ARCH: Good afternoon. Welcome to the Health and Human Services Committee. My name is John Arch. I represent the 14th Legislative District in Sarpy County and I serve as Chair of the HHS Committee. I'd like to invite the members of the committee to introduce themselves starting on my right with Senator Murman.

MURMAN: Good afternoon, I'm Senator Dave Murman from District 38, and I represent most of eight counties along the southern border in the middle part of the state.

WILLIAMS: Matt Williams from Gothenburg, Legislative District 36.

ARCH: Also assisting the committee is one of our legal counsels, T.J. O'Neill; our committee clerk, Geri Williams; and our committee pages, Aleks and Savana. And I'm sure we'll have other members of the committee join us over the, over the time here. A few notes about our policies and procedures. First, please turn off or silence your cell phones. This afternoon, we'll be hearing three bills. We'll be taking them in the order listed on the agenda outside the room. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters of the bill then from those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given the opportunity to make closing statements if they wish to do so. For those of you who are planning to testify, you will find green testifier sheets on the table near the entrance of the hearing room. Please fill one out and hand it to one of the pages when you come up to testify, and this will help us keep an accurate record of the hearing. When you come up to testify, please begin by stating your name clearly into the microphone and then please spell both your first and last name. We use a light system for testifying. Each testifier will have five minutes to testify. When you begin, the light will be green. When the light turns yellow, that means you have one minute left. When the light turns red, it is time to end your testimony, and we will ask you to wrap up your final thoughts. If you wish to appear on the committee statement as having a position on one of the bills before us today, you must testify. If you simply want to be part of the official record of the hearing, you may submit written comments for the record online via the Chamber Viewer page for each bill. Those comments must be submitted prior to noon on the workday before the hearing in order to be included in the official record. And additionally, there is a white sign-in sheet at the entrance where you may leave your name and position on the bills before us today. And

with that, we will begin today's hearing with LB929. Welcome, Senator Wishart.

WISHART: Well, good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Anna Wishart, A-n-n-a W-i-s-h-a-r-t, and I represent the 27th Legislative District, which covers west Lincoln and now because of redistricting parts of southwestern Lancaster County. I'm here today to introduce LB929. It's a bill to expand Medicaid coverage for postpartum women from 60 days to 12 months. And I have to be honest with this committee, I was pretty shocked that this wasn't already the current law in Nebraska. It's astounding to me that a woman who has given birth would not be given a full year of coverage continued if she qualified while she was pregnant, which matches up with the healthcare that her child is being provided. Most people are familiar with the three trimesters of a woman's pregnancy, but more and more experts are recognizing the time after a woman gives birth as the fourth and even the fifth trimester of pregnancy. The weeks following birth are critical to a woman, the baby, and the whole family's long-term health. We are used to the idea of many visits to the pediatrician for a newborn during their first few weeks of life. But for new mothers, typically, there is only one postpartum visit scheduled around six to eight weeks after giving birth. The American College of Obstetricians and Gynecologists recommends a comprehensive postpartum visit within the first 12 weeks, providing a full assessment of physical, social, and mental well-being that includes mood and emotional well-being, infant care and feeding, physical recovery from birth, chronic disease management and health maintenance, and long-term planning for the coordination of continued care. Their committee recommends that changes in the scope of postpartum care should be facilitated by reimbursement policies that support postpartum care as an ongoing process rather than an isolated visit. In fact, our own Department of Health and Human Services agrees with this statement. In their report, Maternal Morbidity and Morality-- and Mortality in Nebraska, which was released September of 2021, they actually recommended extending Medicaid eligibility to one year postpartum pregnancy. Great care is taken during the first three trimesters of a woman's pregnancy, and it is time that the same level of attention and care is paid to women and their families following the birth of a child beyond the fourth trimester. You will hear from many women and advocates today to discuss additional research and experiences that will provide you with the full picture of why this bill is essential for new moms and their babies. This is the bill that I am seriously considering prioritizing. I have 21 cosponsors, which is a mix of Republicans and Democrats on this bill currently. That's

how important this issue is to me, and I would be happy to answer any questions. And there will be experts following me who can talk specifically to the details of this.

ARCH: Are there any questions for Senator Wishart? Seeing none, thank you very much for the introduction. And now--

WISHART: If, if you may--

ARCH: Yes.

WISHART: --Chair can I ask it, can I provide one more--

ARCH: Sure.

WISHART: --information on the fiscal note? The way the fiscal note was, was drafted, actually, it probably will be less. It did not to take into account Medicaid expansion. Some of the women that are listed in terms of the fiscal note would actually fall in the Medicaid expansion category. So what you're looking at is actually probably not, does not reflect the amount, it will be less than that.

ARCH: OK, thank you.

WISHART: Thank you.

ARCH: First proponent for LB929. If I could, if I could have just a show of hands, how many, how many would like-- how many plan on speaking on this bill? OK. All right. Thank you. Please.

BOB RAUNER: My name is Bob, B-o-b, Rauner, R-a-u-n-e-r. I'm testifying on behalf of the Nebraska Academy of Family Physicians, the Nebraska Medical Association, and the Nebraska Association of Physician Assistants, all of whom are in support of this bill. I actually would echo some of what Senator Wishart said. The current-- there's a couple of big reasons to support this. One, is that the current method of, of discontinuing postpartum coverage at 60 days is outdated, basically. There's been a large change in understanding of pregnancy, where they used to think that, you know, the first six weeks everything's taken care of, we move on. But subsequent data, they've shown that about half of maternal deaths happen in the year after birth can be due to things like postpartum cardiomyopathy or blood clots. And not all that's addressed by the time 60 days is up, and so that's one of the reasons why we consider extending what we consider the postpartum period or fourth trimester much longer. I've attached a policy brief that has some reference about this that you can kind of look at if you

want to at your leisure. There's other things that you can also prevent. So, for example, a lot of women in, in pregnancy will develop something called gestational diabetes, and sometimes this is the first sign of later Type 2 diabetes. And there's a window of opportunity after the pregnancy where you can intervene, intervene, you can actually prevent and delay the onset of Type 2 diabetes for years or even decades. And so there's some long-term savings that, that people don't think about that if you could intervene during that time and not discontinue coverage prematurely, you could affect that. Also, better access to postpartum care assists improved spacing and planning of subsequent pregnancies. And so it's not just this pregnancy but the next pregnancy you can impact. And so having that adequate time to address some of these issues can put women in a place that their next pregnancy is a much healthier pregnancy. And this is a key intervention. If we want to lower Nebraska's both maternal and infant mortality, this would be intervention that would help us do that. Nebraska is kind of middle of the pack. It's not the worst in the country, it's not the best in the country. But this is something that actually could have a lot of long-term consequences. And the other thing, as Senator Wishart mentioned, I don't think the fiscal note is accurate. It only looks at the cost. And some of those, I think, are a little excessive because it doesn't consider Medicaid expansion, but it doesn't address the cost savings that occur years afterwards. If you can set the next pregnancy up so that it's in a better situation, the next pregnancy will also be less expensive. In my day job, I work on health system projects that both increase health and lower costs. And I think some people don't think about those costs that accrue two, five, ten years later. An example I would use, and I'm not supposed to use handouts so you can flip over to the last page and look at it if you want. But on that graphic, it's the costs of, of healthcare in 20- to 44-year-olds. Far to the right is what cost the most, to the top is what is increasing the most. You'll notice the single biggest category in that age group is pregnancy and postpartum care. Well, most of those costs have already been incorporated up until 60 days, so this extension for that next ten months isn't going to add much to the cost, but what it can prevent is very large. So, for example, a normal vaginal delivery in Nebraska might cost $7,000, $8,000. A C-section might be $20,000 to $30,000. But if you have a pregnancy that ends up with preterm complications and a kid that ends up the NICU, that can go into the hundreds of thousands of dollars. And some of those complications are lifelong. So you may not just have it that next year, but years to come. That kid who has cerebral palsy and developmental disabilities, he may be on Medicaid or she may be on Medicaid for decades. And so you have to incorporate some of those

costs. Those aren't addressed in the fiscal note. And so I think it's a far underestimate. And what I do in my day job, we actually make a lot of investments in our-- in the care of our patients in year one that plays-- that pays off in the years two and five and ten. And I don't think that's addressed in the fiscal note. And so that's, in short, the reasons I would advocate for this bill and I would be happy to answer any questions.

ARCH: Thank you. Are there any questions? Senator Hansen.

B. HANSEN: Thank you for testifying. You mention here that-- oh, where's it at, that pregnancy-related deaths continue to rise in the United States. Why is that? Is it just because the rise in diabetes that we, that we see or is there, is there a specific cause or is it kind of multifaceted?

BOB RAUNER: It's multifaceted. Diabetes is one of those complications. The risk of our pregnancies going over, over time partly because of diabetes, [INAUDIBLE] chronic disease, higher rates of obesity, high blood pressure. And again, some of those lifestyle changes. The best time to make a difference is when a young mom has a new baby, her life perspective changes a bit and it's a good opportunity to make some of those behavioral changes, and so it's a combination of things. It's also just bad-- poor access to care. When women don't have access to care, they don't get a lot of these things. They're worse in rural areas for minority, low-income people. And so there's-- we have some-- Nebraska, one of the things we do worst on is our health disparities in Nebraska. And they're not just minority or low-income, they're actually urban-rural. We have some of the worst urban-rural health disparities in the country. And so access to care is a big obstacle, and this would help address that.

B. HANSEN: OK. All right, thanks. Just curious. Thank you. Appreciate it.

ARCH: Other questions? Seeing none, thank you very much for your testimony. Next proponent for LB929. Good afternoon.

ANDREA SKOLKIN: Good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Andrea Skolkin, A-n-d-r-e-a S-k-o-l-k-i-n, and I'm the chief executive officer of OneWorld Community Health Centers. And I'm also here representing the Health Center Association of Nebraska, which is the seven federally qualified health centers. We provide comprehensive primary care services to over 107,000 individuals annually, regardless of insurance

status or ability to pay. We are in strong support of LB929 and would like to thank Senator Wishart for introducing the bill. The American Rescue Plan Act of 2021 created a new option for states to expand postpartum Medicaid coverage to a full year, as opposed to the 60 days. Coverage can begin as soon as April '22, and funding for this program lasts a full five years. LB929 adopts this option, and the federally qualified health centers in Nebraska strongly urge support of this bill. We believe that this bill will improve access to needed care and help improve maternal health and mortality rates. Federally qualified health centers in Nebraska provide care to over 2,300 prenatal patients annually. Over 900 of those alone are at OneWorld Community Health Center that gave birth in the last year. Many of these patients were covered by Medicaid. Federally qualified health centers in Nebraska see approximately 13 percent of all Medicaid patients. And nationally, over 40 percent of all births are covered by Medicaid. Medicaid coverage can and does improve access to important services in the postpartum period, including mental health. As many as 20 percent of pregnant women experience depression and in the pre and postnatal period. Pregnancy, as you heard, also can exacerbate chronic health conditions such as heart disease, diabetes, and hypertension. Extending postpartum coverage ensures timely access to needed services, improves continuity of care, and reduces gaps in coverage. This helps people get the care they need when they need it. As you may have seen in the Omaha World-Herald this morning, moms-- a study that the outcomes have just come forward. But it shows that moms that are healthy and have access to financial supports are better able to nurture their babies, which can result in better development in the baby's brain. So we urge you to support this and advance this bill to General File. And again, thanks to Senator Wishart for introducing it. I'm glad to take any questions.

ARCH: Thank you. Are there any questions? Senator Hansen.

B. HANSEN: Thank you, Chairman. As you were talking, you mentioned a couple things that me me think of a couple of questions. If you can't answer them, that's fine. Maybe somebody afterwards could, and I hope I didn't miss Senator Wishart saying it. But how many other states have coverage of one year for Medicaid? Do you know off the top of your head?

ANDREA SKOLKIN: I don't know the answer to that question.

B. HANSEN: And that's fine. Like I said, maybe--

ANDREA SKOLKIN: I'm sure there's a follow-up testimony that will include that.

B. HANSEN: OK. The other question I had, and again, in case you can't answer it, but I, I, I recognize a common theme here also is that the disparity of, of people of color compared to people who are white and other kinds of cultural, I think, disparities. When we-- when other states have implemented the yearlong Medicaid, I'm curious to know if that has improved that disparity or improved that gap? That's kind of the only kind of statistic I'm just kind of curious of, so.

ANDREA SKOLKIN: Again, I was hoping I'd be knowledgeable on that. But I am not. I can't assume-- I mean, I can make assumptions. But we know just from our personal experience at OneWorld, the moms that get everything they need fare better than the moms that don't.

B. HANSEN: Sure. I, I appreciate it.

ANDREA SKOLKIN: But that's anecdotal not every-- you know, our data.

B. HANSEN: Yep, and that's perfect. I appreciate it. Thank you.

ANDREA SKOLKIN: Um-hum.

ARCH: Other questions? Seeing none, thank you very much. Next proponent for be LB929. Good afternoon.

CAROL GILBERT: Good afternoon, Chairperson Arch and members of the Health and Human Services Committee. I'm Dr. Carol Gilbert. For the record, that's C-a-r-o-l G-i-l-b-e-r-t. I am a faculty member of UNMC. However, today I am speaking for myself and not as a representative of the university. My academic training is in mathematical statistics and public health. I worked for many years at a maternal and child health membership organization called CityMatCH. CityMatCH is located at UNMC and it has 170 local public health department members across the country. So we partner with these health departments to decrease health disparities in maternal and child health and improve outcomes for everyone. And I'm here today in support of LB929, which will draw down federal matching dollars from the American Rescue Plan to extend postpartum coverage under Medicaid from the current 60 days to a full year. Roughly half of states are expected to extend coverage under this new opportunity, and I believe Nebraska should be in this group of states for three reasons. First, extending postpartum coverage is good health policy, as you've just heard. Women who receive extended postpartum care are less likely to have another pregnancy within 18 months. If they had an adverse pregnancy outcome, they're less likely

to have another and references, some references for this are in Appendix A. As the committee knows, our nation has a high maternal mortality rate, and extending postpartum coverage would also help with this likely. In, in Appendix B, I've included data presenting an overview of pregnancy-related deaths among the 13 states that undertook extensive 5-year reviews, and you can see in the highlighted column that about 12 percent of pregnancy-related, that's causally related, deaths took place in the period after the minimum Medicaid coverage ends between 43 days and one year postpartum. Nebraska's Department of Health and Human Services issued a report that was mentioned earlier on maternal morbidity and mortality and found that more than half, 59 percent of pregnancy-associated deaths occurred in that period after standard Medicaid coverage. The report also said that women with public insurance at their baby's birth were more than two and a half times more likely to die compared to women with private insurance for delivery. So passage of this bill will likely save lives, the health part. And second, extending postpartum coverage crosses political boundaries. Among the 12 states that didn't expand Medicaid. As part of the ACA, seven have already taken action to extend the postpartum coverage, and six already have passed this. The list is in Appendix C. One of these states is Texas, which actually started working on this way before others did and way before the American Rescue Plan, because they had very high maternal mortality rates. There's a reference for that also. Further evidence of consensus on-- of the importance of extending postpartum care is the fact that the Surgeon General appointed by President Trump, Jerome Adams, issued a call to action that put forward the definition of postpartum as the period immediately after the birth of a child and up to 12 months after delivery. In Appendix D, you can see a map showing that half of the U.S. states have now adopted or taken steps toward extending coverage for postpartum care past the six weeks. Our nation is rapidly coming to terms with the fact that extended insurance coverage for postpartum care is needed to save the lives of women and infants. The third thing is that this is good physical-- fiscal policy and with federal funding for five years. And so I urge the committee to advance this bill and thank Senator Wishart for introducing it.

ARCH: Are there questions? Seeing none, thank you very much for your testimony. Next proponent for LB929.

