analysis of all capital improvements and structural changes to the facilities at the Youth Rehabilitation and Treatment Center Kearney location and to report the results of said analysis to the legislature. In December and January, a leadership

team at DHHS assembled a committee of key stakeholders. This group met several times to review the work being done and the experiences being offered to the youth assigned to the Kearney YRTC and to other facilities in the system. In addition to DHHS directors, key stakeholders included representatives from each of these entities: state offices of probationary services, juvenile justice, mental health practitioners, the Nebraska's Ombudsman Office, the Nebraska Department of Education and the Nebraska State Education Association. The focus of this group was aimed at three distinct areas: facilities, staffing and programming. A complete review of recent renovations at Kearney was shared along with the resulting effects. There have been fewer incidents of intense aggressive behaviors; fewer assaults by youth on staff and peers; and fewer documented attempts at escape from the facility. Additional facts were shared about further planned improvements to the facility which fall under the approval and accreditation process for the YRTC. Many of these concepts were introduced following a review of youth programs being offered in other states. A comprehensive study and a cost analysis of all capital improvements and structural changes being planned for the facilities at the Youth Rehabilitation and Treatment Center in Kearney as well as the other YRTCs in Nebraska will provide the legislature with a more accurate picture of the resources required for a Department of Health and Human Services plan that will better provide for the needs of the Nebraska youth assigned to these facilities. The NSEA, on behalf of our 28,000 members across the state, asks you to advance this bill to General File for consideration by the full body. Thank you.

STINNER: Any additional proponents? Seeing none, I do have support letters from the National Association of Social Workers and Nebraska Nurses Association in support of LB185. Is there anyone that is an opponent? Seeing none, is there anyone in the neutral capacity? Seeing none, I don't see Senator Brewer. So that concludes our hearing on LB185. We will now open with LB585, Senator Vargas.

VARGAS: Good afternoon.

WISHART: Afternoon.

VARGAS: Vice Chair Wishart and other members of the Appropriations Committee, for the record, my name is Tony Vargas, T-o-n-y V-a-r-g-a-s. I have the pleasure of representing District 7, downtown and south Omaha, here in our Nebraska Legislature. Now LB585

appropriates $5 million of General Funds to local public health departments. Within that appropriation is about $75,000 specifically for critical health services aid to be divided equally among the 18 public health departments and $3.6 million for proportional health services aid to be divided proportionally based on population among the health departments. Now, you'll recall this last year I introduced LB1018, which asked for $6.5 million appropriation to our public health departments. This committee decided to include an additional $1.5 million in our budget last session, which at the time was a good start in meeting the needs of our 18 public health departments. Right when we were debating and working through the legislative process to pass the budget last March, COVID hit and dramatically and drastically changed the needs of our health departments. We, as legislators with the constitutional power of the purse, appropriated additional federal emergency funds to help them deal with the health crises our communities were facing. Unfortunately, it wasn't enough and that's why it's so important that we continue to prioritize public health funding in our budget this year. Aside from what will hopefully be a once in a lifetime global pandemic, our public health departments deal with many other things on a regular basis, like the consequences that happen when communities don't have access to medical care, including the lifelong consequences of childhood lead poisoning, opioid abuse and addiction, communicable infectious diseases like the measles and whooping cough and higher cancer rates. Investing funds in these public health departments helps prevent chronic diseases, which keeps kids in school and keeps-- keeps our workforce healthy. Now the demand for services, growing challenges, and increased inflation since public health districts and departments were created 20 years ago have skyrocketed. I cannot think of a more appropriate time to fully invest in our public health infrastructure than right now and honestly think we should have done it years ago. There will be others testify behind me about the work they do, and they'll be equipped to answer any questions from the committee about how they've dealt with the ongoing pandemic and other public health issues. The only addition I will provide to you is, you know, we had this hearing last year before everything sort of expanded in regards to the pandemic. This original bill was drafted, conversations with our public health departments in 2019 at the end of that year. Every minute, hour, day where our infrastructure isn't meeting the needs of our communities is slowing preventative care and right now reactive care and support that our communities need. I've said it before but public health,

unfortunately, as lawmakers sometimes we view public health as only in need of emergency. I think it's why right now when you think about all healthcare, public health across the country only compromises [SIC] about 2 to 3 percent of funding on health. And we're looking at an industry where over the last five-plus years we've seen tens of thousands of full-time equivalent individual staff in the public health local departments, those positions have disappeared. It's folly. It is shortsighted for us to not invest in our infrastructure when we are not amidst a pandemic. It's dangerous for us to not do it when we are in the pandemic, especially when we're seeing variance in the expansion of what we know is going to be a long-term problem. So colleagues, I ask you to support this bill because I think we should have supported it fully last year and I think it's the right thing to do. And I appreciate your time. I'm happy to answer any questions. And if I can't answer them, people behind me will be able to.

WISHART: Any questions from the committee? Senator Erdman.

ERDMAN: Thank you, Senator Wishart. Thank you, Senator Vargas. So, Senator Vargas, I see in the bill this is a one-time appropriation of $5 million.

VARGAS: Yes.

ERDMAN: Is that correct? So what happens next year?

VARGAS: We're going to revisit the budget like we do every single year, and then we determine what we're going to be doing with every single agency and every single program.

ERDMAN: So-- so if you know, if you can tell me what are they going to do with the $3.6 million that's going to be designated by the number of populated-- population in each district. Correct?

VARGAS: I will allow public health departments to share what they would be doing. My aside is when we rely on one-time federal funds to provide long-term infrastructure, we get what we-- what we're getting funded with. And what we're doing is battling for staffing individuals to do this work. Even right now, our vaccine preparedness is only as good as the staffing that we have to be able to get the roll out. I applaud our public health departments for doing what they can with the resources they've been provided, especially one-time, short-term

resources that we've been provided. But we need some long-term infrastructure improvements. It's not solving the entire problem. This is getting us and sort of rightsizing the ship so. But I'll let them speak to some of the res-- some of the things that they would be doing to answer your question, Senator.

STINNER: Senator Clements.

CLEMENTS: Thank you, Mr. Chairman. Thank you, Senator Vargas. You said that LB1018 passed or a portion of it. What was the amount that passed?

VARGAS: This $1.5 million--

CLEMENTS: 1.5.

VARGAS: --across all the health departments equally.

CLEMENTS: Oh, equally.

VARGAS: Um-hum.

CLEMENTS: Thank you.

STINNER: Senator Wishart.

WISHART: So when we passed $1.5 million last year, my understanding was ongoing. Was it just one time?

STINNER: One time.

VARGAS: One time.

WISHART: It was just one time.

STINNER: It is ongoing.

VARGAS: Well, it-- so-- it is ongoing in that it's in the budget right? But we still have to approve that. But it's $1.5 million split equally across all the public health departments.

WISHART: Right. But with this $5 million and kind of going back to what Senator Erdman was asking, would the goal be to raise the--

VARGAS: That is the goal.

WISHART: --continuous appropriation of $5 million moving forward, so as public health departments--

VARGAS: That is the goal.

WISHART: --as that's divvied up, if they staff up, that funding will happen moving forward.

VARGAS: Yeah, that's the intent.

WISHART: OK.

VARGAS: And sort of to come back to Senator Erdman's--

WISHART: OK.

VARGAS: --question, we're putting this and I view our budget as, yes, we're putting money into it. I view it as not just one time. And I'll clarify this. I view this as increasing our funding from here on in, but we still have to approve our budget every two years on everything that we say we're going to put in our biennial budget. This would fully fund the bill from last year to try to answer that question.

WISHART: OK.

STINNER: And I stand corrected. It was an increase in the base, so it's ongoing.

VARGAS: Yeah.

STINNER: Senator Dorn.

DORN: Thank you, Chairman Stinner. Thank you, Senator Vargas, for being here. That was part of my question. But then also, I believe I don't remember exactly when we did it, if we did it in special session or when we brought, you know, we appropriated $83 million for CARES or I call it for COVID funding. We brought $20 million of that back in. But didn't we at that time also approve $2 million additional for the public health departments at that time? And that's just more for clarification than anything. I'm not saying that or whatever. But I guess my question is a little bit along the lines of Senator Erdman.

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This is, and we'll find out more answers later that. But this is a one-time appropriation. It's not a so much, so much, so much. It's a one-time appropriation.

VARGAS: And that's sort of the clarification. We have other bills that will sort of increase maybe every single year. This is increase in the base. Right? So this is increasing what we would do from here on in. And to try to answer your sort of first, so this is trying to rightsize where we left off last year. And that additional federal money was we gave the authority that money to be given. It was one time and it needed to be spent. So it's not ongoing. That federal CARES Act fund.

DORN: The $2 million when I talked about though, that was our state funding.

VARGAS: Oh, our state, $85 million authority.

DORN: That was our state-- if you remember, we had that $83 million we approved for I call it the government-- Governor's emergency fund. And I think it was during special session where we brought $60 million back in, left $20 million in there. But in that time, we also appropriated $2 million directly for the public health systems I think. Because if I remember right, you even made that motion whatever to--

STINNER: That was left in there as a contingency if they needed it.

DORN: If they, OK.

STINNER: Yeah, I remember what you're talking about now. I was a little vague on it, so. Yes. And I believe that money is still in there and with that condition as well.

DORN: OK.

STINNER: OK. Additional questions? Thank you.

VARGAS: Thank you.

STINNER: Good afternoon.

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PAT LOPEZ: Good afternoon, Chairman Stinner and members of the Appropriations Committee. My name is Pat Lopez, P-a-t L-o-p-e-z, and I am the health director at Lincoln-Lancaster County Health Department. I'm here to testify in support of LB585 on behalf of the Friends of Public Health in Nebraska. We are so grateful to Senator Vargas for introducing this bill. A strong statewide local public health system that was developed after Senator Jim Jensen and Senator Dennis Byars, the Chair and Vice Chair, and the Health and Human Services Committee prioritized the creation of the local health department system in Nebraska. And when LB692 was passed in 2001, the original funding for public health, for population health and infrastructure was established. Can you hear OK if I leave my mask on? I'm sorry.

STINNER: I think so.

PAT LOPEZ: I saw Senator Hilkemann--

STINNER: Senator Erdman is shaking his head no, but--

HILKEMANN: That's all right. I'll read your testimony.

PAT LOPEZ: I'll try it.

STINNER: The most important one is the person who's transcribing to make sure that they can understand.

PAT LOPEZ: OK.

STINNER: So.

PAT LOPEZ: The current pandemic has put a bright light on the need for ongoing additional funding. The local public health response has been critical. Emergency funding has allowed us to access basic resources that we have needed to carry out our local public health responsibilities. The pandemic has clearly demonstrated the leadership role the local health department has developed in convening the health systems and community to respond to our local needs. Since their inception, the local health departments have formed partnerships, task forces, and coalitions to leverage funds to address the unique public health needs in local communities, whether it's higher rates of cancer, smoking, diabetes or heart disease, low birth rates, fluoridation of our water, lack of adequate dental, medical or childcare, the need for bilingual interpretation, injury prevention,

underage tobacco and alcohol use or addressing our opiate drug use in our communities, domestic violence or worksite wellness or environmental hazards, our local public health responds. The current health departments have assumed the leadership role in the coordination and planning to meet health needs and have been successful in bringing together local organizations to address the public health needs in each of our district. Health departments are the leaders in developing healthy communities across the entire state. And as you all know, the demands on local public health have increased dramatically in the 20 years since they were formed and the current resources are not supporting the huge challenges of our public health in Nebraska. Our local public health funding has not kept up with inflation and population growth. New dollars are critical to meet this ever increasing workload and will allow our communities and their public health departments to have the capacity to respond to current and emerging public health threats and provide our critical resources to address our statutory response-- responsibilities. So I urge you to support LB585. And thank you for your time and service.

STINNER: Thank you. Additional questions? Senator Erdman.

ERDMAN: Thank you, Senator Stinner. I'll take a shot because I didn't hear what you said exactly. But here's my question. Did you get any CARES money?

PAT LOPEZ: Yes, we did.

ERDMAN: How much did you get?

PAT LOPEZ: That varies for each department. It's based on our actual expenses and what the Governor approves and was approved through FEMA. CARES Act money is not ongoing money. It is only for COVID-related expenses.

ERDMAN: OK. What-- so let me ask it again. So you're public, you're the director of Lancaster Public Health. Correct?

PAT LOPEZ: Right.

ERDMAN: How much money did Lancaster Public Health get--

PAT LOPEZ: $4.7 million to date,--

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ERDMAN: 1.7?

PAT LOPEZ: --Senator.

ERDMAN: OK.

PAT LOPEZ: And that was used directly to respond to the COVID pandemic.

ERDMAN: I understand that. I didn't ask that. I just asked how much did you get? So can you tell me what was your-- what's your background training? What was your [INAUDIBLE] you trained in the medical field to become the director of the health department?

PAT LOPEZ: I'm trained in nursing. I have a master's degree from the Nebraska Medical Center.

ERDMAN: And you say you had a master's degree?

PAT LOPEZ: Yes.

ERDMAN: From what?

PAT LOPEZ: From the University of Nebraska Medical Center.

ERDMAN: OK, thank you.

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

PAT LOPEZ: Thank you.

