ARCH: Good morning and welcome to the Health and Human Services Committee. My name is John Arch. I represent the 14th Legislative District in Sarpy County. I serve as Chair of the HHS Committee. I'd like to invite Senator Murman to introduce himself, if you would do that at this point.

MURMAN: I'm Senator Dave Murman, represent District 38, have about eight counties along the southern tier of the middle part of the state.

ARCH: Also assisting the committee this morning, one of our research analysts, Lisa Johns; our committee clerk, Geri Williams; and our committee page, Malcolm Durfee O'Brien. A few notes about our policies and procedures. First, please turn off or silence your cell phones. This morning, we'll have a briefing from the Department of Health and Human Services on Medicaid and the new MCOs when we'll hear two interim study resolutions. We'll be taking them in the order listed on the agenda outside the room. The hearing on LR407 is open to anyone wishing to testify. However, the hearing on LR409 is limited to invited testimony only. This afternoon we will hear two more interim study resolutions-- LR366 introduced by Senator Wishart and LR397 introduced by Senator McDonnell. For those of you testifying on either resolution, you will find green testifier sheets on the table near the entrance of the hearing room. Please fill one out and hand it to the page when you come up to testify. This will help us keep an accurate record of the, of the hearing. I'm asking that you try to limit your testimony to 5 minutes. And I understand some of the-- some of those that are invited testimony on these briefings, that's not going to apply to that. So we just want a thorough briefing. The light system will give you an indication of how long you've been speaking. At 4 minutes, the yellow light will come on and the red light at 5 minutes. These are study resolutions for information gathering purposes and not bills so there is no record of proponents and opponents. Just as with legislative bills, comments for the record may be submitted online via the Chamber Viewer page as long as comments are submitted prior to noon on the work day before the hearing. And with that, we will begin today's hearing with a briefing from DHHS. And I welcome director Kevin Bagley to please come up. Good morning.

DR. KEVIN BAGLEY: Good morning. I can honestly say it feels good to be back in this chair.

ARCH: Good.

DR. KEVIN BAGLEY: So good morning, Chairman Arch, Senator Murman. My name is Dr. Kevin Bagley, K-e-v-i-n B-a-g-l-e-y, and I'm the director of the Division of Medicaid and Long-Term Care in the Department of Health and Human Services. I'm here today to provide an update on Medicaid's reprocurement of managed care contracts. I want to acknowledge the hard work of our dedicated team who are passionate about helping their fellow Nebraskans live better lives. In April, we released our request for proposals, which included several key changes that I'll discuss in more detail here in my briefing. In July, we announced the five bidders, all of which were well-qualified to meet the requirements of the RFP. As I'm sure the committee is aware, Medicaid selected UnitedHealthcare, Nebraska Total Care and Molina Healthcare to provide managed care services for Medicaid beneficiaries over the five-year period outlined in the new contract. We're confident in these plans' ability to provide quality care to the hundreds of thousands of Nebraskans who depend on Medicaid to access important healthcare services. While all five bidders presented excellent responses in the RFP, we believe these three will be the best choice for Nebraska over the next five years. I'd like to spend a few moments today discussing some of the biggest changes contained in these upcoming contracts. Many of these changes come directly from lessons we've learned over the past several years as well as feedback from stakeholders across the state. We've heard from our stakeholders about the need to improve access and availability of dental services. As part of the new contracts, each of our plans will provide dental care alongside physical health, behavioral health and pharmacy services that they already provide. This is part of a broader effort on our part to improve access to these important preventative services for Medicaid members in the state. In addition to integrating dental services into these contracts, we implemented a 10 percent rate increase starting this fiscal year and are making changes to our dental policy, including removing the annual benefit maximum for adults that we believe will improve the availability of these services. We heard from providers about the administrative burden that they experience when enrolling and credentialing as new providers, among other areas. We included specific language in the RFP to address the issues with provider credentialing. We're also working to build transparency in processes and policies across our plans in order to reduce the burden experienced by our providers and improve their experience within the program. We recognize that by reducing these burdens on providers, we will allow them to focus their time on our patients, improving the quality of services our members receive. To improve the experience for our dual-eligible members, those who have

both Medicare and Medicaid, we included more robust requirements around care and case management and coordination of services. These changes will challenge our plans to improve the member and provider experience by focusing on integration, access, accountability and innovation. These core values drive our division's strategic vision and shape how we interact with our stakeholders. As my team and I traveled around the state to hear from our members and providers, we heard from them the need to improve transparency and accountability, not just with respect to our plans, but with our program more broadly. While we work diligently to make ourselves available to stakeholders, we recognize the need to be more proactive in our communication and outreach. We also recognize the need to communicate in clearer terms what we are doing to improve our program and why. Over the coming months, we'll be sharing with stakeholders additional resources that we believe will create additional transparency and accountability. We will share key quality outcome measures by which we measure our program's success. We will share our plans. We will ask our plans to create additional clarity around our policies and processes. This move toward fostering increased transparency and accountability is part of our strategic vision as we move into 2023 and beyond. We shared in our press release announcing the RFP awards that the implementation date will be January 1, 2024. We believe this timeline will allow adequate time for our agency, health plans, members and providers to prepare for that transition. Over the next year, we will work to ensure this transition goes smoothly, minimizing any negative impacts on our members and providers. In addition, we'll be sure to keep this committee and our stakeholders apprised of our progress throughout the implementation process. Finally, I'd like to take just a moment to discuss potential upcoming changes related to the end of the COVID-19 public health emergency. As this committee is aware, since March of 2020, we have not disenrolled members despite potential changes in their eligibility. This is a requirement from our federal partners tied to the Public Health Emergency Declaration. When the federal public health emergency ends, we will be required to reevaluate eligibility for all 375,000 members currently enrolled. This will be a tremendous undertaking that will likely take the full 12-month period allowed by the Centers for Medicaid and Medicare Services. We believe that during that process there will be somewhere between 35,000 and 75,000 individuals who will lose their coverage. Individuals may lose coverage for two primary reasons: first, they may no longer meet the eligibility criteria, and second, they may fail to respond to requests for additional information needed to verify their eligibility. For those in the first group, coverage through the federal marketplace

will be available, likely with significant subsidies. We have systems in place to automatically transfer an individual's information to the federal marketplace where they may qualify for subsidized private coverage. Those who lose coverage due to a failure to respond may still meet eligibility requirements. We will need to ensure that we have updated contact information for our members to avoid this type of unnecessary coverage loss. While we will be actively working to communicate these changes with our members, we will need the help of providers, tribal and community partners, other state agencies and this committee to get this message out. We have developed a comprehensive communication plan to ensure that members and our partners are aware of what members will need to do to complete these reviews, including making sure that we have current contact information. We have developed information materials that will be posted on our website. We'll conduct a multimedia outreach campaign that includes letters, text, email, public service announcements, press releases, webinars and social media. In addition, our managed care organizations have agreed to partner with us and will conduct their own outreach to support our messaging. Thank you again for the opportunity to come and speak with the committee today. I'd be happy to answer any questions that you all have.

ARCH: Thank you, Director Bagley. Questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Director Bagley, for being here. So we have three awarded MCOs.

DR. KEVIN BAGLEY: That's correct.

M. CAVANAUGH: And two of them are from the previous.

DR. KEVIN BAGLEY: Yes.

M. CAVANAUGH: And then their third one is a new one.

DR. KEVIN BAGLEY: Yes.

M. CAVANAUGH: Can you take me through the process? As I'm sure you can imagine, when we're making big changes like this, I'm a little hesitant as to what that's going to look like. And so if you could just take through why we're making the change, I think that would be helpful.

DR. KEVIN BAGLEY: Certainly, I think we recognize that there has been significant scrutiny around RFP processes, especially through the department over the last several years. With our managed care procurement process, as with most procurement processes, we're required to reprocure periodically. In our case, those contracts were coming to a close from their five-year period with a couple of one-year extensions that could be included. One-year renewals-- I'm sorr, I think that's the technical term is renewal. So with that coming to a close, we needed to reprocure. Now managed care procurement is unique in the state. For most procurements, at the state level, we're required to account for cost in the sense that we ask for bids related to price. In the case of our managed care plans, they're required to accept our per member, per month rates that we calculate with our actuarial firm that we contract with. And so in the case of our managed care plans, there is no consideration for price. However, we did do a thorough review of not just the administrative requirements that they would need to meet, so things like their ability to take calls from our members, their ability to network with our providers and do those administrative tasks that need to be done in order to have a well-functioning health plan. In addition, we asked a significant amount of questions about care and case management, their approach to identifying and, and assisting with marginalized communities, whether that is our rural communities who may have to travel further for care, or some of our urban communities who may not have to travel as far but still struggle to get there. We asked a lot about their approach to bringing innovation to the state and what that looks like. All of these companies have a national footprint. All five of our bidders have a national footprint. And those all come with an ability to bring innovative best practices from other states. But we also asked about how they would cater those to the specific needs of the state of Nebraska. We feel like the three that were selected, based on the scoring associated with those criteria, really represent the best of the five bidders moving forward.

M. CAVANAUGH: So when you talk about innovation to the state, what does that actually-- what does that mean in layman's terms?

DR. KEVIN BAGLEY: Yeah, so it could, it could be in a number of areas. I think, specifically, one of the areas we're looking at is how are you addressing the overall whole person health? So our plans are in a unique position to really work with community-based organizations and other stakeholders to come up with innovative approaches to care. And sometimes that may include looking at social determinants, sometimes that may include innovative approaches to outreach and innovative

approaches to payment with some of our providers where they create value-based purchasing agreements. While we require that they bring some of those to the state, we're not overly prescriptive on how. We recognize there is an opportunity to find good ways to do things and then try to apply those across the board as we identify them.

M. CAVANAUGH: OK. And-- so UnitedHealthcare's been reawarded.

DR. KEVIN BAGLEY: Yes.

M. CAVANAUGH: That's one that I believe, if I'm not mistaken, we've heard a lot of complaints about from providers and that relationship. And so is that-- are those types of things taken into consideration in the scoring?

DR. KEVIN BAGLEY: They are. I would say one of the things that we, we could have included and we chose not to directly was an opportunity to score based on the types of issues that we may hear locally. We chose not to include that specific type of criteria, as we recognized there would be plans who would bid who have not been here locally. And so we didn't feel like that would be an equitable way to assess. That being said, I think I can say I have heard concerns from providers regarding all of our plans. That's not to say that they are performing poorly necessarily, but I think what it really implies is that there's an opportunity for us, not just as an agency, but with our plan partners, to really make sure we're sitting down with our providers, with our members, to understand their experience better. I can share as we've gone and done our listening sessions, and we plan to continue doing those roughly twice a year, we've had a presence from all of our plans and they've been quick to sit down with stakeholders who share their experience and try to understand better how they can improve. The reality is, I think Medicaid sometimes is a slower-moving boat than we would maybe all like to see. And so those changes don't come immediately. But I think as we put ourselves on, on a track toward making some of these significant changes and we're putting those out there as the direction that we're taking, that inertia helps kind of keep us on that track. So hopefully that helps answer your question, Senator. I'm, I'm not sure if that does or not.

M. CAVANAUGH: Yeah, I'm not trying to pick on any one MCO. That just is one that has stood out in hearings here. And so as we're making this change in this contract and we have heard, over my four years in the Legislature, a lot of testimony about providers and issues they've had with various entities, and have you taken this opportunity to

incorporate that feedback into what the services and the contracts of the-- was that incorporated into the RFP? Is there a new understanding of-- these are issues that we've had, whether you're new to the state or not, and we want to see those issues not continuing forward or how-- can you take us through how that works?

DR. KEVIN BAGLEY: Yeah, that's a great question. We're frequently asked, you know, how have you incorporated that feedback into the RFP, into those contracts moving forward? And I'll say, to the extent we can put some of that language in contracts, we've tried to do so. Sometimes it's difficult to put into contract language the cultural approach that we want our plans to take. And so those end up getting captured a little bit in some of the key performance measures that we may put in place. We ask our plans, for example, to have less than a five-minute average wait time for member and provider calls. We find that they generally meet and exceed that standard, exceeding in the sense that they're far below that 5 minutes. We ask for a number of other standards, and one of the things that we hope to do as part of our, our move to address that transparency and accountability is to-- I'm sorry-- is to make sure that we're sharing those, those measures with our stakeholders, with the public, so that they can see and understand how we're holding ourselves and our plans accountable. I think the reality is there's a lot of positive things that are happening, a lot of conversations that are taking place, but they don't always take place out in the public sphere. They don't always take place here in front of the committee. And so it may not be apparent to all of our stakeholders what is happening on that front. We want to try and change that to make sure that they know what we're working on, when we expect it to be done and how we are going to hold ourselves accountable, how we measure our success.

M. CAVANAUGH: Thank you. I have questions on the second part of the testimony, but so--

ARCH: Senator Murman.

MURMAN: Well--

DR. KEVIN BAGLEY: We'll get back to it.

MURMAN: --I might be asking kind of the same question again over. But if I heard you correctly, past complaints about providers, it was not a consideration in renewing the contracts?

DR. KEVIN BAGLEY: So we didn't have any specific scoring criteria associated with that. One of the things we did do was have them provide references of other states that they've worked in, and we took those references into account as we went through that process. I can say, for the most part, we didn't really receive any negative feedback from those references. That being said, I don't want to be dismissive of the concerns and complaints we've heard. I think those are very legitimate. Some of them have been resolved with our plans, but I think there's still more work to be done.

MURMAN: OK. Personally, I would think if, you know, if you did have more complaints, say, from certain, a certain provider, that would-- should be a consideration on whether or not to renew the contract.

DR. KEVIN BAGLEY: Yeah, I can't necessarily disagree with you, Senator. That being said, I think the difficulty for us is how do we do that in a way that is objective and equitable across all of the plans was really the struggle for us. And so what we did do was, was really try to push and focus on what do you plan to bring to the table in terms of quality and outcomes? And so that was the bulk of our scoring.

MURMAN: OK. It seems like talk is kind of cheap. You know, the past performance would be the best indicator. I'll let it go with that.

DR. KEVIN BAGLEY: That's fair. Thank you.

ARCH: I'd like to take that in a little different direction, because I think that's a concern, obviously, of the committee. Going forward in the contract itself, what are the consequences of not meeting key performance indicators? So, for instance, the question of responsiveness to the patient and billing issues with providers and all those things, which I would assume will be part of those key performance indicators, what are the consequences of not meeting those indicators?

DR. KEVIN BAGLEY: So those consequences are-- they can vary quite a bit. And one of the things we try to do is to really look at the specific situation. So I'll, I'll share one example, relatively recently. Our partners that operate our dental plan through MCNA, a lot of their call center resources are based in Texas. And when Texas had those significant weather issues, it took out a lot of the infrastructure. They saw their wait times increase significantly. As we had that discussion-- and we discussed these measures with them

monthly. As we had that discussion with them, we talked through their approach. We talked through how they plan to resolve it. We have an option to put a corrective action plan in place, which outlines specific actions we need them to take. We also have an option to do some financial withholding associated with those poor outcomes. We have a quality incentive program where if they meet certain quality thresholds, there is money that is pooled and held until the plans meet those thresholds. When they meet them at the end of the year, that money can be paid out. In addition, there are options that we have to replace key executives within those plans here locally. And if it came to it, we would have an opportunity to revoke that contract. While I think we see that as somewhat of a last resort, that is also something that would be on the table.

ARCH: And those are spelled out in the contract?

DR. KEVIN BAGLEY: They are.

ARCH: Those options. OK. Another question that I have is, is we've struggled with provider panel for dental, having enough dentists on the panel. I see you've-- you are putting in a 10 percent rate increase, which I'm sure is an attempt to address some of that. What else? That's, that's just been a chronic problem, not having enough dentists willing to take the patients.

DR. KEVIN BAGLEY: Yeah, that's been an area where we've really spent a considerable amount of time. That 10 percent rate increase that went into effect on July 1 of this year-- what we've heard from dentists has been thank you. It may still not be enough. And we're working with the Dental Association to try and understand better how those rates could be formulated to better address their needs. Rates is one of the areas we routinely hear, not just from dentists, but I would say from providers in general. Medicaid is, by statute, always going to be probably one of the lowest payers in terms of rate. That being said, we ought to be one of the best payers to work with and I think we have some room to improve there. The other issues we hear from our dentists are around the annual benefit maximum for adults. That's been particularly poignant for our expansion population. Those are individuals who may not have seen a dentist in decades in some cases. And so they're coming with a significant amount of work that needs to be done. That $750 annual benefit maximum, in many cases, prevents that dentist from completing the amount of work that would need to be done. And so it's, it's causing dentists not to want to take new adult patients. And so we believe removing that will do a lot to address

that. We've also heard concerns from dentists around previous audits that have taken place that has soured our dental community's opinion of the program. We're working to try and put in place some additional education and awareness of what those requirements are. And we've also heard that there are other policy issues that, though well-intended, may be causing them to rethink their relationship with the program. As we come to better understand their needs and the unintended barriers that are in place with those policies, we're working to remove them. While that takes time, this is something that in conjunction with our plans, we can create, I think, a sustainable and stable and consistent set of policies that will incent our dentists to work with us again. We've seen a fairly precipitous drop in the number of dentists per capita that work with our plan over the last several years. These are all steps to address that. I don't have data yet that suggests that we've solved it, but we're continuing to monitor that.

ARCH: It sounds like there's quite a bit of work left to be done with the, with the dental benefits and the panel.

DR. KEVIN BAGLEY: There is. We've had a lot of discussions with our new plans around how they plan to work together to address that. We also, through our medical care advisory committee that consists of both members and provider representatives, have done a lot of discussion around how we can improve that. And our current chair of that committee is actually a dentist, a pediatric dentist from Hastings.

ARCH: OK. Thank you.

DR. KEVIN BAGLEY: Thank you.

ARCH: Other questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Before I move on to my other questions for the second half, I did-- I asked my staff to bring down the-- I know there's a protest happening and-- in the MCO contract award. And I just wanted to ask for some clarification on some of the things that are in the protest.

DR. KEVIN BAGLEY: Sure. I'll see what I can address. I may not be able to address all of it, but--

M. CAVANAUGH: OK. Well, there's-- at the start of it, it has the, the grounds for protest. There's four points. And I'll just quickly read them for everyone. Molina should be disqualified for its failure to

disclose numerous subcontractors. There's information about that. And then they should be disqualified for materially misrepresenting the amount of work to be completed by its corporate parent. Intentionally deceived reviewers regarding the services Molina provides through its in-house applicants-- applications and overall score should be adjusted for its deficient subcontracting disclosures. I'm sure similar things can be said about any of them that-- it's a robust process. But some of these do seem-- again, it's the sins of the former sort of thing. But I really want to make sure that we are being as diligent as possible when we're reviewing these-- the misrepresenting of the work by the corporate parent. It lists a bunch of services and then the subcontractors. Is there a reason that-- or maybe the score was taken into, those things were taken into consideration in the scoring? Was the scoring adjusted after those considerations were made? Could you just maybe speak to that a little bit?

DR. KEVIN BAGLEY: So I, I don't know that I can speak directly to that. I want to make sure that it goes through that, that--

M. CAVANAUGH: Process?

DR. KEVIN BAGLEY: --that statutory process there for those protests. I can speak a little bit more to our process as we went through the scoring and the review of those scores.