ANN ANDERSON BERRY: Good afternoon, Chair Arch and members of the Health and Human Services Committee. I am Dr. Ann Anderson Berry. For the record, A-n-n A-n-d-e-r-s-o-n B-e-r-r-y. I'm a faculty member of UNMC and the medical director of the Nebraska Perinatal Quality Improvement Collaborative. However, I am not speaking as a

representative of the university today. I am here speaking as an individual and on behalf of NPQIC. I'm here testifying with regards to LB929. As a medical director of NPQIC and a neonatologist, I work with hundreds of families each year with high-risk medical situations for both mother and baby. Additionally, I work with healthcare professionals from across the state who are dedicated to providing care that leads to the best outcome for Nebraska mothers and infants working to ensure that every family has the healthiest start possible. Unfortunately, we still face situations every day where inadequate access to healthcare impacts mothers and, therefore, their ability to care for their children. In the neonatal intensive care unit, we have many preterm and seriously ill newborns whose days extend past the 60 days postpartum that Nebraska currently provides postpartum coverage in Medicaid. It is common for mothers to discuss their health with me as their infants' doctor. When medical coverage expires, mothers lament their inability to fill their antihypertensive medications, seek care for prenatal depression or easily treated illnesses like mastitis, which is an inflammation and infection of the breast in a breastfeeding mother, which left untreated, can prevent breastfeeding and cause serious illness in the mother. What is less obvious and just as concerning, is the impact of this lack of healthcare on the newborn infant, the family, and other Nebraskans. As healthcare providers, we know that postpartum care is an ongoing process that typically requires multiple visits and follow-up care that may last a full year. This is particularly important for those who experience pregnancy complications or have chronic conditions, such as hypertension or diabetes. The implications of lack of healthcare coverage for maternal health is profound and plays a role in rising U.S. maternal mortality rates. Suicide drives mortality rates in the first year among pregnant and postpartum people and has risen over the past decade with poor access to treatments among communities of color and low-income women driving disparate outcomes. Mental health treatment and coverage can prevent that. As a neonatologist, I know from experience the death of a mother is one of the most tragic events that can befall a family and a community. The short and long-term impact of such a tragedy on her surviving children, family and community and the healthcare professionals who cared for her cannot be underestimated-- overestimated. We also know that the health of the child linked to mother's health-- is linked to mother's health. Improving these outcomes for mom will also improve the health of the child as noted in the 2020 Surgeon General's Call to Action and the Health and Human Services Action Plan. Lack of access to healthcare and insurance coverage contributes to poor outcomes and racial and ethnic health disparities. Extending coverage provides an opportunity to monitor

recovery from pregnancy and birth, as well as to address ongoing health concerns and behavioral health. Improving women's overall health reduces chances of complications during subsequent pregnancies, preventing potential subsequent NICU admissions, which are incredibly expensive, as you've already heard. A study in 2017 found that improved maternal coverage was associated with improved attendance at well-child visits, which are the primary platform for growth and developmental screening, vaccination, and provision of anticipatory guidance. Children who attend these visits are more likely to complete immunizations and less likely to have avoidable hospitalizations reducing state expenditures. New parents need to thrive, especially during the critical time before and after birth. The first year of parenting is filled with anxiety and exhaustion. Mother is physically recuperating from childbirth, especially if she suffered from pregnancy complications. This is coupled with the demands of caring for infant, scarce money and time, and all of this plus a lack of sleep is strongly correlated with postpartum depression. Untreated maternal depression significantly impacts the health and well-being of women, infants, and families. Low-income mothers are more likely to experience depression as high as 40 to 60 percent. Perinatal depression is associated with poor outcomes in children including increased morbidity and mortality, family dysfunction and increased risk of abuse and neglect, impaired child-- parent-child interaction bonding, and attachment issues leading to delays in motor, cognitive, and language development, discontinuation of breastfeeding, failure to thrive in colic and emotional and behavioral disorders that persist into adolescence. Untreated maternal depression is associated with increased medical costs and inappropriate medical treatment of the infant. Mothers not covered under Medicaid may not get the appropriate care, including diagnosis, therapy, or medication. In conclusion, Nebraska's mothers and babies need the work of not only our prenatal collaborative, but all stakeholders including most importantly our state governing bodies. Supporting maternal healthcare for 12 months after delivery will have a positive impact on Nebraska babies and their families. I urge you to provide this coverage to Nebraska mothers. Thank you to Senator Wishart for introducing this legislative bill. Together Nebraska's perinatal collaborative will continue to work so that Nebraska will be a state where a great life starts with healthy moms and healthy babies. And I'll finish by answering Senator Hansen's question. Twenty-five states have enacted the motion to move to this-- to adopting this; 18 have accepted it and 7 are in progress. And that's as of January 21. Nebraska was not on that list yet. Let's hope it becomes on that list.

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

B. HANSEN: And you said it was 25. Sorry.

ANN ANDERSON BERRY: Twenty-five, 18--

B. HANSEN: Thanks for testifying. Sorry.

ANN ANDERSON BERRY: Yeah, absolutely. Twenty-five, 18 are fully implemented, 7 are in the process.

B. HANSEN: And that's the postpartum, you're testifying the 1115--

ANN ANDERSON BERRY: That's the 12, that's the year.

B. HANSEN: --just the 1115 waiver. OK. All right.

ANN ANDERSON BERRY: Yeah. Yep, with this federal supplement.

B. HANSEN: Cool.

ANN ANDERSON BERRY: And, you know, so I am hopeful that we'll add Nebraska and that others through their legislative sessions will, will move on.

B. HANSEN: And one more just professional question. I know you mentioned in your testimony that you're-- that we're starting to see suicide rates or even depression among postpartum mothers on the incline. I've seen it as well.

ANN ANDERSON BERRY: Yes.

B. HANSEN: Why do you think that is in just your professional opinion?

ANN ANDERSON BERRY: Well, it's very stressful to raise a child and we have increasing comorbidities. We have increasing costs to raise a child. We have the pandemic that we're dealing with. There's a lot of stressors on families, and we know our maternal mortality rate in the U.S. has been rising over decades, but it's taken a significant increase in recent years. I can't even imagine what it's going to be like when we start to get the reports from 2020, 2021, and 2022 with the impacts of the pandemic. As I testified earlier to this committee, maternal mortal-- or maternal depression rates are as high as 33 percent now with the onset of the pandemic in preliminary reports, and we know that maternal suicide drives a fair amount of maternal mortality because maternal mortality is measured up to a year after delivery. And so I think we cannot underestimate the impact of

peripartum depression on maternal health and how it drives not only mental health, but also the physical health and well-being of not only the mom, but also the children and our community.

B. HANSEN: OK, thank you.

ANN ANDERSON BERRY: Yeah.

ARCH: Other questions? Seeing none, thank you very much for your testimony.

ANN ANDERSON BERRY: Thank you for the opportunity.

ARCH: Next proponent for LB929. Hello.

JO GILES: Hello, good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Jo Giles. That's J-o G-i-l-e-s, and I'm the executive director of the Women's Fund of Omaha. The Women's Fund testifies in strong support of LB929, a bill to extend postpartum coverage for Medicaid recipients from 60 days to 12 months. The majority of pregnancy-related deaths, about 60 percent, are preventable and increased access to postpartum healthcare through Medicaid in the year following childbirth will save lives. The CDC names access to clinical care, inappropriate or delayed treatment, lack of continuity of care, and case coordination or management as contributing factors to those preventable pregnancy-related deaths. All of these factors would be addressed by expanding postpartum Medicaid coverage to 12 months. The most recent data available in Nebraska show that 39 percent of pregnancy-related deaths occurred in the later postpartum period. So that's the 43 days to one year. The maternal death review process in other states has found that a significant number of maternal deaths have occurred outside the 60-day Medicaid postpartum coverage period. For example, we found in Illinois it was 51 percent of all maternal deaths occurred after that period, 56 percent in Texas, and 62 percent in West Virginia. In Illinois, poor continuing-- continuity of care and the lack of care coordination were identified as factors that contributed to the death in 93 percent of preventable pregnancy-related deaths in that postpartum period. So expanding postpartum coverage would mitigate delays in treatment, support that continuity of care, and provide lifesaving care during this vulnerable period. Expanded postpartum coverage through Medicaid also can reduce costs to the overall program through access to preventative care and family planning. Postpartum coverage could reduce costs by better managing healthcare conditions before they become chronic or more expensive to treat. Additionally, expanded

postpartum coverage would also increase access to family planning services, which can reduce unintended pregnancies, thus generating savings and averted prenatal care, birth and healthcare costs for the first year of the child's life through Medicaid. The most common pregnancy and postpartum complication, as has, as has been mentioned, is perinatal depression. That includes major and minor depressive episodes that occur. They occur either in pregnancy or in the first 12 months after delivery. One in every seven birthing people experience perinatal depression. It can lead to poor health outcomes for mother and baby and is associated with an increased risk of suicide and a leading cause of maternal mortality. The good news is that that is treatable, and extending postpartum care and Medicaid coverage to recipients would be key in addressing maternal depression and promoting the health and safety of moms and babies in Nebraska. Medicaid plays an important role in supporting maternal health, paying for 35 percent of Nebraska births in 2018. According to national data, Medicaid paid for a larger share of births in rural areas and among black and Latinas. Self-reported Medicaid coverage drops to 18.8 percent for the postpartum period. So if we think about the perinatal period, the percentage of self-reported insured during that period of time is very low, so 1.5 percent and then it jumps to 14.5 percent for the postpartum period. National research demonstrates that half of all uninsured new mothers report losing Medicaid after pregnancy as the reason they became uninsured. Extending Medicaid coverage through the postpartum period would address coverage gaps, ensure healthcare support, and contribute to the safe and healthy start to life for babies and parents in our state. The Women's Fund respectfully urges your support of LB929 with a vote to move this to General File to protect the health of new moms and babies by extending Medicare coverage for 12-month postpartum period. Thank you and I am happy to try to answer any questions.

ARCH: Thank you. Are there any questions? Seeing none, thank you for your testimony.

JO GILES: Thank you.

ARCH: Next proponent for LB929.

CHRISTIAN MINTER: Good afternoon, Chairperson Arch and members of the Health and Human Services Committee. I am Christian Minter. That's C-h-r-i-s-t-i-a-n M-i-n-t-e-r. I am manager of Maternal and Infant Health Initiative for March of Dimes, leading nonprofit organization fighting for the health of all moms and babies. Thank you for this opportunity to offer testimony in support of LB929. We can measure the

health of our state by looking at the health of our moms and babies. We are not a healthy society when the rate of maternal death, severe morbidity, and mental health disorders continue, continue to increase and when moms do not have consistent access to health insurance and healthcare. While parenthood is a joyful time, the experience of pregnancy and childbirth can take a toll both physically and mentally. Women continue their postpartum recovery for up to one year after birth. In the United States, 30 percent of maternal deaths occur one week to 365 days after birth, and black women have a higher risk of maternal death occurring 43 to 365 days after birth compared to white women. In Nebraska from 2014 to 2018, nearly 60 percent of maternal deaths were due to medical reason and 59 percent of maternal deaths occurred more than 43 days after birth. The Nebraska Maternal Mortality Review Committee found that the majority of maternal deaths were preventable and the top contributing factors included lack of access to care or financial natural resources and continuity of care. Just last week, we sat in this room and talked about the importance of perinatal mental health screenings that should occur during postpartum and well-child visits. Approximately one in eight Nebraska women report experiencing symptoms of postpartum depression. Providing moms with access to screenings, referrals, treatment and health insurance to cover this expense is critical throughout the first year of postpartum period. Left untreated, postpartum depression and other mental health disorders can impact the mom's ability to carry out daily life activities or care for her baby and cause developmental delays in children. In Nebraska, many moms are depending on Medicaid for health insurance during pregnancy and postpartum. In 2020, one in three Nebraska births were covered by Medicaid. This number is much higher among women of color. Native American and black women are two and a half times more likely to have their birth covered by Medicaid than white women. Extending Medicaid coverage to 12 months postpartum has a significant impact on a large number of the state's birthing population and can help address maternal health disparities. Uninterrupted coverage helps to ensure access to the continued care that Nebraska moms need during the postpartum period. By extending Medicaid postpartum coverage, you are making an investment in the lives of Nebraska moms and the health and well-being of our state. When our moms are thriving, our communities are a healthier place. I encourage you to support LB929 and help improve access to perinatal healthcare. Thank you for prioritizing the health of Nebraska moms and their families.

ARCH: Thank you. Are there any questions? Seeing none, thank you very much for your testimony. Next proponent for LB929.

NYOMI THOMPSON: Hello.

ARCH: Hi.

NYOMI THOMPSON: Good afternoon, Chairman Arch and the rest of the Health and Human Services Committee. My name is Nyomi Thompson. That's N-y-o-m-i T-h-o-m-p-s-o-n. I'm here to testify on behalf of myself, not as a representative of any organization I'm affiliated with. I wanted to share my personal story with you all in support of LB929. I am a black single mother in addition to a Nebraska transplant. Almost two years ago, I gave birth to my beautiful daughter. This life-changing event happened several months before finishing my second master's degree at the University of Pennsylvania. During my pregnancy, I was more determined than ever to finish graduate school. I wanted to go above and beyond in my accomplishments in order to obtain an exceptional job and to provide a comfortable life for myself and my daughter. Postpartum, I spent my time completing classes, upholding my extracurricular responsibilities, and completing an internship. I balanced those commitments while nursing and caring for a newborn alone at the beginning of the pandemic. As a person who is predisposed to mental health issues, in addition to the way my life was set up, I developed severe postpartum depression. My condition escalated 90 days postpartum. I knew my daughter felt the weight of my emotions. I started snapping at her more, she'd cry more, and I felt like a failure as a mother. This carried into my studies. My work quality diminished. I didn't feel like myself. I knew something had to change to reach my personal goals and, more importantly, set my daughter up for immediate and long-term success. Receiving mental health services was imperative to realign myself with my goals. Therefore, I reached out to a therapist and received help. As a graduate student with little income, I was fortunate enough to qualify for Medicaid after Pennsylvania 60-day postpartum cut off. It was only due to that financial support that I received the help I needed, graduated from my dual degree program with a near-perfect GPA, and landed my dream job as a policy analyst here in Nebraska. Extending Medicaid postpartum coverage won't only address the physical traumas that come with childbirth, it will provide mental health services to address the mental trauma that can cripple the livelihood of families. In addition, extending coverage will give more young, talented birthing people the opportunity to achieve economic sufficiency for their families and contribute to making Nebraska the best it can be. I encourage you to advance LB929 and thank you for your time.

ARCH: Thank you. Are there any questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for your testimony. First of all, what's your daughter's name?

NYOMI THOMPSON: Troy Emery Jean [PHONETIC].

M. CAVANAUGH: And she's almost two now?

NYOMI THOMPSON: Yeah, she'll be two in March.

M. CAVANAUGH: OK. Well, I just that, that you're were very impressive. Having children myself and knowing how hard it is to juggle things, I just very much appreciate you taking the time to tell us this because that is quite the story and quite the journey. So thank you.

NYOMI THOMPSON: Thank you. It was hell but we made it, so.

ARCH: Questions? Seeing none, thank you very much.

NYOMI THOMPSON: Thank you.

ARCH: Next proponent for LB929.

JENNIFER GRIFFIN MILLER: Hello.

ARCH: Hello.

JENNIFER GRIFFIN MILLER: Senator Arch and members of the Health and Human Services Committee, I appreciate you taking the time to hear our testimony today. I'm Jennifer Griffin Miller. My last name is G-r-i-f-f-i-n M-i-l-l-e-r. I'm a faculty member at the University of Nebraska Medical Center. I'm a physician, obstetrician, gynecologist, and I'm the medical director of the Olson Center for Women's Health at Nebraska Medicine. I'm here today in my individual capacity in support of LB929, which would extend Medicaid coverage for eligible women in the first year after birth. As an OB/GYN, our relationship with our patients often begins at the time of a new pregnancy. For some women, especially those who may be of low income in our communities, this may be the first time in their adult lives when they had good access to healthcare. It's also a time when women will feel a new commitment to focusing on their health because they know it impacts the health of their unborn children. We work hard as OB/GYNs to capitalize on the opportunity to identify and treat health concerns that will improve outcomes for women and babies. We know that management of key medical issues make a huge difference in the outcome of pregnancies. And when I talk about pregnancy outcome, I'm talking about healthy moms and healthy babies at the end of the pregnancy. We know that maternal

mortality has increased in Nebraska, and there's no one who is more important to the healthy life of a child than its mother. The key medical issues that we address every day are hypertension, which may exist before or during pregnancies, diabetes, obesity, substance abuse disorders, and perinatal depression. Women often enter pregnancy with some of these conditions, and they are often more likely to continue to exist beyond that six-week postpartum visit. At a postpartum visit when a mother is returning to her pre-pregnancy physiologic state, we, as OB/GYNs, make a plan to establish ongoing issues with the patient. The postpartum visit marks the beginning of the inter-pregnancy care and well-women care that make a huge difference, not only for maternal health and well-being, but will also reduce adverse outcomes in subsequent pregnancies. It is critical to have continuity of care for mom following pregnancy in order to have good outcomes for mom and baby. For some of the examples that we see every day at those postpartum visits, our treatment of high blood pressure, which can reduce the risk of stroke in the mother postpartum, as well as long-term vascular disease that will affect her future pregnancies and her long-term health, treatment of depression and substance abuse disorders, which we know that this treatment can reduce the risk of suicide, infanticide, and can also improve quality of life for mom and baby. We follow up abnormal screening tests such as pap smears, and this can help us to prevent cervical cancer. We manage contraception, and this allows women to space their pregnancies adequately so that they can have the healthiest possible outcome with future pregnancies. We also support breastfeeding, maternal nutrition, and obesity management, which is obviously crucial to the health of the entire family going forward. We know that none of these things end at the postpartum visit. To make a difference, we really need to prioritize the access to inter-partum pregnancy-- inter-pregnancy care as well as well-woman care. As a physician, it's particularly heartbreaking if we establish a relationship with a patient, and we emphasize to her the importance of ongoing care for hypertension or depression, and then knowing that she's going to walk out of our clinic unable to actually access that care or medications that she needs going forward. We also certainly fear that women will suffer from adverse outcomes due to their lack of treatment, and we've certainly seen that in many cases. Whether-- rather than making postpartum visits the end of the road for our women in Nebraska, this should be part of a continuation of healthcare and healthcare relationships that women establish during pregnancy. We know intuitively that mom's well-being makes a huge difference to her family and to society, and evidence supports that inter-conception or inter-pregnancy care as well as well-woman care

are key determinants of lifelong health and outcomes for subsequent pregnancies. Thank you for your time.

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

WILLIAMS: Thank you, Chairman Arch. And thank you, Dr. Griffin Miller, for being here. As, as I think about this when, when you're visiting with a, a mom shortly after childbirth.