ROGER REAMER: Good afternoon. I'm Roger Reamer, that's R-e-a-m-e-r. I'm the current CEO of Memorial Health Care Systems in Seward. I'm also the vice president for the Four Corners Public Health Department, which represents the counties or serves the counties of York, Polk, Butler, and Seward. Chairman Stinner and members of the Appropriations Committee, including Senator Kolterman, who is from my district, I thank you for your service and the opportunity today to testify. I'm testifying today in support of LB585. It has been my pleasure to be on the board of directors for the Four Corners Health Department for the past 18 years. Over those years of serving on the board, I've personally witnessed the growth and many efforts that line up well with our mission statement which states: promote health, prevent

disease, protect the environment, and improve the health of our communities. Our local health department has grown to where it now includes efforts with health surveillance, nursing services, medication assistance, emergency preparedness, pandemic preparedness, just to name a few. Our public health department has and continues to develop strong community partnerships in its efforts to find ways to meet the various needs of each community. These coordinated community partnerships have been one of the game changers that is made when this COVID-- that was needed when this COVID-19 pandemic hit our state. My healthcare system and other hospitals, along with other smaller groups, have partnered with the local health department throughout this entire effort. We started off educating people what quarantining meant before we could test. We've also coordinated testing and now we've very fortunately and very happily have started mass vaccinations in our district against COVID-19. These partnerships didn't just start with this pandemic. They have been in place for many years, which has allowed our communities to deal with a variety of public health issues through various programs, programs such as cancer coalitions, newborn education, and diabetes education programs, just to name a few. Because of these longstanding relationships, the local public health department can be and is a strong responder to the many preventative efforts that are required of them. Over my years on the board, I've witnessed the staff's compassionate work on preventative and emergent situations. Through it all, they've found ways to get their work done with limited resources. Well before this pandemic year, the local health department managed their budgets in a reasonable and responsible manner in an attempt to get as many critical health services covered as they could with the limited budgets they had to work with. The health departments greatly appreciate the monies they have been appropriated. We continue to feel the pressure of needing to address more disasters in local communities. Because of the solid work that has been done by our local health departments with these disasters, more demands are put on them as communities continue to learn of their value. These demands are welcomed because that is what we are here to do. But we can't continue to ask these departments to do a lot with a little. One of the best investments the state has made was in 2001 when the Legislature supported the development of public health system. As a private healthcare CEO at that time, I wasn't sure what a district health department could bring to the table in helping with the health of our communities. So I decided to get involved at the very beginning by agreeing to be a spirited member of the district

board of health. I actually remember the meeting where we picked the name of Four Corners Health Department. That's how long I've been around. That was 18 years ago and I've learned a great deal over that time, just how valuable a public health district can be in helping with prevention, disasters, coordination of care across all health care sectors, and partnering with your private health care sectors. In summary, whether it's trapping mosquitoes to help identify if West Nile virus is in our area or it's testing water for communities dealing with flooding, offering up assistance after a tornado damages a community within our district, partnering on care coordination initiatives, or taking the lead in a 100-year pandemic, the responsibilities of a public health department are important, and they continue to grow. I was very glad to see Senator Vargas introduce LB585 and that this committee take it up for consideration. I know firsthand the value our local health department brings to our communities, and I also understand just how hard their work is without the proper funding and budget to get the work done that needs to get done. I respectfully ask that you support LB585 and thank you for the opportunity to testify today.

STINNER: Thank you. Senator Kolterman, I figured you wanted to lead off the questions.

KOLTERMAN: I could ask a question.

ROGER REAMER: With his mask on, I wasn't sure if he was smirking or smiling.

KOLTERMAN: Welcome, Roger.

ROGER REAMER: Thank you.

KOLTERMAN: We go-- we go back a long ways, don't we?

ROGER REAMER: We do.

KOLTERMAN: So you've been doing this since 2001 when-- when healthcare was started, the healthcare--

ROGER REAMER: Yes.

KOLTERMAN: --programs were started in the state.

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ROGER REAMER: Yes. The Four Corners Health Department was developed and started in 2003.

KOLTERMAN: Were you still in David City at that point in time?

ROGER REAMER: At-- at the beginning, I was.

KOLTERMAN: That's what I thought, you came to Seward from David City.

ROGER REAMER: Real early, yep.

KOLTERMAN: All right. Do you know if-- are all five of the hospitals in our district in the Four Corners, are they still regularly involved in Four Corners Health?

ROGER REAMER: Absolutely. I think it's really been-- has really shown up here with the pandemic. I mean, our health district, we meet every Thursday as a group of hospitals and-- and local government to discuss nothing about what's going on with the pandemic, with the health department, everything from, you know, what are we doing for safety measures when we had to shut down our elective surgeries, what would that mean to our communities? What does it mean to our schools? What does it mean to our activities for children in the area? All those things are being dealt with on a weekly basis. And the hospitals, all five hospitals are involved in this.

KOLTERMAN: But you rely, other than through this pandemic, you rely a lot on Four Corners Health to help educate the general population about things like diabetes, as you said.

ROGER REAMER: Yes.

KOLTERMAN: And you do some immunization through Four Corners as well. Don't you--

ROGER REAMER: That's correct.

KOLTERMAN: --underserved population?

ROGER REAMER: That's correct. Yeah.

KOLTERMAN: Thank you.

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ROGER REAMER: Yeah. You know, when I said earlier in my testimony that, you know, I got on the board when it first started and to be honest with you, the private sector wanted to know what is this public health department going to do? You know, are they-- they kind of coming into our territory of delivering care or whatever? And what we've learned over the 20 years is it's been a great partnership because they do help promote preventative things and it just goes hand in hand with your local hospitals, your local clinics. It didn't start off exactly that way. But as we've all learned what public health is all about and-- and learned more about what public health is, we've just seen that partnership grow over the years.

KOLTERMAN: Thank you.

STINNER: Senator Clements.

CLEMENTS: Thank you, Mr. Chairman. Thank you, Mr. Reamer.

ROGER REAMER: Yes.

CLEMENTS: Do you know how much your share would be of this $5 million if it's approved?

ROGER REAMER: I cannot speak to that. I-- I'd have to get that for you.

CLEMENTS: I'm just guessing $150,000. What is your annual budget?

ROGER REAMER: Again, I'm not the director, so I can't respond to that at this time. I can get that for you, though. I apologize.

CLEMENTS: I was kind of wondering what percentage this would be of a health department's--

ROGER REAMER: Sorry about that.

CLEMENTS: --budget.

ROGER REAMER: But some of the other folks can probably give examples for you--

CLEMENTS: Thank you.

ROGER REAMER: --a little bit better than I can. Sorry.

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STINNER: Additional questions? I should have asked Pat this and you as well. If you get this additional dollars, are there things that we're not doing in public health that we could be doing and you'll use this money for new programs or expanding the ones that you have or?

ROGER REAMER: I believe as I look back on the services that we're currently offering and we have to kind of step back away from the whole pandemic and kind of relook at what it is we're here for, what are we trying to accomplish? And so prior to the pandemic, we feel that these extra funds will help us get caught up in things that we can't get our arms around. Every year, like with the mosquitoes and things like that, that's pretty common stuff that we can get staff, but we're seeing more need and more education. And we just think that that's-- that's an area we can grow in and continue to grow in. And with all the surveillance we're doing, I think coming after a pandemic, you're going to see more surveillance kind of work, trying to keep-- keep control and understanding of-- of infectious diseases in our district. Healthcare systems work a lot in infectious disease, but now we need to look at it from a public health perspective, not within our-- not within our facilities, but within our public.

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

ROGER REAMER: Thank you.

STINNER: Afternoon.

GINA UHING: Afternoon. My name is Gina Uhing, G-i-n-a U-h-i-n-g, and I'm the public health director for Elkhorn Logan Valley Public Health Department in Wisner, Nebraska. Thank you to Senator Vargas for introducing this bill. And thank you for the-- to the committee members for your support of our health departments as we navigate through the pandemic. If we rewind back to a year ago today, a virus that had been spreading overseas had now made its way to the U.S. It was no longer if, but when it would arrive in Nebraska and then in our jurisdictions. While the general public watched on television a pandemic unfold, your local public health workers were-- were gearing up and training rigorously for what we believed to be the biggest challenge that we would ever face. That pandemic put a bright light on the funding and infrastructure needs of our departments. About two weeks into the pandemic, we all realized at that time that we didn't have the staff or resources that would be needed to meet this virus

head on, the critical resources that we were going to need to fulfill our mission. This is a responsibility that we took very seriously, but we lost sleep worrying about how we would rise to the occasion without the infrastructure that was needed and how we would come out in the end without that support. For me, it was equivalent to flying a plane without a pilot's license and bearing the weight of having to land the plane safely with all the passengers on board alive and well. Moving ahead to April 5, 2020, when I had to announce the first COVID-19 death in my jurisdiction, that was the day that I felt defeated. And every death since then that I've announced from that point forward is a death that I've taken very personally, a let down, if you will, that I wasn't able to land the plane. Serving in this role is more than a job. It's a passion and a calling. And the public health workers truly do care about everybody that we've been called to serve. Simply speaking, we would not have been able to do what we've been doing for the past 12 months without your critical support. Each day presents new challenges with changes in details coming down the pike faster than we can absorb them. The workload and stress is unimaginable. Most public health department workers were in our positions prior to the pandemic. We knew that a pandemic was always a possibility. And yes, this is something that we signed up for when we accepted our positions. We planned for pandemics and our career choices were ours. But those choices have come with consequences also. Behind the scenes, the personal price that we've paid is in the form of sleepless nights, being on call, having to respond to requests 24/7, having to bear the burden of the worry, and for those of us that have young families at home seeing our children after they're tucked into bed at night and leaving for work again in the morning before they wake up. It's a challenge to adequately summarize and describe what we're all facing and juggling, from contact tracing to media requests to reviewing event plans, linking individuals to relief programs, inventorying and delivering supplies, and now the rigorous vaccine element. We show up to our departments each day to try to boost our staff and make the morale stay high so they can continue doing the work that they do, even though they're not always treated with grace and respect. Again, I can't thank you enough for all your support for our public health system. We ask that you support this funding proposal from Senator Vargas. Your support makes the burden that we're carrying on our shoulders a little bit lighter and will help us to continue to do the help that we do to support Nebraskans. Thank you. And I can answer any questions that you have.

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

GINA UHING: Thank you. I'm going to jump out now to go to a vaccine clinic. So thank you for everything.

STINNER: Thank you.

ADI POUR: I'm going to take this mask off because I'm seeing there is some difficulty hearing. So good afternoon, Chairman Stinner.

STINNER: Good afternoon.

ADI POUR: Good afternoon, members of the Appropriations Committee. I'm Adi Pour, A-d-i P-o-u-r, and I'm the director of the Douglas County Health Department. First, I would like to thank Senator Vargas. He is a true public health advocate. On behalf of the Board of Health and the Douglas County Health Department, I testify in support of LB585. Over the last year, every day we are talking about the pandemic and COVID-19. And the other popular term is public health. It has been frustrating to hear everyone talking about public health will do it. Public health will decide. Ask your public health department. The burden on public health has been unheard of over the last year, but it also has clearly shown us how marginalized public health departments have been before. The U.S. pays for more for healthcare, but has higher rates of preventable hospitalizations and avoidable deaths than other high-income countries. We have an unprecedented opportunity to strengthen our local public health system. We need a public health Renaissance that builds a resilient, interconnected system able to address the full range of health threats. For this, we need much better data systems with modern informatics that are real time, accurate, consistent, as well as substantially increased funding for staff for public health at the local level. To accomplish this, we will need a new way of financing public health to ensure that funding not only increases, but is predictable and sustainable to avoid the cycles of panic and neglect that have plagued public health for decades. Even before COVID-19, people would speculate that we are more likely to be killed by a pandemic than a terrorist attack. How true is this now? I can give you many specific examples for this additional funding, but a few of them would be our IT infrastructure, including our surveillance systems, our data reporting systems. This has led to our data analyst to download data from the state from four different systems, downloads that sometimes take more than 30 minutes every

morning just to provide data to me. This public health crisis has made great expectations of public health. We answer our information line seven days a week and have now had more than 40,000 calls to that line. We managed the PPE distribution in Douglas County to healthcare and other organization. And we have up to now distributed more than 10 million pieces of PPE; that's masks, gowns, gloves, etcetera. And now we are vaccinating and overseeing more than 15 vaccine clinics this week with first dose. Some have second doses. We have potentially at this time as I looked this morning for next week, we have 12,000 doses of vaccine that we will administer within seven days. Everything that we get in, we try to get out within seven days. You may say that we are receiving CARES and FEMA funds. That financial emergency funding is one-time funding and we need funding that is consistent so that we can plan. If we get this emergency funding, you know what we are doing? We are hiring temporary staff and our staff needs to train them first and then oversee them. That's not efficient and that's not giving us the outcome that I think you all require from us. In addition, over the last few years, everyone has been recognizing that some of the illnesses have their start in the social determinants of health, i.e., people not having access to food, to work, to housing, just to mention a few. We need to work with the communities to connect them to these resources and look at system change to address these shortcomings. This all requires infrastructure and a professional workforce for us to respond to the expectations of the public. The Douglas County Health Department could have needed, used these funds a year ago to make sure that we were a strong agencies with professionals that can provide the necessary activities and services that the community expects. In summary, I hope that you see the urgency of this continuous funding, especially if you value a strong local public health system for the future. And thank you all for your service.

STINNER: Thank you. Questions? Senator Clements.

CLEMENTS: Thank you, Mr. Chairman. Thank you, Director Pour. Do you know how much funding Omaha or Douglas County would receive under this bill?

ADI POUR: I know it to a penny: $1,058,500.