M. CAVANAUGH: Could you let us know-- first, before you do that, where are, where is the protest at in the process?

DR. KEVIN BAGLEY: I would probably have to get back to you, Senator. I'm not 100 percent certain on that.

M. CAVANAUGH: OK. There's also one of the more concerning things is that Molina's disclosed investigations were improperly redacted and Molina should be provided-- required to provide the unredacted version. Have they provided an unredacted version?

DR. KEVIN BAGLEY: Yes. So I can speak to that. So those redactions are what we put out in the public facing document. None of those redactions existed in our reviewer's scoring of those documents.

M. CAVANAUGH: And is there-- can you speak to why you put them, why the department redacted parts of their--

DR. KEVIN BAGLEY: I can't speak to necessarily those specific ones, but generally when we redact that information, it's often because it's proprietary or is information that, for some reason or another, would not be appropriate to disclose. But I'm not certain, the specific reasons for those redactions.

M. CAVANAUGH: OK. Can we get an answer to that in the future from the department?

DR. KEVIN BAGLEY: Yes. So as part of the protest process, we'll be responding specifically to all of the, all of the items in that protest.

M. CAVANAUGH: OK.

DR. KEVIN BAGLEY: And, and I'm just-- because I am not the person that, that follows through specifically on those.

M. CAVANAUGH: Yeah, I, I understand.

DR. KEVIN BAGLEY: I don't, I don't feel like I can speak to what exactly the status is on that.

M. CAVANAUGH: I'm asking you a wide variety of questions that--

DR. KEVIN BAGLEY: Which is fair.

M. CAVANAUGH: --fall maybe to somebody in your department, not you specifically. And my last area of concern is that they listed the CEO of DHHS as a reference. It says Ryan Sadler, the CEO and plan president for Molina lists CEO Smith as a reference on his resume. She's a final reviewer in the process so that seems like a conflict.

DR. KEVIN BAGLEY: So CEO Smith was not a scorer in any of this. As she and I both, in our role, effectively looked at the final scores and agreed with those final scores, but we did not participate in the scoring ourselves.

M. CAVANAUGH: OK. I guess-- always just want to be conscientious of the perception of impropriety. I'm not sure that there is any and I'm not trying to insinuate that there is. It just-- it is a red flag for me personally, but I appreciate your answers to that. So I have more questions. But sorry.

ARCH: I've got an additional question.

DR. KEVIN BAGLEY: Sure.

ARCH: First of all, thank you for for coming. This is, this is very helpful for us. I, I have a, I have a question on the transition of-- you know, you've, you've put it out a year plus.

DR. KEVIN BAGLEY: Yes.

ARCH: Why so long? We have, we have one, one, one MCO replacing two, two are current. Why, why do you believe that it's going to take that long to, to move to the three, the three identified MCOs?

DR. KEVIN BAGLEY: So there's, there's a couple of, a couple of reasons why we looked at that. So initially in a lot of the conversations we had, we were talking about a date as soon as July 1 of 2023. Two things, I think, that are the key differences between that date and the one we have now in January 1, 2024. One is we still have yet to see the end of the public health emergency. If that does end in January, then we should be receiving notice from our federal partners as early as next week that that will be the case. And if that happens, we would want to make sure that we had as much of that under our belts as possible before we make this transition. The second is because we are making some other significant changes, including bringing on a new plan and having them operate dual eligible special needs plans, it made sense to align it with the start of the year. It makes it easier from a Medicare enrollment perspective, from our Medicaid open enrollment perspective, it just lined up appropriately. In addition, there are a few policy changes that are going to be required at the federal level that will align with that release. And so we thought that would be an appropriate way to do it.

ARCH: OK. So if-- assuming, assuming the decision that has been made it stays, are you-- what do you intend to do with, with the existing patients, with the existing MCOs versus, versus if there's a, if there is a new third MCO, what-- how are you going to-- is everybody going to choose new? Were you going to start all over? What, what's your plan with that?

DR. KEVIN BAGLEY: It's a great question.

ARCH: Well, it's not a great question, but I think you understand the question.

DR. KEVIN BAGLEY: I think it's a great question. No, it's one that we've heard several times before. And the answer really is it will

depend. That being said, every year in October we have an opportunity for members to select a new plan for any reason. If they choose to select a new plan, they'll be moved into that new plan. When members enroll, if they do not select a plan, we will select one for them. And we make that selection, effectively, in an effort to keep a relatively even distribution of members across our three plans. When we make that transition, all of those individuals who are enrolled with our Healthy Blue Nebraska plan may, and I say may, end up moving to our Molina plan. That was part of the reason we felt like having this happen in January instead of July made more sense because our members are already going to have the opportunity to make choices about their future year's plan in that October period. So they'll be able to make the choice of whether or not they want to move to Molina. If they do not make a choice, we can assign them. We don't intend to force people to change plans, with the exception of those who are enrolled with Healthy Blue Nebraska, as that would not be a plan as of January 1, 2024. So they'll have an opportunity to make a choice of those three plans in October. If they do not make a choice, we'll assign them. And so for those folks who are enrolled with Healthy Blue Nebraska who do not choose, the most likely outcome would be that they would move to Molina.

ARCH: So is it your, is it your intention that you-- that the number of beneficiaries here are roughly divided equally between the three MCOs? And is, is it, is it more than an intention? Is that, is that what you are requiring? What's, what are you doing with that?

DR. KEVIN BAGLEY: Right now, that is effectively something we require. We are doing that in an effort to move the spirit of competition between our plans away from just trying to acquire more members, more covered lives, toward having better quality outcomes. There are really two ways that our plans can, can make money, and that is either getting more people to increase their revenue or having healthier outcomes and lowering the costs of that care. And so our hope is that they're focused on the latter. And so that's part of the reason we have that intentional split.

ARCH: I want to shift for a second to the question of, of redetermination of eligibility that will be-- the federal government will require that once the emergency is, is over. What, what, what's the role of the MCOs versus the role of the state in that process?

DR. KEVIN BAGLEY: So the state's responsibility is to make a determination of eligibility. That is something that isn't different.

One thing that, that I try to help folks understand as we have this conversation is the process itself isn't necessarily different with this unwind. The difference is that there's a lot of people who are likely going to have a change, whereas typically that would be spread out month to month and happening over the course of years as we are going to be approaching three years in March of this public health emergency declaration. There has not been any churn over that time period, which is why we believe we'll see that 35,000 to 75,000 number come to fruition. That will be spread out across that 12 months, though I don't know what the proportion will be in any given month. That will depend on the number of people who don't meet the criteria. But the role of the MCOs in all of this is going to be a little bit new. One of the things we are going to have them focus on is helping with some of that outreach to our members who are at risk of losing their eligibility. When we identify someone who-- for whom we have returned mail, we've made a request for information, that mail comes back as they're no longer at the address. The address doesn't exist. In those cases, we are going to work with our managed care plans to identify do they have additional contact information that's different from ours? If so, we'll work to use that. And then if we have that not work, we're even going to have our plans look and identify, is this an individual who has gone to their local pharmacy in the last 90 days? If so, does the pharmacy have contact information that may be different from what we all have? And let's try that. So that in-depth level of outreach will be new. That is something they have agreed to do in working with us on this. In addition, we will also have our plans work over the course of the 90 days following a determination of ineligibility to identify any other contact information, opportunities to bring someone back into the program who is eligible. The reason that 90 days is important is because if we find someone ineligible because we have not heard back. It's one of those procedural issues. If they can get us that information within 90 days and we find they're eligible, we can cover them back to the start of that period, meaning they don't actually have a loss of coverage. From our perspective as an agency, that additional work we would love to not have to do, but we also do not want to lose people from coverage who would otherwise be eligible. So that-- those two dueling priorities are something we plan to have our health plans help with.

ARCH: Well, I'm also concerned with what, what you've got here that, that we do a good job of helping the individuals that may not be eligible to move to the federal marketplace.

DR. KEVIN BAGLEY: Yes.

ARCH: And where they could, where they could find perhaps 100 percent subsidized healthcare. How-- is that, is that going to be the state's responsibility for that? Or MCOs, will they be involved with that at all?

DR. KEVIN BAGLEY: So the first thing the state will do on that front is send an automated file to the federal marketplace notifying them of who we have determined is ineligible and they use that as part of their outreach campaign for individuals.

ARCH: The marketplace does.

DR. KEVIN BAGLEY: The federal marketplace does, so that does not fall to us as an agency. That being said, we do plan to include in our letters notifying individuals of their disenrollment that they may qualify for significant subsidies in the marketplace and encouraging them to seek out that coverage. So there's that portion of it. The other side of this is we do have one of our health plans that does offer a marketplace plan. And so in cases where, in cases where they have an individual in their Medicaid plan who is losing coverage, they're going to be able to let them know about the continuity opportunity there with their marketplace plan. So there is some work from our managed care plans in kind of helping that handoff. There's not much of an obligation at this point for us as an agency or the managed healthcare plans to have a warm handoff there to the federal marketplace. That being said, we're trying to identify what resources we have and can put towards that. Our hope is that that is as good of a handoff as we can make it. But we don't have control over all the levers in that process.

ARCH: Well, I know that, I know that that, that is a concern and will be a concern of the committee. It will be a, it will be an unpleasant surprise to some individuals if they are, if they're, if the redetermination is that they're no longer eligible and they lose their insurance coverage of Medicaid. So to the ability-- to our ability, the best of our ability, we would want to help these individuals find their way to that marketplace and, and see the options there for them, including the subsidies available.

DR. KEVIN BAGLEY: Absolutely. And while I can't speak to too many specific processes at this point, we're working with a lot of our community partners who do a lot of this work right now, whether it's our healthcare navigators, community health workers, benefit assisters and others to try and identify how we can work together better on that

front. So our hope is that we can take the lessons learned through this unwind and really apply them moving forward.

ARCH: Yeah. Good. Other questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. So you mentioned to Chairman Arch's question about the 90 days after ineligibility due to the lack of contact. What is the notice? How long will you give notice to those that are ineligible that you-- for the other reasons, that they're just ineligible? How long do they have notice before they are moved off of?

DR. KEVIN BAGLEY: So obviously the specific amount of time per person will end up varying a little bit. But I'll speak to how that process works so that you can have a better idea of.

M. CAVANAUGH: Sorry, the specific amount of time will vary?

DR. KEVIN BAGLEY: Let me, let me speak to that really quick.

M. CAVANAUGH: OK.

DR. KEVIN BAGLEY: Part of that is just due to the time it takes a letter to come in the mail.

M. CAVANAUGH: Don't we have a basic minimum requirement?

DR. KEVIN BAGLEY: Yes, we do. So the amount of time may vary, but we have to give advance notice. And because of the way our eligibility is set here in the state, we do it in month-by-month increments. So I'll give an example. If the public health emergency were to end in the middle of January, may or may not, but hypothetically, if it does, we wouldn't see anyone lose coverage before February 1. If they were to lose coverage February 1, we would have to notify them at least 10 days prior to that, the end of that coverage, which means that letter would have to go out mid-January. So if we determine on January 30 that someone is no longer eligible and we put that notice together and send it out, their coverage would not end until March because of the time frame required to give that advance notice. In addition, anyone who has that adverse action, which losing coverage constitutes an adverse action, has a right to request a hearing with the department for us to go back and evaluate whether or not that was done correctly. So if they request that hearing within a certain time frame, they can request that their coverage be maintained until that hearing is completed. So they have 30 days within which to file a hearing and within that time, they would have to request that that coverage

continue. So those options are all available for individuals as well, but there needs to be at least that ten-day advance notice.

M. CAVANAUGH: So if they are deemed ineligible on January 20, then their coverage ends on February 1?

DR. KEVIN BAGLEY: It may. And part of that-- I don't think it's quite that straightforward from a math perspective. But hypothetically, we need to give that ten-day notice. And so-- sorry, not hypothetically. Hypothetically, if that were the correct formula for doing those 10 days, and I am not the expert on that 10 days, then yes, it could end as soon as February 1.

M. CAVANAUGH: And that ten days starts from the postmarked date?

DR. KEVIN BAGLEY: I believe so. I could get you better details on that, Senator, because like I said, I'm not the expert on how those notices are sent.

M. CAVANAUGH: So does the department intend to use just the 10-day notice? Or will the department extend the notice? Do you have-- first of all, do you have the ability to say we as a department are going to ensure that everyone has 60 days' notice?

DR. KEVIN BAGLEY: So we won't necessarily have the opportunity to change a lot of those requirements because they come from our federal partners.

M. CAVANAUGH: But isn't the federal government making allowances as we come to the end of this--

DR. KEVIN BAGLEY: Yes.

M. CAVANAUGH: --emergency?

DR. KEVIN BAGLEY: Those aren't necessarily allowances that they're making, but we plan to have as much outreach as possible so that we ensure people aren't taken by surprise.

M. CAVANAUGH: I would say ten days is taken by surprise.

DR. KEVIN BAGLEY: Yeah, I think in those cases-- so I will share-- we're planning once we have that 60-day notice to send a letter to anyone that we have flagged over the last three years as potentially at risk of losing that coverage.

M. CAVANAUGH: And will that notice include instructions on next steps and what they can do?

DR. KEVIN BAGLEY: Yeah, it will include instructions on where they can go to see what their renewal date will be. So I'll, I'll share here as well just because, again, hypothetically, the public health emergency ends in January, we won't be reevaluating everyone's eligibility for February 1.

M. CAVANAUGH: But you'll be reevaluating some.

DR. KEVIN BAGLEY: That's right. So it's roughly evenly distributed across the 12-month period, each of those 375,000 people. And so we'll be reevaluating roughly 30,000 each month for eligibility.

M. CAVANAUGH: And you'll be giving the 60-day notice to people that they're being reevaluated?

DR. KEVIN BAGLEY: That's right. We're required to give advance notice if we have those questions. For a lot of individuals, a third to even almost half of the individuals we review, we can do that verification without having to reach out to them for additional information. However, if we find they are not eligible, then we would be sending out notices to let them know that we don't believe they're eligible and so they would have that advance notice through that process.

M. CAVANAUGH: I'm sorry, I need more clarification. So you have-- when you're doing the reevaluation, anybody who's being reevaluated, you're going to give them 60-day notice that they're being reevaluated and that at the end of that 60 days, they could potentially be deemed ineligible.

DR. KEVIN BAGLEY: I may have to get back to you on that 60-day question, Senator. We will share with everyone what their renewal date is in our system. That's something they can access through ACCESSNebraska today, but we want to make sure that's clear to folks.

M. CAVANAUGH: And how will you and when will you be sharing that with them?

DR. KEVIN BAGLEY: So we'll share instructions on how they can find that information as part of that notice that would be sent out 60 days prior to the end of the public health emergency, so we'll receive notice 60 days prior to the end of the public health emergency. We'll be sending out that, that notice shortly after that.

M. CAVANAUGH: OK.

DR. KEVIN BAGLEY: So that's where that 60 days comes in. I apologize if I created some confusion there.

M. CAVANAUGH: OK. OK. I have other questions.

DR. KEVIN BAGLEY: Be happy to--

M. CAVANAUGH: I can pause [INAUDIBLE].

DR. KEVIN BAGLEY: Be happy to share more as time comes on. I will share, Senator, we plan to put out our plan, including communications and timelines and everything else publicly, soon. We're, we're working to finalize that now. And we also plan to have data that is updated fairly regularly on how that process is going. We want to make sure this is as transparent as possible, not just for our members, but for our providers and any other stakeholders, including the committee. So more to come, I guess, on that front and we're happy to have continual discussions on that.

ARCH: You may proceed.

M. CAVANAUGH: OK. I always have a lot of questions. I'm a curious person. I wanted to go back to the, the--whatever this is called, the con-- the complaint or--

DR. KEVIN BAGLEY: The protest?

M. CAVANAUGH: Thank you. Not enough coffee yet today.

DR. KEVIN BAGLEY: I understand.

M. CAVANAUGH: So on, I think, maybe the last page under D-- I know you don't have it in front of you, but I'm just referencing it for the record.

DR. KEVIN BAGLEY: Sure.

M. CAVANAUGH: There-- it looks like there was a request for documents. And on September 23, 2022, and it says that they cannot be released until 2023. And this, this hit me as sort of a big number that the requested documents, DHHS has forecast that it would need to expend 2,300 hours of attorney time and $126,621 to produce the requested emails and an additional 950 hours and $24,000 to produce the WebEx

messages. Does that mean that you would be hiring outside legal counsel to do this?

DR. KEVIN BAGLEY: That would be an option to complete that request. So in this, in this particular case-- and, and this is often true of public records requests that we receive. They're often written fairly broad, which is understandable. That being said, when they're written sufficiently broadly for us to meet the requirements of the law, we would need to expend a significant amount of energy. So in this particular request, there was some language that would have requested that we provide any communication between reviewers and the plans, which I think is an understandable request. But in this case, because we do a lot of work with our plans on a daily basis that involves individual member cases, that would not be appropriate to disclose in a public records review. And so, what it would require is that we go through the potentially hundreds of thousands of emails and WebEx messages that the-- and text messages and other things that the, that the department may have that could be responsive and evaluate all of those for whether or not there is private, proprietary or individual health information. And that really would be the significant lift there. That being said, I think in any opportunity we have to be responsive, we want to be. Sometimes it's difficult with the way those requests are worded. And in this case, that was one of those.

M. CAVANAUGH: I appreciate that. I've made some broad requests, and the department has been really great about coming back to me and asking me and working through what I'm really looking to get. And then it's more specific and less arduous. And so I just want to say that for the record that I appreciate that. But it does strike me that this type of request is not unusual after our RFP process, and maybe this is more for Director Jackson, but-- with DAS. But have we, has the department and the state ever considered creating a process for capturing that information as you go along so that this isn't an arduous process in the aftermath?

DR. KEVIN BAGLEY: So I can share-- we have put a hold on all of those communications that we felt were relevant to the reprocurement. And so we have a lot of that information. The way this particular request was written, it would have-- at least our interpretation of it would have been a lot more expansive and included any communication between our teammates and the plans, which was not something that we would have planned to hold in association with the procurement so.

M. CAVANAUGH: OK. So sounds like in this specific case, they just need to refine their request.

DR. KEVIN BAGLEY: Yes.

M. CAVANAUGH: OK. I think this is my last question. I hope it's my last question. This came up during previous procurement processes that there's the scoring based on just the, the evaluations and the scoring. And then there is an option to do an oral portion. And that option was utilized in this.

DR. KEVIN BAGLEY: It was.

M. CAVANAUGH: And can you give some clarification as to why that option was utilized in this procurement process?

DR. KEVIN BAGLEY: Yeah. So as we went through the process, I think we recognized, we recognized two things. There was very close scoring between the third and fourth place plans after the initial review, and so we felt like it would be prudent for us to do some additional oral interviews. We also felt like it would be important for us to have an opportunity to really ask some of those questions and hear from the plans themselves. I think, I think, Senator Murman, your comment was talk is cheap, and sometimes typing it out in a document is even cheaper. And so I think what we wanted to make sure we did is heard from those plans on how they really planned to do the things that they proffered in those responses to our request for proposal. So the oral interviews focused primarily on integration, innovation and improving access, particularly for our marginalized communities, whether those are rural folks who have to travel a long way, or our urban folks who struggle to get into clinicians even if they're relatively close-by.