JENNIFER GRIFFIN MILLER: Right.

WILLIAMS: What I think you're telling us is that you are making a plan, but you know that at the end of 60 days you're going to, in many cases, have to end that. If we were to pass this legislation, how would you change your management of, of that situation?

JENNIFER GRIFFIN MILLER: Right. So I think that we know that a lot of things that we would recommend at the end of a pregnancy are going to require ongoing treatment. So for example, if you had a new diagnosis of hypertension. We manage hypertension during the pregnancy slightly different than we do after the pregnancy, but they're both very important. If you yourself had a new diagnosis of hypertension, your doctor would say, let's start this medication and let's see you back in two months and see how you're doing on it. And is your blood pressure controlled? Or could you stop by and get a blood pressure check at the doctor's office, you know, a couple of times a month or something like that? So really, our strategies for dealing with care after pregnancy is very similar to how we deal with our patients in general, which is when we have new diagnoses, we want to make sure that they're stable on their medications, that things are going well. And with a new mom, there's even more reason to expect that things might not be because we know they're dealing with the stresses of a newborn. Their physiology is changing. You know, their bodies are changing. So there's a lot of variables that affect kind of how their body responds to new medications and to treatment and what's going on in their lives. So ideally, we'd want to be able to see that person back, in some cases, frequently. In other cases, a woman might not need to be seen right away. They may have medications that can be managed, you know, with greater intervals of, of visits. But I guess that's, that's the general answer to your question.

WILLIAMS: Thank you.

ARCH: Senator Hansen.

B. HANSEN: Thank you. I appreciate some of the stuff you mentioned here, support of breastfeeding, maternal nutrition, obesity management. Because again, I guess if we're trying to use taxpayer money to help the overall health and well-being, I think of, of, of our state and one of the things that's crucial we look at is not just the management of current conditions, but also the prevention of conditions--

JENNIFER GRIFFIN MILLER: Right.

B. HANSEN: --that might be coming forward. Do you know if Medicaid covers any of that at all by chance?

JENNIFER GRIFFIN MILLER: So yes, Medicaid covers nutrition services at the Olson Center for Women's Health. We have a nutritionist available to women that they will access during the pregnancy if they're covered by Medicaid, as well as during the postpartum interval. Obviously, those services kind of drop off if the woman doesn't continue to have coverage, but certainly a lot of those things, lactation consultants, WIC. They're all services that we offer to women during and after the pregnancies.

B. HANSEN: OK. Because that seems again one, another common theme that what I'm hearing from the testimony is the two main things I think we're kind of looking at is diabetes and mental health, right? And so and I see with diabetes, I think that's, you know, treatment of the current condition also trying to figure, OK, how do we prevent that? And I'm, I'm--

JENNIFER GRIFFIN MILLER: Correct.

B. HANSEN: --assuming that comes, like, well-mom visits, they probably have them, like, once every three months or at postpartum?

JENNIFER GRIFFIN MILLER: So normally, like a well-- like a, a woman who's had a pregnancy normally will have a visit with her physician at six to eight weeks postpartum, potentially other visits prior to that. And then from that point on, it just really depends on the individual person, what their medical conditions are, and what kind of support they need. I think, you know, diabetes you mentioned, very important. Frequently diabetes, we do diagnose during pregnancy for the first time. Some moms come in with diabetes, but many times it's the first time we've identified diabetes as a concern. And so at that postpartum visit, we're able to say, do you have ongoing diabetes? And is this something we need to continue to address with you to make you healthy

for your next pregnancy? Hypertension is also a huge one. Hypertension and stroke and vascular events are actually a, a big source of maternal mortality in, in the United States. Hypertension, as I mentioned, you need to see people on a regular basis to make sure that the interventions you're starting are actually effective because if they're not effective, then that woman is still at risk. And so and it also certainly affects long-term health outcomes for the rest of their lives. So these are just all things that in the most ideal role for a physician, we want to have a woman with those diagnoses getting regular follow-up care. So we know that what we're doing is actually making an impact.

B. HANSEN: Sure. Yeah. Thank you. Appreciate it.

ARCH: Thank you. Other questions? Seeing none, thank you very much for your testimony.

JENNIFER GRIFFIN MILLER: Thank you.

ARCH: Next proponent for LB929.

CANDY ZOLLICOFFER: OK. Hello.

ARCH: Hello.

CANDY ZOLLICOFFER: Good afternoon, Senator Arch and the members of the committee. Thank you for taking the time to listen to my story. My name is Candy Zollicoffer, C-a-n-d-y Z-o-l-l-i-c-o-f-f-e-r. It's a, it's a mouthful. But I am a wife. I'm a mother of four. I'm a community breastfeeding advocate, and I desire to have healthy births and I desire for other people, other birthing persons to do it as well. I'm here as an individual in support of LB929, as well as a member of I Be Black Girl. And I really just want to request and urge that you expand postpartum coverage after birth from 60 days to 12 months. I'm here to share my personal story. As I said, I'm a mother of four. My third pregnancy, I experienced postpartum depression, something that I'd never experienced before, and I was able to find a therapist to help me through that process. My fourth pregnancy, my little guy. He is currently 19 months, so I had him during the pandemic. During that time, excuse me, I delivered him and all of my appointments prior to his delivery, I had to go by myself because of COVID, because of COVID restrictions. I was diagnosed early on at the 20-week mark with gestational diabetes and learned later that it wasn't actually gestational diabetes but preeclampsia. So preeclampsia, excuse me, is a-- it's hypertension. It's a dangerous

complication characterized by high blood pressure, and it usually begins after 20 weeks of pregnancy in a woman whose blood pressure had, had been normal. So this was not something that I had prior to being pregnant. Preeclampsia is very fatal, and during my entire pregnancy, up until I learned that I had preeclampsia at 34 weeks pregnant, I moved from my provider and moved to the Nebraska to the Olson Center Nebraska Medicine, where I was able to receive care. When you have preeclampsia, preeclampsia, as the previous person spoke, you have to have care every single week. I had appointments every week for my-- for the care of my preeclampsia. I also was battling extreme morning sickness where I was sick most of the day. Because of these combinations, I had to leave my work where I was a fundraiser at a nonprofit. I've been there for five years, worked-- working with Fortune 500 companies, as well as high individuals who are able to give at high capacity. I left that work at the height of a fundraising season to be on essentially bed rest and attend appointments every week. Initially, I was on six medications and due to just the urge of my, my doctor, I was-- my new doctor at Nebraska Medicine was able to come off of those medications and only have two. Because we had, my husband and I had limited income, I did use-- was able to access Medicaid in order to pay for those medications, attend every single appointment, as well as receive care after. After I delivered my son, not only did I experience-- continue experiencing the effects of preeclampsia, but I also experienced postpartum anxiety, carpal tunnel and tendinitis in my hand, in my arm. And so without that care or without the support of Medicaid, I would not have been able to afford all of the care that I needed in order to have a healthy postpartum experience. And so I urge you to pass LB929, and I really appreciate you listening to my story.

ARCH: Thank you for your testimony. Any questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you so much. And how is your son after going through the preeclampsia?

CANDY ZOLLICOFFER: You know, he, he's doing great. It's actually been a very-- his story to me is inspiring. Right now, or after I delivered him because of the preeclampsia and the tendonitis, I wasn't able to really hold him because my hands were very weak, and so, but he is a healthy little guy. He has been experiencing some effects from a-- from another disorder that he was born with. And so he was in NICU actually for a couple of months ago for about six and a half weeks. But he is better now, or not NICU, PICU. So he's better now. But you know, he's, he's overall a, a very sweet and joyful little guy.

M. CAVANAUGH: Well, thank you. I, I've had personal experiences with losing people to preeclampsia, and so I know how serious that can be. So thank you.

CANDY ZOLLICOFFER: Yes, thank you so much.

ARCH: Senator Hansen.

B. HANSEN: Thank you. You have four kids?

CANDY ZOLLICOFFER: Yes.

B. HANSEN: And you had postpartum anxiety? I have one kid.

CANDY ZOLLICOFFER: Yes.

B. HANSEN: Man.

CANDY ZOLLICOFFER: Yes.

B. HANSEN: I don't know whether to congratulate you or say I'm sorry, but that's, that's a lot of stuff gong on.

CANDY ZOLLICOFFER: They're wonderful.

B. HANSEN: Just actually more of a question as a participant of Medicaid.

CANDY ZOLLICOFFER: Um-hum.

B. HANSEN: Did you find it hard to enroll in Medicaid when, like, was it a pretty easy process for the most part when you were, when you were pregnant?

CANDY ZOLLICOFFER: I feel like for the most part it was easy. It's, it's, it's a long process. So I will say that it is a long, a longer process than what I would have liked. And so-- but yeah, it--

B. HANSEN: OK. Just curious because I know with preeclampsia and then you have, you know, financial issues then I know time is of the essence sometimes in applying for that and getting it. I'm just more from, from some issues.

CANDY ZOLLICOFFER: Yeah, there was definitely a gap.

B. HANSEN: OK, just kind of curious.

CANDY ZOLLICOFFER: There was a gap in that, in that care. But thankfully it was approved and I was able to get some things taken care of.

B. HANSEN: All right, thank you.

CANDY ZOLLICOFFER: You're welcome.

ARCH: Other questions? Seeing none, thank you very much.

CANDY ZOLLICOFFER: Thank you.

ARCH: Next proponent for LB929.

CLAIRE WIEBE: Hi. Good afternoon, Chairperson Arch and members of the Health and Human Services Committee. So we've already heard some really awesome testimony today, so I'm going to keep mine pretty short. My name is Claire Wiebe, C-l-a-i-r-e W-i-e-b-e, and I'm the senior manager of public affairs at Planned Parenthood North Central States in Nebraska. Our mission at PPNCS is to empower vital generations by providing and advocating for sexual and reproductive health so that more people can choose their own path to a healthy and meaningful life. And to that end, we are strongly in favor of LB929, which would extend vital healthcare services to new families across our state. The United States is experiencing a maternal health crisis and Nebraska is no exception. We're the only industrialized nation where maternal mortality is actually on the rise, and more than half of maternal deaths each year are preventable. We also can't overlook the disparities in birthing and postpartum care experienced by black people and other people of color in our state. In Nebraska, the share of births for black people covered by Medicaid is 65 percent, which is much higher than other groups. The Legislature has the power to narrow this gap and improve birth outcomes for all Nebraska families with LB929. When new parents have access to the healthcare they need, the chances of post-birth complications decrease. According to the American College of Obstetricians and Gynecologists, nearly 70 percent of women describe at least one physical problem in the first year of the postpartum period, and about one in nine women experience postpartum depression, which can be a debilitating condition that puts mothers and their families at risk for negative health outcomes. Expanding Medicaid coverage for the first year after birth will help doctors identify these issues, treat them and ensure that all Nebraska parents and families have a healthy start. When people choose to parent, they deserve to have safe, healthy pregnancies, and all Nebraska families deserve that healthy start. LB929 is a commonsense

measure that would help Nebraska families to thrive. So we'd like to thank Senator Wishart for bringing LB929, and we would like to urge the committee to vote it out onto General File. Thank you.

ARCH: Thank you. Any questions? Senator Hansen.

B. HANSEN: OK. Thanks.

ARCH: You can flip a coin.

B. HANSEN: I think this is a question that I asked earlier. I just don't know if it's really been answered yet, and you kind of mentioned in your testimony about, again, it's that disparity between white and black maternal morbidity rates.

CLAIRE WIEBE: Yeah.

B. HANSEN: And then you mentioned the Legislature has the power to narrow this gap and improve birth outcomes. And so I'm curious for the states that-- if, if you know, again, states that have implemented yearlong postpartum Medicaid coverage, has it narrowed the gap? Have we seen, have we seen, have we seen that proven, I guess in statistics or data? I just don't know.

CLAIRE WIEBE: Yeah, that's a good question. And I, I don't know the answer off the top of my head. I'm sure-- I mean, my educated guess would be that, yes, increasing access to healthcare increases better outcomes no matter what. But again, I don't have a statistic--

B. HANSEN: Yeah.

CLAIRE WIEBE: to that-- for that at the moment.

B. HANSEN: I think you made a good point. I think I would expect it to, yeah,--

CLAIRE WIEBE: Yeah, absolutely.

B. HANSEN: --increase the health outcomes of everybody that, that, that participates. But I'm just curious to know if that does narrow the gap there, so.

CLAIRE WIEBE: Yeah.

B. HANSEN: But, yeah, thank you.

CLAIRE WIEBE: Good question.

ARCH: Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here.

CLAIRE WIEBE: Um-hum.

M. CAVANAUGH: As a healthcare provider, I assume, but please let me know if I'm correct that you provide prenatal and postpartum coverage.

CLAIRE WIEBE: Yeah. So Planned Parenthood usually refers out for that coverage, but this bill helps us, you know, knowing folks would be covered if we were to see them in our clinic and then refer them out. Yeah.

M. CAVANAUGH: And what percentage of your patients would be covered under this program?

CLAIRE WIEBE: That is a good question. And again, I would have to get back to you, I don't know--

M. CAVANAUGH: Thank you.

CLAIRE WIEBE: --off the top of my head. Yeah.

ARCH: Thank you. Other questions? Seeing none, thank you very much.

CLAIRE WIEBE: Thank you.

ARCH: Next proponent for LB929.

KAREN BELL-DANCY: Good afternoon.

ARCH: Good afternoon.

KAREN BELL-DANCY: Senator Arch and other members of the committee, my name is Karen Bell-Dancy, K-a-r-e-n B-e-l-l hyphen D-a-n-c-y, and I am the executive director of the YWCA of Lincoln. As many of you know, the mission of the YWCA of Lincoln is the elimination of racism and the empowerment of women. Members and supporters of the YWCA in Lincoln include women from many different faiths, ages, backgrounds, beliefs, and cultures. It is the state of Nebraska that we have been engaged in for over 134 years, and we are proud to be a part of this community. I am here in strong support of LB929, a bill which requires the submission of a Medicaid and state plan amendment to expand postpartum coverage. I want to express my gratitude to Senator Wishart for introducing this very important bill. I also want to thank you, the members of this committee, for your time and thoughtful attention

and consideration. Forgive me, my sheet went out of order and I am messing up on my time. In many cases of maternal mortality, they occur in the postpartum period. Annually in the United States, approximately 700 deaths occur from pregnancy-related complications, of those for which timing was known, 51.7 percent occur between one and 365 days postpartum. As a result of these statistics, extending the Medicaid coverage to postpartum people beyond 60 days is nationally emerging as a key strategy to address these maternal mortality rates. In Nebraska, Medicaid currently provides coverage for beneficiaries for a period of 60 days postpartum. Passage of this bill will extend that period to 12 months. In 2013, the Nebraska Legislature had the foresight to pass the Child and Maternal Development [SIC] Review Act. And I won't go into all the specifics of the act. But since 2014, Nebraska has examined maternal mortality rates via a multidisciplinary Maternal Mortality Review Committee. For this purpose, maternal mortality is defined as the death of a person while pregnant or within one year of the end of the pregnancy. In 2021, the MMRC issued a 27-page report summarizing their findings from 2014 through 2018. For your convenience, I've included a link to the entire report at the bottom of this testimony, and there is a couple of other sources as well. Just a few points, a few bullets that I would like to note. Women with public insurance at their baby's birth were more than two and a half times more likely to die compared with women with private insurance for delivery. Many pregnancy-related complications, including death, occur after the 60-day limit. Fifty percent of Nebraska pregnancy-related date-- deaths were due to medical factors. The most common contributing factors to maternal deaths included lack of access, financial resources, and continuum of care. And we've talked about that. We've heard that testimony earlier. As I mentioned before, one of the intents of the Child and Maternal Death Review Act of 2013 was to provide future legislators with recommendations to enable them to make necessary changes in response to child and maternal deaths. In 2014 through 2018, the report says Medicaid eligibility one year post-pregnancy was among the top ten recommendations of the MMRC in response to maternal deaths in Nebraska. Passage of LB929 is imperative, is a very concrete action that this Legislature can take to preserve and improve the lives of low-income Nebraska women and their families. After all, the need for healthcare services does not end at two months after childbirth. I strongly encourage you to move this bill out of committee. And with that, I'll apologize, I had a root canal so I can take questions that you may have.

ARCH: Thank you for coming after that.

KAREN BELL-DANCY: Thank you. This is very important.

ARCH: Questions? Well, see none.

KAREN BELL-DANCY: Thank you.

ARCH: Hope you recover well.

KAREN BELL-DANCY: Yes, thank you.

ARCH: Thank you for your testimony. Next proponent.

LELYNDA BRIGGS-LINSTADT: Good afternoon.

ARCH: Good afternoon.