CLEMENTS: OK. I guessed (960,000 so you're better than me. And what is your annual budget?

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ADI POUR: The annual budget for the Douglas County Health Department is around $14 million. And I'm saying around because about 60 percent of our funding is from grants. And that can vary from year to year so around 15-- 14, 15 million dollars.

CLEMENTS: And does Douglas County contribute to part of that budget?

ADI POUR: Absolutely. The county contributes approximately 20 percent of our budget, so that would be around $4 million.

CLEMENTS: Very good. Thank you.

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

ADI POUR: Thank you.

***JON CANNON:** Good afternoon members of the Appropriations Committee. My name is Jon Cannon. I am the Executive Director of the Nebraska Association of County Officials. I appear today in support of LB247 which would appropriate $5,000,000 from the General Fund to Public Health Aid, for FY2021-22. We thank Senator Vargas for his continued support for appropriating funding to our essential public health departments. Such funds would be provided for 18 local public health departments. Included within the appropriation in this section would be $75,000 for critical health services aid to be allocated to each of the public health departments and $3,650,000 for propOliional health services aid to be distributed proportionally based on population among the eighteen public health departments. While public health departments were created in 2002, they took on a special role in our everyday lives in 2020 as we were faced with the COVID-19 pandemic and now as the vaccine roll-out is taking place. The public health departments have faced the new challenges and continued to address their additional functions they are responsible for without missing a beat. We ask you to please consider our thoughts prior to taking action on LB585. Thank you for your willingness to consider our comments and we encourage you to provide funding to the health departments as identified in LB585. If you have any questions, please feel free to discuss them with me.

STINNER: Any additional proponents? Seeing none, any opponents. Seeing none, anyone in the neutral capacity? Seeing none, would you like to close, Senator?

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VARGAS: Thank you. Members of the Appropriations Committee and thank you to the testifiers that they came here, the public health department directors and individuals on their behalf. I just wanted to see if you had any questions. The only additional clarification I wanted to make was that $2 million that was referenced earlier was included in the July budget and was the-- was from the Governor's emergency fund, which we stated that was distributed to departments in early February of this year, about $110,000 per department, and has to be spent by June 30 on COVID-19 related expenses only. So it was a one-time. But other than that, I, I introduced this bill last year. We funded part of it. And my intention is that we fund the full amount. And I think what we've seen, I think actually Dr. Pour's last statement that how many times have you heard over the last year the public health department will take care of that. Talk to your public health department. You've had constituents engaging more and more with our public health departments and agencies. They have become our local point of information, access to resources, a gatekeeper. And if we're not going to invest in them when we're not-- when we're not seeing public health emergency arise, I want you to just think what the-- what the life of our public health departments and staff and our communities have been like the last three years. Flooding, a pandemic, and continued growth of our state is dependent on the livelihood of our public health departments because they ensure that on the back end down the line, we are reducing our reliance on the rest of the healthcare system by being preventative. With that, I appreciate it. Happy to answer any additional questions.

STINNER: Additional questions? Seeing none, thank you, Senator. We do have written-- submitted written testimony from Jon Cannon, who is a proponent of LB585. We have 35 letters of support for LB585. That concludes our hearing on LB585. We'll now open our hearing on LB662, Senator McDonnell.

McDONNELL: Thank you, Chairperson Stinner, members of the Appropriations Committee. I'm here today to present LB662, which would increase the appropriation for domestic violence services by $480,000 in fiscal year 2021 and '22 and fiscal year '22-23. We currently appropriate $1.5 million to these domestic violence services throughout the Department of Health and Human Services. Please also note that this appropriation has not been increased since 2015, when the Legislature increased funding for services and prevention by $134,000. Prior to 2015, this program had not received an increase in

funding since 2002 in the amount of $150,000. This means the total increase in the state funding for these programs over the last 20 years has been less than $300,000 to be divided among 19 domestic violence programs and for tribal domestic violence programs throughout the state. We know the need for these services is growing at a much faster pace than the rate of which we are funding it. Domestic violence, sexual assault, and sex trafficking are taking place each and every day. National figures estimate that one in four women and one in seven men have experienced severe physical violence by an intimate partner at some point in their life. And across the country, one out of six women has been the victim of an attempted or completed rape in her lifetime. I'm asking this committee to please consider this meaningful increase in an effort to better allow our statewide network of programs to address what we know is a critical and persistent need. There will be people testifying following me that will speak on both the incredible increase in need across our state and the services that these additional dollars will fund. I'll be here to answer your questions, and I'll also be here for closing.

STINNER: Any questions? Senator Dorn.

DORN: Yeah, and I don't know if you have the fiscal note in front of you. I guess maybe between your testimony and then this on the last page of the fiscal note, maybe I'm missing something. But I think you said there's a hundred and-- $1,500,000 in the fund already.

McDONNELL: We've already appropriated 1.5. We're adding $480,000. Take a look at prepared by Liz Hruska, your fiscal note LB662 and you'll see it in the comments. Clearly, the base appropriation in Program 354 domestic violence services is $1.5 million from the General Funds. The funds are not earmarked. This bill adds an earmark at a higher level than the current allocation based on the earmark $480,000 of existing General Funds.

DORN: But that last sentence there, though, if sufficient funding is not available, portion of the existing child welfare services. So it's going to use other funds or this is new funds?

McDONNELL: No, I want to increase it by $480,000.

DORN: Increase it by $480,000. Thank you.

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STINNER: Additional questions? Seeing none, thank you.

McDONNELL: Yep.

STINNER: Afternoon.

LYNNE LANGE: Good afternoon, Senator Stinner. And thank you to Senator McDonnell for introducing this bill for us today. Hello, members of the Appropriations Committee. My name is Lynne Lange, L-y-n-n-e L-a-n-g-e, and I'm the executive director of the Nebraska Coalition to End Sexual and Domestic Violence. I'm here to testify in support of LB662, which provides for an increase in funding for domestic violence prevention and services through the appropriation to the Department of Health and Human Services. The Nebraska Coalition is a statewide nonprofit advocacy organization committed to both the prevention and the elimination of sexual and domestic violence. We provide training and program capacity building for our network of member programs supporting and building upon their services. The funding that our member programs receive from DHHS is tied to Nebraska's Protection from Domestic Abuse Act and is the only state funding that is specific to assistance and prevention efforts. While our member programs can apply for federal grants, they are largely competitive, limited to specific activities, and do not cover the full range of services that are required under our state statute. Federal funding is also directly tied to the capacity of our member programs to provide matching state dollars. Many of our programs already struggle to meet the match requirements due to limited state funding. State funding for domestic violence prevention and services has historically been extremely low, with the only increase over the last 19 years consisting of 10 percent. Yet services have increased by 85 percent during that time frame, providing 60,692 shelter beds. This is a noteworthy-- this is noteworthy during a time of pandemic when survivors have additional barriers to leaving their homes where they are in isolation with abusive partners. In examining our neighboring states, Kansas currently allocates over $6.1 million for domestic and sexual violence services, with $550,000 coming from their problem gambling fund, $4.6 million from state general funds, and around $1 million annually through their protection from abuse fund. Iowa designates $5 million for domestic violence services through their state general funds. Nebraska state General Funds for domestic violence services currently total a little over $1.4 million. And there is not state funding for the purpose of providing sexual assault services through our network

of member programs, which is also one of our primary focus areas. We are respectfully requesting that this funding be increased to $1,980,000 as stated in LB662. This allows for an additional $498,700 to be shared across 19 domestic violence programs and for tribal domestic violence agencies. We realize the decisions that you're faced with and appreciate your thoughtful consideration of our request and your support of survivors in Nebraska. Thank you for your consideration and I'm happy to answer any questions.

STINNER: Any questions? Senator Dorn.

DORN: Thank you, Chairman Stinner. Thank you for being here. What-- what are most of these funds used for when you-- you had housing for one, what else or what?

LYNNE LANGE: So in your packet, you can see a list of the funds or the services that are provided by our programs. They provide crisis line 24 hours a day, seven days a week, so people can access services immediately. They provide emergency transportation, also assistance with protection orders and legal advocacy, as well as accompanying for sexual assault exams, emergency shelter facilities, support groups, all of those types of services just to make sure survivors have those supports.

DORN: Thank you. I hadn't gotten to the last page yet.

LYNNE LANGE: It's OK. I just want to make sure that you have it there for future reference.

DORN: Thank you.

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

LYNNE LANGE: Thank you.

CARMEN HINMAN: Good afternoon, Senator Stinner.

STINNER: Afternoon.

CARMEN HINMAN: How are you? Members of the Appropriations Committee, thank you. My name is Carmen Hinman, C-a-r-m-e-n H-i-n-m-a-n. I am the executive director of Hope Crisis Center, serving Fillmore, Gage, Jefferson, Saline, Seward, Thayer, and York Counties in southeast

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Nebraska. I am here to testify in support of LB662. Hope Crisis Center is committed to empowering victims of domestic and sexual violence as well as our communities through advocacy, education and confidential emergency services. Our primary office is in Fairbury with satellite office locations in Crete, Beatrice, York and Seward. We provide all services that are mandated under Nebraska's Protection from Domestic Abuse Act, including constant access and intake to services through a 24-hour hotline, emergency transportation, medical advocacy, legal advocacy and referrals, crisis counseling through one-on-one support, emergency financial aid, and safe shelter for survivors and their children. Hope Crisis Center also prioritizes prevention programming with the hope of stopping violence before it occurs. From October 2019 to September 2020, Hope Crisis Center served 512 individuals, which is a 12 percent increase from the prior 12-month time frame. The number of crisis line calls for the same period increased by 50 percent. These increases are deeply alarming given the fact that much of this time was during a pandemic, when survivors were isolated with abusive partners and faced new challenges in seeking help. Since the onset of COVID-19, we have experienced an uptick in the most serious forms of abuse. In one instance, a survivor was severely strangled and beaten, literally black and blue. Due to the extremes of isolation-- isolation, excuse me, she had no means of supporting herself and was only able to flee when a small window of opportunity presented itself. The availability of emergency shelter literally saved her life. The resources that we as a network provide are a crucial steppingstone for so many survivors in similar circumstances. Our network of programs has a long history of working successfully with the Department of Health and Human Services, and we have a strong working relationship today. They have praised us for our work and we have responsibly spent our dollars annually to serve survivors in Nebraska. On average, 88 percent of our network programs' budgets are dedicated to program services, showing good stewardship of the money received. Budget allocations to service providers like Hope Crisis Center is money well invested. Our state's network of domestic violence sexual assault programs are literally a lifeline for Nebraskans in dangerous and potentially lethal situations. Thank you for considering the increase in allocations to our network programs. I would entertain any questions if you have any.

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

CARMEN HINMAN: Thank you.

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STINNER: Any additional proponents? Seeing none, are there any opponents? Seeing none, are there-- is there anyone in the neutral capacity? Seeing none, would you like to close, Senator?

McDONNELL: Thank you, Chairperson Stinner. When we become senators, I believe people will share more with us. They come with their stories and a lot of times those stories are extremely painful. Previous job as a firefighter, you make calls and you witness domestic abuse. And when people share those stories with you, then looking back at my past and what I've seen and, of course, you want to-- you want to help and you want to try to make a difference. And in our position, as-- as the Appropriations Committee, something that stood out to me was that over a 20-year period, you looked at less than $300,000 that was put into this program to-- that was increased only by less than $300,000 over 20 years. We're talking about 19 agencies, 4 travel agencies around the state. Unfortunately, the numbers are not going down. And I think with the people that this program has helped, the difference it's made, I believe it's a-- it's an investment for us. I don't know if asking for $480,000 this year is enough, but I hope it will make a difference. I believe it will make a difference. I'm here to answer your questions.

STINNER: Questions? What would be helpful out of your folks is to see the increase in activity over, say, a five-year period of time if they could prepare that so when we talk about this we had a pretty good idea of that increase in activity relative to a stagnant income.

McDONNELL: I'll get it for you.

STINNER: Thank you. OK, that--

McDONNELL: Thank you.

STINNER: I don't have any letters one way or the other on that. And that concludes our hearing on LB662. We'll now open on LB421. Senator Wishart, you've got the helm. Make sure I got the right folder out. Good afternoon, Vice Chairperson Wishart and fellow members of the Appropriations Committee. For the record, my name is John, J-o-h-n, Stinner, S-t-i-n-n-e-r, and I represent the 48th District, which is all of Scotts Bluff County. LB421 appropriates $3 million from General Funds in 2021 or 20-- 2020-21 and fiscal year '22-23 for student loan repayment for eligible healthcare professionals under the Rural Health

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Systems and Professional Incentive Act. This is a carryover bill from last year, which I brought to the committee as LB778. The primary difference between this year's legislation and last, an increase from 2 million to 300 in appropriations. This amount will cover the current-- current waiting list of 52 applicants and begin to build up a supply of future interest in the-- future interest in the program. I've distributed a map to you showing that those-- where those applicants are from. Currently there are 73 loan recipients under the program with an average debt load of $249,231. With this legislation, the Legislature would increase the funds available for the Nebraska loan repayment program under the program. This assists over 90-- 90,000-- 900,000 Nebraskans living in rural communities by recruiting and retaining primary healthcare professionals. Qualified recipients are awarded loan repayments on a 50/50 match basis in state designated shortage areas. The program has a 93 percent success rate; up to 180,000 to 200,000 for doctors and dentists have been repaid; 90,000 to 100,000 for other professionals. Local entities can match up to $25,000 to $30,000 per year for doctors and dentists; $12,500 to $15,000 per year for other professionals. Some of the most widespread shortages we see in the state are in the mental health professions. Almost all of Nebraska counties have both a federal and state designated shortage of clinical psycholo-- psychologists, licensed mental health practitioners, master level alcohol and drug abuse counselors, child and adolescent psychiatry, and general psychiatrists. Some of the other widespread shortages include pharmacists, profession-- professions in general, internal medicine, pediatrics, general obstetricians, gynecologists, pediatrician, dentists, oral surgery, with many other shortages in other professions. However, over the years, over 688 providers under the program have been placed throughout Nebraska, all but eight counties-- in Nebraska, all but eight counties. This program was-- has a substantial financial impact, totaling $125 million over the life of the program, far in excess of the $6 million that the state has funded. In small town and rural areas, approximately 40 percent of the family medicine medical providers have participated in incentive programs. Economic analysis based on years worked shows a significant economic benefit associated with these healthcare providers with an average 14 percent of the total employment in rural communities attributed to the healthcare sector. This benefit far outweighs the financial investment in the incentive programs. Marty Fattig of the Rural Health Advisory Commission is here to testify to support the

bill and can give you more detail about the program, the wait list. In the meantime, I'd like to thank you, members, for your consideration. I'd welcome any other questions.