M. CAVANAUGH: So the protest process does raise some serious concerns. You move-- you had the scoring. I'm assuming that the scoring, because there is a protest, changed who number three was?

DR. KEVIN BAGLEY: It did.

M. CAVANAUGH: OK.

DR. KEVIN BAGLEY: Following those, following those oral interviews, it did.

M. CAVANAUGH: And-- but in those oral interviews, did any of the information that is stated in the protest about things that Molina

failed, had a failure to disclose, did any of those come out in the oral interview? At what point did DHHS come to understand that there-- because if that wasn't part of their scoring originally, did we ever go back and rescore based on the information that we realized wasn't included?

DR. KEVIN BAGLEY: So there were no changes to score associated with anything. Let me phrase this better. That original set of scoring based on those documents did not change as a result of the oral interviews. Those scores for the interviews were in addition.

M. CAVANAUGH: Right. I guess what I'm asking is in the, in the protest, it says that there's information that was not disclosed. There's a few things that were not disclosed. And so we had a scoring. And I'm extrapolating from information here that Molina was the fourth, and it was, but it was close. And so you did an oral interview. But my question is that the things that are, are not, that were not disclosed, that were material--

DR. KEVIN BAGLEY: Would they have materially changed that score?

M. CAVANAUGH: Yes.

DR. KEVIN BAGLEY: So-

M. CAVANAUGH: The, the original score.

DR. KEVIN BAGLEY: So I'm not, I'm not in a position to say what the result of the protest is, because I'm not sure where it is in the process. But part of that process would be to identify should that have changed--

M. CAVANAUGH: OK.

DR. KEVIN BAGLEY: --any of the scores?

M. CAVANAUGH: And will --so will, in the protest process, will the information that was not disclosed be now asked for from DHHS to Molina? And will you take that and look at how it impacts the scores?

DR. KEVIN BAGLEY: Yes. So part of that protest review process is to take into account those items and see whether or not it would materially change any of the score and then whether or not that change in score, assuming it's appropriate, would materially change the outcome. And so that's part of that review process, because those are

done independent of me. I can't speak to exactly what the status is on that, but I do know once that is, once that review is completed, the notice of that completed review gets posted to our RFP website. And so that is publicly available once that is completed.

M. CAVANAUGH: And what is considered a material change to the score?

DR. KEVIN BAGLEY: I think procurement folks would be better to answer that than I, but I think it, it is really does the evidence provided suggest that we really did not score that item appropriately as part of our process for reviewing these? As we went through the RFP process, we had a third party, independent third party come and look at our criteria, look at the actual scores from our participants and identify whether they saw any variation that raised any red flags. As we went through that process, we didn't identify any of that. And so we believe this has been a very robust and clean process. That being said, I think we always want to take these protests seriously and ensure that we aren't missing something material. So, again, like I said, I don't know that I can speak to the specifics of the protest, but once that review is completed, that notice does get posted to the procurement website.

M. CAVANAUGH: I appreciate that. I just-- since we've had this happen before where we've selected to do an oral and that changed the outcome, I just want to make sure that we're being very transparent, so I appreciate you answering all of my questions. I'm going to sit on my hands.

DR. KEVIN BAGLEY: So I'll share one last thing for you as well. When we did that initial scoring prior to the oral interviews, the difference between third and fourth place was less than 0.1 percent of the overall score. And so for us, we just felt like that-- if it were an election, it would be an automatic recount. Right? And so for us, it was we need to really make sure we're doing our due diligence here. When we did those oral interviews, third and fourth place did switch. But that gap was pretty significant. And so for us, that was a reflection that the key issues of integrated service delivery, innovative practices and access to care were best addressed by that third place, who ultimately, which was Molina, ended up getting that third place, and we believe they were best addressed there.

M. CAVANAUGH: Thank you.

ARCH: Thank you. Are there any other questions? Seeing none, thank you for answering the questions directly and very much appreciate your time coming this morning to brief us. I'm sure that is-- as we go through the this next year, the committee is going to be very interested in hearing progress. And the issue of the unwinding and the redetermination of eligibility will be a large one. I'm sure that, I'm sure the committee will be asking for some input on that as well. But thank you.

DR. KEVIN BAGLEY: Thank you. Always happy to be here.

ARCH: Thank you. We will now proceed to LR407 and I'm going to change the process a little bit different, use my discretion. I'm going to, I'm going to sit here. The-- both of these next two are my, are my LRs and I'll just sit here and, and, and present them. Let me begin. For the record, my name is John Arch, J-o-h-n A-r-c-h. I represent the 14th Legislative District in Sarpy County, and I'm introducing LR407. LR407 is an interim study resolution I introduced to examine how Nebraska is utilizing Temporary Assistance for Needy Families, or TANF funds. As you know, TANF has an annual federal block grant to provide assistance to low-income families with children and comes with certain stipulations on what types of programs it funds. I've asked legislative fiscal analyst Liz Hruska to prepare a brief overview of Nebraska's TANF funds for this committee, which we have, which we-- prior to this hearing we've distributed to the committee. And she will discuss her report following my opening. I've also asked Director Stephanie Beasley to offer some insight of how those, of how these funds are being used and are planned to be used. As we know, unexpended TANF funds are able to carry over and the state now has a rainy day fund in excess of $110 million. While I recognize that these funds can be used at the discretion of the department and the Legislature does not have to approve expenditures of these funds, we have been hearing for a number of years, there is a plan for this money. I thought this resolution would give us an opportunity to learn more of those plans, a timeline for the expenditure of those excess funds, and give us the opportunity to provide input. I will stop there and let Liz come up and go over her report, which I found to be very helpful. Thank you, Liz, for writing it and your extensive knowledge of DHHS and its programs will be greatly missed by this committee and the Legislature as a whole when you retire at the end of the year. So you may proceed with your report on LR407.

LIZ HRUSKA: Thank you and good morning, Senator Arch, and members of the Health and Human Services Committee. My name is Liz Hruska, L-i-z

H-r-u-s-k-a. As always, it is a pleasure to appear before, before this committee. As Senator Arch mentioned, sadly, this will be my last legislative briefing. My replacement is here. Her name is Mikayla Findlay, M-i-k-a-y-l-a F-i-n-d-l-a-y, and she is in the audience here behind me. Today's topic is TANF. TANF is the Temporary Assistance for Needy Families. It is a federal block grant program to states for time-limited and work-conditioned income, income maintenance assistance and other supportive services for low-income families and children. Nebraska receives approximately $56.6 million a year from the block grant. In Nebraska, the block grant is used for traditional economic support programs, which include cash assistance, employment related services, childcare, child welfare and administrative costs. TANF may also be used for less traditional supports, such as home visitation and intensive care management, which are offered in Nebraska. In 1996, Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. The federal Aid to Families with Dependent Children program changed from a federal/state match program to a block grant. The change to the block grant gave states greater flexibility in designing programs and providing services, but also came with new requirements and a major focus on work and work incentives. All uses of TANF funds must meet one of four purposes: assisting needy families so the children can be cared for in their own homes, reducing the dependency of needy parents by promoting job preparation, work in marriage, preventing out-of-home wedlock pregnancies, and encouraging the formation and maintenance of two-parent families. Although the four purposes are broad in nature and allow states greater flexibility in designing programs and delivering services, there are also specific requirements that states must meet to continue to receive their full block grant. A state-- I will summarize the-- some of the major areas that a state could be penalized in: use of the funds in violation of the purposes, failure to meet the maintenance of effort, and failure, failure to satisfy minimum work participation rates. As I just mentioned, one of the requirements for states to receive their full allotments of the block grant is that their maintenance of effort must be met every year. This is re-- often referred to as the MOE. The amount is based on 80 percent of the amount, of the amount the state spent on cash assistance and work programs in 1995. It drops to 75 percent for any year in which the state meets its TANF work participation rate requirement. So Nebraska would be at the 75 percent level. In Nebraska, the MOE is approximately $28.4 million. If the state fails to meet the MOE, there would be a dollar reduction for every dollar below the maintenance of effort. Maintenance of effort expenditures

can be a combination of state support for direct assistance programs or tax credits benefiting low-income families. And Nebraska uses both of those. In federal fiscal year '19 and '20, General Fund expenditures on programs were 13 and $14.5 million. State expenditures alone do not meet the maintenance of effort. During those two fiscal years, the Earned Income Tax Credit and the Child Care Tax Credit made up the rest of the maintenance of effort. It also contributed towards the state's excess maintenance of effort. The excess MOE helps with meeting work requirements, which I will describe next. The state's work participation rates are 50 percent overall and 90 percent for two-parent families. States can reduce the targets through caseload reduction credits. Excess maintenance of effort spending serves as a caseload credit reduction. Nebraska has claimed child welfare funds, tribal TANF, respite care expenditures and the two tax credit programs for the excess MOE. Failure to meet the work participation requirements would result in a penalty. The first year it would be 5 percent, or $2.9 million, and an additional, and an additional 2 percent for approximately $1.2 million for each subsequent year of noncompliance. Nebraska is in compliance. The last-- where there were-- and we've always been in compliance. But in federal, federal fiscal year 2006, the state barely met the work participation requirement, and that is when the tax credit programs came in and, and have assisted in that. TANF funding is not allowed for all assistance programs serving low-income families. There are two categories of programs not allowed to be paid from TANF. One is a separate state program. Those count towards meeting the state's maintenance of effort, but the participants are not counted toward meeting the state's work requirement. Nebraska has two separate state programs. One exempts single parents or minor parents receiving ADC from work requirements if they meet the following criteria: pregnant women meeting-- beginning the first, first of the month before the month of the mother's due date, and parents or needy caretaker relatives of a child under the age of 12 weeks. The other separate state program allows parents to pursue postsecondary education in lieu of work. Under regular TANF, postsecondary education is not, not allowed. The other category is a solely state program, and those in the solely state program do not count towards the work requirements and the funding does not count towards this maintenance of effort. So these are 100 percent state programs and are totally separate from TANF. Two programs that the state has under solely state program are those where the adult or minor parent is incapacitated with a medically determinable, physical, mental or emotional impairment, and those who have significant barriers to participation in approved work

activities. Those barriers include: a parent who is needed to provide continuous care for a family member with a disability, victims of domestic violence, single parents who are unable to obtain childcare, and parents who are over the age of 65. Next, I will talk about allowable transfers. Federal law allows transfers of the TANF block grant into two other block grants: the childcare block grant and the social services block grant. The combined total of the transfers is capped at 30 percent. The childcare block grant could receive the full allocation of the 30 percent, which would be $17 million in the Title XX Social Services Block Grant can receive up to 10 percent, which is $6 million. But again, it's capped at the $17 million. Nebraska transfers the full 30 percent and it splits it between the two block grants. I will skip the programs funded by TANF since Director Beasley will be addressing that. As mentioned earlier, the state receives $56.6 million a year. It has consistently spent much less. In the last four years, the highest amount expended was $49.6 million, and the lowest was $41.1 million. States are allowed to carry over unspent funding for use in subsequent years. The carryover funding may be used for any allowable TANF purpose. The carryover bala-- balances are referred to as rainy day funds. The underspending in the annual block grant alot-- allotment has resu-- resulted in the rainy day fund balance increasing. The September 30, 2022, balance is $110.7 million. Nebraska has had a carryover balance since the start of the TANF Block Grant, as have all other states. This is because the block grant amount was determined by using the base year of 1994, when public assistance caseloads in Nebraska and across the country were at an all-time high. As welfare reform measures were implemented, caseloads declined significantly. Cash assistance covered approximately 15,000 families in 1994. As of August '22, 2,787 families were receiving cash assistance. The Department of Health and Human Services is projecting that, that the balance will decline. However, this has been a projection most years, but the balance continues to grow. And then a 20-- 2014 report by then Auditor Mike Foley, it was noted that the level of the reserve, which was $50 million at the time, it was noted that some level of reserve may be appropriate, but the then $50 million balance at that time was more than what was needed. It was suggested that the funding could be used to increase assistance to needy families, as that is the purpose of TANF. Today, that balance is more than double that amount. That concludes my presentation. I'd be happy to answer any questions.

ARCH: Remind me again of the, of the-- of when that-- since when has it doubled? What was the, what was the date?

LIZ HRUSKA: 2014.

ARCH: 2014. So from that time to now, it's doubled. OK. All right. Questions for Liz? Senator Cavanaugh.

M. CAVANAUGH: Thank you so much for another robust report. On page 7 of your report, you have the TANF block grant balances and estimated expenditures. Is this based on information from the department on what they plan to do? And is this--

LIZ HRUSKA: I didn't bring the report with me. The fiscal year should be at the top of that.

M. CAVANAUGH: I have an extra copy. Could you give this--

LIZ HRUSKA: I'm sorry.

M. CAVANAUGH: No, that's all right. So on page, it's on page 7. You don't have your own report memorized?

LIZ HRUSKA: I tried.

M. CAVANAUGH: So it says the TANF block grant balances and it's FY 2022 to 2028 expenditures. And I was just curious because it looks like it's spending down the rainy day funds. Is that accurate?

LIZ HRUSKA: That's on page 9. It's projected to go down.

M. CAVANAUGH: OK.

LIZ HRUSKA: It's the start--

M. CAVANAUGH: I'm looking at page 7, that chart.

LIZ HRUSKA: Oh. I'm looking at 9.

M. CAVANAUGH: OK.

LIZ HRUSKA: But that is the chart.

M. CAVANAUGH: OK.

LIZ HRUSKA: Yes, that's the department's projection, projection. And it is projected to start to decline.

M. CAVANAUGH: And is this based on information, new information that they have given you or is it based on? I'm sure they can answer this as well but I know you've been working on this in the past. Is this based on old information?

LIZ HRUSKA: I ask for this every year about this time of year because the federal fiscal year just ended September 30. And again, they project out. Generally, I have found with some of the ongoing programs, they tend to be conservative and project high. And in the past, they have projected starting new programs. And as I've done this report either formally or informally every year, some of the new programs they have projected to start were slow in starting. I didn't see expenditures, but now they do seem to be rolling out some, some new initiatives.

M. CAVANAUGH: OK. Since this is your last time in front of us and you are a fount of knowledge, is there anything you want to leave us with that we should keep in mind moving forward when it comes to TANF? And also, thank you so much for all of your work. For decades, literally, decades.

LIZ HRUSKA: It's been my pleasure and definitely a great opportunity just to serve all of you. Going back to the Auditor's report, when it was suggested that maybe the balance, which they did say it's appropriate to have a balance, but indicated they felt this one was probably on, on the high end. It was discussed in the audit that the agency can and has an issue-- initiated some programs. I didn't go through that since Director Beasley will be discussing it, but like home visitation, intensive case management, there's a new fatherhood initiative. But the benefits like for the cash assistance that is determined by the Legislature, the basic amount really has not been changed in decades. There's been some minor adjustments there. That's also one reason why the caseloads decline. In addition to the welfare reform initiatives which, across the country, every state saw big declines is the eligibility is so low that it doesn't take much income to, to be above that. So you'll just naturally feel a lot of people who, who will not meet the eligibility criteria. I guess-- those are thoughts I would leave you with.

M. CAVANAUGH: Thank you.

ARCH: Other questions? Seeing none, stop. I don't, I don't want to turn this emotional, but, but thank you. This is, this-- your service has been huge. I mean, to a committee chairman, we have committee

staff and we say so, you know, who, who can help us answer this question? And it's call Liz. That's, that's just been the answer. And so, appreciate it very much, all that you've done.

LIZ HRUSKA: Oh, I appreciate your support.

ARCH: Yep.

LIZ HRUSKA: Like I said, it's been a great opportunity to--

ARCH: We'll miss you.

LIZ HRUSKA: --to serve this institution.

ARCH: And enjoy, enjoy retirement.

LIZ HRUSKA: Thank you.

ARCH: Thank you. Next, we'll ask Director Beasley to please come and brief us. Good morning.

STEPHANIE BEASLEY: Right. Good morning, Chairperson Arch and members of the Health and Human Services Committee. My name is Stephanie Beasley, S-t-e-p-h-a-n-i-e B-e-a-s-l-e-y, and I'm the director of the Division of Children and Family Services in the Department of Health and Human Services here in Nebraska. I'm here to provide a briefing for LR407, which examines how Nebraska utilizes Temporary Assistance for Needy Families, also known as TANF funds. DHHS receives approximately $56 million annually as a TANF federal block grant. Section 404(e) of the Social Security Act allows states to carry over unspent TANF funds. As of October 1, 2022, Nebraska had a total TANF grant balance of $131,634,734. To receive federal funds and avoid a financial penalty, the state must also spend some of its dollars, known as maintenance of effort, or MOE, which obviously Liz explained very well. To meet the MOE requirement, Nebraska is required to spend state funds on TANF-eligible programs or services based on 75 percent of its 1994 contribution to the AFDC, Aid for Dependent Children, related programs. Nationally, states spend an average of 25 percent of their TANF funds on cash assistance programs. Currently, Nebraska spends approximately 29 percent of the annual TANF grant on the Aid to Dependent Children, also known as ADC, cash assistance program for families' basic needs and 16 percent on the Employment First program. Employment First is a mandatory work program for ADC recipients. It provides training, education and employment preparation. The remaining grant funds are spent on programs and services for impoverished

families and administrative costs for the TANF program. DHHS must follow TANF-- or federal TANF regulations when spending funds on programs to support families. Both federal TANF and state MOE funds must be spent on programs or services that meet one of the more-- one of the four purposes of TANF. The first is to provide assistance to needy families so children may be cared for in their own homes or in the homes of relatives; number two, end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage; number three, prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and number four, encouraging the formation and maintenance of two-parent families. In addition, when DHHS determines whether to fund a program with TANF, it must align with the department's mission: helping people live better lives. Programs that assist families in achieving economic mobility and self-sufficiency are a top priority. Preventative programs are also considered for funding to avert unnecessary entry into more acute systems. One example of a preventative program funded by TANF is the Healthy Marriage and Responsible Fatherhood Initiative. Funds were awarded on January 1, 2021, to Charles Drew Health Center in Omaha and Lutheran Family Services of Nebraska to provide fatherhood services to noncustodial fathers across the state. The TANF program offers fathers training in parenting skills, effective coparenting, employment readiness, child support education, and other need-based training. Studies show children with fathers who are engaged in their lives have more positive life experiences and develop healthy relationships. They are less likely to have-- pardon me-- to have emotional or physical problems, use drug or exhibit, exhibit, violent or antisocial behaviors. Children with engaged fathers also perform better academically, are more likely to graduate high school and maintain more successful employment. Additionally, in 2021, the Nebraska Crisis Pregnancy Program began to provide services to pregnant women, parents, and other relatives caring for children 12 months of age or younger. The program promotes childbirth, parenting, and provides support during pregnancy. On August 1, 2021, funds were awarded to Nebraska Children's Home Society and Nebraska Parent Care Network to develop a statewide network for prevention and support services. The program offers the following services: number one, information and counseling regarding pregnancy, fetal development, childbirth, childcare, parenting and adoption, mentoring services related to parenting, and life skills; number two, referral to other services available to support pregnant females, delivery, including neonatal healthcare services; number three, promotion of public

awareness of other resources that support childbirth; and number four, assistance for expectant parents and their unborn children in obtaining certain goods such as-- and services, including cribs, car seats, maternity, and baby clothing. In March of '22, the Division of Children and Family Services, also known as CFS, launched a TANF Workgroup. The Workgroup was created to assess low-income families needs and provide a transparent TANF funding process and evaluate the effectiveness of current TANF-funded programs. In addition, the Workgroup provides program funding recommendations to address the needs of families in Nebraska. Workgroup members are internal and external stakeholders with a broad range of experience, allowing the Workgroup to address families needs comprehensively. Internal stakeholders from DHHS include: the administrator of the CFS Economic Assistance Programs, our TANF Program Manager, our TANF Program Coordinator, our Community Prevention Administrator, our Social Services Block Grant Administrator, our Deputy of Finance, our Deputy of Analytics, a Division of Public Health Program Manager, and the Division of Behavioral Health Systems of Care Administrator. We have external, external members of the Workgroup that include: Nebraska Department of Labor, the Department of Education, Community Impact Network, Nebraska Children and Families Foundation, and seven Nebraska residents with lived experience. The Workgroup utilized a strategic decision-making process to determine whether or not to propose a new program considering the following: data indicating the need for the program, evidence-based practices that support the proposed program, clear identification of the program's alignment with at least one or more of the four purposes of TANF, alignment with DHHS's mission, long-term sustainability of the program, and alignment with Nebraska's Welfare Reform Act and other state laws governing economic assistance. At the initial meeting, Workgroup members received an orientation to the TANF program and TANF federally allowed expenditures. In the four subsequent sessions from April through June of '22, the members received presentations from subject matter experts on currently funded programs in TANF. And in July of 22, members received a presentation on the current TANF budget and projected expenditures. In August, members received a funding request from a current TANF-funded program and provided a recommendation to address the needs of families in Nebraska. At a meeting in September, the Workgroup received a consensus on priority areas for TANF funding for federal fiscal year '23. In reviewing the needs of Nebraskans and researching other state models, three priority areas have been identified: the first is family support coaching programs; the second is Emergen-- Emergency Housing Stability Program; and the third is kinship childcare assistance. With

input from the Workgroup, DHHS program administrators are developing a proposal for TANF expenditures to be reviewed by the DHHS leadership. The proposal will suggest how funds may be used to support additional TANF programs and services beginning in federal fiscal year '23. I appreciate this opportunity to share updates of the TANF program, and I'm happy to answer any questions you may have.