LELYNDA BRIGGS-LINSTADT: My name is, and this is a long one, sorry, Lelynda Briggs-Linstadt, L-e-l-y-n-d-a B-r-i-g-g-s hyphen L-i-n-s-t-a-d-t. I come to you as an individual supporting LB929. My birthing and postpartum experience continue to affect me to this day-- I-- and also affects my family. I worked 40-hour weeks as an early childhood mental health consultant. All the way up until the evening I went to the hospital to deliver. I saved up all of my PTO so that I would have hopefully enough time for maternity leave. However, even with insurance paperwork, that wasn't enough. So by the time I went to put in for my maternity leave, I was thankfully informed that there was going to be a lapse of insurance coverage between that and when I returned to work. So even with short-term disability, my now husband working full, full time, we were able to get by. However, I did end up having to apply for and thankfully was granted Medicaid coverage to continue my healthcare after I delivered. As I progressed during my pregnancy, my doctor noted that my blood pressure continued-- consistently elevated. Hypertension had never been a medical concern for me or anyone in my family to my knowledge. It got to the point where I did get to-- I did have to start going weekly to have my blood pressure monitored and also had to get a kit at home to monitor my blood pressure as well. While I was in labor the evening to deliver my son, I was placed on a magnesium IV because I was-- my blood pressure got into the upper 300 range and I was in danger of having a stroke while I was delivering my son. Here I was in the hospital with a newborn trying to bond with my child, spending time with my husband for him to bond with my child-- with our child-- guess he's his, too, and, and also trying to nurse and having medical professionals come in every hour on the hour, either for blood work or to monitor my blood pressure. So being, imagine being told relax, take it easy. I can't, because you're poking and prodding me every hour on the hour. I ended up being in the hospital for an additional eight days post-delivery

due to having to go back and forth between medications, dosages, and also going back and forth between floors because there's the labor and delivery floor. And if you are on an IV, you have to be on that floor because you have to be consistently monitored. But then I was able to go back to the maternity floor because, oh, no, your blood pressure went down. We think you're almost ready to go home. We moved a total of four times between the two floors over the course of eight days. So addition, in addition to that, by the time we were finally able to go home, my husband had used up all of his PTO and he had to immediately go back to work the next day. And so here I am at home with a newborn trying to nurse, bond with my child, do the typical, you know, new mom things as this is my first born. He'll be three in March. And also moni-- having, having to continue to monitor my blood pressure up to three times a day and report it to my OB/GYN. Even to this day, I continue to have to maintain medication management to manage my blood pressure, which, as I noted earlier, was never a issue for me medically. That in addition to the, quote unquote, usual postpartum concerns of anxiety, depression, which again, I still manage to this day. Thankfully, I have medical professionals that listened to me, advocated for me, and supported me. I also had supportive family and friends that were able to help me. Thankfully, I was-- I have insurance that was able to cover me past that 60-day limit once I returned to work, but that so many women don't have that and that should not be an issue to this day. So I thank you for your time and for listening to me, and I really hope that you support this bill.

ARCH: Thank you. Are there any questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you so much for sharing your story. I actually just wanted to thank you and all of the mothers that have talked today about postpartum depression because we need to destigmatize it and make sure that everyone's getting help. I, too, suffer from that. So thank you.

LELYNDA BRIGGS-LINSTADT: Absolutely. And as a mental health professional, I thought I had all the resources and tools. And it turns out, no, I did still need support and help.

M. CAVANAUGH: Yeah, it's hard.

LELYNDA BRIGGS-LINSTADT: Um-hum.

ARCH: Thank you. Any other questions? Seeing none, thank you very much for your testimony. Next proponent for LB929.

ASHLEI SPIVEY: Good afternoon, everyone. And thank you, Senator Arch, and the rest of the Health and Human Services Committee members. My name is Ashlei Spivey, A-s-h-l-e-i S as in Sam -p as in Paul -i -v as in Victor -e-y, and I'm representing I Be Black Girl. I Be Black Girl supports LB929, which expands postpartum coverage from 60 days to one year. I Be Black Girl is a collective that creates space for black women, femmes and girls to access and reach our full potential to authentically be the reproductive freedom. This means we get to decide if and when we get pregnant and deserve to have an environment that allows us to thrive when we parent and raise our children. At I Be Black Girl our goal is to expand access to quality and culturally relevant maternal health services. We know that if you center those impacted by the inequities, including black women and birthing folks when considering policy solutions, all women and birthing people will benefit. Black women are three to four times more likely to die during or after delivering. The top leading causes of death for black women when pregnant, giving birth, and after birth are mostly all preventable causes. To improve black women's maternal health, we need a comprehensive approach that addresses our health across the lifespan, including improving access to the delivery of quality care. Expanding postpartum coverage absolutely does that. And this is what we know. Many pregnancy-related deaths can be prevented, and many factors stem from lack of insurance. In Nebraska, around one in three births are covered by Medicaid. Of Nebraskans who died from pregnancy-related issues, 60 percent were due to medical factors. Of factors contributing to maternal mortality, almost 40 percent are due to lack of access, financial resources, or continuity of care. Many pregnancy-related complications, including death, occur after that 60-day limit. LB929 will also extend mental health treatment for moms facing postpartum depression, or PPD. More than 50 percent of low-income mothers experience depression between 14 days and one year post-birth, which again is well over the 60-day coverage time frame. PPD can create issues in bonding, feeding, and cause mental, emotional and developmental complications in children, which we heard a lot of that testimony today. As I mentioned, centering those most impacted and the solution will have a positive ripple effect for all birthing people. And we know that the current state of maternal health services, including the length of postpartum coverage, are disproportionately impacting black birthing folks negatively. Inequities experienced by black birthing people are in part due to the antiquated laws that cap state Medicaid coverage. About 26 percent of Nebraska's Medicaid beneficiaries are black, despite being about 5 percent of the state's population. The share of births covered by Medicaid is much higher for black birthing people at about 65 percent.

The severe maternal morbidity rate, or near-death experiences, is 63 percent higher for women in black communities in 2020 than in white communities. Black birthing people are most likely compared to white birthing people to endure risk factors during their birth that increase the likelihood of infant mortality or death and can have long-term, negative consequences for children's health. Advancing LB929 aligns to the values of protecting human life through natural death. This policy will provide a huge step in the right direction to realizing accessible maternal health services in Nebraska for moms and babies. So I hope and encourage you to support the advancement of LB929 to General File. Thank you so much for your consideration.

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

B. HANSEN: Thank you. You list off a lot of statistics here. So I'm-- I, I, I figure maybe I could ask you this. And again, if you can't answer it, maybe somebody else could.

ASHLEI SPIVEY: OK.

B. HANSEN: I was just thinking about it while you're talking there. So sorry. If we're looking at the potential cost savings with implementing yearlong postpartum care to the state, I'm curious to know other states that have, that have implemented yearlong postpartum care, if that has decreased? We would assume if we're taking care of them sooner, they won't be getting diabetes--

ASHLEI SPIVEY: Exactly.

B. HANSEN: --as opposed to waiting to get diabetes. And now our new Medicaid coverage and its more extensive and we have, you know, more. So I'm curious to know if we've seen that in other states. So if we have implemented this, we're seeing less cases of diabetes overall, we're seeing less cases of hypertension, which, which are then in turn save the taxpayer money and less money the state has to pay for overall Medicaid if we did implement it. I'm just curious to know if you were seeing it in your stats.

ASHLEI SPIVEY: Yeah, I mean, you know, the expansion is relatively new and a lot of states are using that state amendment through ARPA. And so most of these statistics come from Health and Human Services through the Maternal Mortality Review Committee and in the PRAMS Committee, which is a Pregnancy Risk Assessment Monitoring System. And so I think, you know, when you think about the data collection and what will come out there really is the opportunity to utilize those

two entities to collect the data over this period of time with all of the new expansions happening and then to see the results in, you know, a few years. But I think just based on the professional medical testimony of doctors and what we know to be true around access and resources, that this will absolutely have a positive swing in what we're seeing in terms of birthing people.

B. HANSEN: OK. I think you made a good point. It's still kind of early yet and we were talking to some other people who said there are more states that are starting to implement it, they're starting to kind of get at legislation. So I'm sure some that data might come out here soon to see how much maybe it saved them, whether it did or not.

ASHLEI SPIVEY: Absolutely. And we partner, so part of our role is to think of ourselves as an intermediary and community. So we partner with the Perinatal Collaborative, with MMRC, we have Nebraska Med at the table, CHI, like, all of these medical institutions, as well as community-based organizations like a doula association and we're looking and thinking about like, how do we share these metrics over time? What are the right sets of interventions? And what we for sure know to be true is that this access piece is something that we can change, and we'll absolutely have positive impacts as we think about then the other factors that need to be addressed. So it really is a comprehensive approach, and this is a very accessible way for us to start to chip away at what we're seeing happening to birthing people.

B. HANSEN: OK. Thank you.

ASHLEI SPIVEY: You're welcome.

ARCH: Thank you. Other questions? Thank you,--

ASHLEI SPIVEY: Thank you all so much for your time.

ARCH: --for your testimony. Next proponent for LB929.

BRIAN KRANNAWITTER: Chairman Arch and members of the Health and Human Services Committee, good afternoon. My name is Brian, B-r-i-a-n, Krannawitter, that's spelled K-r-a-n-n-a-w-i-t-t-e-r, and I'm the government relations director for the American Heart Association here in Nebraska, and I'm here to testify to, to express our support for LB929. I also want to thank Senator, State Senator Wishart for bringing this issue forward. Extending Medicaid coverage to 12 months after delivery is critical to identifying and treating chronic and postpartum health issues, pregnancy-related complications, including high blood pressure, blood clots, cardiovascular disease, stroke and

other heart problems may not surface until weeks or even months after delivery. Health issues such as gestational diabetes or pregnancy-related hypertension are conditions that require ongoing monitoring and active management. And on a personal note, and I, I know there's been a couple of examples of the issue of preeclampsia. I have a very good friend, and during her pregnancy she was diagnosed with preeclampsia. Hope I'm saying that right. And part of that is high blood pressure. And in fact, she was-- the technical term, she was sudden severe, sudden onset severe preeclampsia, and she has a treatment plan with her doctor. But it's been ongoing for months, even after the birth of her daughter and her daughter is now three years old, and she's still addressing the issues and dealing with the issues of preeclampsia. Guidelines from the American College of Obstetricians and Gynecologists recommend that postpartum care should be an ongoing process with services and support tailored to each woman's individual needs. Organizations including the American Medical Association, American Academy of Pediatrics, American College of Physicians, and the Society for Maternal-Fetal Medicine all support extending postpartum coverage. Extending postpartum Medicaid coverage to 12 months would align the mother's coverage with that of her baby as Senator Wishart said in her opening statement. And with that, I would just say, please support LB29 [SIC--LB929]. Thank you.

ARCH: Thank you for your testimony. Any questions? Seeing none, thank you very much. Next proponent for LB929.

KELSEY ARENDS: Good afternoon. Chairperson Arch and the Health and Human Services Committee, my name is Kelsey Arends, that's K-e-l-s-e-y A-r-e-n-d-s, and I'm the Health Care Access Program staff attorney at Nebraska Appleseed, testifying today in support of LB929 on behalf of Nebraska Appleseed. We are a nonprofit legal advocacy organization that fights for justice and opportunity for all Nebraskans. One of our core priorities is working to ensure that all Nebraskans have access to quality, affordable healthcare. Nebraska Appleseed supports this bill because it addresses significant issues facing Nebraskans' health by extending essential postpartum coverage in Medicaid. Extending Medicaid's postpartum coverage to 12 months after birth is important in promoting the health and well-being of all Nebraskans. Poor maternal health is a significant problem in the United States, and maternal deaths have been increasing since the year 2000. It is estimated that at least one-third of all maternal deaths happen in the postpartum period. Many of these deaths are avoidable. Evidence shows that around three and five pregnancy-related deaths were preventable, and poor maternal outcomes also disproportionately affect people of color. Extending postpartum coverage in Medicaid to 12 months after

birth can help improve maternal health and, and address disparities. Typically, Nebraskans eligible for Medicaid under the pregnancy eligibility category are only able to access healthcare services through Medicaid for 60 days after the birth of their child. However, the need for postpartum care does not end after 60 days. Significant health issues can present beyond the 60-day period, and if left untreated, these health issues can harm Nebraska families. Both physical and mental health needs often present beyond the limited 60-day postpartum period. Monitoring childbirth recovery, treating complications from childbirth, providing reproductive care, and treating chronic health conditions are all important components of postpartum care. In addition to physical health needs, mental health treatment is also essential. At least 10 percent of birthing people experience perinatal depression. Further pregnancy and postpartum disruptions in coverage, which is what can happen when those who depend on Medicaid fall out of coverage after the 60-day postpartum period, unevenly impact black, American Indian and Alaska Native and Hispanic Nebraskans. Extending Medicaid postpartum coverage would not only make crucial care more accessible, but it can also help address disparate health outcomes. LB929 allows the state to choose between two different mechanisms, either a waiver or a state plan amendment to extend postpartum coverage. Twenty-five other states, including Texas and Missouri, already have pending or approved applications to extend postpartum coverage in one of these two ways. We have also had the opportunity to review the fiscal note on this bill. We anticipate that the actual state costs of implementing LB929 would be lower than described in the fiscal note, primarily because the calculations are based on data from 2019. Since 2019, Nebraska has expanded Medicaid coverage. The federal match for people in the expansion group is 90 percent, as opposed to the 57.87 percent used in the fiscal note. It does not appear that the numbers in the fiscal note provided by the department take into account the Medicaid expansion group. Because this bill promotes better coverage stability and addresses racial disparities in maternal health, Nebraska Appleseed supports this bill. Thank you.

ARCH: Thank you. Are there any questions? Seeing none, thank you.

KELSEY ARENDS: Thank you.

ARCH: Thank you for your testimony. Next proponent.

SCOUT RICHTERS: Hello.

ARCH: Hello.

SCOUT RICHTERS: Hi, my name is Scout Richters, S-c-o-u-t R-i-c-h-t-e-r-s, here on behalf of the ACLU of Nebraska in support of LB929. Deciding to become a parent is one of the biggest decisions we make, and the ACLU of Nebraska works to ensure that Nebraskans can make these important decisions with autonomy and dignity and have the resources they need to ensure that their families and their communities thrive. Every pregnant person deserves quality prenatal and postpartum medical care. Yet, as we've heard time and time again today, this is far from the reality for too many Nebraskans. Again, as you previously heard, we must recognize the decision to have a child in the United States comes with disproportionate maternal mortality rates for people of color and black women, specifically. The current 60-day cutoff of coverage does not align with the reality for new parents in the postpartum period, and extending the coverage would undoubtedly lead to better outcomes for Nebraska families. Taking my-- off my ACLU hat for a second and putting on my mom hat, I can tell you personally that I needed treatment and medication for postpartum depression that extended well beyond the 60-day cutoff that's currently in place for Medicaid. I'm fortunate to have private insurance through my employer, and I can tell you that this care was truly essential to my health and to my well-being. Extending coverage so, extending coverage so vital healthcare is available for a year after birth for all Nebraskans could truly be a matter of life and death for some of our neighbors, as you've heard again, time and time again today. LB929 reflects the support that all new Nebraska parents should be getting when they decide to give birth. As such, we urge your support and advancement of the bill, and I'd be happy to answer any questions.

ARCH: Thank you for your testimony.

SCOUT RICHTERS: Thank you.

ARCH: Are there any questions? Seeing none, thank you very much.

SCOUT RICHTERS: Thank you.

ARCH: Next proponent for LB929. Is there anybody else that would like to speak as a proponent for LB929? Is there anyone that would like to speak as an opponent to LB929? Anybody that would like to speak in a neutral capacity for LB929? Seeing none, is Senator Wishart going to close? No, she waives close. I, I would, I would say that as far as for the record, 11 letters electronically submitted were-- excuse me, 27 letters electronically submitted as, as proponents for the bill. No opponents. None neutral. And with that, that will close the hearing

for LB929. The hearing is still in progress. I, I would-- however, we are going to take a five-minute break at this point, so we will resume at approximately 10 after 3:00. Thank you.

[BREAK]

ARCH: [RECORDER MALFUNCTION] committee hearings for the afternoon with LB862 and, Senator McCollister, you're welcome to open.

McCOLLISTER: Good afternoon, Chairman Arch and members of the Health and Human Services Committee. I am John, J-o-h-n, McCollister, M-c-C-o-l-l-i-s-t-e-r, and I represent the 20th Legislative District in Omaha. LB862 is a bill with a significant opportunity to change how Nebraska treats its residents at a very basic humanitarian level. I was approached by doctors at Creighton University last year and came to learn about a deficiency in the coverage from Nebraska's Department of Health and Human Services for treatments of end-stage renal disease that could be easily remedied with passage of this bill and would improve the lives of many and save the state money. Emergency Medicaid, known as Nebraska's Emergency Medicaid Services Assistance, is accessible as the only coverage for option for undocumented individuals with end-stage renal disease. As it stands, if one's condition is severe enough, a person may receive emergency treatments and those treatments will be covered by the state. According to current internal DHHS rules and regulations, eligible emergency medical conditions are conditions that may result in serious jeopardy to patients' health, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. A broader interpretation, according to the Mayo Clinic, defines end-stage renal disease as an advanced state kidney disease in which your kidneys no longer work as they should to meet your body's needs. However, Nebraska's Emergency Medicaid Program employs a more narrow interpretation and currently covers only the most serious treatment needs for undocumented individuals with end-stage renal disease. That is to say that merit a visit to the emergency room. This means individuals in Nebraska are forced to wait until they are near death to visit emergency room to receive emergency dialysis treatments when their condition deteriorates to emergency levels. An open letter, which I have provided to you, was signed by ten nationally recognized organizations and was distributed to all state Medicaid directors in September of last year. The letter mentions 12 states who have made changes to allow regularly scheduled dialysis to be covered under the state's Emergency Medicaid Programs, and urges all states to further expand their coverage of end-stage renal disease treatments under Emergency Medicaid. Nebraska has not yet elected to adopt these recommendations.