WISHART: Any questions from the committee? Senator Erdman.

ERDMAN: Thank you, Senator Wishart. Thank you, Senator Stinner, for bringing this bill. So $3 million annually into the fund; $750,000 of that will go to assist those employed by the seven community healthcare centers?

STINNER: That's what-- we're trying to target those because they have a shortage. You know, in our [INAUDIBLE] for example, we have a shortage of doctors, dentists, psychologists, those type of positions. So we're going to make that available to them, but it has to be on a matching program.

ERDMAN: That'll help pay their salaries?

STINNER: That will help pay their student loans.

ERDMAN: Oh, student loans. OK.

STINNER: Yeah. This is a tool that, like our hospital out west would use to attract doctors and hopefully over a long period of time they would stay. It shows that 93 percent success rate. That's about as good as I've seen in any program that we have.

ERDMAN: OK. Thank you.

WISHART: Senator Hilkemann.

HILKEMANN: Senator Stinner, is this in addition to what they-- there's if they take the HEAL loan that the med school student, which is repaid by the federal government if they work in these shortage areas, is this on top of that?

STINNER: You know, Senator Hilkemann, I believe so. But I think Marty Fattig could probably answer that question better than myself. I know that there's a federal program for rural healthcare providers, but I don't know if it covers the broad scope of what this is. Plus, I don't know if this is an add-on or not. I'll have to research that.

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WISHART: Any other questions? Seeing none, thank you.

STINNER: Thank you.

WISHART: We will move on to proponents.

MARTY FATTIG: Good afternoon. It's good to see you again. Senator Stinner and Ms. Wishart, thank you. Members of the Appropriations Committee, I am Marty Fattig, M-a-r-t-y F as in Frank-a-t-t-i-g, and I am the CEO of Nemaha County Hospital in Auburn, Nebraska. And I am here representing the hospital, also the Nebraska Hospital Association and also the Nebraska Medical Association. I'm also the chairman of the Rural Health Advisory Commission, which selects recipients for the funds being requested under LB421. I am here today in support of LB421 which will be, which would appropriate an additional $3 million in General Funds to be used for the repayment of qualified educational debt owed by eligible health professionals submitting applications to the Rural Health Systems and Professional Incentive Act. The Rural Health Systems and Professional Incentive Act was passed in 1991 and created the Rural Health Advisory Commission, the Nebraska Rural Health Student Loan Program, and the Nebraska Loan Repayment Program. The Nebraska Loan Repayment Program assists rural communities in recruiting and retaining primary care professionals by offering state match-- state matching funds for the repayment of health professionals, government, or commercial educational debt. Applicants for the program must agree to work in a state-designated shortage area for a period of three years to receive funding. The program calls for the state to match local funds up to a maximum $30,000 for doctorate level providers and $15,000 for master's level providers. This means that between the state funds and the local matching funds, doctorate level providers can receive a maximum of $60,000 per year and a master's level providers can receive a maximum of $30,000 per year for the repayment of qualified student loans. This may seem like a large sum of money, but the average physician comes out of residency with over $200,000 in debt. While the program primarily focuses on rural shortage areas, specific federally designated sites such as tribal areas or community health centers can also qualify for family medicine and or general dentistry loan repayment, even if they're not located in a state-designated storage area. The state loan repayment program has been very successful. As you can see from the map that I've attached to my testimony, 579 participants have completed the program and practice for varying lengths of time in Nebraska. As you can also

see, almost every area of the state is represented on the map. In fact, it is because of this success that I am here today. We have more applicants than we can fund with available resources. When I visited with the Office of Rural Health last week, they told me we currently have 52 applicants on the waiting list. And with the current appropriation, the earliest many of these applicants will be funded is July of 2022. These are medical professionals that have already signed agreements to practice in underserved communities. If we cannot fund these applicants sooner than this, we risk losing them to states with more money to spend on loan repayment. The question I would have if I were sitting in your position is what kind of investment is this? If this state gives money to repay student loans for those willing to practice in medically underserved shortage areas, what is the economic impact of that money? According to the National Center for Rural Health Works, a primary care physician generates about $1.4 million in economic impact each year they practice. For the fiscal years 1994 through 2020, the state has funded $16,966,543 and some change in local repayment to applicants which generated $1,361,910,000 in economic impact in the rural communities where they serve just during the time that they were obligated to be there. That's an 80 to 1 return. And this does not even take into account the lives that were impacted by having a med-- medical providers in those communities. So I hope I have demonstrated today the loan repayment program is good for the state. It simply needs to be properly funded to do even more good. I ask you to vote LB421 out of committee where it can be passed by the Legislature. Thank you for your consideration.

WISHART: Thank you. Any questions? Senator Erdman.

ERDMAN: Thank you, Senator Wishart. In your comments-- thank you for coming in-- your comments you said that stayed there as long as their obligation required. What is their obligation? How long do they have to stay?

MARTY FATTIG: It's a three-year obligation.

ERDMAN: So, do you know, past that three years are the majority of those people hanging around there?

MARTY FATTIG: They really are. The majority hang around. What happens is because the community has-- has invested in these people, they have

skin in the game and they make sure that these providers fit well in their community and want to stay. Yeah, they hang around.

ERDMAN: OK, thank you.

WISHART: Any other questions? Senator Hilkemann.

HILKEMANN: Quick clarification. So you said that the community has to match with the state.

MARTY FATTIG: Yes.

HILKEMANN: Is providing this, OK. And these, so they get from the community and the state and then the federal government repayment.

MARTY FATTIG: We generally don't double it up. The state, state Office of Rural Health, when a person makes an application to the-- to the department for loan repayment, we have some federal funds available in a federal program where some people qualify for that and another program is this state fund. So we try and get them qualified for the federal fund and use those monies to save the state funds. But not everyone qualifies, excuse me, for those federal funds

HILKEMANN: OK.

MARTY FATTIG: So we don't double it up.

HILKEMANN: So, OK, so if they get the federal funds, they don't get these as well.

MARTY FATTIG: Right.

HILKEMANN: OK.

MARTY FATTIG: And it's getting harder and harder and harder to get the federal funds. They keep changing the criteria. And Nebraska just doesn't score well on-- on the criteria that they have in place. So it's getting harder. We could probably qualify for having a general surgeon to go to Mullen, Nebraska. But, you know, in Mullen a surgeon would starve to death unless he worked on cattle in Mullen, Nebraska.

WISHART: Any other questions? I have one. My-- I know personally how well this program works. My husband and I grew up with one of our best

friends who was the doctor in Fairbury and otherwise probably would have been-- stayed in Lincoln or Omaha. But he's built a house, renovating-- renovated an old house and his growing roots there. So I know that this does work. Are we thinking big enough with this program? We hear all the time issues with nursing shortages, for example. Are there other states where you look at other healthcare professions beyond physicians and use this as an incentivizing tool?

MARTY FATTIG: I really appreciate your-- your question. And the answer is I would love to-- to branch out and involve other healthcare providers: nurses, laboratory professionals, various other people that are really, really hard to recruit. We would have to go back to this body and change the statutes for that to happen. So right now, let's take care of the existing problem. And I am more than willing to work with you or anyone else that's interested on that problem as well.

WISHART: OK, thank you. OK, thank you so much.

MARTY FATTIG: Thank you very much.

WISHART: Further proponents. Good afternoon.

AMY BEHNKE: Good afternoon. Vice Chairwoman Wishart and members of the committee, my name is Amy Behnke, A-m-y B-e-h-n-k-e, and I am the CEO of the Health Center Association of Nebraska. I'm here today representing the seven federally qualified health centers in Nebraska, and we stand in strong support of LB421. And we'd like to thank Senator Stinner for introducing the bill. Nebraska's community health centers provide primary medical, dental, and behavioral healthcare, as well as enabling services like transportation and translation services, regardless of insurance status or ability to pay. Nearly 50 percent of health center patients are uninsured and uninsured and underinsured patients contribute to the cost of their care based on a sliding fee scale. In 2019, health centers served over 115,000 individuals, 93 percent of whom were low income. Overall, 36 percent of low-income Nebraskans sought care at a community health center at some point in 2019. Nebraska's health centers are the safety net providers in the state, and loan repayment programs are integral to recruiting and retaining providers. As you've heard, the state loan repayment program is significantly underfunded. Exacerbating this problem due to changes on the federal level, most community health centers in Nebraska will now have to rely on the state program to

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retain loan repayment as a recruiting tool. Historically, health centers have not utilized the state loan repayment program because they were able to access the federal loan repayment program through the National Health Service Corps. However, recent changes in the federal program have effectively eliminated Nebraska health centers' ability to qualify. Prior to this rule change, approximately one out of every four health center providers received loan repayment through the federal program. Finding staff who understand and can address the complex needs of health center patients is not always easy, and health centers often lack the financial resources to offer large incentive packages during the recruitment process. Loan repayment programs are a powerful recruiting tool for our health centers, particularly in rural areas where there are significant barriers to recruitment. As part of the funding expansion in LB421, there is included a $750,000 set aside for community health centers, which will address the loss of access to the federal loan repayment program without obstructing the ability to address the existing waiting list or limiting the ability to expand loan repayment opportunities to other providers. This set aside would provide enough funding for at least eight new providers at community health centers. And for each additional physician, a health center can serve an additional 1,000 patients annually, nearly 75 percent of whom would be uninsured or on Medicaid. In the event that full hundred seven hundred-- in the event that full $750,000 is not accessed by the health centers, that funding reverts back to the main loan repayment fund. Recruitment of additional providers is crucial to maintaining and expanding the safety net in Nebraska, ensuring all Nebraskans can have access to high-quality primary care services. LB421 will help Nebraska attack-- attract and keep medical professionals in areas where they are badly needed, both in rural areas and underserved communities, HCAN strongly supports this bill and encourages the committee to support access to healthcare across the state. Thank you. And with that, I'd be happy to answer any questions you may have.

WISHART: Any questions from the committee? Seeing none, thank you.

AMY BEHNKE: Thank you.

WISHART: Further proponents? Seeing none, any opposition? Seeing none, anyone in the neutral? Seeing none, Senator-- Chairman Stinner waives closing. And I do not see any written testimony or letters for the record. So-- oh, we do have eight letters of support for LB421, and

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that concludes our hearing and we will move on to our next bill, LB340.

STINNER: Good afternoon, Vice Chairperson Wishart and fellow members of the committee. For the record, my name is John, J-o-h-n, Stinner, S-t-i-n-n-e-r, and I represent the 48th District, which is all of Scotts Bluff County. LB340 creates a separate and distinct budgetary program within the Department of Health and Human Services, identified as the Medicaid Nursing Facility Service Program. I think you all know that we've had a struggle with-- with trying to identify the funds and trying to make sure that what we appropriate actually goes out to nursing homes. I've been in that personal struggle. I think the committee has been a part of it. We actually broke it out as a separate line item within the budget so we could follow it. But the problem with that is the budget goes away every two years, so whoever's Chair after me would have to set it up as a special budgetary item. I think what I'd like to do with this legislation is to actually set it up as a program, specific program so we wouldn't have to do that on an annual basis. That way you can track the expenditures. Now, I did have discussions with the department. They're going to be up here opposing it, and I'm having a hard time understanding why. It's so easy to do as we're doing it now. But when we switch it over to a budgetary program, why that suddenly becomes a complicated process. But I think they can articulate that. I'll sit and listen. But that's-- that's the whole purpose of this is to separate it out, have a program so everybody can follow it and making sure the dollars go out. And I think we-- I think this committee has done a great job with the nursing homes in identifying and reconciling and making it more transparent. So with that, I'll take some questions if there are any.

WISHART: Any questions?

STINNER: And I do have some people that are going to testify behind me that can talk about the history and maybe take you through some of the-- some of the situations that we looked at and had to deal with.

WISHART: Senator Kolterman.

KOLTERMAN: Thanks for being here today, Senator Stinner.

STINNER: It's great to be here, Senator Kolterman.

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KOLTERMAN: Glad you could make it. I looked at this fiscal note, LB340. How do you-- if all we're doing is accounting change, how do you come up with $236,280 fiscal note and then another $90,000? You know, just this morning we were talking about upgrading our MMIS system anyway. That ought to be part of the whole program. So do you have any insight on why the cost of this?