ARCH: Thank you, Director Beasley. I'm sure you, you know that this is kind of an ongoing discussion of this committee and, and, and other directors who have, who have sat in your chair. I, I think-- I mean, I'm finishing four years now, and I think the first, first year it, it was just, immediately, what are we doing with the rainy day fund for TANF? Liz Hruska presented us with a plan that showed the draw down of this. You're talking about the development of a plan to do that. So how, how did, how did she receive those numbers? There appears to be a plan of drawing down and yet you're in the development, in the development phase of that.

STEPHANIE BEASLEY: So the plan that was submitted really is about current programs and what we're currently doing in-- and projected expenditures from our current programs. What I asked the Workgroup to-- we challenged the Workgroup to really look at what do children and families need across Nebraska that would be eligible programs through TANF funding so that we have a really great sense of-- from partners with lived experience. We have partners, they are actual-- you know, I would, I would use the-- they participate in our services, to tell us what's working and what's not, and an opportunity for us to evaluate some of the programs that we currently have implemented, what needs to be expanded, what outcomes are we achieving, and then what is missing? And so, certainly, our intent with this Workgroup is to have this as an ongoing Workgroup that is continuously evaluating where we are, what are we seeing with our outcomes and hearing from our community partners who are on the ground working with kids and families to tell us what we're missing.

ARCH: Thank you. I, I seem to recall that one of the early ones four years ago, discussions, I think Senator Bolz was involved in, in the questions. It was, it was, it was a very similar plan that was presented to us. And I don't, I don't mean the plan of the, of the Workgroup, but I mean, it was-- and here's, here's what we're doing and here's what, what will draw down these funds, and yet that did not occur. As a matter of fact, the funds increased. And so what has changed since you have become director that would, that would indicate that this time the funds are actually going to be drawn down?

STEPHANIE BEASLEY: So I-- I'll, I'll say a couple of things. You know, during the pandemic, we have had quite a bit of federal dollars, COVID, ARPA dollars that have come that we've really focused on expending those funds. Now I think it is time to be very intentional and evaluate our utilization of our TANF programs. We have started a few in this last 18 months that are ramping up. We're seeing successes. I think we can continue to look at programs that other states are utilizing and missing pieces from our community partners where they're saying families and children can benefit. So I-- you know, I do think that, that certainly our other federal dollars have been the priority, including TANF. We have started new programs, but I think we really do have an opportunity to partner with our community coalitions and other stakeholders, including parents, to tell us how we spend it differently.

ARCH: The number that, the number that you presented in testimony, I believe, is $130 million as of October of 2022 in the, in the rainy day fund. And I think that, and I think that Liz's report showed $110 million, if I'm not mistaken. And so even, even now, it continues to go up. That, that's obviously why we're here. We're, we're, we're concerned. We want to, we want to see those dollars well used and within, obviously, the federal, the federal guidance of, of how we use those dollars. But, but we have some, we have some opportunity to improve services and create some innovative services and all of that. So we're, we're, we're very interested in hearing. Questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Director Beasley. I echo everything that Chairman Arch just said. Lots of concerns and questions, and this fund just keeps growing. There is an economic crisis happening right now in this state, in this country. And people are very much struggling to afford food and to afford transportation. And I see that we have the opportunity to do Aid to Dependent Children, and I know we've done that in the past. Is there a reason that the department is not choosing that as an option if we're sitting on $130 million, that we're not giving money directly to those most in need so that they can take care of the children that are most in need?

STEPHANIE BEASLEY: So there are-- Senator, there are two forms of cash assistance that are provided. The first is ADC cash payments. Those are those monthly payments for eligible households, which we have seen the numbers of households both applying and participating decline. And then the second is for emergency assistance. And we had some recent changes to our emergency assistance program, have increased the amount

of emergency assistance that our parents can receive, including the price of vehicles. We increased that. That hadn't had an increase. I got approval to do that. So there are two forms of cash assistance that are provided in Nebraska. So when you reference ADC, that's the form of cash assistance, that's the monthly stipend. It's an average of, I think it's like $440ish-- don't quote me-- but on a monthly stipend, that's [INAUDIBLE].

M. CAVANAUGH: But you have a discretion to increase the amount of that stipend. Is that correct?

STEPHANIE BEASLEY: I think that many of the criteria are actually set by statute.

M. CAVANAUGH: Of how much the stipend itself is? Or who is eligible? Who's eligible is most likely set in statute. But the amount of the stipend?

STEPHANIE BEASLEY: You know, I can get back with you on that, exactly what the statute defines, whether or not it's eligibility or payment.

M. CAVANAUGH: OK. So then for the emergency assistance, is that also set in statute as to eligibility and payment?

STEPHANIE BEASLEY: So I actually think that's-- I don't know the answer to that either. I know we just increased it from-- I think it's a regulation that that is in.

M. CAVANAUGH: So--

STEPHANIE BEASLEY: We just increased it significantly.

M. CAVANAUGH: And you said that those that are eligible has declined?

STEPHANIE BEASLEY: It has. Well, yes. Our participants have declined. I've, I've asked as we've been monitoring this and obviously very low unemployment rates--

M. CAVANAUGH: Right.

STEPHANIE BEASLEY: --would be something that I think is linked directly to our decline in recipients, particularly over the past couple of years. But in 2022, we are below 2021 rates on a monthly basis as well as far as eligible households, participating households.

M. CAVANAUGH: OK. So I'm concerned that we have all-- and I'm also concerned of the appearance that the state has $130 million for temporary assistance for needy families. And we aren't doing everything we can to get it out the door as fast as we can, especially considering what we all are dealing with right now. I mean, every single person in this room is experiencing the, the demands of-- our grocery store bills are going up so much. I know it's a joke about asking politicians the cost of a gallon of milk, and it is a lot right now. The cost of a gallon of milk is significant. And so-- and that is also a significant source of nutrition for children. And so what I appreciate-- we have a Workgroup. We're working through a strategy, a longer term strategy, but we are in a crisis. And what are we doing right now to address the crisis so that we aren't sitting on $130 million when we have families that can't afford rent, they can't afford gas to get to work, they can't afford food for their kids, and they're already getting government assistance, but that government assistance isn't increasing based on inflation? So what are, what are we doing right now?

STEPHANIE BEASLEY: So there are two things that-- first, we had pandemic ADC, about $4 million that went out last year. The second thing that-- there are two ways that we have most recently tackled, and the first is emergency assistance. So if someone is having difficulty making rent or they are-- received an eviction notice, let's just go through received an eviction notice, our old standard was and continues to be that has to ameliorate the problem. So if I'm coming to you as a candidate and I say it's going to take me $1,000 to eliminate this issue otherwise I'm going to be evicted, our old standard was very low of what we could pay. And so therefore, since it wasn't going to alleviate the entire problem, we weren't, we weren't allowed to comply with that. Increasing the amount of emergency assistance that is, that we're able to provide, I think, goes a long way to support parents who are in crisis to keep them in their own home. The other way is, is that we increased our vehicle allotment, did a lot of research. And what we were seeing was that, you know, while vehicles can be purchased, the amount of vehicles have obviously increased during the pandemic. And so we did research on vehicles that were available, the types of vehicles, because we certainly want to make sure that families have that resource, so that was recently increased as well.

M. CAVANAUGH: So-- but we still have $130 million. So that didn't really answer my question as to how are we getting that money into the hands of the people that need it the most?

STEPHANIE BEASLEY: So our team is following the design on the eligibility criteria and what we can pay. Certainly, we're at 29 percent cash assistance. We're above other states. And what you're speaking to, I think, is the cash assistance piece. One of the things that I do think, you know, as you look at our programs that have been ramping up and-- JAG, etcetera, and you'll see it does take providers a little bit of time to ramp up. But we are seeing successes in the programs that have started and successes in the programs that are ongoing. But I think that those are two separate issues that families are faced with. One is what are the right supports and services that we can put into the community and into homes and make available for parents and families versus what are those concrete economic supports that are driven by what we are allowed to pay. And I, I do think that, that the piece of the unemployment rate being so low is a huge factor in seeing the decline in the number of families that are actually receiving this payment.

M. CAVANAUGH: So-- I have more questions but I'll--

ARCH: Other questions? I do not so.

M. CAVANAUGH: OK.

ARCH: OK.

M. CAVANAUGH: OK.

ARCH: You, you may continue.

M. CAVANAUGH: OK. Thank you. OK. So I'm looking at page 3 of your testimony, and at the bottom you have the three identified priority areas of the Workgroup. And all of those are, you know, excellent priorities to have. But I, I'm going to keep coming back to this because we are in a crisis and none of those are addressing the fact that we are in a financial crisis and that people are struggling and we have $130 million. And I'm, I'm not going to-- I'm going to push for an answer on this as to what, what are we doing? I appreciate that there's this longer term planning, but every single time the department comes and talks to us about TANF, this fund has increased and every single time we are told that there is a plan. And I think that we are at this point now where the plan is not happening, it's not happening fast enough. And we have people who are hurting in our communities across this entire state, and we're sitting on $130 million. And that does not sit OK with me, and I don't think that's OK

with any of us. So what are we doing to fix that now, not when the Legislature comes back in session, but now?

STEPHANIE BEASLEY: So these programs would take time to roll out. What you'll see in any of our designs, we rolled out fatherhood, we rolled out crisis pregnancy, JAG has-- everything takes time to ramp up.

M. CAVANAUGH: But we have-- this program is designed for emergency assistance. TANF is designed to ensure that people who are most in need have access to assistance immediately. And we have the programs that do that. But then we have this extra fund of money that isn't doing its job because it's just sitting there waiting for something to roll out when we could be putting it into something actionable right now. So why can't we put it into something actionable right now? What is stopping us from doing that?

STEPHANIE BEASLEY: So if we are talking about cash assistance--

M. CAVANAUGH: I'm talking about any assistance, any of those-- these programs that are listed here in Liz Hruska's report, the programs supported by TANF, why aren't we infusing all of these with cash from the rainy day fund and just getting money into the hands of the people?

STEPHANIE BEASLEY: So can you tell me which programs on Liz's report that you're referencing?

M. CAVANAUGH: I mean, there's childcare assistance, there's, there's the aid to children and dependent families, there's child welfare funds for an array of safety and in-home services. Employment-- well, Employment First is already-- home visitations, increasing the home visitations funding, family-focused case management. I don't even know what the SSBG Transfer and St. Monica's Women are Sacred, but it sounds like they sell-- they provide services to expectant mothers.

STEPHANIE BEASLEY: They are funded by this.

M. CAVANAUGH: And community response?

STEPHANIE BEASLEY: Yeah, so if you'll-- so part of our expenditures are those very things that you're, you're mentioning. So St. Monica's, The Bridge are all programs that are also TANF funded. These are opportunities for moms to remain living with their child while they're receiving treatment. TANF funds can't go for the treatment, but they can, they can go for some of the other expenses to keep them housed.

That-- this, the TANF dollars actually are going into prevention services. And when you think of Alternative Response or other services, a service arrays that are being provided to kids and families to keep them out of the deeper end of the system, there are funds that are actually expended in that. Certainly, you know, your point is, is well made about the amount of money and the, the what I'm going to call the carryover. It is-- it has grown. Our focus the last two years were other childcare assistance dollars. We did push the pandemic TANF dollars out the door to the tune of about $4 million into the hands of families. So it was a opportunity to really support those families we are seeing. There are a list of programs that we are using the TANF dollars for, and some of what you mentioned are just, just those dollars that are being submitted. The childcare dollars, our numbers in childcare have actually decreased. While we have about 13,000 eligible, we're seeing about 83 percent-- or 18,000 eligible, we're seeing about 80-83 percent of those participants. We haven't needed to move the same level of TANF, TANF dollars into the childcare to cover because of some of the pandemic dollars that we've received. So we haven't, we haven't needed to make that transfer.

M. CAVANAUGH: And why are we seeing a decrease in childcare utilization?

STEPHANIE BEASLEY: Again, that is one of those questions where I, I'm not really sure what's happened. I don't-- I only know that they're eligible. They aren't submitting why they aren't utilizing that childcare. So are they staying home? Are they, you know, or have they made a decision not to use youth subsidy at this point? I'm not really sure.

M. CAVANAUGH: Do they not have access to a childcare that will take them? Because not all childcares will take spots. They only have-- allot so many spots for subsidy children.

STEPHANIE BEASLEY: That has not been raised as an issue. We do have childcare deserts throughout the state and we know that, where we don't have enough quality childcare providers to meet the needs. But I have not heard that there is a denial of slots for someone who is wanting to utilize their subsidy. That has not been listed as a concern to me.

M. CAVANAUGH: So is this something that we, as the Legislature, in January, need to immediately address, that we need to raise the income eligibility for these programs so that you can utilize these funds

more fully? It sounds like you're, you, you're-- from what you're telling me, you're utilizing them to your capacity and we need to increase your capacity.

STEPHANIE BEASLEY: If you're referencing that the, the monthly--

M. CAVANAUGH: Who, who is eligible?

STEPHANIE BEASLEY: --who is eligible, that would be at the discretion of the Legislature.

M. CAVANAUGH: So--

STEPHANIE BEASLEY: If that was going to be increased that's-- it would require--

M. CAVANAUGH: So in order for you to expend the $130 million, you need to have more people who are eligible to receive the assistance?

STEPHANIE BEASLEY: I don't know if that's all we need. [INAUDIBLE]

M. CAVANAUGH: But it's one thing you need.

STEPHANIE BEASLEY: I think right now we're seeing a decrease. I think that the unemployment rate, again, is a huge factor for us right now in why we've seen, even from 2021, a significant decrease in, in who is working with this. We also, we track reasons that people withdraw their application or, or the reason that they're denied. About 10 percent withdraw their application pretty much immediately upon talking to our team. We have Employment First requirements and so those are explained to our participants when they apply. And so it's, it's hard to say. I don't know exactly why they withdraw their application, whether or not they would be eligible or not, they're just withdrawing. So I, I think shifts-- we will continue to analyze any shift that's made and work to ensure that we're certainly applying our standards and making the changes as directed by statute.

M. CAVANAUGH: OK. So you said that unemployment rate is low, which it is. So has the number of people who are eligible for these programs decreased over the years?

STEPHANIE BEASLEY: I would have to get that information to you.

M. CAVANAUGH: Because I'm, I'm trying to understand.

STEPHANIE BEASLEY: I believe so, but I can get the specific percentage for you.

M. CAVANAUGH: OK. Because I mean, to Chairman Arch's point, we were at, Ms. Hruska's testimony, $110 million, and your testimony has us up to $130 million. That's not an insignificant jump. And so if we have fewer people who are eligible than were previously eligible because of unemployment, that's an important benchmark to know. But also, if we don't have enough people eligible because our eligibility requirements are so stringent, that's another important thing for us to know that-- you, you can't change eligibility requirements. We have to do that. So I want to make sure that we know what tools we need to have at the ready for you come January, and also that you are utilizing all of the tools that are currently available to you.

STEPHANIE BEASLEY: Our top three reasons for ADC denials, the first is that they withdraw their application.

M. CAVANAUGH: OK.

STEPHANIE BEASLEY: I-- you know, that's, that's client discretion, certainly. The second is that their income is too high to be eligible for the program. And then the third most common reason why we deny is their sanction for a lack of compliance with the Employment First requirement.

ARCH: I think, I think you sense the, the tenor of the, of the committee. We're just-- we just see an opportunity here of $130 million. It's not all ADC. It, it's, it's employment. It is helping people get back on their feet. There's supporting of pregnant women, there's a number of things that can be done. We just see it as an opportunity and, and, and, and want to make sure that the department sees it the same way and, and will apply themselves to the expenditure of these dollars appropriately, because it-- there's much that can be done in our state. And, and I think that that's, that's probable-- certainly the consensus of the committee that-- and this, like I say, this has been an ongoing issue with the growing rainy day fund. We just don't want to, we don't want to miss the opportunity. There are people that could benefit from this.

STEPHANIE BEASLEY: And Senator, I agree wholly. And I think one of the opportunities-- and I can't speak to directors prior to me. I'm certain that you guys have worked closely with them. You know, as-- it's part of the reason for this Workgroup is I also think that CFS is

not the most, that we are not the best suited to determine what the needs of kids and families are in the communities, which is why we've reached out to you, having external partners give us some direction, including parents who are receiving services. You know, we are looking at data. We're looking at what other states have done because our goal is to-- that very first pillar of TANF is to keep kids and families together in their own homes or in the homes of relatives. And I think that is a very powerful utilization of TANF and one that our community partners can best help us direct. How do we do that? What does that look like? Because I think there are programs that are working in other states. I don't know that those are the right programs for Nebraska, but that's really the goal that I'm hoping having this external participation will not be CFS directing how these dollars should be directed and what programs and services are needed, but what is-- what are communities across Nebraska telling us? What, what do these dollars need to be expended on?