Those states who have made some version of this coverage available under their Emergency Medicaid Programs are Arizona, California, Colorado, Illinois, Massachusetts, Minnesota, New York, North Carolina, Pennsylvania, Virginia, Washington, Wisconsin, as well as the District of Columbia. This letter also includes a reference to a study conducted by the Journal of the American Medical Association that found over a $5,000 per person month savings, net savings when utilized scheduled dialysis treatments as compared to cost of emergency dialysis. States are realizing the appropriate coverage of these regularly scheduled treatments will cost less money. The passage of LB862, DHHS estimates that 71 individuals would be receiving scheduled dialysis treatments at a cost of $5 million total. However, this number fails to acknowledge the cost of emergency dialysis treatments is substantially higher. If we knew the number of individuals receiving emergency dialysis in Nebraska over the last several years in this category, perhaps a more comprehensive fiscal note could be produced. In summary, LB862 is a bill requiring a simple change that will make people's lives better, while also costing the state less than we spend today. This committee and the Nebraska Legislature can demonstrate its humanity with passage of this bill that will dramatically improve people's lives and ensure that currently under-- underserved community has access to, to vital treatments. One last note. I've drafted for the committee's consideration, AM1682 to remove transplants from this bill after learning that federal law expressly prohibits the coverage of these specific procedures under Emergency Medicaid. This amendment will lower the fiscal note by over a million dollars. Thank you, Mr. Chairman.

ARCH: Thank you. Are there any questions for Senator McCollister? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Senator McCollister. I just noticed that in your amendment, there's also a date change. I don't know if that's intentional or not.

McCOLLISTER: Can you say that again?

M. CAVANAUGH: There's a date change from October 2022 to October 2023. I didn't know if that's intentional or just--

McCOLLISTER: I'm sorry, still didn't hear the question.

M. CAVANAUGH: There's a date change. Maybe we can follow up with your staff.

McCOLLISTER: I'll, I'll assume it's a typo.

M. CAVANAUGH: We'll follow up with you.

McCOLLISTER: OK.

M. CAVANAUGH: Thank you.

ARCH: Any other questions for Senator McCollister? Seeing none, thank you very much.

McCOLLISTER: Thank you.

ARCH: First proponent for LB862.

CHARLES D'ALESSANDRO: Hello, Chairman Arch and members of the Health and Human Services Committee. My name is Charles D'Alessandro, spelled C-h-a-r-l-e-s D-'-A-l-e-s-s-a-n-d-r-o, and I am now a fourth-year medical student at the Creighton University School of Medicine. I would like to begin by sharing the story that inspired my fellow classmates and me to bring awareness to this important issue. Roughly a year ago, my classmates seated beside me and I were caring for a young patient who we had just diagnosed with end-stage renal disease, otherwise known as ESRD, a condition in which a person's kidneys are in the process of failing and cannot perform their normal functions. The only treatment for ESRD is either a kidney transplant, which can take years to receive, or dialysis, a treatment in which a machine can perform the functions of failing kidneys and offers the patient hope and possibility for a more normal and manageable life. The patient I am talking about in a young male in his 30s was an undocumented immigrant from Mexico who has been living in the United States for over 15 years. He had children, a wife, and a job at a local restaurant where he worked full time. He attended church, his children's sports games, and school concerts. Above all, he is a member of our community, and someone working to make his family's and his own life better while also contributing to our local economy and state. While we discussed this new, life-altering diagnosis with him and his wife, the idea of the life they have built and struggled for years for was shattered. They asked questions regarding next steps, treatment options, and long-term outcomes. In any other scenario, this conversation would have included a social worker, a case manager, and multiple other members of the healthcare team to find a suitable dialysis center for this patient to complete his routine three times a week scheduled dialysis treatments, which is the standard of care for ESRD. Unfortunately, in the case of our patient, this conversation

focused around his undocumented status and how simply where he was born decades prior now makes him ineligible to receive the lifesaving care that thousands of individuals across the United States receive every single day in outpatient dialysis centers. We discussed how his only options were to either uproot his family and move to a state that offered routine dialysis care to undocumented individuals, move back to Mexico, a country he had not known or lived in for years, or present to the emergency room roughly once every week or so when he was feeling the effects of his kidney disease so severely that he quite literally felt he would die, in which case the emergency department would be legally forced to perform a one-time dialysis since he would be actively dying. I would like to believe that we can all agree these three options are not only less than ideal, but violates our values that we hold dear as Americans and more specifically betrays the very motto of the state we live in, "Equality before the law." A motto enacted shortly after the Civil War to signify to the rest of the Union that Nebraska was committed to equality for all persons first and foremost. As a native New Yorker, I felt that when I moved to Nebraska for medical school, I was welcomed with open arms, kind faces, and more waves from strangers than I was used to. But it was evident that a man who has lived here longer than I have was not being treated as such. I personally called dozens of advocacy groups, immigration organizations, and refugee centers refusing to accept this new reality for a man I had met a mere two days prior. No one could help. I cannot imagine if any of my own family members or myself were told this news and presented those options when a superior, more affordable, and more convenient option is available to so many others without the possibility of coming close to death each week. It was not what I had envisioned when I chose to enter into the medical field. In my eyes, we as a team and as a community had failed one of our own, a human being. Following discharge of this patient now stripped of hope, my team of medical students, resident physicians, pharmacists, and attending physician contemplated the ethical, social, and medical implications of the situation we were put into by a health system that failed one of our own. But we did not stop there. My fellow classmates and I worked diligently with the NMA and our attending, attending physicians to bring awareness to this issue. We published an op-ed in the Omaha World-Herald to bring light to this humanitarian injustice. With all of these inspiring voices and guiding resources, we now find ourselves being invited to the Capitol Building of the state of Nebraska, appealing to your esteemed committee with the help of Senator McCollister to take a stand and rise up for the members of our community as 12 other states in our nation have done. As my classmates

and colleagues will discuss, the issue-- this issue far spans far beyond just the humanitarian call to serve and do best by our neighbors, but rather this initiative can work to ease an already congested and overworked medical system in a state that I personally have seen can be so great. I respectfully urge you to support this bill so that all members of our community can receive this lifesaving treatment, can attend their children's soccer games, can go to work, and most importantly, wake up each day without the fear of death. Thank you.

ARCH: Thank you. Are there any questions? Seeing none, thank you very much for your testimony.

CHARLES D'ALESSANDRO: Thank you.

ARCH: Next proponent for LB862.

KAITLYN YOUNG: Hi, good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Kaitlyn Young, it's K-a-i-t-l-y-n Y-o-u-n-g, and I'm also a fourth-year medical student at Creighton University. My classmate and colleague, Charles, just told you the story of what kind of set us on this path in the first place. And I'm here to discuss the effect of the current system of providing dialysis for undocumented patients with end-stage renal disease has on healthcare providers, specifically, including nephrologist, primary care physicians, and nurses. All of the healthcare providers that work with these patients can agree that hemodialysis three times per week is the standard of care for patients with end-stage renal disease and that emergency-only dialysis is substandard care. According to a study published in 2018 in the Annals of Internal Medicine, healthcare workers forced to provide substandard care in the form of emergency-only dialysis experience higher burnout, as well as increased moral distress. In this study, healthcare providers specifically reported feeling exhausted, both physically and emotionally due to witnessing unnecessary human suffering. The undocumented patients they were caring for were experiencing completely avoidable symptoms, suffering needlessly at home until they met criteria for emergency hemodialysis. Some participants in the study reported worrying about the risk of imminent death for these patients, noting multiple examples in which their patients required CPR in order to bring them back. This consistent anxiety about the well-being of their patients can certainly wear down those caring for undocumented patients with end-stage renal disease receiving emergency-only hemodialysis. Because of this exposure to needless suffering, providers caring for these patients reported detaching

emotionally, especially since they felt powerless to change the situation and have noticed a similar pattern in residents involved in the care for these patients. This observation is particularly concerning to us since we will be residents ourselves next year. Our medical training has emphasized empathizing with your patient, working to build a trusting physician-patient relationship involving shared medical decision-making. The current situation involving undocumented patients requiring dialysis takes away this option of shared decision-making, forcing us to only offer substandard care despite wanting to provide better care. Nebraska's current policy on dialysis for the undocumented also places healthcare providers in a difficult position, stuck between the desire to provide care in order to ease suffering, even if the patient does not meet emergency dialysis requirements, and maintaining their personal integrity. This phenomenon has been referred to as moral distress, defined as knowing the morally right thing to do, but being unwilling or unable to do it because of external constraints. Healthcare providers who are forced to make medical decisions based on nonmedical factors such as social status, believe this form of practice is unethical. Due to this, some providers have been tempted to bend the rules to provide emergency hemodialysis, with some admitting that they have exaggerated patient symptoms or lowered the cut-off lab values to make patients eligible for dialysis. However, this resulted in personal concern for their own integrity having to make those decisions. As medical students, it was difficult to wrap our mind around the only discharged plan we had available, which was to have the patient come to the emergency department when he needed dialysis, knowing that he may not meet the requirements at that time to receive dialysis and would have to come back when his situation was more critical, or that the emergency medicine providers would be put in a difficult position and may exaggerate his symptoms to allow him to receive dialysis. We were frustrated knowing there was better care in the form of scheduled outpatient dialysis that this patient was unable to receive. During the time that our team was caring for this patient, the disappointment with the system is obvious. While we are inspired to advocate for this patient population, there are many other healthcare providers who feel helpless in the face of this issue, leading to increased emotional exhaustion and moral distress. The primary role of a physician is to be an advocate for their patient. We are here today fulfilling that duty. We believe that including routine outpatient dialysis treatment for undocumented patients under the emergency provision of Medicaid will alleviate some of the unnecessary human suffering and ease part of the stress placed on healthcare providers. Thank you to Senator

McCollister for introducing this bill and allowing us to be a part of it today.

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

B. HANSEN: Thank you. Fourth year?

KAITLYN YOUNG: Yes.

B. HANSEN: You getting tired of it yet?

KAITLYN YOUNG: Almost done.

B. HANSEN: I'll bet. OK. Just a quick question. And if, if you don't know, it's fine. Are all people-- I mean, U.S. citizens, I guess, because it seems like that's what this bill is pertaining to. Is it, is it typically for undocumented workers? Because I think--, I, I thought everybody who has end-stage renal disease, renal disease is almost automatically covered under Medicare. Do you know?

KAITLYN YOUNG: Well, from our experience with this patient, he had end-stage renal disease but was not able to be covered under Medicare or Medicaid.

B. HANSEN: Because he was undocumented?

KAITLYN YOUNG: Because he was undocumented.

B. HANSEN: OK.

KAITLYN YOUNG: Yeah.

B. HANSEN: OK. Just kind of curious, again. All right. Thanks.

KAITLYN YOUNG: Yeah. That's just my-- that's just our one single experience, but.

B. HANSEN: All right.

KAITLYN YOUNG: Yeah.

B. HANSEN: Thank you.

KAITLYN YOUNG: Um-hum.

ARCH: Senator Williams.

WILLIAMS: Thank you, Chairman Arch. And thank you, Miss Young. Do you have an idea of the difference in cost of the emergency dialysis versus the normal three dialysis a week? What we're looking at difference?

KAITLYN YOUNG: I don't-- it was in our resolution that we did, but one of my classmates will be testifying more to the--

WILLIAMS: OK.

KAITLYN YOUNG: --cost of--

WILLIAMS: OK.

KAITLYN YOUNG: Yeah. Um-hum.

WILLIAMS: Thank you.

ARCH: Other questions? Senator Murman.

MURMAN: Thank you for being a medical trying-- working at being a medical provider,--

KAITLYN YOUNG: Thank you.

MURMAN: --and appreciate what you do and what you're going to be. The-- and, and these are tragic situations, of course, that you're talking about. Is there any other alternatives? I'm sure you've, you know, thought about other alternatives. I mean, is there faith-based organizations or churches or anything like that, that could help in these situations?

KAITLYN YOUNG: From our experience, no. There used to be, from our understanding of talking with people involved in this, there used to be contracts that were signed between the patient and some outpatient dialysis centers that were run through the hospitals. And our understanding is that at Creighton, that went away for some unknown reason. UNMC still does it a little bit. I think a few patients can sign this contract to have the hospital kind of foot the bill and then during that process, they have to be showing that they're actively trying to become a citizen to remain and keep their outpatient dialysis chair. But otherwise, we haven't come across any other options.

ARCH: OK, that's too bad that was ended. That, that would be the, the answer to the alternative, I would think. Thank you.

KAITLYN YOUNG: Yeah. Um-hum.

ARCH: Other questions? Seeing none, thank you very much.

KAITLYN YOUNG: Thank you.

ARCH: Next proponent for LB862.

NATHAN OSTLIE: Good afternoon,--

ARCH: Good afternoon.

NATHAN OSTLIE: --Chairman Arch and members of the Health and Human Services Committee. My name is Nathan Ostlie. I'm also a fourth-year medical student at Creighton University and I'm part of the care team or was part of the care team for the undocumented individual that was just introduced to you by my colleague.

ARCH: Could you please spell your name for us, please?

NATHAN OSTLIE: Oh, I'm sorry. Yes. My name is Nathan Ostlie, N-a-t-h-a-n O-s-t-l-i-e. My testimony will focus on addressing a potential criticism of the proposed bill. That is, would the provision of routine versus emergency dialysis care for undocumented patients with end-stage renal disease place an undue cost burden on the Nebraska healthcare system? And Senator Hansen, I hope to answer your question during my testimony. I'm not an expert in healthcare billing, nor do I have experience running a hospital or dialysis center. Thankfully, there are experts around the country who have researched this issue. I would like to present to the committee their findings. One of the first studies to look at the cost comparison of routine versus emergency-only dialysis for undocumented patients was undertaken in Houston, Texas. At a Houston public hospital before 1997, undocumented patients were able to receive dialysis on a scheduled basis. Following a change in hospital policy that occurred that year, newly encountered undocumented patients instead received emergency-only dialysis while patients already receiving routine dialysis were grandfathered in. This provided two distinct groups, which could be compared side by side. What the study found was that emergency-only patients utilized more hospital beds, had more ED visits, and total costs were 3.7 times higher than their routine dialysis counterparts. These numbers correlate with a study in 2002, which estimates that the annual hospital expense was two hundred and twelve hundred thousand dollars per emergent dialysis patient, compared to $55,000 per scheduled dialysis patient. Since these studies, further research has emerged to illustrate this point. In

2019, a study was published in JAMA, or the Journal American Medical Association, of 181 undocumented patients with end-stage renal disease in Dallas, Texas. The study showed that individuals receiving scheduled versus emergency-only dialysis had a one-year mortality rate of 3, compared to 17 percent, six fewer emergency visits per month, one and a half fewer hospitalizations, ten fewer hospital days in a-- sorry one and a half fewer hospitalizations and ten fewer days over a six-month period and incurred, as Senator McCollister mentioned, $5,768, $5,768 less in healthcare costs per month. This evidence is further corroborated by a multicenter study involving undocumented patients in Colorado, Houston, and San Francisco, which showed that emergency-only dialysis patients spent an average of ten times as many days in an acute care setting compared to scheduled dialysis patients. Consider also that undocumented patients with ESRD are often working prior to renal replacement therapy. In fact, one study found that this group was twice as likely to be working when compared to documented persons with this disease. In another study, 90 percent of undocumented patients receiving emergency-only dialysis were employed prior to starting renal replacement. However, only 14 percent were able to continue while on emergency dialysis. It is estimated that undocumented individuals contribute $11 to 14-- or to $15 billion in Social Security payroll taxes each year, $2.4 billion of which goes to Medicare. An analysis of the Medicare Trust Fund between 2002 and 2009 found that undocumented immigrants contribute substantially more than they withdraw towards the Trust Fund. As the research has shown, this requested policy change not only results in better outcomes for undocumented individuals with ESRD, but can also be undertaken without an undue cost burden placed on the healthcare system. In fact, this policy would be cost saving. The state of Colorado, which adopted a similar policy change in 2019, expects to save $17 million per year in Medicaid costs. The time has come for the state of Nebraska to include routine dialysis treatment for undocumented patients under the emergency provision of Medicaid. And I would also like to add to my point of the Medicare payments made by undocumented persons, I understand that Medicaid and Medicare are different programs. However, undocumented individuals don't have access to either of these programs, so their payments into and fewer withdrawals from that was, would be less.

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

NATHAN OSTLIE: Thank you.

ARCH: Next proponent.