STINNER: I would-- I would submit to you that you need to ask the department that. I'm having a struggle with it as well. But--

KOLTERMAN: All right.

STINNER: --that's what they supplied us. That's what we put down. And I think Liz Hruska also has some questions about why it's so complicated so.

KOLTERMAN: All right. Thank you.

WISHART: Any other questions? Senator Erdman.

ERDMAN: Thank you, Senator Wishart. Senator Stinner, a follow-up on what Senator Kolterman said, I'm having trouble. I mean, he brought up a good point there. So we're doing this now, right?

STINNER: We are doing it now, yeah.

ERDMAN: What does it cost to do it today?

STINNER: I would suggest to you there is no additional cost that I know of. They can probably answer that question.

ERDMAN: OK.

STINNER: There must be a lot of complexities in this--

ERDMAN: Must be.

STINNER: --or maybe it's death by fiscal note, which--

ERDMAN: I appreciate you talking with Senator Kolterman. Thank you.

WISHART: Any other questions? Seeing none, thank you, Chair.

STINNER: Thank you.

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WISHART: We will move on to proponents for LB340. Welcome.

HEATH BODDY: Thank you. Good afternoon, Vice Chair Wishart, members of the Appropriations Committee. My name is Heath Boddy, that's H-e-a-t-h B-o-d-d-y. I'm the president and CEO of the Nebraska Health Care Association. On behalf of our 192 nonprofit and proprietary nursing facilities, I'm here today to testify in support of LB340 as it will provide ongoing transparency of the nursing facility appropriation and the Medicaid rate calculation process. As Senator Stinner laid out, LB340, would create a separate program for Medicaid nursing facility services in the state budget as a way to ensure that the Legislature's appropriation for these services is publicly transparent and that this amount is used in the calculation of nursing facility rates. Two years ago, this committee implemented a similar change in its budget with intent language that identified the nursing facility appropriation as a specific dollar amount rather than a percentage change from a base number. This allowed the Legislature and Medicaid to be in alignment on the amount intended to be used in the nursing facility rate calculation. The Medicaid team expressed appreciation for this clarity as it allowed them to understand the exact amount to be used for rates in the fiscal year for 2020 and 2021, when previously they needed to identify their own base number as a starting point. When the current state budget expires on June 30, 2021, our concern is that the Legislature will revert to identifying a percentage change in its future budgets rather than a dollar amount for nursing facilities. Rather than introduce legislation every two years to add intent language to the budget, LB340 was introduced to make an ongoing change by adding statutory language-- by adding statutory language. And I want to clarify a couple of things. LB340 does not require a specific amount of funding, and LB340 does not require an annual increase in funding. This bill would only require the identified appropriation for nursing facility services be transparent and that that amount be used in the calculation of the rates. You have in front of you a fact sheet that provides some additional details if you're interested. And I urge you to vote in favor of LB340. Would be happy to try to answer some questions.

WISHART: Any questions? Senator Dorn.

DORN: Thank you, Vice Chair Wishart. So if I understand you right, they're already doing all these calculations that we're asking them to keep separate in this, for this program?

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HEATH BODDY: Yes, Senator. By your directive two years ago, the budget language, I guess the word would be forces a hard number that Medicaid uses to build the rates from, but it does it in budget language. This would put it in statutory language.

DORN: Statutory.

HEATH BODDY: This would mean I wouldn't have to come back in front of you or come back in front of the Legislature every two years to do it again.

DORN: So does Medicaid-- Medicaid currently is part of the reason we're doing, I mean, part of the reason we did this. So they're requ-- for to get to their number, we need that data.

HEATH BODDY: Yes, Senator. In history, the number that the department would use was not aligned with the number that the Legislature would use. So when we try to true up, well, how did we get to those rates? They were different numbers. And that was not necessarily intentional, but that's just how it works. So by you saying in your budget language, this is the number that you will use for nursing facility rate calculations, then it just became clear. And so our point is that seemed to be a beautiful way to do this. It really has worked. Everybody has gotten along with it. We would just like to make it permanent or as permanent as you can in a legislative body.

DORN: So I'll go back to Senator Kolterman and Senator Erdman's question then of why the fiscal note I guess. So thank you.

WISHART: Any other questions? Seeing none, thank you.

HEATH BODDY: Thank you, Senator.

WISHART: Further proponents? Good afternoon.

ROGER THOMPSON: Good afternoon, Senator Wishart, Senator Stinner and the Appropriations Committee. My name is Roger Thompson, it's R-o-g-e-r T-h-o-m-p-s-o-n. I'm a healthcare audit and reimbursement partner with Seim Johnson. We are an accounting and consulting firm in Omaha, Nebraska. I spent my entire 40-year career serving the healthcare industry and that includes hospitals, nursing facilities, home health agencies. Seim Johnson currently provides services to over 25 percent of the state's long-term care facilities. I've personally

been involved with the Nebraska long-term care Medicaid reimbursement system since the 1980s and been responsible for working with the department on the rate data and calculations they put together. We, if you will, we review them. We look at the-- the accuracy of the numbers that they put together in the past. And I always like to point out I'm a native Nebraskan. Before I begin my testimony, I would like to acknowledge and thank Jeremy Brunssen and his staff at the department for working with the industry in a collaborative manner to create revisions to the long-term care nursing rate facility that went into effect July 1, 2020. It was a great process to have that-- to work collaboratively-- collaboratively with everybody to come up with a good solution. Because of my knowledge with the Nebraska long-term care Medicaid rate setting process and current financial viability of Nebraska facilities, I'm here to testify in support of LB340. Historically, Nebraska Medicaid funds used to set rates for long-term care facilities that care for Medicaid beneficiaries were commingled with funds used to pay all healthcare providers. This process subjected these facilities to appropriations changes provided for all healthcare provider groups. It's important to note that Nebraska Medicaid beneficiaries typically represent nearly 60 percent of all Nebraska long-term care facility residents, making adequate Medicaid long-term care rates essential to the financial viability of these facilities. It's become even more important, obviously, during this unprecedented pandemic. Other providers do rely on good Medicaid funding, but again, to a lesser extent, because their utilization is not in that 60 percent range that we have for long-term-- for long-term care facilities. Again, although long-term care facilities rate funding was commingled with other healthcare Medicaid funds, long-term care facilities did not always receive rate increases at equaled increases in budgeted amounts. And there's reasons for that. There's a number of items that go into the calculation of those rates for long-term care facilities. Many of those rates are based on projected spending, projected days, projected acuity of-- of residents in different facilities and projected prior total facility Medicaid spend. There's a lot of projections. At the end of the day, the projection is put together, an inflation factor is determined. For many years prior to the last two, that inflation factor was a negative inflation factor, not a positive one. Given the difference in actual utilization that was projected, which ultimately determines projected cap, that cap could have been reduced in future years. And LB340 will kind of establish that cap on an ongoing basis. Again, creating a

separate, distinct budgetary program within the Department of Health and Human Services for Medicaid Nursing Facility Service Program allows stakeholders to evaluate how budgeted amounts are currently spent and then carried over for future years if such a carryover exists. Again, creating this separate and distinct budgetary program will also allow for differentiating the importance of Medicaid reimbursement for long-term care facilities when setting biennial budget amounts. Because, as I indicated earlier, we do serve about 25 percent of the state of Nebraska's long-term care facilities, and we have witnessed a universal deterioration of financial results of many of these facilities due to previously mentioned negative inflation factors in the historical Nebraska Medicaid rates. Again, having a separate and distinct budgetary program within the department is a step in greater transparency in rate setting and for needed reimbursement changes for Nebraska nursing facilities. Again, I appreciate very much the opportunity to be in front of you here today and testify on behalf of LB340 and would respond to any questions that you might have.

WISHART: Any questions? Seeing none, thank you. Or did you have one? Senator Clements.

CLEMENTS: Yes, please. Thank you, sir. I see your comment that the facilities were averaging about 60 percent Medicaid residents.

ROGER THOMPSON: It's about 56, 57 percent statewide, some more than others.

CLEMENTS: Is there a critical percentage that where they can't survive or does it vary?

ROGER THOMPSON: I think-- I don't know if there's a critical percentage. Again, obviously there's facilities that have 90 percent Medicaid utilization. There's probably others that might have 45 percent. So it does vary throughout the state. Obviously, Medicaid historically and historical rates had paid less than the actual cost. So the higher-- the higher the Medicaid utilization, the more difficult it is for the financial viability of that organization.

CLEMENTS: So you see some that are cash flowing with 90 percent residents,

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ROGER THOMPSON: 90 percent of residents?

CLEMENTS: Yeah, 90 percent Medicaid population.

ROGER THOMPSON: Cash flowing possibly in the short term, but not being able to invest in their facilities.

CLEMENTS: All right. I was just wondering, where is a red flag that you see when you see a percentage of Medicaid population?

ROGER THOMPSON: It would be dependent upon different types of facilities, quite frankly, location of facility, age of facility, but I think generally speaking, the profit that takes place in nursing homes usually is coming from Medicare and private pay beneficiaries.

CLEMENTS: All right. Thank you.

WISHART: Any other questions? Seeing none, thank you. Further proponents.

CHRIS ULVEN: Good afternoon, Senator Wishart and members of the committee. My name is Chris Ulven, C-h-r-i-s U-l-v-e-n. I'm here to speak as a provider and as a proponent of LB340. I'm executive director of the Rose Blumkin Jewish Home in Omaha. And I have 17 years of senior living experience, ten as a controller and seven as an administrator. So numbers are kind of my thing. A little bit about where I work right now. RBJH is a five star, not-for-profit, traditional Jewish home, and very likely the most unique nursing home in the state of Nebraska, in both appearance and in the things that we do. We're mission driven, like many other facilities. We serve the Omaha Jewish community as well as the community at large. We have people from all over the state and frankly, all over the country that come to us. Everything we do starts with the Jewish tradition of the elderly being highly respected and highly regarded. In the 2010 remodel, the Blumkin home was made a community hub so the residents could feel like they're still part of the general community. Pre-COVID, we had over 100 active volunteers and over 100 visitors per day in our home. So the residents truly were active and vibrant and part of the community. Some unique expenses that are specific to us. Obviously we have a kosher facility. So in a traditional Jewish home, that means a meat kitchen, a dairy kitchen, separate plates, separate silverware. We have a mashgiach that ensures kosher law compliance

when the meals are being prepared. With Passover coming up, we will have to completely clean our kitchen top to bottom, have all the equipment rekoshered for Passover, and bring up different silverware, different dishes for the ten-day Passover period. So there are some pretty good expenses there. Our average food cost is probably about double what a normal facility would be. As you can imagine in the Midwest, kosher food is not in high demand. Therefore, the cost is high, most of which we can't even get. So we order from the East Coast and then pay East Coast kosher prices and have a $1,500 shipping bill to get it here. So like other not-for-profits and mission- driven facilities, we do not deny services or admission based on ability to pay our private pay rates. Under the cost report based system, we currently have one of the higher reimbursement rates from Medicaid due to our higher costs. I still currently lose $150 a day on every single Medicaid resident we have. To combat that, our private pay rate is at or near the highest in the state. It's imperative that providers have transparency and growth in funding to allow us to appropriately budget and plan. We must ensure that all funds earmarked for long-term care are paid to providers. This has not been the case in the past. There can be no discretion with these funds. The only way to do this is to approve LB340. To providers, every dollar matters. Even $2 a day for me at pre-COVID census added up to $40,000 a year. With that, I could hire more staff. I could invest in the facility. I could buy new equipment that I couldn't have otherwise. And it's not so big a deal for me. But for those providers that are getting by, by the skin of their teeth, it's everything. And in fact, that $40,000 may have kept some doors open of the 57 facilities that have closed since 2015. No increase and no future growth in funding will result in more closures. Nobody's asking to profit off of Medicaid, but we have to get closer to covering our costs. We need you now. We need you in the future to keep our doors open and be able to care for our most vulnerable Nebraskans. LB340 closes that loophole and makes sure every dollar that you allocate and intend to go to us gets in our hands. Any questions?

WISHART: Any questions? Senator Erdman.

ERDMAN: Thank you, Senator Wishart. Thank you for coming today. That's an interesting concept. So how many residents do you have?

CHRIS ULVEN: Today we have 65.

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ERDMAN: 65.

CHRIS ULVEN: My pre-COVID census was 95.

ERDMAN: 95. You said you had 100 volunteers before COVID.

CHRIS ULVEN: Yeah. Not every day, but they were-- they were in and out different things.

ERDMAN: So you may not have an opinion of this, but when we open up, do you hope or do you see those people coming back, those 100r people?

CHRIS ULVEN: It will not be that, to that extent. They would want to come back, it's just I don't want 100 people in the building right now until we get a lot more back to normal.

ERDMAN: OK. Are all the people in your facility Jewish people?

CHRIS ULVEN: No. No.

ERDMAN: Thank you.

WISHART: Any other questions? I have one. Are you seeing in terms of long-term trends, more people coming to your facility who are qualifying for Medicaid as opposed to being able to afford private-- private pay?

CHRIS ULVEN: Absolutely. And it's going to get worse.

WISHART: And is-- is-- what is the reason when somebody comes in your door and is able to afford private pay? Is it that they were independently wealthy? Did they invest in retirement early? What are some of the reasons that somebody can do private pay?