ARCH: Other questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. And yes, to Senator Arch's point, this is an ongoing frustration and I very much appreciate you answering all of my questions. I know that this is a historical problem, not a new problem that just started, so my frustration is coming through a little bit. I apologize. I did want to ask some questions about the Workgroup. You gave us a list of those that are the sort of identifiers, but it's not a list of who the actual people are. Is that a possibility to have? Is there--

STEPHANIE BEASLEY: Oh, absolutely.

M. CAVANAUGH: OK.

STEPHANIE BEASLEY: I will-- I'll seek permission from our--

M. CAVANAUGH: Yeah.

STEPHANIE BEASLEY: --our families.

M. CAVANAUGH: Yes. And, and--

STEPHANIE BEASLEY: But everyone else, yes.

M. CAVANAUGH: And then the seven Nebraskans with lived experiences, does that-- is that people who have had the cash assistance or the childcare subsidies or are any of them currently partaking in the

programs, or are they all people who have previously partaken in the programs?

STEPHANIE BEASLEY: I think it's a mixture. I can also tell you that it is yes, they will have participated in a program or they will have received the assistance. Right. So it's, it's either/or, either they have been a recipient of one of our programs or received the assistance.

M. CAVANAUGH: And then how often do they meet?

STEPHANIE BEASLEY: So they've been meeting monthly. There are external partners and so it's kind of a big ask for them to come and evaluate all of this. And so at this point, it's set for every 3 to 4 weeks.

M. CAVANAUGH: And the full recommendations for moving forward-- I'm sorry if I missed that in your testimony. When do we expect to have their recommendation?

STEPHANIE BEASLEY: So they've made initial priority areas where they felt like those were the highest. Those were the top three. There were other areas that they looked it up. One of the things they're continuing to work on that report, and the next thing they're also going to be looking at is our current programs. What are the outcomes we're seeing in our current programs? So I, I think we can have a report finalized in probably the next couple of months of their initial-- it's not the end report, though. So my, my hope for them and my goal is to continue to have this ongoing process of collaboration with partners that can tell us what's working and what's not. And certainly, when you start looking at-- one of the things that-- it takes programs time to ramp up. And so, as they list out a list of programs that could aid families in Nebraska, the next step would then to be identify which ones do you prioritize? We have a select group of providers who are working with kids and families, and so their ability to ramp up programs, we'd have to work directly with them to see what is your ability to ramp up programs, what could you do most quickly and what would we prioritize?

M. CAVANAUGH: So are they, again going back to eligibility, are they going-- are they looking at what our eligibility requirements currently are and if they need to change?

STEPHANIE BEASLEY: They are not.

M. CAVANAUGH: OK.

STEPHANIE BEASLEY: They're really looking at services and programs and impact. What do families, if they're identifying concrete economic supports like dollars we would certainly put that in there. But we really have them looking at programs and what are-- like healthy families, visiting, home visiting programs, and so they are looking at those types of programs, not, not the calculations of income limits and, and payments.

M. CAVANAUGH: So is there any entity within the agency looking at the eligibility and if or how it needs to be adjusted? Are there going to be any recommendations or requests made to the Legislature, or is it being left up to us to determine that entirely?

STEPHANIE BEASLEY: We have not been tackling that at this time.

M. CAVANAUGH: OK. I think that's it.

ARCH: OK. Thank you. I do want to recognize in the report that Liz provided, there's, there's a number of new programs that I see in '20 and '21 that are, that are, are started and are, are ramping up. We don't-- we're not keeping up with, with the additional dollars, but, but I certainly want to recognize that, that those new programs are there and we encourage that, that kind of thinking, so. Thank you very much for your testimony today.

STEPHANIE BEASLEY: Thank you.

ARCH: I want to be sure and leave time for the public to comment on this as well. And I know there's people here that want to, that want to comment on this so you can come on forward and, and we'll, we'll be using the light system now. So we'll ask that you limit your testimony to 5 minutes. And I think you're, most of you are familiar with the light system. So green means go, red means stop. Welcome.

JENNIFER MONROE: Thank you.

ARCH: You may proceed.

JENNIFER MONROE: Good morning. My name is Jennifer Monroe. I was in foster care in Alliance, Nebraska, from age 14 until I aged out of the system. And I have previously utilized the TANF and ADC programs when I was a young single mother living in Chadron. When my son was six years old, I realized that if I was going to be able to provide for him and become a contributing member of society, I would need to advance myself in the workforce by getting a college degree. I

enrolled at Chadron State College and applied for ADC to help me avoid the financial strain that college would put on my two-person family. I graduated my bachelor's degree in May of 2014 and I have been financially independent since that time. I am what many would call a success story when considering the national statistic that only 3 to 4 percent of former foster youth will graduate with a bachelor's degree and only 8 percent of single mothers who start college classes will earn a degree within 6 years. I was able to earn my bachelor's degree within five years from enrollment to graduation. I'm here to tell you that the TANF and ADC programs are not only essential, but they are invaluable to creating opportunity for families to thrive in Nebraska's communities. I'm here to also, I'm also here to see-- so that you can see the face and hear the words of someone who truly needed the support of this program but also so that you can hear directly from a former participant of ADC to learn how much better our state could serve future parents and families in Nebraska if the excess funds were utilized to improve the current policies and funding allocations. In order to explain some of the difficulties that families face, I want to share a few personal stories from my experiences. Hopefully in doing so, you'll be able to see how reinvesting excess funding into these programs could create positive, positive outcomes for Nebraska. First, regarding child support, my former husband had been ordered to pay a mere $50 per month in child support. So when I was informed that my child support would be garnished from me in exchange for what was, at that time, $293 of cash assistance grant, I was grateful for the larger amount and more consistent and more consistency. But today, it is my opinion that single parents who are so far below the poverty line that they qualify for this program should not be having their child support garnished at all. Second, during my first semester in college, my biological mother was diagnosed with lung cancer. I had to take a semester off so that I could care for her during chemo and radiation. I went back to classes the next fall when we were told that the cancer was gone. Excuse me. But just a few weeks into my second semester, the cancer came back and she was put on hospice. The overwhelming experience of watching my mother die while attempting to meet all of the many requirements that ADC and Employment First has, keeping up with classes, volunteering my time to meet the remainder of the required hours of Employment First, and praying not to be sanctioned in the process was beyond anything any human should have to endure. Participants of ADC live under constant fear of having their funds sanctioned. Of course, all programs need guidelines to ensure active participation, but many of the requirements need flexibility in real-life situations that arise

for real-life families. A third story. As you may know, ADC participants taking college classes must collect signatures every single week from their professors as proof that they attended class. This is a daunting and humiliating experience, but in order to receive the monthly grant, participants must do this demoralizing step every single week. I was once mocked by a college professor who was upset with me that I was on a program that was using his tax dollars. Hearing those words from someone whose signature every week is essential to my success made me want to quit his class, quit the program, and quit college altogether. Policies like this one are deterrents for active participation across the state. Removing this one requirement would increase participation and thereby increase the impact this funding can have on families and communities. Again, I am speaking today so that you can see a true real-life experience and so that you can gain a greater understanding of the complex circumstances that families face while trying to adhere to the hurdles that must be mastered in order to continue qualifying, complete the program successfully, and gain their own financial independence. Clearly, I did it. I beat the odds without ever being sanctioned. I graduated with my bachelor's degree while barely ever having more than two pennies to rub together, and I left college with $23,000 in debt. But I do not represent a typical experience for families who attempt to use these programs. I want you to hear how hard it is for families to succeed and impress upon you the need to better fund this program and correct some of these hurdles so that more Nebraskans have the opportunity to become a success story. I have listed several ideas in your copies of my letter about how these programs could be more successful, not for the state but for the families you seek to impact. There is a common belief that people use state programs without the intention of improving themselves. But the reality is the programs are too complicated for most families to use. Today, I want you to consider my testimony and try to see that-- the funding differently. I want you to see that the increased benefits-- sorry, the increased benefits and reducing oversurveillance of participants will inc-- will create genuine escape routes for those living in poverty who are trying to make a better future for their children. If we truly want families to thrive in Nebraska, we must make it possible for all of them, not just a rare few. I want to thank everyone involved today for their dedication to Nebraska's families, and I welcome any questions you may have.

ARCH: Thank you for your testimony. I see as well that you've, you've included recommendations for us here. And I, I just tell you that I

really appreciate that thoughtfulness and the thought you've put into this that, that you would have recommendations on how to improve it. And so we will, we'll read those carefully. Are, are there questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you so much for your testimony and for sharing your story. And I'm in awe of your ability to do all of that. And what is your degree in?

JENNIFER MONROE: Marketing.

M. CAVANAUGH: Oh, fantastic. So would it be OK if we shared these recommendations with the department as well?

JENNIFER MONROE: Yes, absolutely.

M. CAVANAUGH: OK.

JENNIFER MONROE: And--

M. CAVANAUGH: Yeah, go ahead.

JENNIFER MONROE: I could-- while I was listening to Ms. Beasley's-- I have a couple of things I'd love to say if that's OK-- that I added. I think-- because I personally know families and while I was in the program for several years, I witnessed families intentionally apply for ADC in November, plan their Christmases with the available money, and then refuse the program afterward-- waive their grant because they really only did it so that they could afford Christmas but the requirements were too difficult to keep up with, especially with multiple children. So in talking about ways to utilize the money, an idea that I had that is not on my list is maybe an annual stipend near the holidays for those who already qualify for the program so that they can do Christmas for their children.

M. CAVANAUGH: Oh, thank you. That's a very thoughtful--

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

JENNIFER MONROE: Thank you.

ARCH: Next testifier for LR407.

DIANE AMDOR: More paper. Sorry.

ARCH: Morning.

DIANE AMDOR: Good morning. Chairperson Arch and members of the Health and Human Services Committee, my name is Diane Amdor, D-i-a-n-e A-m-d-o-r, and I'm a staff attorney for the Economic Justice Program at Nebraska Appleseed. We have long been supporters of improvements to Nebraska's administration of the TANF program, in particular the cash assistance provided to low-income families with children to help meet their basic needs known as Aid to Dependent Children or ADC. We want to thank Senator Arch and the members of this committee for introducing this interim study and holding this hearing today. The purpose of LR407 is to examine how Nebraska is using TANF rainy day-- TANF funds. The focus of our testimony is the fact that there is over $100 million and maybe, apparently, even over $130 million in our TANF rainy day fund or the TANF Cash Reserve that we're not using but should be. We're here to make three points: first, the TANF cash reserve should be used to help families make ends meet during times of economic hardship. For years, the department has claimed to have a plan for spending down the reserve, but in reality it continues to grow every year. And I respectfully just want to say we have a healthy amount of skepticism for even the plan that was discussed today. Second, Nebraskans across the state are struggling to make ends meet right now due to record of record inflation, increases in the cost of living. And there's an acute need for these rainy day funds to be deployed now. Third, the Legislature can and should allocate a significant portion of the rainy day fund by increasing the amount of ADC benefits that families receive and look into an array of other options to strengthen our TANF program. First, to that first point, and this has been covered so I don't want to belabor the point, but it's important. Year in and year out, advocates have come before this committee in support of proposals to spend down the rainy day fund. Every year, the department says that they have a plan for the funds. A portion of the funds are already obligated and the Legislature shouldn't get involved. Next year, turns out those funds that were supposedly obligated have actually not been spent, the cycle continues and the reserve fund grows. I have provided some specific bill examples in my written testimony. This most recent proposal for spending down the rainy day fund-- the one that we saw was provided earlier in this year by the Fiscal Office, and it included less than $1,000,000 each fiscal year of an increase for ADC funds. Well, we-- I acknowledge, as Director Beasley said, Nebraska does provide more of our TANF funds to ADC than other states do, it's still a very small amount and they apparently don't anticipate that increasing over the

next few years. They're including increases in other programs, including several new programs. People need direct assistance so they can afford basic necessities. It doesn't take more time to roll out an increase in the eligibility limit. It doesn't take more time to increase the amount that people receive every month like these new programs do. That's, that's how you get the money out the door faster to help people now. And just reducing that overall percentage of TANF funds that we're spending on ADC is the wrong direction. Moreover, we know that oftentimes this-- there's a hesitancy to provide low-income families with direct cash assistance, and that's rooted in harmful and false stereotypes of low-income families. Recent research has documented the ways in which TANF policies, specifically, policy choices have been influenced by anti-black racism and sexism and they have particularly harmed black families and other families of color. Which I'm now noticing, the copy of my testimony that I provided does not include my citations. After the hearing, I will email that to you so you have those references. I had a printing error. I apologize. So there's been years of this back and forth, right, between the Legislature and the department. The fund has not been spent down. It has ballooned to its current balance, and enough is enough. It's beyond time for the Legislature to intervene and ensure that we are using these funds and using them as they were intended to impro-- to provide temporary assistance to Nebraska families who need it. Additionally, at a time when the need for assistance is surging, the ADC caseloads are plummeting, and that needs to change. You can see in the chart that I provided that over time, ADC caseloads are dropping but the number of families with children in poverty and even children in steep poverty in Nebraska is not dropping. These caseload numbers represent real family, real people like the previous testifier. And I'm encouraged to hear the department has included people with lived experience on the TANF Workgroup because it really is important to focus on the children and families who these caseload numbers and these dollar signs represent. We have to be listening to families who were or currently are recipients of ADC, and I've provided a few specific stories in my written testimony as well. Finally, the Legislature can and should take action. Low-income families in Nebraska have needed assistance for years, and that need has only become more urgent today. Low-income families are the experts when it comes to knowing how to move their families forward. We just need to provide them with the temporary assistance they require. I see that red light is on, so I'm going to stop talking.

ARCH: Thank you. I, I have a question. I know that, I know that TANF has four purposes, according to the testimony that we've received, one of those being ADC. The others, the others are, you know, promoting job preparation and encouraging two-parent families and, and, and reducing incidence of pregnancies of out-of-wedlock and so-- federally, federally identified priorities. Has Nebraska Appleseed considered any, any particular recommendations on those other three besides, besides the ADC?

DIANE AMDOR: In my mind, the-- those four broad purposes like-- ADC isn't the only thing covered by that first one of aid to needy families. It is, in our opinion, the one that meets that need the best. Programs are great. People do need supports in addition to cash. But if you have all the supports available but you don't have the cash to meet-- make your ends-- make your daily, meet your daily needs, then those supportive programs are great, but it's not enough at the end of the day. So that's, I guess, why we focus in particular on this one piece of the TANF-funded programs.

ARCH: OK. All right. Thank you. Other questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for your report. I was going to comment about the citations, so I'm really relieved. I'm just kidding. So between your testimony and our last testifier, it seems like there's-- maybe you could provide clarification from your view as a staff attorney on how-- what, what do you see as the disconnect between what the department is proposing and what I think we all collectively would like to see happen? Not asking this very well, but I think you maybe get what I'm saying.

DIANE AMDOR: I think I guess maybe. Why, why am I still skeptical of this plan?

M. CAVANAUGH: Yes. Yes.

DIANE AMDOR: Because when you look at-- I guess, I took that plan that we looked at in early January which I'm guessing is pretty similar to what's been provided today. And I'm a visual person, so I put it in like a pie chart. If you look at the pie chart of what-- how much of each expected expenditure is going to which program, the big, big chunks of that are Aid to Dependent Children, Employment First, and childcare subsidies. The department seems to be planning on spending a lot more in the next few years on childcare subsidies than they are currently, which doesn't make sense to me because, as Director Beasley

mentioned, there are still a large amount of federal dollars that have been assisting that program, needing less in TANF funding. Also, the number of people accessing that program has been lower in recent years than it has in the past. So, number one, I don't think we're going to spend it down because they seem to be planning on spending most of it on childcare subsidies and I, I don't know how that's going to happen. But second, the new programs and things that they're mentioning, it's $1,000,000 here. It's $2 million here. I think the program recommendations are slated for maybe 4 or $5 million a couple of years down the line. That's, that's not enough to chip away at five-- or at $130 million. The thing that needs to be done to really spend that down is, one, an increase in the benefit level that would help families meet their needs, an increase in the eligibility limit, and also just removing those hurdles and roadblocks that make people hop off the program even though they really, really need it, because it's just like nearly impossible to follow along with all of the thing, the regulations that are involved. Does that answer your question?

M. CAVANAUGH: I think so. Thank you.

ARCH: Thank you. Seeing no other questions, appreciate your testimony.

DIANE AMDOR: Thank you.

ARCH: The next testifier for LR407. Morning.

ERIN FEICHTINGER: Good morning. Chairman Arch, members of the Health and Human Services Committee, my name is Erin Feichtinger, E-r-i-n F-e-i-c-h-t-i-n-g-e-r, and I am the policy director for the Women's Fund of Omaha. Thank you to Senator Arch for introducing LR407 and giving us this opportunity today. We would urge this committee and Nebraska DHHS to utilize the excess funds in our rainy day reserve to increase the amount of direct cash assistance going to eligible families through ADC. Doing so will increase the economic security, long-term financial stability, and improve the lives of Nebraska women and children. The TANF program allows for states to save unspent funds and place them in a rainy day reserve to help when needs become more acute, such as during an economic crisis or a recession, both of which Nebraska families experienced over the last several years as a result of COVID-19. Women were disproportionately impacted by both the economic downturn and subsequent rising inflation and cost of living. Nationally, there are now 817,000 fewer women in the labor force than in February 2020. In Nebraska, more women filed for unemployment than men during COVID-19. For comparison, in 2019, women made up about 40

percent of the unemployment insurance claims, and in 2020 accounted for more than 50 percent. Utilizing our excess rainy day funds to increase direct cash assistance is critical to Nebraska women and children. Cash assistance to low-income families with children is a sound investment in our future. The National Academies of Science, Engineering and Medicine's 2019 Report on reducing child poverty concluded that income support for families experiencing poverty can improve children's health and academic achievement, which in turn leads to better health and higher earnings in adulthood. 34.8 percent of Nebraska children living in single mother households were living in poverty; 22,531 Nebraska children are living in the kind of poverty that would qualify their families for TANF, but only 20 Nebraska families of every 100 who would otherwise qualify are receiving those benefits. Additionally, our work in Freedom from Violence programs and interventions across the state supports the need for increased direct cash assistance to Nebraskans. There is a reciprocal relationship between domestic violence and poverty. Financial hardship and stress may increase the risk of domestic violence, and violence can also lead to financial issues for survivors, trapping them in poverty and abusive relationships. The financial consequences of abuse are particularly acute for survivors with low incomes, as leaving an abusive relationship may result in losing access not only to a partner's income, but also to housing, employment, healthcare and childcare. A 2018 National Resource Center on Domestic Violence Study found that 67 percent of survivors returned to an abusive relationship or stayed longer than they wanted due to financial concerns. This effect was especially pronounced for survivors with children. A larger study found that nearly all survivors reported that public benefits, including TANF, helped them meet their basic needs. Eighty-five percent of victim advocates say access to TANF is critical for survivors to meet their basic needs. A study in conjunction with the University of Nebraska at Omaha and Creighton University found that approximately a third of the people evicted in Omaha had previous court experiences with domestic violence victimization, which is, I think, a testament to the need for increased assistance to meet those basic costs of living in our current economic moment. Increasing the direct cash assistance available under TANF now will help Nebraskans recover from the rainy day that we've all experienced over the last several years. Increased cash assistance will ensure that families, those who are experiencing the greatest need in our state, as well as those who are looking for safety, can meet their basic needs. And I appreciate your time and I'm happy to answer any questions you may have.