ABIGAIL JONES: Good afternoon. Good afternoon, Chairman Arch and the entire committee. Thank you for having me here today. My name is Abigail Jones, A-b-i-g-a-i-l J-o-n-e-s, and I'm also a fourth-year medical student at Creighton University. Thank you to my fellow colleagues who have discussed various pieces of this important issue, and my testimony aims to discuss the gap in care and the outcomes for patients receiving emergency dialysis compared to the regularly scheduled patients. While I'm not a nephrologist, I've been trained for the past three and a half years as a medical student to know common medical conditions and their standards of care. We will get to hear from Dr. Brock, an expert in the field of nephrology and kidney disease, and I encourage you to take her professional opinion and testimony into consideration. As a medical student, you learn that it is your duty to give the best care possible to all your patients. It is in the oath that we take when we are starting our long journey to become doctors. You can imagine the distress that we feel that when we experience the healthcare team providing such substandard care to a patient and being powerless to change that. As myself and my classmates encounter these patients in situations and begin to learn more about how widespread this issue was, we couldn't help but take a dive into the outcomes of this treatment causes. It is well-studied in medical literature that the standard of care for end-stage renal disease described previously by my colleagues testimonies is the most effective care for patient outcomes. The difference in death, disease complications, symptom burden, and hospitalizations between patients receiving regular scheduled dialysis and emergency-only dialysis is also very well-studied and published in major medical journals like the American Journal of Kidney Disease and Journal of American Medical Association, JAMA. The nature of emergency-only dialysis relies on patients having to wait until their condition is at critical levels before they can come in and be eligible for care. Some of the symptoms they might be experiencing during that time include shortness of breath, a strong sensation of drowning, confusion, nausea, vomiting, constipation, and fatigue. Additionally, even though these patients are receiving dialysis eventually when they come into the emergency department, it's not on the same frequency and timeline as a standard of care. And as a result, the toxic material that your kidneys normally filter out builds up in the body and causes harmful effects on other organ systems. Because of this, patients experience ten times more hospital day stays than patients on regular outpatient dialysis, including intensive care unit stays. Some of the reasons these hospital-- some of the reasons for these hospital admissions include heart arrhythmias due to the buildup of potassium in the body, kidney or other widespread blood infections, complications with the dialysis

access site, heart failure, among other causes. Possibly the most startling statistics when it comes to patient outcomes receiving this care is that patients receiving emergency-only dialysis have a five-time higher death rate after three years of starting dialysis and a 14-time higher death rate after five years compared to the standard patients. Because of the lack of coverage for these patients, we are forced to provide inhumane care and are unable to carry out our duty as physicians to care for our community and give our patients the best outcomes and lives possible. Among the other incredibly important factors that my colleagues have testified about, passing this bill will allow physicians to deliver the best healthcare possible and limit human suffering. Thank you.

ARCH: Thank you. Any questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch. And thank you, Miss Young [SIC]. And thank you to you and your classmates for your willingness to be here to advocate on behalf of, of your patients and Nebraskans. My question is there's stress involved with being a fourth-year medical student. How does that stress compare to come to testify in front of the Committee?

ABIGAIL JONES: Well, in our fourth year, we have a little bit of time off to do residency interviews. So a lot of us are kind of on a, a lower time commitment rotation right now, and we're really excited about the--

ARCH: We kind of add stress to your life because I know sometimes we do. Thank you for your advocacy.

ABIGAIL JONES: Thank you for having us. We really appreciate it.

ARCH: Other questions? Senator Hansen.

B. HANSEN: Thank you. One of the statistics that you mentioned was higher mortality rate for those using emergency only versus hemodialysis.

ABIGAIL JONES: Yeah.

B. HANSEN: Is it strictly because of the, the mode of dialysis or are there other factors involved in that statistic? Because it sounds the way, the way you paint it is, like, a lot more people are dying because they're getting ER visit dialysis as opposed to the alternative. But we also know there might be a whole lot of other

factors that contribute to that and I didn't know if there are in the study that you cited.

ABIGAIL JONES: Yeah, from my understanding, and again, I'm not a nephrologist, possibly Dr. Brock would be able to further answer your question. But from what I had read about, there are other confounding kind of medical conditions that are at play sometimes. But a large portion of that disparity in the death rate has been studied to do because of kind of the timeline and how when these patients are getting emergency-only dialysis, they're coming in way less frequently. They're not eligible for the three times weekly care and what that does. And I kind of tried to mention this. What that does is it helps detoxify the blood and prevent those toxins from having all these other end-stage organ damage and because these patients are getting that treatment less often, it causes a lot of those adverse effects, which in the end ends up causing a higher, a higher death rate and a higher chance of dying from this disease at an earlier age.

B. HANSEN: And if they get the hemodialysis three times a week, they're probably more likely to get follow-up care, which then might help with their current condition, etcetera?

ABIGAIL JONES: Yeah.

B. HANSEN: OK.

ABIGAIL JONES: Yep.

B. HANSEN: Good. Thank you.

ABIGAIL JONES: Yeah.

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

ABIGAIL JONES: Thank you.

ARCH: Next proponent.

ANDREA SKOLKIN: Hello again.

ARCH: Hello.

ANDREA SKOLKIN: And good afternoon again, Senator Arch and members of the Health and Human Services Committee. My name is Andrea Skolkin, A-n-d-r-e-a S-k-o-l-k-i-n. I'm the chief executive officer of OneWorld Community Health Centers, and I'm also representing the Health Center

Association of Nebraska. As you know, that's the seven federally qualified health centers, and we provide comprehensive primary care to over 107,000 individuals regardless of insurance status or ability to pay. We are in strong support of LB862, and would like to thank Senator McCollister for introducing this bill. LB862, as you've heard, would cover the treatments for end-stage renal disease, such as inpatient and outpatient dialysis under Emergency Medicaid. This would include those who are uninsured and immigrants access to lifesaving services in a compassionate way. In other states, as you have heard, such as Colorado and Arizona, have adopted similar policies and found that not only was care provided in a better, more humane way, but it actually saved their state money. End-stage renal disease, also known as irreversible kidney failure, is a condition in which the kidneys no longer function properly. Normally, your kidneys filter waste and toxins out of the blood for excretion out of the body. In patients with end-stage renal disease, this function no longer happens adequately. Most individuals rely then on hemodialysis, a procedure that filters the blood by machine three times a week. However, these treatments are very costly around $90,000 a year. For many individuals, Medicare does cover the cost of this treatment. However, for some uninsured and many immigrants and likely refugees it is far more grim. Emergency Medicaid in Nebraska doesn't cover this regularly scheduled dialysis, but only as an emergency. This means that these people-- for these people, the only option is to wait until they are deathly ill and go to the emergency room. But that's not the end of the process. They have to continue to repeat this process to get the dialysis they need. This standard of care is inhumane and inefficient. These individuals are 14 times likely, more likely to die as those on regularly scheduled dialysis. This places intense financial and medical burdens, both on the systems and on the individual and their families. The type-- this type of care costs the system more and again is inefficient. Inpatient emergency dialysis is covered by-- at 100 percent by the state and is very expensive way to provide care. Regularly scheduled dialysis is 40 percent less expensive than providing dialysis on an emergency basis. Colorado projected that allowing dialysis to be covered under Emergency Medicaid would save up to $15 million annually. Again, I'd like to thank Senator McCollister for introducing this important bill, and I encourage you as the committee to advance this bill onto General File. Thank you, and I'm happy to answer your questions.

ARCH: Thank you. Are there any questions? Seeing none, thank you for your testimony. Next proponent for LB862.

RACHEL BROCK: Sorry, guys, I got a hearing aid here. OK, it's bright. Good afternoon, Chairman Arch and members of the committee. I'm Dr. Rachel Brock. Rachel is R-a-c-h-e-l, Brock is B-r-o-c-k. I am a nephrologist or a kidney doctor here in Lincoln. I'll mention I am also chairman of nephrology for Bryan Health. I also serve on the End-Stage Kidney Disease Network 12 Board. I am serving here testifying on behalf of the Nebraska Medical Association in support of Senator McCollister's LB862 to extend Medicare coverage for Emergency Assistance Program for treatments for end-stage renal disease. So I came here today to speak with you all about things I did and things I did not learn when I was in medical school, OK? The first thing I did not learn in medical school was how to run a business. And as you all probably know, doctors are notoriously horrible business people. But you've heard some numbers already today, and we're talking about standard scheduled dialysis costing a quarter of what emergency dialysis costs. That sounds like a no-brainer. It's a $6,000 cost reduction per person per month that undergoes scheduled dialysis versus emergency dialysis. An estimated cost of $72,000 a year in cost savings per person. So I may not have gone to business school, but even a doctor can understand that level of math. The second thing that I did not learn in medical school was about crisis management. However, this is in fact a healthcare crisis. Minimizing inpatient resources right now matters more than ever. Surely, COVID has taught us that the best way to avoid hospitals having to declare crisis standards of care is to keep people healthy enough to keep them out of hospitals. Access to scheduled dialysis keeps people out of hospitals. It leads to reduction in ER utilization and costs, reduction in hospital utilization rates, reduction in costly services like blood transfusions, labs, imaging. In other words, it keeps beds open for high-acuity patients in already high-volume hospitals. The third thing that I did not learn about in medical school is immigration. As someone who rounds on both COVID patients and dialysis patients every day, the juxtaposition right now about how we treat COVID patients and how we treat the undocumented dialysis patients is quite stunning to me. We are literally at the point of rationing care. The amount of unvaccinated, super sick people in our ICUs is overwhelming. We, as healthcare workers, are simply exhausted. We've been screaming at the top of our lungs about lack of resources and being told by the powers that be that resources aren't an issue and that the community of medicine is basically just over exaggerating the issues. But here we are. We talk about uninsured immigrants, and all of a sudden, those same resources that are so plentiful in COVID are now scarce. I even hear concern that somehow passing this sort of bill, will it lead to this massive influx of immigrants, undocumented dialysis patients into

the state, which will devour state resources? Data doesn't support that. California, these other states that have similar bills, have had no significant increase in their undocumented dialysis patient populations since they started these, these bills over-- some of them over a decade ago. We are expected to provide COVID patients with unbiased care. Withholding treatment in a COVID patient would be considered unethical if we did that based on something like their insurance status. Yet, here we are with very clear data, which they already told you about showing huge mortality and morbidity increases in patients that dialyze "emergently" versus patients that dialyze on a scheduled basis. And it's somehow acceptable with this population of people to withhold lifesaving care due to their insurance status. The hardest thing that I ever had to learn in medical school was how to give bad news. But telling a 35-year-old female mother of four who works to go back to California because she can't receive the same dialysis care in this state that she received there isn't delivering bad news, that's politically based chastisement, that's brandishing social judgment. And those messages are the antithesis of the oath that I made when I became a doctor. Nothing makes her less worthy of receiving dialysis coverage here versus there. Nothing about her dialysis status has changed. Nothing about her immigration status makes her less worthy of lifesaving coverage here, especially given that we have the ability to provide it. So lastly, I want to tell you the most important thing that I learned in medical school, and that's I learned medicine. The increase in morbidity and mortality that is endured by patients forced to dialyze "emergently" just makes sick people sicker. The current system restricts effective targeted care. It predisposes people that are vulnerable already to even more adverse health outcomes then they would have had should they had access to appropriate care in the first place. That's just bad medicine. Rejecting this bill doesn't make the problem smaller. It ignores the complexity of the topic, and it ensures that this condition-- that this discussion will just continue down the road when it gets even more complex. We get our vegetables from our local farmers. You probably get your haircut from a barber. I know I call a certified plumber when I have a problem with my sink. Please let me, the doctor, do the doctoring. At it's most simple level, this bill is about providing medical care to people who need it. Please don't make me withhold lifesaving care for my patients. This bill is a solution. Trust me when I tell you that what's best for patients here is not financially unattainable for the state. This is a solution. For these reasons, Nebraska Medical Association requests that the committee support the advancement of LB862 to General File. Thank you for your time. Happy to answer questions.

ARCH: Thank you. Are there questions? Senator Day.

DAY: Thank you, Chairman Arch. And thank you, Dr. Brock, for being here today. A couple of previous testifiers had touched on what you mentioned, which is the financial aspect of this. So I just want to clarify so that I'm making sure I understand it correctly. Essentially, the state is already paying for emergency care. We're already paying for this type of care for, for, for these undocumented individuals, correct?

RACHEL BROCK: Absolutely.

DAY: We're just paying a lot more--

RACHEL BROCK: Absolutely.

DAY: --than we need to be paying in a much less humane and unfair, I guess, way or, or people, more people are dying and we're spending more, more money on it, is that--

RACHEL BROCK: I think that's wholly accurate.

DAY: OK.

RACHEL BROCK: I really do. I think these, these people are-- need dialysis care regardless. So the question is, can we do it in a way basically that is more humanitarian and saves money? We can. And that's exactly what this bill does because they don't just not receive dialysis care if this bill doesn't get passed, they just still receive it in the ER and the state is still paying for it.

DAY: Thank you.

RACHEL BROCK: Um-hum.

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

RACHEL BROCK: Thank you.

ARCH: Next proponent for LB862.

MICHELLE DEVITT: Good afternoon, Chairman Arch, members of the committee. My name is Michelle Devitt, M-i-c-h-e-l-l-e D-e-v-i-t-t, and I'm here on behalf of the Immigrant Legal Center. The mission of ILC is to welcome immigrants to Nebraska by providing high-quality legal services, education, and advocacy. I'm here in support of this bill today because we believe that this is a win-win. It would require

Emergency Medicaid services for end-stage renal disease already allowed by federal law, which addresses an urgent financial-- or an urgent humanitarian need at a savings for care that the state is obligated to perform one way-- or pay for one way or the other. So we're here to highlight the fact that this is not simply an issue of undocumented care because undocumented immigrants are not the only noncitizens impacted by this issue. There are dozens of, there are dozens of noncitizen statuses and only ten provide full, and provide full access to full-scope Medicaid. Of those, three of them require a five-year waiting period. And there are other statuses that provide it only-- provide care-- or provide Medicaid only for children and pregnant mothers. Excuse me. Pregnant prospective mothers. So we wanted to stress that this is not an issue of undocumented-- access for just undocumented noncitizens. So, for example, special immigrant juveniles who are here because they have been either abandoned, abused, or neglected by their parents, they have status and they are able to get full-scope Medicaid only while they're children. Unfortunately, even if they maintain their status or adjust to a lawful permanent resident status, that status can be lost. We see firsthand this impact, especially as it, as it impacts ESRD patients. Through our immigrant-focused legal medical partnership, we provide legal screenings and representation to noncitizen patient-clients at three Omaha area hospitals and we routinely receive referrals from nephrology departments of patients suffering from ESRD. In fact, kidney failure is one of the most common illnesses that we see in those referrals. But unfortunately, many of those clients are ineligible even if we're able to help them get status. So when one patient that I'd like to highlight her story was Emma, she was an immigrant, a special immigrant juvenile like I described earlier. She was a survivor of abuse, abandonment, and neglect, and we were able to get her status. So she was able to get the regular three times a week hemodialysis you've been hearing about until she reached the age of 19. Unfortunately, she had been discussing with her doctors on how to plan for a kidney transplant that they were unable to complete by the time she was 19 and she lost her care. So now she has to wait until she is able to adjust status to a lawful permanent resident. Then she'll have another five years to wait until she's eligible. Even though she's maintained status this whole time, she's now back to being reliant on this emergency care. So this, yeah, so we just want to stress that this is more than an issue of undocumented status. So this would-- this bill would allow people like Emma to proactively manage their care in a long and sustained way. We understand that with the striking of the, the kidney donation part, that that would not be a, a fix for Emma, but she would at least be able to receive that

regular care to manage her condition at a substantial cost savings for the state. So in closing, we are supporters of this bill. We're hoping that this committee will advance it to General File, and I'm happy to take any questions.

ARCH: Thank you. Are there questions? Seeing none, thank you very much for your testimony. Next proponent for LB862.

KELSEY ARENDS: Hello, Chair Arch and members of the Health and Human Services Committee. My name is Kelsey Arends, K-e-l-s-e-y A-r-e-n-d-s, and I'm the Health Care Access Program staff attorney at Nebraska Appleseed and I am testifying on behalf of Nebraska Appleseed today. We are a nonprofit legal advocacy organization that fights for justice and opportunity for all Nebraskans, and one of our core priorities is to ensure that all Nebraskans have access to quality, affordable healthcare. Nebraska needs to improve the treatment available to Nebraskans living with end-stage renal disease who do not qualify for Medicaid. We have an opportunity in LB862 to expand our state's eligible treatments under the Emergency Medical Services Assistance Program, sometimes called Emergency Medicaid, to include effective, efficient, and cost-saving services. Specifically, this bill seeks to cover outpatient and home dialysis, hemodialysis, and directed living donor kidney transplants or with the amendment maybe not the transplants. Nebraska Appleseed supports LB862 because it expands access to coverage for Nebraskans who need it, and there is evidence that covering these treatments leads to state cost savings. The Emergency Medicaid program covers emergency care for individuals who do not have citizenship or a qualified noncitizen status for Medicaid. The individual must be eligible for Medicaid except for their lack of citizenship or qualified noncitizen status. States have wide authority to define the emergency services covered by Emergency Medicaid. And just to emphasize, this bill only makes changes to Emergency Medicaid. Currently, regular dialysis, hemodialysis, and kidney transplants are not considered emergency services for Nebraska's Emergency Medicaid program. Today, Nebraskans without qualified noncitizen status are forced to rely on emergency-only hemodialysis. This course of treatment forces patients to wait until their condition worsens to the point of severe life-threatening symptoms before they receive any care. Restricting access to care in this way leads to physical and psychological distress, longer hospital stays, higher mortality rates, and more costly care. LB862 addresses these problems by making the standard treatment of schedule dialysis available to Nebraskans with kidney failure who do not meet the qualified noncitizen criteria for regular Medicaid. LB862 also presents an opportunity for more cost-effective treatment. There's evidence that scheduled dialysis is

associated with vast cost savings as compared to emergency-only dialysis, and that renal transplantation is often even more cost effective than dialysis. At least 12 other states have expanded their Emergency Medicaid programs to cover more services for people living with end-stage renal disease, including Colorado, Arizona, and Illinois. Colorado began covering scheduled dialysis under its Emergency Medicaid program in February 2019. Prior to the change, emergency-only hemodialysis was costing the state more than $20,000 per person per month. By contrast, scheduled dialysis costs Colorado Medicaid an average about $2,400 per person per month. Preliminary analysis indicates that states could save tens of millions of dollars per year with this change. A quick note on the fiscal note. Other states have covered the majority of the services contemplated in the original bill and receive a federal match. Our understanding is that with the exception of transplants, all the other services included in the bill should receive some type of federal match. And other states have been able to receive a federal match for those services, even if they use state funds to cover the transplants only. So we would anticipate with or without the amendment, there would be a higher federal match than is currently indicated in the fiscal note. Because this bill will provide critical coverage to Nebraskans who need it and presents an opportunity to save on health costs, Nebraska Appleseed supports LB862.