CHRIS ULVEN: I think it varies. I think a lot of people either own their own business or had good jobs, inherited money. I mean, there's a variety of reasons. But we-- we are currently about 45 percent of our residents are Medicaid, but it amounts to 30 percent of our revenue.

WISHART: OK, well, thank you.

CHRIS ULVEN: Yep.

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WISHART: Senator Kolterman.

KOLTERMAN: Thanks for coming today. It's intriguing to hear your model. So what I hear you saying is that 55 percent are private pay.

CHRIS ULVEN: We have some Medicare in there, too, so it's about 45, 45, and 10 percent Medicare.

KOLTERMAN: So of those 45 percent that are private pay, is there a lot of those that are accommodated by long-term care insurance?

CHRIS ULVEN: Yes.

KOLTERMAN: So you have a high percentage of that or is that?

CHRIS ULVEN: We probably-- we probably have 20 long-term care insurance policies that we send information in every month.

KOLTERMAN: 20 out of the 45.

CHRIS ULVEN: Yeah.

KOLTERMAN: That's still not overwhelmingly high.

CHRIS ULVEN: No.

KOLTERMAN: OK, thank you.

WISHART: Senator Dorn.

DORN: Thank you, Vice Chair Wishart. Thank you for being here today, and I guess I should have asked maybe earlier today, I guess. More for clarification or my understanding, when a person-- how does a person become Medicare eligible for your facility? Do you classify them or, I mean, data information you're getting from them or just explain that a little bit so I understand it for sure.

CHRIS ULVEN: So we don't make that determination. The Medicaid eligibility criteria has to be met. We just ask that they communicate with us and then we'll help them fill out the application. Let us know when they're getting-- when their funds are getting low, they'll usually tell us, hey, we're getting-- Mom's getting low on funds. We say, OK, here's what you need to do and we'll help you through the entire process of Medicaid application.

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DORN: But generally speaking, I mean, the-- the-- the individual has to-- has to supply that information.

CHRIS ULVEN: Yes.

DORN: And then that-- you will help them fill out the forms--

CHRIS ULVEN: Yes.

DORN: --to see if they qual-- because when they walk in the door, you don't necessarily know whether they will or not or you'll have a good idea.

CHRIS ULVEN: Correct. All we can rely on is communication from the family or [INAUDIBLE]

DORN: And then what happens if they do not become eligible for the Medicaid care?

CHRIS ULVEN: Then we have a serious problem because I don't have a payer source.

DORN: OK, thank you.

CHRIS ULVEN: So the $4,000 in assets is the cutoff, so they have to be $4,000 or less.

***JENIFER ACIERNO:** Chairman Stinner and members of the Judiciary Committee, I am Jenifer Acierno, President & CEO of LeadingAge Nebraska. I am submitting this testimony on behalf of LeadingAge Nebraska in support of LB340. LeadingAge Nebraska is a non-profit association that represents non-profit providers of long-term care services across Nebraska. The past year has been a significant challenge for long-term care providers, in light of the COVID-19 pandemic. Providers have been challenged by workforce, PPE, testing, census, vaccinations, and reimbursement issues and are laser focused on keeping COVID-19 out of their buildings in order to protect Nebraska's seniors. Prior years have also been challenging for providers of long-term care, in part, because funding appropriated for use in long-term care rates, has not always been used in that way. This bill will help address the need for transparency with the appropriation and its use specifically for long-term care services. This bill would also ensure that funding that is set aside at the

beginning of a budget year as contingency, is dispersed for the intended purposes, versus being rolled in to the general Medicaid budget for other uses. Long-term care providers lose an average of over $35/day for each Medicaid eligible resident they serve. Providers of care in many communities feel compelled to care for their community members regardless of the payor source, which can leave some providers with a high percentage of Medicaid residents and therefore, significant losses. Due to losses like these and other factors, Nebraska has seen an unprecedented number (over 40) of nursing facility closures in the past four years. These closures have predominantly occurred in rural Nebraska and have resulted in seniors being unable to access necessary long-term care services in or near their own communities. The creation of a separate and distinct budgetary program within DHHS specifically for the Medicaid nursing facility services program should make the management of the allocation easier for DHHS, the tracking of the spend easier for legislators and others, and ensure that the funds allocated to the program are used exclusively to reimburse or pay for the care of Medicaid beneficiaries. Thank you for the opportunity to support LB340. This bill is important to ensure the on-going access and availability of long-term care services to Nebraska's seniors.

WISHART: Any other questions? Seeing none, thank you. Any other proponents? OK, we will move on to opposition. Hello again.

KEVIN BAGLEY: Hello. It's good to be back. Good afternoon, Vice Chair Wishart and members of the Appropriations Committee. My name is Kevin Bagley, K-e-v-i-n B-a-g-l-e-y, and I'm the director for the Division of Medicaid and Long-Term Care within the Department of Health and Human Services. I'm here to testify in opposition to LB340, which would create a separate DHHS budget program for Medicaid nursing facilities. Before I begin, I would like to thank Senator Stinner for meeting with the Medicaid Division and other stakeholders to discuss our concerns and share what some of the goals were of the legislation so that we can work with the senator on finding a potential resolution to some of the concerns we raised. As the committee may be aware, the Medicaid Division pays for beneficiary services through both managed care and fee for service. Nonskilled stays per diem are one of the few services that Medicaid pays via a fee for service. Medicaid beneficiaries who reside in a nursing facility have their physical health, behavioral health, and pharmacy benefits covered through their managed care plan. Additionally, services such as hospice care are

paid to the facilities to reimburse hospice providers. As written, it's unclear what specific services are expected to be paid out of the new budget program. I will add here that as we've had additional conversations with Senator Stinner, I think we've been able to clear up some of those questions. However, the language, as it stands, does not make that clear for us. Currently, all appropriations are sub-- and subsequent payments to nursing facilities come out of the main Medicaid budget, which is Program 348. The Medicaid Division has concerns with creating a separate budget program. At this time, it's unclear what exactly would constitute the payment, as I mentioned earlier. In addition, separating the funds out would limit the division's ability to manage the budget as utilization changes occur, creating scenarios whereby we may need to request deficit funding for this new program or others. We have been able to manage through these scenarios without needing to take that type of action in the past. Creating a new budget program would come with additional administrative costs to the department. And that's a question obviously that's been raised here by the committee. And I'd like to try and address that. At a minimum, we would need to hire an additional budget analyst to accommodate the increased reporting requirements associated with the new budget program. And I want to clarify here. We're doing a lot of the work I think that's intended to be done through this bill today in that we're providing a lot of information on how we come up with rates based on budget information that we've received. And last year, I'll take the opportunity now to say it was really helpful to have that intent language to provide an anchor for future budget discussions. That anchor hasn't been present in the past. So there has been confusion and discussion that predates my tenure here as to what the anchor point would be. When we see a 2 percent increase, well, 2o percent from what? Well, now we have that anchor. And that, even though that may or may not be present in future legislative action that takes place, the fact that we have it now means we can reference back to it in any future discussions on this point. But having a separate program requires now that we do some additional reporting that comes with having a separate program. In addition, our computing systems such as N-FOCUS and our MMIS system would need updating specific to allocating payments to the appropriate program line. Internal and external reporting documents would need to be updated prior to the programs being separated and after they were as well. The technology updates would qualify for 75 percent federal funds, while the staffing would only qualify for 50 percent federal

funds. And that's really the source of that administrative cost in the fiscal note. In addition to the new costs administratively, we'd like to remind the committee that creating a separate budget program does not guarantee that 100 percent of the funds appropriated to the program would be used as Medicaid payments are subject to actual utilization. If a service isn't provided, we're unable to pay for it. And the example of that here would be if there is not someone in that bed, those costs can't necessarily be directly reimbursed because there isn't a service per se from a Medicaid perspective. In summary, LB348 [SIC LB340] would further complicate how Medicaid pays for nursing facility services and would likely hamper our ability to respond to changes in service utilization. It would also lead to new administrative costs for the department, while not necessarily providing for any known direct impact to providers or beneficiaries, aside from the potential certainty memorializing those numbers, which we believe are effectively already done. Thank you for the opportunity to testify today. I'd be happy to answer any questions.

WISHART: Any questions? Senator Hilkemann.

HILKEMANN: So if I'm hearing you right, good idea, it's hard to execute.

KEVIN BAGLEY: Yes, and let me elaborate on that a little bit, if I-- if I may. We really appreciate having the number from which to anchor future budget decisions on. So we can take that, for example, and say if we believe we're going to be paying for, and I'm going to make up some numbers, if we believe we're going to be paying for 100,000 patient days in the coming year, then we can take that budgeted amount and leverage that to help understand what the rate should be moving forward. If that number, 100,000 patient days, is different, if it turns out to be 75,000, for example, that doesn't necessarily-- having this in a separate budget program doesn't give us the authority to spend what would have otherwise been allocated to those patient days because there aren't patient days on which to spend it. Conversely, if there were 150,000 patient days in that year, what may end up happening is we would run short in that budget program and we would need to come back to this committee and request deficit funding. So it really would make it more difficult, I think, for us to budget, which isn't the intent, I don't believe, of the legislation. As we see it, this is a potentially blunt instrument in doing the precise work that

I think all of us would like to be able to do in terms of managing the budget on this.

WISHART: Senator Erdman.

ERDMAN: Thank you, Senator Wishart. I don't know where to start, but maybe I'll use your definition of make up some numbers here. Is this an annual cost or is this a one-time on this fiscal note?

KEVIN BAGLEY: Let me look at the fiscal note here in front of me to make sure I don't misstate any of that. A portion of it would be ongoing with another portion, I believe, one time. So part of the ongoing cost would be the potential FTE required to manage a lot of the additional reporting that would need to take place with the new budget program. So right now, with the-- the three budget programs that we-- we work with from a program perspective, the Medicaid, the Medicaid expansion, and CHIP, we have folks that are working on those reports and managing that-- that information on those budget programs. Part of this would be an ongoing cost for that FTE.

ERDMAN: So this is more difficult for you to do to the point you have to spend 236 mill-- $236,000 compared to what you're doing now?

KEVIN BAGLEY: Yes.

ERDMAN: OK. I won't say on the mike what I think of that deal, but thank you.

WISHART: Senator Kolterman.

KOLTERMAN: Director, I understand it's difficult to walk into a situation like this, and this is just a general observation. Have we gotten to the point in our bur-- bureaucracy that we can't come up with simple answers to simple questions? I mean, really here, I mean, we-- you have to account for this anyway. And we have a guy that came in here from an accounting firm that works with this kind of stuff all the time and this just baffles me. I mean, $236,280. The other thing is this morning we talked about in the new system you're going to have to look at and upgrade, couldn't we figure out a way to incorporate this into that new system as we go forward? I mean, there's got to be a way to simplify what we're doing in HHS, because I got to tell you, this is my first year sitting here listening to this. I've been on the other side where we make the rules of how we're going to spend the

money. But now we're looking at how we pay it out and how we appropriate for it. I don't get it. I mean, it's just a nightmare what you must be facing on a daily basis, on a monthly basis, weekly basis. It's-- it's just a general observation, but people ask me all the time, why is government getting so big? Well, here's-- here's 236,000 reasons right here to make one change that we're already at the-- we already have the information. It's just pulling it out. Doesn't make any sense. Am I wrong?

KEVIN BAGLEY: You know, I-- I would-- I would say the initial statement that it is overwhelming to deal with some of the bureaucracy that takes place is true. I think to the extent that-- that we can reduce that bureaucracy from our point, from our vantage point and within the division, we try to do that. That being said, there's this is a joint program with the federal government and we don't always have the opportunity to reduce their red tape. Now to your direct question here of-- of the costs, I think the reality for us is we actually see adding this additional budget program as adding a little bit of red tape for us. I don't think that's the intention that Senator Stinner has here with this. And I think as we've had discussions with him, it's very clear that's not. But that's the reality I think that we have is that this actually would create some additional red tape for us, some additional work that doesn't necessarily benefit the providers in this case.

KOLTERMAN: Thank you.

KEVIN BAGLEY: Thank you.

WISHART: Senator Clements.

CLEMENTS: Thank you, Vice Chair Wishart. Thank you, Director. You talked about possibly creating a deficit request. If utilization goes up now over the expected amount, you don't have a deficit request?

KEVIN BAGLEY: Because right now our-- our budget program is for all of Medicaid or almost all I guess. The expansion is currently carved out. But because that-- that broad budget program is defined, if we were in a point where utilization overall within Medicaid exceeded the established budget, we would have to come for that. But if we're in a situation where we see an increase in the nursing home utilization without similar increases in other areas, it may be that-- that the

increases in the nursing home expenditures offset-- are offset by other places where we're not spending as much as we expected. So that's where part of that flexibility in having it all within a single budget program comes in.

CLEMENTS: I see. All right.

WISHART: Senator Dorn.

DORN: Thank you, Vice Chair Wishart. And thank you for being here again. I appreciate it. I guess we sometimes have some questions that we would just like answers for. And I appreciate some of your answers on this.

KEVIN BAGLEY: Thank you.