ARCH: Thank you for your testimony. Are there any questions? Seeing none, thank you very much. Next testifier for LR407. I see no one wishing to testify further. I would mention that we've had two letters submitted: one from First Five Nebraska and one for-- and one from Voices for Children as well. And with that, we will close LR407 and we will open LR409. And I will open that, I will open that hearing. For the record again, my name is John Arch, J-o-h-n A-r-c-h. I represent the 14th Legislative District in Sarpy County, and I'm here this morning to introduce LR409. LR409 is an interim study to examine the Department of Health and Human Services capacity and resources to treat individuals who have been committed to the department for treatment to restore competency to stand trial. I know this is an issue that usually is before the Judiciary Committee, but since the Regional Center falls under the jurisdiction of this committee and mental health is an issue that impacts all aspects of this state's well-being, I thought it would be beneficial for this committee to-- to be up to speed on this issue. We should know that, that what is being done to address the lack of capacity the state has to provide treatment to restore somebody's competency. If you will recall, last session of the Legislature debated and passed LB921, which did come out of the Judiciary Committee and dealt with this very issue. State law requires that when somebody is charged with a crime and has been deemed incompetent to stand trial, that person must be admitted to the Regional Center in order for competency to be restored. However, the Regional Center has not had the capacity. These individuals are languishing in county jails across the state. County jails are not equipped to handle individuals with severe mental illness. During the floor discussion, Senator Lathrop said these individuals spend an average of 128 days in county jails. In addition to requiring DHHS to reimburse county jails $100 per day for housing individuals that are technically committed to the department, LB921 also established capacity criteria for the Regional Center, with the goal of ensuring some beds are reserved for those individuals found comp-- incompetent to stand trial. LB921 also created the Legislative Mental Health Care Capacity Strategic Planning Committee to look more in-depth at the state's inpatient mental health needs as a whole, but this interim study focused just on those individuals needing treatment to restore competency. As noted on the hearing schedule, this is invited testimony only. Following me will be Kate Goodwood [SIC], deputy county attorney for Sarpy County, and following Ms. Gatewood will be Larry Kahl from the Department of Health and Human Services. So I would ask Ms. Gatewood if you would come and provide testimony. And the testimony that I've asked provided in-- from Sarpy County is

what's our current situation and what's been the experience of Sarpy County in, in attempting to place people for competency and treatment. Thank you for coming today.

KATHARINE GATEWOOD: Thank you, Senator Arch, for inviting me to speak today. My name is Katharine Gatewood, K-a-t-h-a-r-i-n-e, last name G-a-t-e-w-o-o-d. I am a deputy county attorney in the civil division of the Sarpy County Attorney's Office. I work on a variety of mental health initiatives in Sarpy County, and I routinely work with the various county systems that deal with mental illness and its related issues. I also advise the Sarpy County Department of Corrections. I'm here today to testify on behalf of Sarpy County and the Nebraska County Attorneys Association about the impact of the Lincoln Regional Center's limited capacity for restoring inmates found incompetent to stand trial. To begin, I wanted to provide you with some recent data from Sarpy, Lancaster and Douglas Counties according to their respective jail facility representatives. So far in 2022, the average length of time from the time the court issues its compat-- competency restoration order to placement at the LRC is 76 days for Sarpy County, 70.78 days for Lancaster County and 131 days for Douglas County. The longest wait time for a single inmate in 2022, thus far, was 123 days for Sarpy County and 435 days for Douglas County. For Lancaster County, their average wait time peaked at 149.6 days during the first quarter of 2022. These long wait times place significant pressure on county jails, both operationally and financially. For example, Sarpy County's estimated costs for housing an inmate is at least $210 per day based on a cost allocation study completed for fiscal year 2021. Given the state of the economy and rising inflation costs, the current figure for 2022 is likely higher. In addition, the cost of caring for high acuity inmates can be much higher. Some require periodic hospitalization. On occasion, acutely mentally ill inmates smear bodily fluids or feces in their cells, creating an unsafe environment that requires sanitization. In the past, the Sarpy County Department of Corrections has hired a hazmat company to professionally clean the cells, the cost of which can exceed $30,000 for one inmate. Then there are other costs that are more challenging to quantify, but are very real. Because many of these inmates suffer from paranoid delusions, they typically distrust corrections and jail medical staff and refuse to take their prescribed medications. This creates a cascade of problems for jails to manage. Many in this cohort require frequent, direct contact with corrections staff and jail medical personnel. Many become violent and assaultive toward staff and others. They are also especially vulnerable to exploitation by inmates in general

population. As a result, they oftentimes need to be separately housed for their safety and the safety of others. There are countless examples of mentally ill inmates decompensating while in isolation in areas of the jail not conducive for treatment and recovery. As I alluded to earlier, they may be unable to maintain appropriate levels of hygiene or meet their basic needs requiring intervention by corrections and jail medical staff that can become dangerous. And it's important to keep in mind that whatever negative impact Sarpy, Lancaster and Douglas Counties experience because of LRC's limited capacity, other rural county jails with their limited resources feel it orders of magnitude more. Furthermore, treatment delays inherently delay the progression of the inmate's criminal case. From a prosecutorial perspective, this may negatively impact the quality of the state's evidence, especially with respect to eyewitness testimony and our ability to optimally resolve the case. Case progression delays can place a substantial emotional and psychological strain on victims as well. To address this problem, the LRC staffing levels should be increased to allow for additional inpatient treatment bed space. Last session, as Senator Arch mentioned, the Legislature passed a bill to require the State Department of Health and Human Services to pay $100 per day to reimburse counties as a per diem rate. This per diem reimbursement requirement and other reimbursement requirements imposed by Nebraska Revised Statute 29-1823 for inmates waiting longer than 30 days for competency restoration treatment is simply not enough to bridge the profound gap caused by the Lincoln Regional Center's inpatient bed shortage. I would also note that to date, Sarpy and Lancaster Counties have not received reimbursement from the Department under Nebraska Revised Statute 29-1823, according to jail facility representatives. In Sarpy's case, since the effective date of LB921, we have not had an inmate qualify for that reimbursement. However, in Lancaster County's case, they have and they have submitted invoices for reimbursement to the department. Apart from that, there may be opportunity to collaborate with the Lincoln Regional Center to expedite access to treatment such as through inreach services or additional training opportunities. In short, county inmates continue to experience long wait times for Lincoln Regional Center competency restoration treatment and the need to increase the Lincoln Regional Center's inpatient bed capacity remains. The Nebraska County Attorneys Association urges the Legislature to pass legislation to require and to fund expansion and staffing for the Lincoln Regional Center. Thank you for your time and consideration, and I'm happy to answer any questions you may have.

ARCH: Thank you. Are you, are you seeing-- I notice in my, in my opening, Senator Lathrop mentioned 128 days in county jails. You're mentioning in the seventies. Are you seeing improvement? Are, are, are the days dropping?

KATHARINE GATEWOOD: Yeah. I, I think that it, it's important to keep in mind for the 2022 numbers, we're not yet done so those numbers may increase. And particularly with Sarpy's numbers, we're talking about a group of inmates that's a small number. So it ranges from, in the past five years, 1 to 4 that we're talking about with this narrow group. So as you can imagine it can--

ARCH: Mathematically, you're-- it could swing pretty significantly, that, that average.

KATHARINE GATEWOOD: That, that's correct.

ARCH: Yeah.

KATHARINE GATEWOOD: That's correct.

ARCH: OK.

KATHARINE GATEWOOD: For Douglas, it's a little bit more stable; the numbers are higher. But for Sarpy in particular, our numbers are lower. And, and that makes sense when you look at our capacity, jail capacities. Sarpy's, for example, currently is 148. Our ADP is typically around 160 lately, whereas Douglas County's capacity is much higher, around 1,450, and their ADP's range higher as well.

ARCH: OK. Right. Thank you. Any questions? All right. I see no questions.

KATHARINE GATEWOOD: I would also just note--

ARCH: Yes, please.

KATHARINE GATEWOOD: --briefly, if I may--

ARCH: Please.

KATHARINE GATEWOOD: With respect to the numbers, I think it's important to also keep in mind that we're coming out of the COVID-19 pandemic. So we're seeing lower average daily population numbers as a result of that, as a result of some of those efforts for mitigation

for COVID-19. We expect and are seeing trends trending upward of the average daily population. So we do also anticipate increased numbers requiring bed space.

ARCH: Well, thank you for your testimony and for responding to my request and for going out to Douglas and Lancaster County and gathering that data as well, so we have a, a fuller picture of where we are currently.

KATHARINE GATEWOOD: It's my pleasure.

ARCH: Thank you very much.

KATHARINE GATEWOOD: Thank you.

ARCH: Next to invite Larry Kahl to come and address the committee.

LARRY KAHL: Good morning.

ARCH: Good morning.

LARRY KAHL: Senator Chairman Arch, members of the Health and Human Services Committee or member of the Health and Human Services Committee, my name is Larry Kahl, L-a-r-r-y K-a-h-l, and I am the Chief Operating Officer of the Department of Health and Human Services. Thank you for the invitation to testify today and to share an update on Lincoln Regional Center's capacity for those waiting competency hearings. DHHS is actively working on expanding capacity and access to services for those who need competency restoration. Our priorities are to reduce the length of stay for patients at the Lincoln Regional Center, reduce the wait list for court-ordered patients, and to increase the availability of services through the behavioral health system of care, thereby reducing the reliance on inpatient and residential services. The department is actively addressing roadblocks to these goals. Like many other healthcare facilities, LRC was challenged by the COVID-19 pandemic, consistent with postpandemic later-- labor shortages. LRC experienced a shortage of licensed professionals. This shortage was exacerbated by wages being significantly below the market's pay scale. Coupled with a regulatory finding necessitating a ligature point mitigation construction project in a market with significant supply chain issues, LRC was faced with an unprecedented shortage of staff and beds. DHHS immediately examined opportunities and implemented a number of initiatives that have helped us to achieve our goals-- working towards achieving our goals. The department reviewed the contracting process

for interim and traveling staff, for example, moving from a fixed-reimbursement rate to an open-ended variable rate, allowing us to respond to the current competitive market values. The stakeholder group that included the Department of Administrative Services, Corrections, the Veterans Affairs collaborated with the Nebraska Association of Public Employees and the Fraternal Order of Police to enact the largest mid-biennium wage increase in Nebraska state history. We reviewed the nursing onboarding process and were able to reduce orientation time from a month to about two weeks. Now new staff members can be on the floor serving patients sooner. DHHS has also created waitlist tracking tools to improve the admissions process, tracking admission rate impacts and forecast admission efforts on lists reduction. A new tracking and communication tool was developed at LRC and shared with the behavioral health regions. Additionally, DHHS developed a shared bed-tracking mechanism within our electronic medical record system. A dedicated forensic service line was also created, along with a leadership position to address the growing trend towards increased use of outpatient competency restoration and jail-based services. Communications between community and facility psychiatrists for each admission and discharge has increased, and the referring and admitting psychiatrists discuss the patient's treatment needs, necessary length of stay, initial discharge plan and discharge disposition. Finally, there have been a number of key leadership changes that have transpired that will allow for the facility to continue to move the quality of care to the next level. And these positions include the-- a regional hospital administrator role, facility administrator, director of nursing, and health information management director. I believe our strategies are working. The court admissions wait days from-- have decreased by 276 percent since November of '21, going from 127 patients on list, and these are actual patient counts not necessarily the patient days, down to 46 as of October 27, 2022. The admissions per month have increased 180 percent year to date. Total court-ordered admissions have increased by 55 percent year to date. For example, in 2016, LRC admitted 96 court-ordered admissions on the year. And year to date in 2022, there have been 211 court patient admissions. I would note that all this has been accomplished while still under construction and still working with key professional staffing shortages. It's also worth noting that DHHS is completely compliant with LB921, from utilization of admitting percentages to jail payments for wait days past the initial 30 days. On November 1, the department rolled out the weekly posting of census and bed counts on its website. LRC also has recently completed the triennial survey and are fully accredited for another three years from

the Joint Commission Accredited-- Joint Commission on Accreditation of Hospital Facilities representing the gold standard of best practice care. In summary, I believe that LRC is firing on all cylinders to maximize its capacity and to grow outpatient resources. DHHS has created dashboards with visible key performance indicators, which are allowing members of the Legislature to be able to track those ongoing successes in real time, basically through that website access. Thank you for the opportunity to testify, and I'm happy to answer additional questions.

ARCH: OK. Thank you. One of the-- I'm, I'm sorry. I have not gone out since November 1 to take a look at that, to take a look at that posting of census and bed counts. One of the issues that we've had at Lincoln Regional Center has been bed availability. Some of that has been your ligature changes that you had to make with the last Joint Commission survey--

LARRY KAHL: Yes.

ARCH: --and some of it has to do with staffing. So, so can you-- do you have those numbers available? Do you-- can you update us on what bed availability you have now at the Lincoln Regional Center? And I mean, I mean, not, not licensed capacity, but, but staffed, open, and accepting patients.

LARRY KAHL: We've gone through the process of-- process improvement processes in terms of actually walking through every single building with clipboards and looking for every possible room and total number of beds; what can be used, what can't be used. We believe that we have our arms around-- of the 200 licensed beds that are available for both mental health board commitments and for forensic admissions. We're using every available bed that is available to us that we can staff. That count does vary a little bit. For example, right now within our forensic building, which is where the majority of our court-ordered incompetency restoration individuals would be admitted to, we have one unit that is down, so we're going to be short 18 to 20 beds, probably-- still between now and the first part of next year, between now and next March.

ARCH: And that's due to staffing?

LARRY KAHL: That's due to construction.

ARCH: Oh, construction.

LARRY KAHL: Yeah. For staffing, as I mentioned, we had reached out and using an inordinate number of travelers, but we're doing what we need to do to be able to staff up to the best of our ability to maintain as full of occupancy as we can. So for example, right now within our building five, our forensics building, where we do the competency restorations, we're running 100 percent occupancy. Every single bed that we have that's available and can staff is full.

ARCH: OK. So you mentioned 200 licensed-- is that the licensed capacity at Lincoln Regional Center?

LARRY KAHL: When you start to get into beds, it always gets a little wonky because we've got both the hospital licensed, 200 licensed beds. Then we also have some residential licensed beds.

ARCH: I'm talking, I'm talking hospital.

LARRY KAHL: Hospital? 200 licensed.

ARCH: 200 licensed. And you mentioned, of those, 18 to 20 in the forensic unit are down due to construction.

LARRY KAHL: Yep. And so then when you walk through and you look at full seclusion rooms and you look at restraint rooms, they need to come off of that list. They're not, not inhabitable on an ongoing basis.

ARCH: It's not a licensed room.

LARRY KAHL: They're still licensed for, for care, for provision of care. They're just not licensed for, for occupancy in terms of sleeping and residence.

ARCH: Right. And they're not a licensed inpatient bed. Those rooms are not licensed for inpatient beds.

LARRY KAHL: Correct. So we, we make sure that those rooms are pulled out of our total count. And so then our number still varies even in terms of a total number. And you'll see that as you look that, in the future at the website, the total number of beds will vary based upon our staffing capabilities and clinical milieu and how many folks we can safely handle within the spaces. I think kind of bottom line to getting to your point was, you know, my goal was to continue to whittle down the waitlist as significantly as possible. My target, Senator Arch, I mean, it's really in many ways about throughput from

an operational perspective. And how many folks can we move through in a most timely basis, reducing lengths of stay, but not to the point of increasing revolving door? So we've also done a lot of examination of our discharge processes and looking at readmissions and readmissions rates and how many of our folks come back in and within what time frame. So it's really encouraged us to look at the entire system as we're going through. My target was if we could get to 30 patients with no more than a 30-day wait, I thought that might be a reasonable goal for the state with the facilities our size. And we're running-- the current waitlist, I think, has 46 people for an average of 53 days. Now my average wait days for admission look at everyone on the list. It doesn't-- this, this-- it's not by particular county or by particular individual. We do have some individuals that end up with a much longer wait time. And in many cases, it's tied to things that are beyond our control. We're still using a first in, first off basis. First on, first off.

ARCH: That's how you decide who to accept. You, you are-- you have a waitlist and you're starting at the one that was referred longest ago.

LARRY KAHL: Ideally, yes. Some circumstances occur sometimes beyond our control. They're not necessarily readily available. There are other court cases. I think I remember hearing one case that was had federal charges and the federal charges needed to be met before the state charges could be addressed. So some of those individuals linger, but it's-- they're other --otherwise engaged in other systems. But if they're ready for admission, eligible, I mean, certainly eligible based off the court order, if they're available for admission, we're working in that first on, first off basis. And our, our indications are, is that we have whittled down and continue to whittle down the list. My simple math is, I've got 20 beds out from running and we're running at 100 percent occupancy and I've got 20 beds out and I've still got 50 people on the waitlist, I may be able to get to 30 by taking that other 20 on board, but then that's-- then we're, we're there. That's it. So in terms of looking at additional need or additional capacity, it comes down to the comfort level, I think, of the, the state, the jailers, the counties, the Legislature. Is that an acceptable wait time? Is 30 people waiting for 30, 40 days acceptable or is the target zero? If the target's zero, we need more beds.

ARCH: When do you anticipate having these 18 to 20 in the forensic area finished with construction?

LARRY KAHL: We've-- with the other construction we did we took down entire buildings at a time and gave the contractors access to the building. And so we condensed and moved patients around on campus. Building 3 is done and up and running. Building 10 is up and running. Building 5, our forensic building, we're not taking down the building. We don't have anywhere to go. So we're taking one unit at a time. We're condensing patients into-- to the, to the rafters in those available units while we take down that-- the one unit for, for construction.

ARCH: At a time.

LARRY KAHL: At a time.

ARCH: So this, this--

LARRY KAHL: Five, five units.

ARCH: --this 19 to 20 comes back on you'll take another--

LARRY KAHL: Yes, sir.

ARCH: --number of beds, so you--

LARRY KAHL: Each, each is approximately 20 beds each for per unit. We're on unit one and there are five. So we have four more to go, approximately a six-week construction time--

ARCH: OK.

LARRY KAHL: --that it's going to be down and rotating. But it'll be spring, early summer, before--

ARCH: Before all of those--

LARRY KAHL: --before I get my building back.

ARCH: --and now we've gained another 20 beds.

LARRY KAHL: Yes, sir.

ARCH: OK. All right. Any other questions?

MURMAN: You covered it pretty well, I think. You know, 30 is getting pretty close, but I would think it'd be nice to even get down to 10 or

something like that, you know, so we don't have people that need the services waiting very long in county jails.