ARCH: Thank you. Are there any questions? Seeing none, thank you for your testimony.

KELSEY ARENDS: Thank you.

ARCH: Next proponent for LB862.

JANE SEU: Good afternoon. My name is Jane Seu, J-a-n-e S-e-u, and I'm testifying on behalf of the ACLU of Nebraska in favor of LB862. Thank Senator McCollister for introducing this legislation. The fundamental constitutional protections of due process and equal protection embodied in our constitution and Bill of Rights apply to every person, regardless of immigration status. Using targeted-impact litigation, advocacy and public outrage, the ACLU protects the rights and liberties of immigrants. This bill provides treatment for end-stage renal disease for all Nebraskans regardless of immigration status. As you've heard for a patient with end-stage renal disease who is undocumented or who is otherwise ineligible for Medicaid, their only option is present to the emergency room when they feel so fatigued and ill and are in critical condition that the hospital is required to provide emergency dialysis. As vividly illustrated, this is not

optimal care or treatment and stresses hospital resources. LB862 will ensure that patients, regardless of immigration status, will receive the necessary and dignified care they need. This bill will also save costs and resources at hospitals across the state when fewer patients need to present for emergency dialysis. The ACLU of Nebraska supports efforts to ensure immigrants can access the critical resources needed to participate and thrive in our communities regardless of immigration status. This is an important human rights, racial justice, and economic justice issue. We urge the committee to advance the bill to General File. Thank you for your time. Happy to answer any questions.

ARCH: Thank you. Any questions? Seeing none, thank you for your testimony. Next proponent for LB862. Is there anyone that would like to testify in opposition to LB862? Good afternoon.

CARISA SCHWEITZER MASEK: Good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Carisa, C-a-r-i-s-a, Schweitzer Masek, S-c-h-w-e-i-t-z-e-r M-a-s-e-k, and I'm deputy director of Population Health 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 the green copy of LB862, which would expand the emergency medical services assistance program, also known as EMSA, for nonqualified aliens and noncitizens not eligible for Medicaid to cover continuous and reoccurring treatment of end-stage renal disease. Our primary concern with LB862 is that it would require coverage of organ transplant services, which would be out of compliance with federal law. Specifically, 1903(v)(2)(c) of the Social Security Act authorizes necessary treatment of an emergency medical condition and states such care and services are not related to an organ transplant procedure. Some states do cover organ transplant services for nonqualified aliens and noncitizens not eligible for Medicaid, but they utilize all state general funds to do so. Also, LB862 would require coverage of at-home dialysis. While some states cover dialysis as an EMSA service, they do not cover it at home. Rather, it is covered as an outpatient service at a facility. Coverage of this dialysis treatment in EMSA would also include the physician and the lab services. LB862 would also require an individual to enroll in managed care for care coordination and transportation. This would require changes to our information technology system and contract amendments with our Managed Care Organizations. As federal law does not allow EMSA to cover treatments related to organ transplants, those costs would not-- would have to be covered 100 percent by state general funds. I want to bring to the attention of the committee that new information that we found after the original fiscal note was submitted shows that there are some of those expenses for dialysis

would be allowable under some federal coverage, although expanding the current definition of EMSA to services currently not covered would still have a significant fiscal impact for the Medicaid program. As a result, we respectfully request that the committee not advance this legislation. Thank you for the opportunity to testify today, and I'd be happy to answer any questions.

ARCH: Thank you. Are there any questions? Senator Day.

DAY: Thank you, Chairman Arch. Thank you for your testimony today. So as I mentioned earlier, we discussed the fact that the state is already paying for these emergency dialysis services. Do we have any idea how much the state currently spends on that?

CARISA SCHWEITZER MASEK: Yes. Thank you for that question, because that is a very important question. Medicaid program did an analysis and pulled our EMSA total spend for fiscal year '21, and I think that's in the fiscal note. But it was $472,000 under the EMSA program, and none of those services were related directly to end-stage renal disease.

DAY: So these are not services related to the emergency dialysis that the patients are receiving?

CARISA SCHWEITZER MASEK: Or any services related to end-stage renal disease based on procedure code. Now it is possible that some of the DSH hospital payments for the Disproportionate Share Hospitals may in-- be indirectly covering some of those end-stage renal disease treatments for uncompensated hospital costs. But we are not seeing the expenses for end-stage renal disease costs under the EMSA program for Medicaid.

DAY: OK, thank you.

ARCH: Other questions? Senator Cavanaugh.

M. CAVANAUGH: Before my question, could you just restate what you said? I'm sorry, I didn't quite follow.

CARISA SCHWEITZER MASEK: Yes. In response to Senator Day's question, it was how much is the state paying for end-stage renal disease treatments? The Medicaid program under the EMSA program, our total expenditure for state fiscal year '21 was $472,000, and of that-- of those services, we could not find any that were directly related or a diagnosis as end-stage renal disease treatments.

M. CAVANAUGH: So what were the treatments?

CARISA SCHWEITZER MASEK: Those were mainly hospital stays, but I'd be happy to pull additional information and provide that to the committee.

M. CAVANAUGH: Hospital stays for renal disease?

CARISA SCHWEITZER MASEK: For other procedure codes, but we'd be happy to pull that information and provide that.

M. CAVANAUGH: I guess I'm confused. So we didn't provide any dialysis for Medicaid?

CARISA SCHWEITZER MASEK: Under the EMSA program based on the information that we were able to pull through Medicaid, we did not find expenditures for end-stage renal disease.

M. CAVANAUGH: But we did provide-- not under the EMSA program, but we did provide kidney dialysis?

CARISA SCHWEITZER MASEK: So under the Medicaid program, no expenses we could find on that $472,000 directly related to end-stage renal disease. It is possible.

M. CAVANAUGH: I guess what I'm asking is it sounds like perhaps the reason that it's not in that group that you're talking about is because they didn't have to wait until they were at that point to get the treatment. So I'm wondering, I don't want to speculate that,--

CARISA SCHWEITZER MASEK: Yeah, yeah.

M. CAVANAUGH: --but I'm wondering if the state under Medicaid covered any dialysis during the year?

CARISA SCHWEITZER MASEK: Yeah, very good question. EMSA is a program covers emergency medical services for nonalien-- or nondocumented immigrants, specific immigration status individuals. Any services that were covered under that EMSA program by Nebraska Medicaid in state fiscal year '21, we could not find were related to end-stage renal disease--

M. CAVANAUGH: OK.

CARISA SCHWEITZER MASEK: --under the Medicaid program.

M. CAVANAUGH: I apologize.

CARISA SCHWEITZER MASEK: So--

M. CAVANAUGH: I think--

CARISA SCHWEITZER MASEK: No, no, it's OK.

M. CAVANAUGH: I'm getting more confused because if we currently aren't covering it for undocumented individuals, then it would-- the reason that we wouldn't be in that number because we're currently not covering it.

CARISA SCHWEITZER MASEK: It is possible that hospitals could be indirectly receiving DSH payments that might cover end-stage renal disease for uncompensated hospital costs.

M. CAVANAUGH: Right.

CARISA SCHWEITZER MASEK: We are not finding that cost directly underneath the EMSA program for Medicaid.

M. CAVANAUGH: So I'm sorry, Senator, is it OK if ask her-- sorry. If we-- OK, so if somebody, an undocumented individual shows up, like the patient of the, the medical students, shows up to the emergency room and receives a dialysis and they can't pay for it and they're undocumented but they have to be provided that, that service, you're saying that none of that, you can't have it, you don't have a record of that being billed to Medicaid. Is it likely that it's being billed or recouped in a different way?

CARISA SCHWEITZER MASEK: That is correct. It is not being billed to Medicaid so it is likely it is being billed or covered under uncompensated care--

M. CAVANAUGH: OK.

CARISA SCHWEITZER MASEK: --at those hospitals.

M. CAVANAUGH: So it's not-- since it's not covered, it wouldn't show up in the numbers, correct, because they wouldn't be billing for it because it's not covered?

CARISA SCHWEITZER MASEK: Emergency services for those of immigrant status that meet the definition for emergency services can be billed to Medicaid.

M. CAVANAUGH: But not for renal failure?

CARISA SCHWEITZER MASEK: Currently, we're not seeing any claim items from hospitals that are being billed to the EMSA program that are for end-stage renal disease.

M. CAVANAUGH: Because it's not covered?

CARISA SCHWEITZER MASEK: If it is an emergency situation, the-- as our clinical experts were able to speak very eloquently to, it is within the scope of the providers in the emergency room to decide what is emergency care.

M. CAVANAUGH: Right.

CARISA SCHWEITZER MASEK: And as a federal requirement, Medicaid has an emergency services program in Nebraska to cover services for those of the immigrant status [INAUDIBLE].

M. CAVANAUGH: But not this particular type of service. So I guess this might be a question for the Hospital Association if they are providing the services, are you not billing Medicaid because Medicaid doesn't cover those services then how are you? So maybe just putting that out there to the Hospital Association. OK, I'm sorry. Thank you.

ARCH: Other questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch. And thank you, deputy director for being here again. Statistically, does, does-- how does the department figure out how large this population is that we are looking at here?

CARISA SCHWEITZER MASEK: Yes, very good question. Because we don't have direct data, what we did is we went out and looked at national resources and we did utilize some of the resources that I did hear referenced today. We looked at the Migration Policy Institute that would estimate the number of immigrant population in Nebraska and then also looked at the kidney.org statistics to look across the nation, the percentages of individuals that would either be receiving dialysis or those that would be receiving kidney transplant took that number.

WILLIAMS: And that's where you came down to potentially 71 people in this population base.

CARISA SCHWEITZER MASEK: Yes, sir.

WILLIAMS: OK. In listening to your testimony, there's two primary concerns, one's the, the transplant issue and the other one is the at-home dialysis issue. It appears to me that at least one of those

may be taken care of in the amendment that Senator McCollister has presented us. If the amendment took care of both of those issues, would that change the position of the Department of Health Human Services on this legislation?

CARISA SCHWEITZER MASEK: So the department believes there would still be a significant fiscal impact due to the dialysis coverage. Once we see that amendment, we will be reviewing that fiscal note and submitting that revised fiscal note to the committee.

WILLIAMS: Thank you. That would be helpful for us as a committee. Thank you.

CARISA SCHWEITZER MASEK: Um-hum.

ARCH: Other questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Will that revised fiscal note include the costs that we are incurring currently to Senator Day's earlier question so that it is a true picture of what we are currently paying for these patients versus what we would be paying with this bill?

CARISA SCHWEITZER MASEK: The fiscal note from Medicaid can only speak to Medicaid expenses.

M. CAVANAUGH: But the Department of Health and Human Services can put into the fiscal note more than just what Medicaid does?

CARISA SCHWEITZER MASEK: Yeah, so we can look across the Department of Health and Human Services and see if there are other funds from other resources going in, too.

M. CAVANAUGH: That would be extremely helpful if the opposition is to the fiscal note and the amount of state funds being expended, it would be very helpful to know the amount of state funds truly being expended currently versus if this bill were enacted. Thank you.

ARCH: Senator Hansen.

B. HANSEN: So Senator Cavanaugh had some good questions and I'm going to try to wrap my head around here, too,--

CARISA SCHWEITZER MASEK: Yeah.

B. HANSEN: --what you two are talking about. Currently, end-stage-- emergency end-stage renal disease is not, is not a Medicaid-covered

service, which is what this bill is trying to change from my understanding. And so if it's not a covered service currently, Medicaid is not paying for anything, which would be the reason, probably why we're showing that Medicaid doesn't pay for anything. There's no cost to the state. And so with that, who pays for it then if the state doesn't? Typically, from my understanding, it's the hospital's responsibility, like they eat the cost or if the patient can pay out of pocket or if they have some kind of insurance, which an undocumented immigrant may not have insurance so if they can't cover it themselves, I'm assuming then the hospital is just eating that cost. Is that typically correct? Again, maybe another question for the Hospital Association, but.

CARISA SCHWEITZER MASEK: The second part is a good question for the Hospital Association. Yes, I would like to address the first part of your question, which is EMSA is defined as emergency medical services. If an individual that's covered under EMSA with the specific immigration status presents to the emergency department, that care that is considered an emergency is-- could be covered under EMSA. And as our clinical experts spoke to, there are situations where a patient could show up at the emergency room with-- in critical status that would require dialysis, which would be an emergency situation covered under EMSA.

B. HANSEN: OK, thank you.

ARCH: Other questions? Seeing none, thank you very much for your testimony.

CARISA SCHWEITZER MASEK: Thank you.

ARCH: Other opponents for LB862? Is there anyone that would like to testify in a neutral capacity for LB862? Seeing none, Senator McCollister, you can come up. While you're coming up, I would mention that we have received seven letters submitted, all, all proponents for, for LB862.

McCOLLISTER: Chairman Arch and members of the committee, thank you for a most interesting hearing this afternoon. I think we learned today that for sure, something we know for sure is that regular treatment of dialysis is far cheaper than emergency care, and I think that's been demonstrated in spades. Yes, we are willing to adjust the bill to not include organ transplants of any kind or in-care dialysis. So I, I think we certainly would be entitled to a new fiscal note and perhaps some more enlightened thinking from HHS. So I would encourage you to

move this bill to General File and let's see what the numbers show us, and I would be grateful for your attention.

ARCH: Thank you. Any final questions for Senator McCollister? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Senator McCollister. I guess I would ask that before you make any changes to the at-home dialysis portion of your bill, I would like to know, not right now in this moment but moving forward, if, if there's some sort of cost savings? Because I think about our rural areas and access to healthcare and before a change like that were to be made, I, I hope we could just maybe have further conversation about that piece and whether or not it's necessary.

McCOLLISTER: Good point, Senator Cavanaugh.

M. CAVANAUGH: Thank you.

McCOLLISTER: Point well taken. Yeah.

ARCH: Other questions? Thank you very much.

McCOLLISTER: Thank you.

ARCH: Oh.

B. HANSEN: That's all right.

ARCH: No, no.

B. HANSEN: I'll ask him later. I'll ask--

ARCH: OK.

McCOLLISTER: You're just waving me on.

B. HANSEN: I have the luxury of seeing him almost every day now.

ARCH: You know, you know where he lives? OK.

B. HANSEN: Yeah.

ARCH: All right. OK, thank you, Senator McCollister. And that will close the hearing for LB862, and I'll hand the committee to Senator Williams.

WILLIAMS: All righty, everyone, we will, we will-- we're going to continue on here. We will open the public hearing on LB1004, a bill introduced by the HHS Committee and it will be introduced by Chairman Arch. Welcome, Chairman Arch.

ARCH: Good afternoon, Vice Chair Williams, fellow members of the Health and Human Services Committee. My name is John Arch, J-o-h-n A-r-c-h, and as the Chair of the Health and Human Services Committee, I'm pleased to introduce to LB1004 to the committee. LB1004 requires the Department of Health and Human Services to engage a nationally recognized consultant to evaluate Nebraska's developmental disability services system. The evaluation will look at the services we offer through Medicaid state plan amendments or waivers, the services offered by other states through Medicaid waivers or other mechanisms, and any other area which may be helpful for the state to assess our developmental disabilities services system. LB1004 came about as a result of LR239, which was an interim hearing held by this committee on December 3, 2021. I really appreciated the education that we received from Director Green and the department at the hearing. It was very helpful. The interrelationships of the waivers are very complex and Director Green did his best to help us understand those. My conclusion from LR239 was that we have a labyrinth of waivers that have been layered on top of each other over decades. I believe it's time to step back and ask a very difficult question. And here, and here's the question. If we had a blank piece of paper and had the opportunity to design a program to serve Nebraskans with disabilities, how would we design a new system to maximize impact while recognizing the reality of limited resources? That's a difficult question, but I think that's the opportunity that we have in front of us here. We also understand that based on our Legislative Research Office's Nebraska At-a-Glance 2021 edition, Nebraska ranks fifth in the nation in terms of Medicaid spending per enrollee. But 32nd in the nation regarding people who identify as disabled. So much of the, much of the Medicaid spending is tied to our home-and-community-based waivers. Don't know exactly what that number is. But those facts raise additional questions regarding the cost effectiveness of our system. While LB1004-- with LB1004, we want to ensure that as a state we have the most current information to continue to make the best decisions for all Nebraskans with developmental disabilities. We'll direct the consultant to examine the variety of waivers and state plans implemented in other states, analyze the cost and benefits of some of these initiatives, and see what might make sense to implement here in Nebraska. We know the Comprehensive Developmental Disability Waiver registry is an issue within our system of services. We've heard we

will need an extra $3 million, at least an extra $3 million per year of funding for developmental disabilities to simply keep the registry from growing. And we know that's unsustainable. We also know that we have issues with staffing levels for providers, which can prevent individuals from coming off the registry and on to the comprehensive waiver. So it's our hope with this evaluation, we can learn what Nebraska is doing exceedingly well. But we also hope the state will have numerous options moving forward in order to mitigate some of the concerns with our current system. While the department is not here to testify today, I will note that Director Green wrote a letter on behalf of the Department and Human Services in support of LB1004, and we-- I have just recently passed that out to the committee. I also, I also want to mention a couple of other, a couple of other things. One is the fiscal note. So the fiscal note indicates an estimate of approximately $500,000 for the consultant fees for this, for this research and this, this project. I've had discussions with administration on that. I challenge that number. I think that's, I think that's quite high, but we will have continued discussion on that as well and see what, what is that right number to put into an A bill. Just again, to kind of frame this. We are, we are spending and, and this is-- these are General Funds only for disability aid for, for the '21-22, we're at about $158 million; for '22-23, we're about $168 million. So those are General Funds that we're applying. Now those are the Federal Funds involved so that number is certainly larger in total, but those are the dollars that we're talking about. And so when I say take a step back and say if we were to spend these dollars, is this how we would do it? And, and I think that again, going back to that, that LR that we had this summer, LR239, when we saw the, when we saw the graphs and the, and the explanation from, from Director Green, I mean, it was-- that was enlightening. We, we saw what that, we saw what that registry really meant. We saw with how the waivers interact with each other. And so this is this opportunity to say, is this the best way to spend this money? Does this have, does this have the most impact? Does-- is this the most effective way? All of those things. So with that, I, I will close and happy to take any questions you might have.