DORN: In your one paragraph here, you talked about Program 348. And then if-- if this new program came about, you would have maybe some difficulties maybe coming back and doing budget request. I guess I don't quite understand, I guess the enormity of it maybe. But quite often we're finding out that dollars are shifted in there and they're used different ways. And I'm going to use an example of yesterday when we talked about Saint Francis. We found out that there was a $31 million amount of money, that they had projected so much of an increase. And two years later, by golly, it wasn't there yet. So they had this $31 million that now they could use for other programs. And I guess I look at it a little different. I look at it, how do we account for those or how do we make sure that the people of the state of Nebraska are finding out about some of this stuff going on right or wrong? And I'm not saying anything is wrong. But how do we in this program-- this to me is a program that would give us a better understanding of the use of those dollars. I guess I under-- am beginning to understand in the whole big picture how some of these dollars are, I call it gone within the program and they're allocated. But we sit here and we talk about in past times, we talk about $100,000 or $200,000 with a certain agency and we argue over whether or not they should have that. And then we're finding out there's $31 million then was-- I guess that's my question. Why?

KEVIN BAGLEY: Yeah, and I think that's a great question, Senator, so I appreciate you asking that. One of the things that-- that I am particularly passionate about is transparency. And one of the things I

think that the division historically, or at least I can say over the past several years as I've been able to see it, it has been good at with provider rates, is explaining where those rates get set. Now, I think there's still been a lot of questions that have come out of that. And so one of the things that I've been having discussions with, with my staff as we look at our-- our budgeting process and as we look at how the dollars that are appropriated get spent on provider rates, we want to be very clear in terms of how we come to those calculations. And so now that we have this anchor in our budgeting process for our nursing facilities, we anticipate including that in the reports that we put out to our provider community and to stakeholders at large on how we come up with those rates. So that way that can be memorialized in that process moving forward. We see that as an opportunity to improve our transparency on that front. I think any time we talk about a $2.8, $2.9 billion budget within Medicaid, there are a lot of places where that money gets allocated and some are easier than others to describe. But in the case of our provider rates and how we develop those, especially when it comes to long-term care, I think we want to be as transparent as we can be. So I think I can express our commitment to that. And I think that is the ultimate goal of the legislation here and would be happy to continue any discussions on that front.

DORN: I think this committee would be happy to continue discussions, too, and see what we can do to work it out, because it-- it definitely, from at least my viewpoint sitting on here, it does help with the transparency of what's going on.

KEVIN BAGLEY: Yeah, and I would add any-- if there's feedback from members of the committee or stakeholders more broadly on how to improve our transparency on that front, we would welcome that feedback.

WISHART: Any other questions?

CLEMENTS: Yeah.

WISHART: Senator Clements.

CLEMENTS: Thank you. I think the, probably the real main reason for this is that we've seen money appropriated for nursing homes that didn't get paid out to them and we couldn't believe it when they're

closing left and right. And are you able to, if this doesn't pass, are you able to assure us that you will be funding what the Legislature wants for facilities?

KEVIN BAGLEY: Senator, I will say we will certainly be transparent in how we develop those. I'm always a little hesitant to commit to, and I apologize for this, but to commit to what the Legislature wants because I think when we look at the intent coming from the Legislature, when it's in language that gets passed in bills, that becomes clear. I think when we look at intent more broadly, that isn't necessarily written into bills, that becomes a little bit more difficult. So I will add that caveat. That being said, I do believe the-- the division's in a position to appropriate and allocate those funds as they're defined coming from the Legislature.

CLEMENTS: OK, thank you.

WISHART: Seeing no other questions, thank you.

KEVIN BAGLEY: Thank you.

WISHART: Any other opposition? Seeing none, we'll move to neutral. Seeing none, Chairman Stinner, you're welcome to close.

STINNER: Just very quickly, and I do want to put this on the record is over the couple of years that we've worked on trying to find that anchor to define different things and to break out this program, I want to thank Jeremy Brunssen and the whole-- his whole crew. And the new director actually came in and we had a pretty good discussion. Do I need to refine some language so that they truly understand what I'm trying to get to with this? That's a-- that's a distinct possibility. You know, Senator Clements asked about deficit. That's exactly what I want to see. If there's a deficit, then I want to know why, and then we could start to research it. But a lot of it's driven on what the department thinks is the utilization rate. If the utilization rate is up or down based on the rate methodology and the rates that they passed out, you could have an excess, which if you remember now, we can define the excess. And after they square their books up after six months, then they add that excess to the rates and get it out, because that's what we as a committee said that's what we want to have happen. A 2 percent increase goes to the 2 percent increase. The dollars get pushed out. So that's-- that's a lot of why and wherefore. But that's

how it's supposed to happen. I'm going to work with the department. I think they, like I said, Jeremy's been good to work with. And I think the new director is as well. We'll see if we've got a way forward on this thing and a general understanding. But I think the committee understands why we're doing what we're doing or asking to do this. So with that, I'll take any questions. I know it's getting late so.

WISHART: Questions? Seeing none, we do have two letters in support; one from the AARP Nebraska and the second from Immanuel. And with that, we will open the hearing for the next bill.

STINNER: Yeah, we'll wait for a minute to clear the room, but we will open hearing LB462, Senator Dorn. You're last up. You're last in the box, Buddy.

McDONNELL: Brevity.

DORN: That's not quite being the last one before dinner, but it's the last one before close, so it's still very, very important. So thank you. Thank you for being here. And I appreciate the time very much. So Senator Stinner and members of the Appropriations Committee, my name is Myron Dorn, M-y-r-o-n D-o-r-n,and I represent Legislative District 30 covering Gage County and southeastern Lancaster County in Nebraska. I am here today to open on LB462, which continues our effort to increase Medicaid behavioral health provider rates by 3 percent. This committee has worked together to ensure that Nebraskans have access to behavioral health that includes mental health and substance use-- substance use-- use treatment. And I have consistently heard from providers in my district, as I am sure all of you had, that the cost of providing services has always been much higher than rates paid. It has been very difficult for hospitals, clinics, and individual providers to maintain services in their community. Every day they lose money. Some may say, didn't healthcare providers receive significant dollars from the federal government through the CARES Act dollars that came to the state? Behavioral health providers, like all small businesses, had access to some dollars and grant programs that distribute money. Those programs were designed to get providers through the most difficult months of the pandemic, but did not deal with the ongoing problem of low Medicaid behavioral health provider rates. If you remember, in 2020, we increased rates in 12 key mental health and substance use treatment services that were at least 30 percent less than the cost of providing those services as determined

by DHHS cost setting. We increased those rates by 5 percent. The increase was significant to providers and their patients. Now it's time to adjust the rates across the board to continue to build the capacity so that Nebraskans can access these services. And-- and one more reminder. There is room in the Medicaid budget to invest in rates because of the federal match, FMAP, increase this year. It is important to remind everyone that Medicaid expansion has now been implemented and a whole new population is accessing healthcare, some for the very first time. Or they move from our behavioral health regional system to Medicaid. These low-income workers may also be those most affected by the pandemic because of their jobs. We have a choice to make: to continue to invest in a very important system of care that has a proven track record or fall back into complacency that we have done enough. I cannot think of a more important time in our history to not fall back on our laurels, but to step up and to continue to build a solid infrastructure that can sustain these critical services. And there will be some other testifiers that will come and visit about this also so.

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

PAT CONNELL: Good afternoon, Chairman Stinner, members of the Appropriations Committee. My name is Pat Connell. I am the health policy advocate for Boys Town and Boys Town National Research Hospital. I'm here today as a cochair of the Nebraska Child Health and Education Alliance, a unique group of individuals and healthcare and education leaders dedicated to the policies that ensure that children become successful adults and pay taxes, which we all would appreciate. We are here today in support of LB462. On the documents that provided, and it will tell you at the bottom who is members of our association. First, let me start off by saying that we are grateful to Senator Dorn, the Appropriations Committee, and the Nebraska Legislature for passing increases to provider rates. In any case, the cost of doing business has never stopped going up. I have a letter from a-- one of my peers that if it entered my packet, it talks about the cost factors or what's going on with salaries and other things that are really kind of outside of the control of the providers, but they're more market driven. And again, thank you for the past provider rates increase. I have to admit, I hate to admit this, but I've been coming to this body for the last 30 years. I started when I was about 10, [LAUGHTER] specifically talking about provider rate increases. And NABHO in the

last 25 years, there will be a couple of people from NABHO that will be talking, we've-- we've tracked 25 mental health provider organizations have gone out of business. And they haven't gone out of business because there's a decrease in demand. They've gone out of business because they can't cover their costs. So they start off by closing or diminishing the size and capacity of a program. And that only goes so far. If you're-- if you're underwater, you just can't make it up by cutting volumes. Again, most of the cost factors are, again, related to external factors that are outside of our-- our domain. And again, the other group-- other members will be more eloquent in discussing that. The one thing I really wanted to turn your attention to today is a report that was prepared by Seim Johnson, which is an accounting firm in Omaha. They have a division of their accounting firm that specializes in reimbursement and in-- in healthcare accounting. And there were several associations, we got together, and I was one of those founding groups that met with Seim Johnson, and we asked him to analyze what was going on with CPI and some of the other indexes in relationship to the history of provider rate-- provider rate increases. And so the-- I provided you all the-- the report to be very transparent. But the big key to this report is the first two pages where they go through and they summarize and they tell you how much that-- that lag is between CPI and what has gone on with provider rates. Every month we hear from public officials, stakeholders, providers, clergy, etcetera, that we need to increase access to mental health services. This is both a national and state issue. It's just not Nebraska. And in 1990, trying to get my head around this, I attended a conference with a Princeton professor by the name of Uwe Reinhardt that spoke about this. And he was asked a question, what's the relationship between provider rates and access? And he got up and he wrote on a-- on a board and he put this formula that is the second page or the third page of my testimony. It says, provider rates equal capacity, which equals access. And that resonated with me right away. Yet it doesn't include cost in that formula, it doesn't include quality in that formula, but it speaks to the pure nature of the services that we're providing and how you have to have adequate provider rates in order to have capacity. And the only way you can have capacity is you-- you have to have access by-- by having adequate capacity. So I sort of wrote out a very short summary at the bottom that-- that explains this particular relationship. So the bottom line is, is if you don't want to generate provider rate increases, then you should be expecting that there will be a

diminishment in capacity and there will be a diminishment in access. So we thank the Appropriations Committee today for, you know, giving us this opportunity to once again come and talk to you about a thing near and dear to our heart. We have no margins in this industry. It's basically most organizations operate on a month-to-month basis and do-- providing mental health services. Thank you. And again--

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

PAT CONNELL: Thank you, Senator.

JON DAY: Good afternoon.

STINNER: Good afternoon.

JON DAY: Thanks for having me here, Senator Stinner and the members of the Appropriations Committee. I'm Jon Day. I'm the executive director of Blue Valley Behavioral Health. We're Nebraska's largest outpatient behavioral health provider in Nebraska. I'm also representing NABHO, which stands for the Nebraska Association of Behavioral Health Organizations. At Blue Valley, we provide mental health and substance abuse counseling to almost 6,000 mostly rural adults and youth over 15 counties in southeast Nebraska. I'm here to support LB462, which is sponsored by Senator Dorn, which allows for a 3 percent increase in Medicaid funding for behavioral health services. Approximately one third of the people we treat through several of our different programs are on Medicaid. This percent of people is expected to increase due to the implementation of Medicaid expansion that occurred last October. This means a greater number of people who may have had their previous services covered by the different regions throughout the state due to a lack of health insurance may now be on Medicaid. As a result, it becomes imperative that these Medicaid rates are increased to match the higher rates of all programs paid by the regions previously. If not, we, like all the other behavioral health providers throughout the state, will be seeing an increase in people with a lower reimbursement. As a business, Blue Valley Behavioral Health has been able to implement a variety of cost-saving measures throughout the past year, as the COVID pandemic has made its way through Nebraska. These efforts and measures have not only kept our staff and the tremendous number of people that we treat safe, but they've also allowed people to have continued access to these services throughout this time. Even though there may be different-- different opinions

*Indicates written testimony submitted prior to the public hearing per our COVID-19 response protocol

regarding COVID, such as the current measures that have been taken to control the spread and precautions to be made in the future, the one true reality that does exist is the emotional and psychological impact that it's had on all of us. During this pandemic, we've seen a consistent number of people not only seeking behavioral health services, but also how COVID has been impacting such a large variety of people. We're seeing a greater number of people dealing with isolation, irritability, difficulty coping, and other changes in their daily living due to COVID. We're also seeing an increase in adults and youth with varying levels of anxiety, depression, family conflict, along with higher incidences of substance use. At Blue Valley Behavioral Health, we are always busy, but this has now become a busy that we've never experienced before and has drastically increased the need for all of our services. We don't see the lingering effects of COVID going away anytime soon. That is why it's become so important to help support behavioral organizations like ours, as well as those in your own communities, with the passing of LB462. If more people are continuing to seek behavioral health services with an increase of them being on Medicaid, that only makes subsequent sense to ensure the payment for these services are at least equal to what was being paid previously. Supporting this measure not only helps people receive the services when it will be needed the most, but also helps the thousands of adults and youth in the rural areas with their own recovery, creating a positive influence on themselves, their families, their employees and the community as a whole. As you can see, your support of this bill will increase funding for Medicaid behavioral health services is not just an investment on an individual basis, but it will also be an investment throughout the state as well. This is exactly the type of financial support that's needed that will make a difference in people's lives. Thank you for your consideration for this request. I'd like to be available for any questions you might have.

STINNER: Thank you for that. Questions. Senator Hilkemann.

HILKEMANN: Just a quick question. What's your patient mix as far as private pay and Medicaid?

JON DAY: Sure. We-- it's basically based on thirds. A third of our staff-- the clients we see are in Medicaid. A third of the clients we see are a sliding fee or through reverse of the regions. And a third is, the last third is based on private insurance.

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HILKEMANN: OK.