LARRY KAHL: You know, I would emphasize that we've really looked beyond the scope of just the hospital. Is, is-- does everyone need inpatient competency restoration? Maybe not. And so I mentioned OCR, the outpatient competency restoration. And Dr. Jennif-- Jennifer Cimpl Bohn is our forensics program lead. And she's done a tremendous amount of work of working directly with the county jails and seeing are there opportunities to do restoration in the jails? Are there opportunities to do mental health inreach within the jails and, and help make the stay easier for the individual and for the county jail until such time that, that we can-- we could get them admitted? We're, we're trying to make sure that the evaluations are done very timely and in some cases, a re-evaluation. If we could re-evaluate an individual who's maybe been waiting for a period of time, have they been-- are they now competent to stand trial? Have mitigating circumstances decreased to the point that they-- they're cognizant enough and competent enough to stand trial? So doing frequent re-evaluations is another component that we've attempted. Personal feelings that we've left no stone unturned and that we're really working on a variety of fronts to try to whittle that down. I would also say, just in maybe in defense of ourselves, there was initially some difference of opinion in terms of what all should be and could be submitted. The Appropriations Committee was very clear that it was $100 a day. We've not gotten clean invoices, multiple costs being added to the invoices, and so we're, we're working through an educational process. I'm striving now to get a follow-up meeting set up with the County Jails Association and with the County Sheriff's Association to provide more information and education about how to access the form is available. It's filled-- you can fill it out online and send it to an inbox. We've tried to make it as easy as possible, along with the counts, you know, being able to see kind of where we're at from an occupancy perspective.

ARCH: Thank you. Seeing no other questions, appreciate your testimony. And we'll stay in touch with you on this matter.

LARRY KAHL: Absolutely.

ARCH: That will close the hearings for this morning. And we, the committee will--

ARCH: Well, good afternoon. Welcome to the second half of the Health and Human Services Committee's day of interim studies. My name is John

Arch. I represent the 14th Legislative District in Sarpy County. I serve as the Chair of the HHS Committee, and I'd like to invite Senator Murman to introduce himself. Senator Murman.

MURMAN: Hello, committee and everyone. I'm Senator Dave Murman. I represent the eight counties in southern tier-- the middle part of the state.

ARCH: Also assisting the committee this afternoon, one of our research analysts, Bryson Bartels, our committee clerk, Geri Williams, our committee page, Logan Brtek. I'll quickly go over our policies and procedures again for those of you who might not have been able to tune in this morning. I'm sure you all did. I'll do it anyway. First, please turn off or silence your cell phones. This afternoon we will hear two resolutions and we will be taking them in the order listed on the agenda outside the room. LR366 introduced by Senator Wishart will be first, followed by LR397 introduced by Senator McDonnell. I know both senators have arranged for specific testifiers, but both of those hearings are also open to public testimony. So we'll take, we'll take the invited testifiers first and then we'll open it up and I'll, I'll let you know the order there. For those of you testifying on either resolution, you will find green testifier sheets on the table near the entrance of the hearing room. Please fill one out, hand it to the page when you come up to testify. And this will help us keep an accurate record of the hearing. I'm asking that you try to limit your testimony to five minutes and we'll be using the light system. It will give you an indication of how long you've been speaking. At four minutes, the yellow light will come on and the red light at five minutes. These are study resolutions for information gathering purposes, not bills, so there's no record of proponents and opponents. Just as with legislative bills, comments for the record may be submitted online via the Chamber Viewer page as long as comments are submitted prior to noon on the workday before the hearing. And with that, we will begin this afternoon's hearing. Senator Wishart, welcome to the Health and Human Services Committee.

WISHART: Well, good afternoon, Chairman Arch and member 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 includes west Lincoln and parts of southwestern Lancaster County. I am here today to bring to your attention LR366, which seeks to study the implementation of a delivery model for behavioral health services in Nebraska known as the certified community behavioral health clinic, which would dramatically change the way behavioral health services are

delivered to Nebraskans. Over my years in the Legislature and my time on the Appropriations Committee, I witnessed the struggles of those in need of access to mental health and substance use treatment care and the struggles of the providers that deliver that care. I'd also like to say that my husband was five years on the Lincoln Police Department, and so as the spouse of somebody who was out all night working with a lot of people who were struggling, I also know firsthand the importance of this in terms of public safety. The Legislature needs to step up and fund a system that has always been underfunded, attempt to build more capacity in the current system, and expand the behavioral health workforce. The CCBHC model isn't new around the country. In 2017, the model was organized as a Medicaid demonstration project that included eight states and SAMHSA, the federal Substance Abuse and Mental Health Services Administration, provided and continues to provide initial start-up grants for the facilities around the country that apply. Currently, there are 450 CCBHCs in the United States. The CCBHC model requires outpatient mental health and substance use treatment services, as well as primary care coordination, including monitoring of key health indicators and health risks; crisis mental health services, including 24-hour mobile crisis teams; emergency crisis intervention and stabilization; screening assessment and diagnosis, including risk management, psychiatric rehabilitation; peer and family supports; and housing. It's kind of a mouthful, but that goes to show you how rigorous and holistic this program is. For me, the most exciting part of the CCBHC model is working with community partners and law enforcement and in our schools. To allow clinics in Nebraska to continue to provide these services and save our resources in other areas of government, we need to establish a financial foundation to expand access to care and improve coordination with community partners by requiring the state of Nebraska to file a State Plan Amendment to draw down additional Medicaid dollars for providers in the system to deliver this array of services. And a lot of this is familiar to you because as you recall, I brought a piece of legislation last-- yeah, well, it was actually this year to, to do this and since it was stalled in committee, decided to come back with an interim study. And now we have more information to provide to you. As you know, Congress recently passed the bipartisan Safer Communities Act, which includes funding for CCBHC's state planning grants. The purpose of the CCBHC planning grant is to support states to develop and implement certification systems for these programs, establish protective payment systems for Medicaid reimbursable services, and prepare an application to participate in a four-year CCBHC demonstration program. The notice of funding

opportunity was just released on October 18, with total available funding of up to $15 million to be awarded through 15 state grants for up to a million. These grants will very compe-- will be very competitive. There's no doubt in that, but so important to help states deliver a comprehensive plan for their behavioral health systems of care and how they may decide to, to develop these certified clinics. Now is the time for us to invest in this modest increase in Medicaid match dollars because the new delivery model has proven its effectiveness, and you'll hear from that today, and savings to government entities across the country, because our criminal justice system is overflowing with individuals in need of these services and because we have a mental health crisis here in the state that continues to get worse. So I would be happy to answer any questions. There will be a number of testifiers behind me who are experts and have experience in this space. And I do have to apologize, but I will have to leave right after this testimony to go to another meeting.

ARCH: OK. All right, questions? I-- you-- and I, I won't ask you to answer this, but you used the term "modest increase in Medicaid match dollars." And that's something that I think would be beneficial. That may not be able to be provided today, but I think having that financial understanding of that impact, I think that we'll, we'll need that, obviously. And, and maybe that'll come if, if a bill is introduced, but where, where, you know, the department can respond to what exactly those dollars look like.

WISHART: Yes, absolutely. We will get you that information. We'll have some idea from, from this year in the legislation that we can get to you and then we'll work as hard as we can to make those projections.

ARCH: OK. Great. Thank you.

WISHART: Thank you.

ARCH: So I, I have a list of testifiers and I'll call them up in order here. We'll start with Annette Dubas. And I know, Annette, you're, you're going to give probably a longer testimony here. And, and so we won't use the lights on you, but we have to be done by 5:00.

ANNETTE DUBAS: OK. OK. [LAUGHTER] I think I can do that. I think I can do that.

ARCH: OK.

ANNETTE DUBAS: I practiced saying it really, really fast. I'm not where Patrick is at, certainly, but, but I will work on that and certainly respect your time. So Senator Arch and Senator Murman and Health Committee, thank you so much for, for the hearing today. My name is Annette Dubas, A-n-n-e-t-t-e D-u-b-a-s, and I'm the executive director for the Nebraska Association of Behavioral Health Organizations, otherwise known as NABHO. We represent over 50 community mental health and addiction provider organizations, regional behavioral health authorities, hospitals, and consumer organizations. We would also like to thank Senator Wishart for introducing this resolution and to you, the committee, for getting it on the schedule. The certified community behavioral health clinics' models brings another dimension to our Medicaid program with a larger financial commitment from the federal government and requires providers to coordinate care with law enforcement, schools, and hospitals to improve access to care. In 2014, the passage of the Protecting Access to Medicare Act established a federal definition and criteria for certified community behavioral health clinics, CCBHCs. These clinics must provide a set array of services, meet additional requirements for staffing, and regularly report on outcomes. In return, the clinics are reimbursed through a prospective payment system. This rate is based on a cost report that documents a clinic's allowable costs and qualifying patient encounters. The costs are divided by the number of encounters to arrive at a single rate. In return, each CCBHC must complete a cost report, including current costs and anticipated future costs associated with being a CCBHC. These rates are clinic specific, but through a process of documenting anticipated costs, state Medicaid agencies can benchmark, benchmark clinics against one another to ensure comparable services are being provided at comparable cost. Only the CCBHC demonstration states, which there are ten, or states that have submitted and received approval through a State Plan Amendment may use the PPS. CCBHCs do bring additional costs as they relate to the PPS and other administrative requirements. But they also bring a very important component, and that is the substantial data reporting. Data that has allowed states like Missouri, which is five years in to CCBHC demonstration, to report an annual savings of $15 million pre- and post-period hospital care, a 35 percent increase in patient access to care, a 16 percent reduction in visits to the emergency department, and an increase of 41 percent over the past year of referrals from law enforcement. These savings do bleed over into other areas, such as schools and the judicial and the Corrections system. There are three ways to become a CCBHC. A state applies and is, is selected as a demonstration. Clinics can apply for a CCBHC expansion grant or the

state Medicaid authority submits a State Plan Amendment. Earlier this year, Congress passed the bipartisan Safer Communities Act, which will provide an additional $40 million to support CCBHCs across the country. And Senator Wishart talked about the planning grants. So from those planning grants beginning in 2024 and every two years after, an additional ten demonstration clinics [SIC] will be added. Every state has a Medicaid plan, which is the official document that describes the nature and scope of their Medicaid program. This plan may be changed or added to through the use of a State Plan Amendment, which must be submitted to the Centers for Medicaid and Medicaid Services for approval. This is a very lengthy and detailed document that lays out all of the particulars of a state's Medicaid program. Included in your packet is an example of a SPA from Kansas, which was just recently approved by, approved by CMS and similar to what we would recommend for Nebraska. Expansion grant clinics are open to individual clinics in all states. They are administered by SAMHSA and must meet their baseline certification criteria. They are not state certified and they continue to bill Medicaid and other payers in the usual manner. Nebraska currently has three expansion grant clinics: Community Alliance in Omaha, CenterPointe in Lincoln, and Lutheran Family Services, which is serving statewide but I believe their, their clinic is, is here in Lincoln. Two additional expansion grants were approved by SAMHSA this past month: South Central Behavioral Services in Hastings and Heartland Family Services in Omaha. CCBHCs bring transformational change to our behavioral health system, not only because of the PPS and reporting requirements, but also because of the standard services that are required. CCBHCs must provide screening and assessment, patient-centered treatment planning, outpatient mental health/substance use disorder treatment, and 24-hour crisis services. Peer support, psychiatric rehabilitation, targeted case management, primary health screening and monitoring, and military and veterans services may also be exclusively provided by the CCBHC, or they may partner with other community providers to provide those services. These clinics are not meant to become the sole provider of behavioral healthcare. Demands for mental health and substance use treatment services are growing. The need for all types of community providers will not lessen. These clinics will help expand access to care and also collaborate and partner with non-CCBHC clinics to help provide all of the required services. Access to care is critical and the recent-- recently released 2022 CCBHC Impact Report is showing that these clinics are helping to meet that need. And I have attached that report in your handouts. CCBHCs and the expansion grantees are on average serving more than 900 people annually per clinic than prior to

CCBHC implementation, a 23 percent increase. With the enhanced rates, clinics report an average of 22 new staff per clinic, an estimated 11,240 new staff positions across all 450 active CCBHCs and grantees. Of the 249 clinics that responded to the, to the National Council survey, 98 percent report that they engaged in one or more collaborative activities with hospitals and emergency departments, which has helped connect patients with community-based care and reduced admissions. Either directly or through referrals, 98 percent of responding clinics offer access to 24/7 crisis lines and 94 percent offer access to crisis stabilization services. The continued expansion of CCBHCs can help reduce police involvement in mental health and substance use crises. Of the responding clinics, 64 percent provide reentry support to those returning to the community from incarceration. CCBHC clinics are able to emphasize data and use it to track outcomes and this is something we just don't have in our system right now. The funding provided in the Safer Communities Act demonstrates the commitment that Congress has made to CCBHCs with the possibility of every state in the country to join a demonstration by 2030. Next in, in line with testimony, you'll hear from four of the six expansion grant CCBHCs in Nebraska. And they'll be able to bring you their personal experiences so that you can see what is already happening in Nebraska with this new model. So I thank you for your time and I will attempt to answer any questions you may have, but the true experts are behind me.

ARCH: OK. Thank you. In your testimony, you say that the planning grants are being offered now. They're $1 million-- approximately up to $1 million--

ANNETTE DUBAS: Yes.

ARCH: --planning grant. And, and you say from those planning grants beginning in 2024 every two years after, an additional ten demonstration-- you use the term clinics here, did you mean states?

ANNETTE DUBAS: Yes.

ARCH: OK.

ANNETTE DUBAS: Yes, I apologize--

ARCH: OK.

ANNETTE DUBAS: --for missing that. Yes, it should be ten demonstration states, not clinics.

ARCH: So beginning in 2024 and every two years after they intend to add ten additional states. Well, you'll get to 50 pretty quickly. Yeah.

ANNETTE DUBAS: That's-- yeah, I believe by 2030 they indicate that every state should be able to, if they apply, should be a demonstration. Yes.

ARCH: OK. This is a question you may not be able to answer. Maybe somebody else can that follows you. But maybe you can. I-- in envisioning the state of Nebraska for CCBHC, there are, there are states, Missouri, I think Kansas have developed, and, and maybe that was, maybe that was a SPA that, that they did but developed a system of rolling CCBHC out across the state. I think Kansas maybe is using regions or, or something like that. Do you see-- if, if a SPA were to be adopted here, do you see that similar? What happens to the existing CCBHC SAMHSA clinics? I mean, I'm sure there's a transition period, but, but how do you see that implemented under a State, under a State Plan Amendment?

ANNETTE DUBAS: Well, the, the state is able to really design what they want that to look like through the SPA, like you mentioned Kansas and others, and then be able to develop that PPS system--

ARCH: OK.

ANNETTE DUBAS: --which is really-- that's really the foundation of what a CCBHC is, is to be able to pay that enhanced-- you know, currently our expansion grantees, they're pretty much doing everything that a CCBHC does, but they aren't able to use that PPS system.

ARCH: Right.

ANNETTE DUBAS: So with use of the SPA, we would be able to put that payment system in place. So, you know, every state SPA can and does look different as far as how the rollout looks and, and what it would, what it would entail.

ARCH: If you were, if you were to become a demonstration state though, I'm assuming that you're-- that that is a comprehensive CCBHC across the state.

ANNETTE DUBAS: I am understanding the way the demonstration is, is that you can design it, you know, you can state the existing CCBHCs are the only ones that we have or I believe now there's been some

changes that you can bring in additional CCBHCs as they're allowed to develop. So a demonstration can also be tailored to what you want it to look like in the state if I'm understanding it correctly.

ARCH: OK. All right. Senator Murman.

MURMAN: Thank you for testifying. I, I do like that there are more people that access behavioral health and-- with the CC--

ANNETTE DUBAS: It's a mouthful. Yes.

MURMAN: Yeah. But, but my concern is that others, I guess privates that provide behavioral health might be squeezed out and everybody will have to be a CCB-- CCBHC. How would, how would you respond to that?

ANNETTE DUBAS: Well, a component of a CCBHC is the ability to partner with other services, other providers in the community. If you are able to meet, you know, some of those that I listed can be partnered with. So there's a lot of opportunity for collaboration. And also, as I said, the need for mental health services and addiction services is just continuing to grow. So we're going to need, you know, all hands on deck, every kind of provider. So I know the jury may still be out a little bit on how the impact of CCBHCs on other types of providers. But what I've been able-- as I visited with some of the other states that have been the demonstration states, they have not seen a closing of clinics, they've not seen an exodus of, of providers. And again, I think with that partnership opportunity and I think that may be referenced in the following testimonies as well is what they've been able to do in their community with other non-CCBHC clinics.

MURMAN: OK. Yeah, it doesn't seem like there's a lot of overregulation, I guess you could say now. But you know, there's always that concern in the future I think.

ANNETTE DUBAS: Yeah, I mean, we certainly don't want to do anything that, that puts any, any mental health or substance use disorder treatment provider or facility out of business. Because, as I said, we, we do need, need everyone. And so it's just as we continue to unfold the project, you know, how do we make sure that that, that happens?

MURMAN: And, and you mentioned that there's collaboration with schools, I guess, with CCBHCs.

ANNETTE DUBAS: Very much so. A lot of collaboration with schools and law enforcement. There's-- that's what, you know, the community part of the CCBHCs. It's very much a community effort and making sure that people are getting-- are staying out of those high costs like, like the hospitals, ending up in the jails and Corrections and we're getting them the services when they need them, where they need them.

MURMAN: I've got questions, I guess, of how it would work in schools and I don't-- maybe there's someone else behind you that addresses that more, otherwise--

ANNETTE DUBAS: Yes, yes they can.

MURMAN: --I guess, I'd like to ask more about how that works?

ANNETTE DUBAS: And if you don't get your question answered, I'll make sure that you do.

MURMAN: OK. Thank you.

ARCH: Thank you. I, I, I got a follow-up question to Senator Murman's discussion of private providers, because I think that partnering, yes. Are there any, are there any regulations on how private providers are paid? If they aren't, if they aren't a CCBHC themselves, there would be pass-through dollars that would come through the CCBHC, correct?

ANNETTE DUBAS: That's my understanding, yes, there's--

ARCH: OK, I got some heads nodding behind you so that's [INAUDIBLE].

ANNETTE DUBAS: OK, very good.

ARCH: OK. And, and so how that rate is determined, how you-- how much will you pay the provider? Because one of the, one of the things obviously is once you, once you establish a CCBHC, there's quite a bit of control, quite a bit of authority of the CCBHC itself to contract, to provide services. If they decide to provide a service where a provider has currently been doing that in the community, I just don't know where that-- what the, what the parameters for the relationship is with private providers and CCBHCs. I don't know that there's a specific requirement as to how the reimbursement model should work and the pass-through there or your ability to self-- the CCBHC's ability to self-perform services versus contracting. Is there a restriction on the number, the percentage of services self-performed by the agency that has the CCBHC? I mean, those are all things that can come in

working out some of the discussion, but those are, those are questions that are on my mind.

ANNETTE DUBAS: And I think if you look at the, the example of the Kansas SPA, some of those questions may be able to be answered.

ARCH: OK.

ANNETTE DUBAS: I'm not, I'm not going to attempt to try to [INAUDIBLE].