WILLIAMS: Thank you, Chairman Arch. Are there questions?

WALZ: Sorry, I'm hyping up now.

WILLIAMS: Senator Walz.

WALZ: Thank you. I'm just curious about the process. Will they be interviewing families, consumers, providers? How does that process

work? Where do they come to their conclusions and make their recommendations?

ARCH: Sure, when the-- I mean, first of all, the selection of the consultant would be the first step. And then the, and then the-- I mean, the scope would be defined when, when people, when people would make application for-- to be the consultant, but the scope would be defined. And, and so we're going to be, we'll be involved in, in, in providing input to that process as well. And, and so at that point then, stakeholders, families, all of those could be identified in that, that the consultant then would, would reach out to, to get input.

WALZ: When you say we, you mean the HHS committee?

ARCH: Yes. Yes.

WALZ: All right. Thanks.

WILLIAMS: Additional questions? Seeing none, we'll move on to proponents and we would invite Alana Schriver to come up first, please.

ALANA SCHRIVER: Good afternoon, everyone. My name is Alana Schriver, A-l-a-n-a S-c-h-r-i-v-e-r, and I'm the executive director of the Nebraska Association of Service Providers, which is our statewide trade association for DD providers. Amongst the rush of and noise of a busy legislative session, we do appreciate that state leadership is facing the important reality head-on that people with intellectual and developmental disabilities who rely on home-and-community-based services are drowning in the dual crisis of an emaciated workforce and an unrelenting pandemic. The status quo isn't working. Even if a global pandemic wasn't happening, Nebraska would be behind the curve due to a flawed study being utilized to determine rates and the rising costs of providing quality services. The pandemic multiplied previously existing issues by shutting off the spigot of a flowing workforce. The system in its current state is not sustainable. I know the focus of the evaluation is on waivers and options, and as a parent of a child with DD, I can appreciate that fully. But as a representative for the providers, I can't miss an opportunity to talk about rates because really, right now, we don't have the staff that we need and if we can't increase wages to a competitive rate, there is no services, there are no DD services. Services are rehabilitative hours, which are essentially human beings right there alongside you as you're growing and achieving your life skills and goals as a person with

I/DD. So while the Governor has approved a temporary 15 percent rate increase, CMS has yet to approve that spending plan, so it's not guaranteed and not yet available to providers. If approved by CMS, that increase is set to end in June with no other aid in sight. A temporary rate increase only offers temporary relief, and providers cannot effectively use temporary funds to increase wages. I won't hammer the fact that increasing wages is the only real solution to address the staffing crisis. You guys well know that, you had to increase state employee wages as well. So I'll just go ahead and, and move on and say that even though funding was made available to bring 500 Nebraskans off the wait list and into DD services this year, and while some of those people have been accepted, they're not yet being served due to the lack of staff. In fact, many providers are being forced to send notices to people already in service that their needs can no longer be safely met, let alone serve new referrals. So even if we have all the waivers in the world, if there is no people to provide those services, we haven't really made any progress in Nebraska. The problem is not unique to Nebraska. It's just exacerbated by our historically low unemployment rate. Providers would love nothing more than to accept and successfully support every Nebraskan on the wait list. It's mutually beneficial to do so. Every provider wants to grow, but we have to recover before we can grow. On average, providers have experienced a 12 percent margin loss since the start of the pandemic, meaning providers have gone from being reimbursed roughly 2 percent above their cost to losing 10 percent on the services they provide because the current reimbursement rate does not reflect recent significant increase in cost to provide care. We agree wholeheartedly that Nebraska's DD system is due for a big picture evaluation, and what providers are asking for is a seat at the table during these conversations to be one of those stakeholders involved. No one understands the system and its issues better than the provider community, many of whom bring decades of institutional knowledge with them. Providers are the key to improving and expanding Nebraska's DD service system. We have a magnitude of unmet need in our state, and opening dialog between providers, state leadership, and impacted families will increase opportunities for people with disabilities to live and thrive in their homes and communities. Additional funding, such as proposed in LB893 and LB1172, would build our system back to a point where growth and innovation become options again, as well as prevent a cliff effect moving forward into future budget cycles. Your support of those bills is crucial. NASP remains committed to protecting and strengthening supports for people with I/DD, like my own son who's currently on the wait list for services, and we hope for that same commitment from state leadership. Thank you for listening,

and I'm happy to answer any questions on behalf of providers or as a parent.

WILLIAMS: Are there questions for Miss Schriver? Senator Walz.

WALZ: Thank you. The other day, we-- thanks for being here, first of all.

ALANA SCHRIVER: Yeah, thanks for having me.

WALZ: We attended a, a, a meeting with you and you talked about-- I just wanted to talk about the 15 percent that's in the Governor's budget.

ALANA SCHRIVER: Sure.

WALZ: And how that, how that helps or what more is needed, I guess, is--

ALANA SCHRIVER: Well, any little bit helps. No one's going to turn away any kind of financial intervention at this point. Most of our providers will most likely be reporting a loss for last year because our last help, the Appendix K, ended in June of 2021. So for the past six months, providers have been dipping into their savings and other ways to try to just simply keep the doors open. Presidents are doing direct care, and, and hopefully we don't get to the point like other states who have called in the National Guard or using the ER like the previous bill was forced to do. So the 15 percent will help because of all the increased inflation costs. Unfortunately, we can't use it for vehicles or some of those capital investments that no one's been able to do over the past few years. But what we can do with a temporary bump is offer retention bonuses, hiring bonuses, or perhaps like a COVID differential like hazard pay for working during a pandemic. Because really, that's our biggest issue is we're just bleeding out workers to Walmart and Target and places that can pay $15, $17 an hour. Beatrice can now pay over $17 an hour, plus better benefits than we can offer for working at the Beatrice State Development Center. So we're just trying to get a bigger paycheck to people, but we can't technically increase their wage because it's only a temporary bump that's going to end in June. So LB893 would make that 15 percent permanent, which would then allow that to become a wage increase. And then LB1172 is using general ARPA funds to try to supplant those programs that do require staff members specifically. Because a lot of programs, if you're a shared living provider, for example, you're dealing with inflation costs right now, but you're not doing as bad as

someone who has to pay employees and health insurance and FICA. You know, everything else that comes along with having a staff.

WALZ: OK, thank you. I appreciate that. I just wanted, I guess I just wanted you to clarify that because the, the staffing situation is serious.

ALANA SCHRIVER: Yeah. And unfortunately, we don't know yet because it's not approved by CMS, so we haven't actually been able to put anything into effect with that bump. We're still waiting on the approval and once approved, then DHHS will determine how to get that payment out to providers. So we don't know whether it will be a quarterly reimbursement, you know, just 15 percent on top of what, whatever you bill for, for three months or if it will be program by program. So at that point, then providers will have a better idea of how they could utilize those funds.

WALZ: All right. Thanks so much. Thanks for being here.

WILLIAMS: Additional questions? Seeing none, thank you for your testimony. Invite the next proponent. Welcome, Mr. McDonald.

EDISON McDONALD: Hello. Hi, my name is Edison McDonald, E-d-i-s-o-n M-c-D-o-n-a-l-d. I'm the executive director for the Arc of Nebraska. We represent people with intellectual and developmental disabilities and their families. For over 60 years we've, we've advocated for the inclusion and support of people with I/DD within our communities. We're here in support of LB1004 because this bill is an opportunity to review our waiver system and significant gaps in our system. I really appreciate Senator Arch's thoughtful approach to this, and I think my mentor always told me to make sure to have the right question. He's got a really good one. I think the only thing just being we don't want to start from scratch, but because we wouldn't want to go and take anybody off of the system. But we want to reevaluate in terms of how do we grow and modify that system? So Nebraska took a gamble to prioritize one type of waiver and a limited target population. Our focus on a, on a limited array of 1915(c) waivers has left us without the proper tools in our tool belt to deal with a lot of issues. This has continually increased the cost of our Medicaid-based services to the fifth highest in the nation. In particular, there are several things that we see that are recurring, expensive, and damaging to the quality of life for many Nebraskans. I know that there were some testifiers who sent you some, some letters. But I wanted to share a few stories in particular that really have stood out to me. I met a grandmother who has to be a caretaker of her grandson, grandma is

5'1", and the grandson is 6'6". Grandson has autism, but an IQ that's too high and has trouble qualifying under our current waiver structure. But what our waiver doesn't identify is his behavioral health issue and the combined needs. So the tiny grandmother couldn't deal with her grandson's increasing behaviors that were frequently violent. She wanted some support. So I tried to walk her through the process. But even if we could get him to qualify under our current waivers, going and getting him actually services would be hard. First, you've got the six to eight year wait list. Second, she could have given him up to foster care, even though I think he was like 16, 17. It would have bumped him up to priority category 3, but she would have had to report herself for neglect. Or she could have reported her grandson for assault as she had bruises all of her arms and several incidents related to his disability. This would get bumped up to a priority 1 status, but only after she reported him for that criminal behavior, which no grandma wants to do. Another family has a young child who's on the DD waiver. They have a large budget due the-- due to the high assessment of needs. But there isn't the service array that they actually need, so their designated funds go unused. LB376 should help this significantly. But further analysis will be helpful, as I'm sure this isn't going to be the last step needed to really address these changes. And then one family in a small rural community who is going to be evicted. In a small, typical town style, everyone chipped in to support them. The pastor helped with a large variety of issues, the coffee shop owner gave them a bunch of free food, and the landlord gave them a tremendous deal on rent. He wanted to do what was right. He wanted to keep supporting them and helping them and keep them in the property. But they didn't have the proper supports to make sure that the property was maintained, and he was losing a tremendous amount of money as the property continued to be damaged. The mom and daughter, who lived there with some basic support, could care for themselves and the property better if they had just a little bit of support. However, our current priority 1 status won't give them that support until they are actually homeless. At this point we go from a small cost to a much higher cost to support them. There are a number of different waiver structures that we can use that I've included in my testimony for you to read through. Within these tools, you can see a structure that will ensure a significant amount of alternative ways to deal with-- to support people. And while part of that is definitely services and rate increases, there's a whole array of other supports within any Medicaid HCBS waiver that are tremendously important that we also need things like physical therapy, occupational therapy, medical equipment that can go and help us to decrease expenses within the long term. I hope within these tools that we're able to really

look into some of the alternative opportunities. I think some of our current waivers will need modifying, like expanding our brain injury waiver that currently serves less than 50 people and it's mostly just in Omaha. I think we also need to look at restructuring part of our service model, look at things like service coordination structure, getting a fiscal intermediary, or a new assessment tool. While we've worked with many experts and I think that there are a lot of great solutions like Senator Stinner's bill to increase provider rates, Senator Cavanaugh's family support waiver, and others, I believe having this consultant will help us to have a broader understanding of the tools used by other states that would be beneficial. I look forward to collaborating with the committee and the department in this effort to better serve Nebraskans with disabilities.

WILLIAMS: Thank you. Are there questions for Mr. McDonald? Seeing none, thank you for your testimony. Invite the next proponent.

KRISTEN LARSEN: Hello. Good afternoon, Senators. I'm going to take off my mask. My name is Kristen Larsen. It's spelled K-r-i-s-t-e-n L-a-r-s-e-n. I'm here on behalf of the Nebraska Council on Developmental Disabilities to testify in support of LB1004. Although the council is appointed by the Governor and administrated by DHHS, the council operates independently and our comments do not necessarily reflect those of the Governor or the department. We are a federally mandated independent council comprised of individuals and families of persons with developmental disabilities, community providers, and agency representatives who advocate for system change and quality services. The council serves as a source of information and when necessary-- oh-- information and advice for state policymakers and senators. And when necessary, we take a nonpartisan approach to provide education and information on legislation that will impact individuals with developmental disabilities. To stay focused on our mission, every five years the council completes a needs assessment in order to identify ways to make a positive difference in the lives of individuals with developmental disabilities and their families. In October of 2020, the needs assessment findings from surveys and interviews with over 500 family members, self-advocates, DD providers, and others were published. Respondents rated the informal and formal services of supports as the top priority areas for the council to address. Specific needs identified as important included issues related to the registry or wait list and the availability of services and the need to bolster family supports. LB1004 requires DHHS to engage a nationally recognized consultant for the evaluation of Nebraska's developmental disabilities service system. It is an avenue to address access issues to services and supports noted in the

council's needs assessment. Last year, the council supported LB376, which would create a family support waiver. Unfortunately, when it was discussed on Select File last May, numerous concerns were shared that stalled efforts and demonstrated that senators lacked understanding of how the current Nebraska HCBS waiver system is structured and the needs of those on the developmental disability registry or wait list. LR239 that you had this summer provided your committee with the opportunity to learn more about Nebraska's current waivers and the populations affected, while exploring possibilities to help serve those with DD and their families in a more efficient manner. The council paid close attention to the testimony during the LR239 hearing. Director Tony Green and other testifiers did an excellent job educating this committee on a very complex subject. The council especially liked testimony that Sarah Swanson from Munroe-Meyer Institute, the state's federally funded University Center for Excellence in Developmental Disabilities, provided. Sarah shared information about how improving access to services within the Medicaid state plan can also provide relief for families who have children with DD who currently do not qualify for Medicaid. The council recognizes the complexity of the Medicaid state plan and the HCBS waiver system. The council supports LB1104 [SIC--LB1004] and also Senator Arch's amendment to LB376. We like that as well. It's very similar, AM1646, to hire the national subject matter expert to conduct this deeper dive evaluation that will provide HHS-- the HHS Committee, and DHHS the information that will guide policymakers to address these pressing needs. The council believes that this bill can be a catalyst for innovative, systemic changes to support people of all ages with DD and their families. Without taking the step, quality of life is compromised for those who still remain on the registry/wait list, and families continue to struggle emotionally, physically, and financially to maintain the caregiving, residential, and independence-focused supports. DHHS and the Legislature must commit to a long-term solution to meet the known and the future unknown service needs of Nebraskans with, with developmental disabilities. Thank you for your consideration.

WILLIAMS: Thank you, Miss Larsen. Are there questions? Seeing none, thank you for your testimony.

KRISTEN LARSEN: Thank you.

WILLIAMS: Are there any additional proponents? Is there anyone here to testify in a neutral capacity? Is anyone here to testify in opposition? There's nobody left in the room. As you're coming up, in addition to the letter submitted that Chairman Arch passed around from

Tony Green, there are also 17 other letters that we received as proponents.

ARCH: Thank you.

WILLIAMS: You're welcome to close.

ARCH: Complex is the operative word, right? People have used that in testimony today, and I've used it. I think we all recognize that. We certainly recognized that when we sat in the LR239 this summer, or this, I guess, December. And, and so we know that this is, this is going to be a pretty heavy lift of a study. This is the complexities that we face with the, with the inter-- interaction of the waivers and, and what has, what has been our system for many years will have to be examined carefully and, and, and lives are involved in this, people that are receiving services and, and dependent upon those services. So we, we recognize that this is going to take some time. And but it's, I think it's a very worthwhile endeavor. We-- I, I'm hopeful that not only are we going to find opportunities for increasing impact, but there may also be opportunities for being more cost effective and how we are spending the dollars. We know that when we were doing our child welfare work this summer as well, we saw, we saw when you get into those federal regulations on, on how these things are funded, there are different ways to do this. And, and this is what I referenced in my opening that, you know, some states are using state plan amendment. Some states are using waivers and, and how those, how those interact-- impact your financials as well. So with that, I'll, I'll close and, and be happy to answer any questions that you might have.

WILLIAMS: Are there questions for Chairman Arch? Seeing none, thank you. And that will close the public hearing on LB1004. And that's our final hearing for today.