STINNER: Additional questions? Seeing none, thank you.

JON DAY: Thank you.

STINNER: Afternoon.

HEATHER BIRD: Hi.

STINNER: It's almost this evening.

HEATHER BIRD: I know. I saw the time. Well, good afternoon, Chairman Stinner and the members of the Appropriations Committee. My name is Heather Bird, H-e-a-t-h-e-r, and I serve as the Nebraska behavioral health director of Heartland Family Service, located in the Omaha metro area. But I appear before you today as the vice president of adult services of NABHO, which NABHO is an association of 45-- 49 behavioral health member organizations with a mission of ensuring quality behavioral health service access in our state. So on behalf of our member agencies who serve Nebraskans across all our counties, I want to thank Senator Dorn for introducing this bill. And for the sake of time, I'm going to skip over the couple of my first two paragraphs that give more of the history of the Medicaid rates. But as you know, the bottom line for us is the low, historically low Medicaid rates are always under-- have been and continue to be below the cost of providing the service and the concern for the Medicaid expansion and the increased number of those clients compared to those on our region clients. And also the impact from COVID is just beginning when we talk about mental health and substance use long-term effects. So it's imperative that we really think about maintaining and creating capacity across the state, which not-- which is not going to be possible on the current Medicaid rates. Although significant federal dollars have flown into Nebraska to offset the costs during the pandemic, those dollars helped sustain our nonprofits and small businesses through the worst times last year. At Heartland Family Service alone, we had an increase of 27 percent more clients seeking services for us in 2020 than 2019 and an increase of 54 percent seeking psychiatric services. Also, think of all the families that have been home so much more and all of the children in and out of school. Sadly, we have seen couples counseling skyrocket. We have former clients that have requested to come back for services because

of an increase in anxiety and depression due to being more isolated, not having support, and their symptoms escalating due to COVID. At Heartland Family Service, we've had teachers call and request services due to the stress and anxiety of the pandemic. We have children and families in our residential facilities that have had to adjust their normal treatment and procedures for safety during the pandemic. And while this is necessary, I can say that it's 100 percent led to more mental health needs for these clients. Think of a youth that we have seen that needs to be quarantined because he showed up and tested positive for COVID when he was admitted and the facility had to develop protocols to help keep him and the rest of the clients safe. And he wasn't allowed family visits. He didn't have access to his therapist in person, if at all, on a regular basis due to the complexity of remote services at times. And he described to our staff feeling like a freak the way people were treating him. And we have another case of a young single mom who lost her job during the pandemic due to needing, staying home with her children and the lack of childcare options. Her three-year-old son has a heart condition which puts him in the high risk category if he would contract COVID. She holds high anxiety daily with the stress of looking for employment, paying her bills, and taking care of her family. We've all learned a lot through this pandemic, and this is just one example of many of the increased anxiety, anger, and frustration and depression and separation of what it does for folks and will continue to do. In our facilities, these families are primarily Medicaid clients and families. And so we encourage you again to vote in favor of LB462 so we continue to meet the need and serve these individuals and families that show up at our door each and every day. Thank you.

STINNER: Thank you. Questions? Senator Erdman.

ERDMAN: Thank you, Senator Stinner. Thank you for your testimony. I see in your testimony you say you've-- you've had more people call in with anxiety, depression, alcoholism, suicide, suicide attempts and suicides completed. Would you agree that if we open up society and go back to normal, a lot of those things go away?

HEATHER BIRD: No. I think the impact of, of the people--

ERDMAN: Have they increased when the pandemic took on, started out, have these increased?

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HEATHER BIRD: Yes.

ERDMAN: So if we went back to normal, would they decrease?

HEATHER BIRD: I-- it maybe. It depends on how you define the normal and what--

ERDMAN: Like we were before.

HEATHER BIRD: --where people are at and--

ERDMAN: Like we were before the pandemic hit.

HEATHER BIRD: I don't know that I could answer that.

ERDMAN: What would decrease these?

HEATHER BIRD: Part of the thing is that behavioral health doesn't go away so quick. And so once you have some of those coping or those trauma or experiences, when you're in similar situations, that might spark up a certain, I mean, to not go into a whole lot of that piece of it, but those symptoms can come up again for you. And so it's not that anxiety goes away just like that, when maybe some of the things come back down. You could be-- see yourself in another situation and something smells the same, looks the same, completely different. And those coping skills pop back up again and people need help again. So we just know that we're going to continue to have a lot of clients for a while. And we do.

STINNER: Additional questions? I find the word here, irritability, I'm in that classification. Anyhow, any additional questions?

HEATHER BIRD: Oh, no, I don't know too many families right now that haven't had some of this happen.

STINNER: Thank you for coming.

HEATHER BIRD: Thank you.

***JOSEPH D. KOHOUT:** Good afternoon, Chairman Stinner and Members of the Appropriations Committee. My name is Joseph D. Kohout and I am the registered lobbyist for the Nebraska Association of Regional Administrators and I appear before you today in support of LB462 on

behalf of the same. We ask that this testimony be made part of the official transcript of the committee on this bill. As the Committee is aware, Nebraska is split into six "regions" for the delivery of behavioral and mental health services. These are local units of government that the state Department of Health and Human Services - Division of Behavioral Health partners with to engage in planning and service implementation. Each county is part of a region and as a result appoints one county commissioner to sit on a regional governing board. They will represent that county and participate in the decision making of the board. The regions purchase services from providers in their area. If necessary, services are purchased from other service providers across the state. The region is staffed by an administrator who in turn hires additional personnel to manage and oversee those contracts and services. The Nebraska Association of Regional Administrators is comprised of the six administrators. LB462 would provide a rate increase for behavioral health services of 3% for FY 2021-22 and 3% for FY 2022-23 to Agency No. 25, Department of Health and Human Services, Program 348, Medical Assistance, and Program 349, Medicaid Expansion. We applaud Senator Dorn for bringing forth LB462. As providers within our regions begin the important work of implementing Medicaid expansion, it equally important to maintain rates at as fair and competitive a rate as is possible. Too, in the limited cases where the regions are providers (as in the case of Region 2 behavioral health) where no other provider can or will provide a service essential to the preservation of the continuum of care, this increase will continue to keep the rates competitive so that providers can pay fair wages, maintain offices, and pay benefits. The last 24 months have been incredibly difficult on providers throughout the state. The pandemic is only the latest in three cataclysmic events affecting all parts of our state. The floods of 2019 were not even a memory yet when Covid began to affect the mental and behavioral health wellness of all Nebraskans. Too, add in the failure of the Gering-Ft. Laramie canal in the panhandle, the collapse of which cut off irrigation water to more than 100,000 acres of farm fields in Wyoming and Nebraska. Providers have stepped up to not only respond to these crises, but have done so with the resiliency of Nebraskans. We hope the committee will not only look at a provider rate increase for those areas identified under LB462, but will also provide a rate increase for those services which are not Medicaid reimbursable. In providing services to Nebraskans, we need to recall that there are many services that are not covered under Medicaid. We

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hope the committee will look favorably on those as well for an increase at 3%. We greatly appreciate the time that you have committed to hear this important bill and urge its advancement.

***TAMI LEWIS-AHRENDT:** My name is Tami Lewis-Ahrendt, I am the Chief Operating Officer for CenterPointe. CenterPointe is a non-profit behavioral health organization providing services to Nebraskans at our locations in Lincoln and Omaha. Our services include Mental Health care, substance use care and primary physical health care. We provide an array of services that include Residential treatment, day rehabilitation, residential rehabilitation, outpatient therapy, community support, housing support, recovery support, peer support, crisis response and medication management services across the life span. We have over 30 programs in 14 physical locations across 2 cities. We provide these services primarily to individuals with low to no income. We bill approximately $550,000 in Medicaid Claims (1500 services) per month. I am testifying in support of LB462, specifically the Medicaid rate increase. Over the last decade, rate increases have been few and far between. These rate increases historically fell below the accepted annual cost of living increase (3%), which means they also fell well below the cost of doing business. For decades, Behavioral Health providers have been expected to fill the gaps created by substandard rates with donations, grants and by cutting programming and staff. In 2019, NABHO organized a state-wide Behavioral Health costing project to better help Behavioral Health providers prepare for Value Base Contracting with Medicaid MCO's and other insurers. Thirteen providers from across the state participated in looking at every billable service delivered in the FY18-19. What the study revealed is that nearly every single service billed for, across every single provider who participated, lost money (I have included a sample of the data from that study as an attachment to this testimony). The outcome of the study was clear that the cost of doing behavioral health business in Nebraska is as little as 10% and as much as 50% above what the rates support. As Medicaid expansion shifts the weight of our revenue from DBH to Medicaid reimbursed services, we hope that the Appropriations committee will also take into account the existing gap between the two payers. Medicaid rates fall 7% - 15% behind that of DBH. The proposed 3% increase each year (6% total over 2 years) is a positive effort to keep providers from falling behind even further and a necessary investment to the health care infrastructure of the state. Behavioral Health is a critical part of

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the overall health and wellbeing of everyone in Nebraska. The providers of those services cannot continue to meet the expectations for quality service delivery, business innovations, and state of the art programming with sub-standard rates. Our staff are underpaid, our facilities go without updates and our technology is handed down and donated from the for-profit companies in our communities. We operate as efficiently and as lean as we are able, year after year. Without the continued efforts to increase rates to a livable standard, agencies will be faced with more difficult decisions, like ending vital services. The table on the following page is a sample from the NABHO study. It represents the averages from the 13 participants (CenterPointe, Houses of Hope, Heartland Family Service, Friendship House, The Bridge Behavioral Health, Goodwill Industries of Greater Nebraska, Lutheran Family Services, Catholic Charities Omaha, Blue Valley Behavioral Health, South Central Behavioral Health Services, Child Saving Institute, Community Alliance and HopeSpoke) in the most frequently utilized services. These services are provided by Master's level therapists, APRN's, MD's, Bachelor level profeSSionals, Peer Support specialists and Residential staff. All are the core of what we do.

***KEVIN BAGLEY:** Good afternoon, Chairperson Stinner and members of the Appropriations Committee. My name is Kevin Bagley (K-E-V-I-N B-A-G-L-E-Y), and I am the director of the Division of Medicaid and Long-Term Care (MLTC) within the Department of Health and Human Services (DHHS). I am here to provide neutral testimony regarding LB462, which would state an intent to increase Medicaid behavioral health rates. While outside of the Governor's proposed budget, behavioral health services are vital to many Nebraskans we serve, and we would expect providers would appreciate increased payments for the services they provide. The Medicaid Division's concern with this bill is that it specifies that the rate increase is for budget programs 348 and 349, but does not include program 344, better known as the Children's Health Insurance Program (CHIP). The Medicaid and CHIP programs are administered side-by-side in Nebraska. Medicaid and CHIP children are eligible for the same services and receive them through the same managed care system. As this bill is written, the Medicaid program would need to maintain multiple payment rates for the same behavioral health services depending on whether a child receiving behavioral health services is eligible under Medicaid or CHIP. Thank

you for the opportunity to testify today. Please enter my testimony in a neutral position on LB462.

STINNER: Any additional proponents? Seeing none, any opponent? Seeing none, anyone in the neutral capacity? Seeing none, Senator Dorn, would you like to close?

DORN: Well, we'd like to close not only on this bill, but probably close for the day, I guess. I-- I think this committee in the past week probably has heard a theme about the provider rates and the Medicaid rate and all of that. So I think everybody has heard quite a bit about the importance of it and the need for it in the undertaking that this committee has on that. So I thank you for taking the time for listening and taking the time for allowing some additional bills to be introduced like this so that we can have that good discussion. So thank you much.

STINNER: Thank you. Any additional questions? Senator Erdman.

ERDMAN: Thank you, Senator Stinner. Senator Dorn, have you seen the fiscal note?

DORN: No, I have not.

ERDMAN: OK. I'll bring it to your attention what it says.

DORN: Yeah.

ERDMAN: I didn't see it either. It wasn't in the book.

DORN: No.

ERDMAN: It says if LB462 intends to a 3 percent increase on behavioral health rates in each of the next two state fiscal years, however, the bill only specifies Programs 348 and 349, leaving out Program 344,CHIP, this must be corrected as it would be a-- it would not be feasible to maintain separate rates for the same services dependent upon the child's eligibility category. So you may want to take a look at that and see. It's a top-- top paragraph there on.

DORN: OK, we will.

ERDMAN: I--

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DORN: Thank you.

ERDMAN: I just seen it. It wasn't in the book. So when I looked it up, I seen that's what it said. So it changes-- it changes the numbers. You'll see it there in the second paragraph under that. OK.

DORN: Thank you. I looked several times for this morning, but I--

ERDMAN: I didn't see it in the book so I had to look for that.

DORN: But it'd never been on the, I call it our legislative home page or whatever.

ERDMAN: Yeah, don't feel bad. I just got my fisca; note for my bill tomorrow.

DORN: OK, thank you.

STINNER: OK, very good. Additional questions? Seeing none, thank you. We have submitted written testimony as proponents for LB462: Jennifer Acierno, Joseph Kohout, and Tami Lewis- Arun, however, A-h-r-e-n-d-t. Anyhow, we were sent other letters for the record, six letters of support for LB462. That concludes our hearing on LB462 and our hearings for today.

WISHART: He made it.

STINNER: There is another one?

WISHART: There's one neutral.

STINNER: Oh, I am sorry. There is LB462 does have a Kevin Bagley, neutral. DHHS is neutral? God help us.