ARCH: The way Kansas did it.

ANNETTE DUBAS: Yeah.

ARCH: Yeah.

ANNETTE DUBAS: Because you do have to-- you have to set up that PPS through your SPA. So--

ARCH: Right.

ANNETTE DUBAS: --as far as being able to put those parameters in place.

ARCH: OK. All right. OK, very good. I think those are all of our questions, both of us--

ANNETTE DUBAS: Thank you very much for your attention.

ARCH: --so thank you. Next, ask Carole Boye to come up from Community Alliance.

CAROLE BOYE: It's, it's been so many-- it's been two years since I've done this so I forgot how to do it.

ARCH: Two years?

CAROLE BOYE: Yeah, the pandemic.

ARCH: Where have you been?

CAROLE BOYE: Didn't we do everything through Zoom?

ARCH: Well, good to see you again.

CAROLE BOYE: Thanks for having me. Can, can I hold off just for a second on this and, and kind of respond to a couple questions?

ARCH: Sure. First, state your name and spell it, if you would.

CAROLE BOYE: See, I have forgotten all the rules. My name is Carole Boye, C-a-r-o-l-e, Boye, B-o-y-e. I'm the CEO of Community Alliance in Omaha, Nebraska.

ARCH: Please.

CAROLE BOYE: Just wanting to, to circle back on, on the questions that you had and payment. I think it's important to understand the CCBHCs are not taking over the world. It's, it's, it's a, a model. It doesn't become the model. And if I'm not a CCBHC, I will continue to bill Medicaid for Medicaid payments in the exact same way that I'm doing it now. I can continue to serve those folks. It's not that these, these clients are moving out. So I, I think that's one of the concerns. It's, it's like an FQHC, Federally Qualified Health Center. The patients they see, they get a PPS payment. We provide primary healthcare at Community Alliance. We get a standard Medicaid payment for an office. So we-- it's, it's hard to figure all this out, but it's--

ARCH: I understand that. But if I can, since we're just dialoging here, this is a--

CAROLE BOYE: OK.

ARCH: --this is a resolution so we can-- we're just trying to get information. If, if I were a private provider, though, and you decide to provide that service, you have a significant financial advantage over me as a private provider. Your-- the, the methodology of your reimbursement is, is significantly different. And so if you were in an area such as many of the FQHCs, if you were in an area that is largely underserved, there's-- providers have not gone into that area to serve, then, then that's one, that's one thing. If then you take that same financial advantage and go into another area and, and compete with private providers, that's where, that's where I stumbled.

CAROLE BOYE: Right.

ARCH: So, I mean, you don't have to respond or answer that, but I'm just expressing that concern.

CAROLE BOYE: Yeah, I probably don't want to respond on, on the record and I, I actually look forward to the day that people compete for Medicaid and under-resourced people.

ARCH: True. Yeah, true. True.

CAROLE BOYE: So.

ARCH: All right. OK. Point made.

CAROLE BOYE: OK. So again, thanks for the opportunity to talk about CCBHCs. Just for context, our organization was awarded a CCBHC expansion grant in August of 2021. We met the, we met the four-month attestation where we, where we could attest that-- self-attest that we were meeting all, all the requirements in December of that year. Our grant came a year after CenterPointe and LFS, our colleagues who you'll, you'll hear from shortly. And we were the first in Omaha. Just briefly in terms of Community Alliance, data is embedded in the report that, that you're receiving where the three agencies that are currently CCBHCs have tried to compile data to see what the impact has been so far. As far as Community Alliance goes, we've documented the use of 35 evidence-based practices. Our fully integrated care approach was identified as a strength and really the breadth of our service array, including a strong and growing stronger rehabilitation and recovery supports, helping people with serious mental illness not only pass that crisis point, but to live, work and contribute as full community participants. Our emphasis is on reduction of emergency room visits and what's called "troubled nights," which is defined as nights in the hospital, homelessness, or time in jail, all costly to the individual, certainly, but also to the system and us as taxpayers. For us, what CCBHC means is a focus on increased access and capacity. Access because we know that when service is delayed and someone is put on a waitlist, 25 percent and as many as 50 percent will never engage in services. Capacity because one in five Nebraskans were facing a mental health challenge prepandemic and now it's grown to one in three Nebraskans. But what I'd really like to talk about is not so much the impact on our agency, but from a public policy standpoint. And I start by reminding us that CCBHC is not a program. It's a model. It's a framework through which we make promises and hold ourselves accountable and through which the state can hold us accountable. It is a framework to help us identify and respond to community needs and one which will help us identify actual cost and cost savings along with comparative efficiencies and effectiveness, systems that we don't currently have now. And it's a framework that can help us better align

access and capacity with need for underserved and vulnerable populations as compared to the patchwork and Band-Aid approach that we all have to rely on now. CCBHC is adaptive to both urban and rural environments. It focuses on access, consistency and quality, not units of service and linear progress through a static continuum of care. Will it solve everything? Is it the solution? No. And I would suggest nothing ever is. And there is no doubt that there are going to be parts if we go forward with this and as we go forward, that we're not going to like with it. But it's viewed by providers and advocates and public policymakers in multiple other states as a significant step forward and a new tool. It's not an exclusive tool, but it's a tool to add to our planning, service delivery, and financing toolbox. CCBHC is not like other healthcare reform from our perspective, which were kind of forced on us as ways to control costs with little regard to the impact financially or operational-- operationally on the little guys or the individuals and families most in need of services. I'm speaking here of initiatives like ACOs and even Medicaid managed care. It's not a hospital-driven system or a payer-driven system. It's also not competitive provider versus provider, but it really is a collaborative model. To be clear, not every behavioral health provider needs to or should seek a CCBHC designation, but every CCBHC should work with every other behavioral health provider to achieve the access promised, especially in areas of specialty care. I would respectfully suggest that this is just good public policy trying to move a, a system forward and that the issues and the concerns that, that are being raised about it, we're, we're talking about it and it's an opportunity to talk about it. So many reforms in the past have just kind of been imposed on us. What has so impressed me about this process thus far is that we have providers at the table. We have service recipients at the table. We have public policymakers at the table, and we have the administrative branch at the table. We've had good conversations with Medicaid and others in HHS. I think we can do this and I think we can do it well.

ARCH: OK. Thank you. Any other questions? Just one final question.

CAROLE BOYE: Um-hum.

ARCH: That is-- does it-- has this allowed you to provide other services, services-- I mean, fee-for-service locks you in.

CAROLE BOYE: Right.

ARCH: It's, it's, it's--

CAROLE BOYE: Right.

ARCH: --it's-- if it's paid for, you do it. If it isn't, it's really difficult to, to do other services. Does this give you dollars to do other services that aren't necessarily reimbursed under fee-for-service?

CAROLE BOYE: Absolutely. It--

ARCH: Do you have an example?

CAROLE BOYE: Yeah, a grant-based system. For instance, we have, we have set up-- access to care is horrendous right now. You know, 6, 8, 12 weeks to, to get an appointment with, with someone. We have set up a centralized access system, which we-- where we can guarantee if you walk through the door, someone's going to see you. May not be a psychiatrist, but someone's going to see you and see what you need today. How do we keep you safe today? What we can do tomorrow. A unit of service-- fee-for-service system, there's no way you can stand that up. And, and grant funding allows us to do that. It's made a huge difference.

ARCH: OK. Good. Seeing no other questions, thank you.

CAROLE BOYE: Thank you.

ARCH: Next, we would call Topher Hansen from CenterPointe. Oh, not Topher.

TAMI LEWIS-AHRENDT: Not Topher. Topher was not able to make it today. I'll do my best to personify Topher. Good afternoon, Senator Arch, Senator Murman, and those present. My name is Tami Lewis-Ahrendt, T-a-m-i L-e-w-i-s-A-h-r-e-n-d-t. I'm the executive vice president and COO of CenterPointe, which is recognized as a certified community behavioral health clinic in Lincoln, Nebraska. Good health and emotional well-being are the foundation for all else. If you have an illness that is debilitating or experience anxiety or depression to an extent that keeps you from doing other things, then you won't be in school, working, or having an otherwise productive life. Economic development and a great education won't happen if people are not able to participate due to poor physical and mental health. It's common sense that we must ensure a strong foundation to thrive as a society. As a policy matter, we must first work toward health and well-being. Integration and whole healthcare are the goals for the healthcare of the 21st century. Our bodies are a system of systems that need to be

addressed at the same time in a coordinated fashion with high-quality, evidence-based practices that produce better outcomes for the person and for our entire population. This is what certified community behavioral health clinic is all about. Access: CCBHCs are set up to provide fast access to care for anyone who seeks the service. One way is through the crisis response, a requirement of the CCBHC model. The other is through same day access to services, a practice system of running outpatient programs to get people in the door for assessments and crisis services on the day they show up. In it's first eight months of being a CCBHC, CenterPointe saw 950 more people than in the previous fiscal year. Quality care: Being a CCBHC means organizations must keep data on processes and outcome measures and use evidence-based practices to deliver the care. Data, quality improvement processes, and accountability are part of what it means to be a CCBHC. It also means using evidence-based practices to deliver the care so the tools we know work the best are used to help those we serve. And services: Crisis response, outreach into the community, outpatient counseling and medication management, youth, family, and adult services, including high-intensity models known as Assertive Community Treatment are components of the model. All these services are delivered in an integrated manner in an effort to treat all conditions of the person, whether it's primary care, mental health or substance use. This is not a new system or one that will replace everything else under Medicaid. There's a value add to what we already have. A CCBHC brings a set of programs, a funding structure, and performance measures that allow organizations to do the things that may not have a billing code and that will impact the quality of health in our community. Programs include care coordination, prevention, education, outreach, community response, among others. Other providers will continue to offer services they have for decades. When Nebraska started Federally Qualified Health Centers across the state, they did not run other primary care providers out of business, but added a layer of care for people who are not necessarily getting that level of healthcare. CCBHCs will add to the system, help those not getting care, and provide services not otherwise offered because there's no payer source. No more than 20 percent of youth and adults who need mental health and substance care receive it. That means 80 percent of those who need care have not been reached. Destigmatizing care and opening all our doors is the direction we need to go. CenterPointe hired 20 new positions to start a CCBHC. We started a primary care practice to service the physical health needs of those needing it in the community. We've helped many people with chronic health issues realize progress towards better health by losing weight, lowering

blood pressure, and controlling their A1C to healthy levels. We've done innumerable warm handoffs from therapists or psychiatric providers to primary care providers to help people address all their health needs under one roof. We've intervened in several crisis outreach circumstances with youth wanting to end their life. Instead, they were connected to our youth and family therapy team to help family address this issue. We've also worked with other organizations in Lincoln by providing primary care coordination, crisis response services, and education on mental health. An execu-- executive summary for CenterPointe's first two years of operating as a CCBHC has been given to the clerk and will be emailed to members of the committee for their use. Respectfully.

ARCH: Thank you. Questions? You're two years into it. Is that right?

TAMI LEWIS-AHRENDT: Two years. Yes. We were awarded the grant on May 29 of 2020 or May 1 of 2020.

ARCH: What's the term of the grant?

TAMI LEWIS-AHRENDT: That grant was two years. We just started under a new grant term on September 30.

ARCH: Another two-year grant?

TAMI LEWIS-AHRENDT: It's a four-year grant this time.

ARCH: OK.

TAMI LEWIS-AHRENDT: Yep, $1 million a year for four years. The first-- the implementation grant was $2 million a year for two years.

ARCH: OK. It sounds as though that increase in volume has been the biggest impact, you've been able to serve more.

TAMI LEWIS-AHRENDT: Yeah, absolutely.

ARCH: Is that right?

TAMI LEWIS-AHRENDT: Serve more and get them in the door quicker, get their needs met quicker.

ARCH: Serve them differently, or serve, or serve more and get them in the door quicker?

TAMI LEWIS-AHRENDT: Yes, all of that.

ARCH: OK.

TAMI LEWIS-AHRENDT: So we expanded our crisis services. We were able to move from a largely office-based crisis to a mobile-based crisis. We now work in conjunction with LPD and Bryan Health to address crisis issues in the community. We expanded to youth crisis. We added youth and family therapy services to our service array and we added primary care. Those were the big pieces along with care coordination and a lot of those non-fee-for-service pieces that you don't have a payer.

ARCH: OK. And your, your, your services are, are-- they're urban services. Right? I mean, that's, that's the demographics, the population. Do you, do you have satellite clinics around, around Nebraska, around the community? Are you, are you largely at the core of the urban center in Lincoln?

TAMI LEWIS-AHRENDT: We're in Lincoln. And we also have a facility in Omaha. But we, we, through our CCBHC, we're able to provide access to Region 2, which is western Nebraska. They approached us not having sufficient access for their crisis care for follow-up care for individuals who call their crisis line. They needed additional access. And through our CCBHC, we were able to offer them access to both psychiatric and primary care via telehealth.

ARCH: Via telehealth. OK.

TAMI LEWIS-AHRENDT: Um-hum.

ARCH: All right. Any other questions? Senator Murman.

MURMAN: Well, that's what I was going to ask a little bit about more how rural access would work. I assume you keep your-- the clinics in Omaha and Lincoln staffed 24 hours. But--

TAMI LEWIS-AHRENDT: Yes.

MURMAN: --in greater Nebraska, would telehealth be the way to go or are you thinking a clinic with someone on call 24 hours?

TAMI LEWIS-AHRENDT: It depends on the need of, of the area, really. In partnership with Region 2, it's been sufficient to be able to offer them access Monday through Friday to meet the needs of the folks who are presenting there. But we do offer them access to our crisis staff as well. So while we can't go out to the community, we do have the ability to do telehealth with our crisis staff as well, so we can

intervene in a crisis over an iPad or an iPhone or a, a tablet device with folks in western Nebraska. And right now, that's, that's what we can offer. You know, I mean, I think everybody would love to have access points or partners in the community that we could work with that have physical locations. But, you know, to your, your concern, Senator Arch, about running people out of business, I've yet to find sufficient business to cover the need that exists today. I don't think there's any concern that CCBHC is going to push anybody out of the market. What it will do will allow us to partner with entities out of state to provide access to the services that we provide.

MURMAN: OK, thanks.

ARCH: Has this impacted children and adolescent services or just adults?

TAMI LEWIS-AHRENDT: All-- across all age groups.

ARCH: OK.

TAMI LEWIS-AHRENDT: Yeah.

ARCH: OK. All right. Very good. I think that's all the questions.

TAMI LEWIS-AHRENDT: Thank you.

ARCH: Thank you very much. Chris Tonniges from Lutheran Family Services. Welcome.

CHRIS TONNIGES: Welcome or thank you. Good afternoon, Senator Arch and members of the Health and Human Services Committee. My name is Chris Tonniges, C-h-r-i-s T-o-n-n-i-g-e-s, appearing before you today as president and CEO of Lutheran Family Services in support of expansion of CCBHC as a statewide initiative. Lutheran Family Services is grateful for the Legislature's commitment to the overall mental health of the people of the great state of Nebraska in continuing to explore CCBHC. As you know, people with untreated and unmanaged mental illness often end up consuming a lot of the state's expensive and intensive services. Many utilize the emergency room or a call to emergency services on a regular and consistent basis for their mental health needs. Many become addicted to drugs or alcohol or even become homeless. We think that CCBHC is a way to combat this taxpayer expense by providing and even requiring care and service coordination and an outcome-driven approach to care. Lutheran Family Services currently serves clients out of our Health 360 Campus in Lincoln through its

CCBHC SAMHSA grant with the planning, development and implementation of grant awarded last May or two years ago in May; for Fremont and greater Dodge County starting this fall. As part of our grant, we have three primary goals: improve the quality of treatment to improve the physical and behavioral health outcomes of people served; two, increase access to integrated CCBHC services like care coordination and case management for people in Lincoln-Lancaster County; and three, expand CCBHC services to serve unmet needs in Lincoln-Lancaster County with all three goals targeting populations of focus, including areas of focus like military and veterans, individuals who identify as having dual diagnosis, etcetera. We see-- we saw success in all three goal areas, having served over 4,100 clients, with clients describing a 25 percent decrease in negative affect, which includes feelings of depression, homelessness; 20 percent increase in satisfaction with self; and a 10 percent increase in social connectedness with the community at large, all key contributors to a healthier population. The three agencies with SAMHSA grants combined data points to examine outcomes for the CCBHC model here in Nebraska. According to our joint report located in the packet, which is this one that looks like this, we had 28 individuals surveyed after six months of receiving services saw reduction in hospitalization. That is the equivalent of 177 nights. That reduction in nights stayed represents approximately $435,000 in savings alone on this small population size. Imagine what the savings could be if the entire state could be served in this manner. Also, the population served by the three current CCBHCs saw a decrease in nights in jail by about 70 nights, saving local communities an additional $10,000. And that doesn't even take into consideration the cost and expense of the first responder time and energy, which ultimately would increase the savings by 2 to 3 times that. There are systems savings all throughout CCBHC in large chunk-- in large chunks as stated above and little pockets like reduction in mental and behavioral health visits for those covered by Medicaid because they feel more equipped to deal with daily life. While there is relatively small increase in, in the first couple of years of implementing CCBHC, it should not be looked at as an acceleration of expense, but rather a short-term investment that will save the state Medicaid system and ultimately the taxpayers money as we saw in the first few years of CCBHC implementation across the three agencies. We encourage the Health and Human Services Committee to advance legislation next session that moves the state in the direction of implementing CCBHC and provides for a system of care that is both comprehensive but is also data driven to focus on long-term client outcomes. More than happy to answer any questions.

ARCH: Thank you.

CHRIS TONNIGES: I've also included our agency report, which is this other document.

ARCH: OK. So, so help me understand, you have an individual who has no resources, no insurance, no-- and has not-- maybe qualifies for Medicaid but isn't currently signed up. You have a Medicaid-qualified person that comes in for services. You have somebody on commercial insurance that, that comes in for services. What, what do you do in those situations under this model?

CHRIS TONNIGES: Yeah, so really the care coordination component we talked about those programs that aren't covered by Medicaid today--

ARCH: Right.

CHRIS TONNIGES: --are the fee-for-service piece. At Lutheran Family Services, that care coordination component really is the driver behind how we get individuals access to care and/or access to the other services that they need.

ARCH: That's true of all the agencies?

CHRIS TONNIGES: It's a little bit different-- CCBHC is implemented a little bit different in each one, and that's why we partner with all of the other two agencies on referring clients back and forth.

ARCH: OK.

CHRIS TONNIGES: But generally speaking, that care coordination component is a, a key driver behind CCBHC.

ARCH: OK, and that would not be, of course. But in the case of somebody with Medicaid or somebody with commercial, you would bill, you would bill for that on a fee-for-service basis--

CHRIS TONNIGES: Correct.

ARCH: --in addition to having the dollars for care coordination the way you're using them.

CHRIS TONNIGES: Correct.

ARCH: Would you use any of those dollars for direct care, in other words, for the person that has no resources? Would you use, would you use dollars for that as well?

CHRIS TONNIGES: Absolutely.

ARCH: And that would be part of the--

CHRIS TONNIGES: Yeah.

ARCH: --part of the-- in your case, SAMHSA, the SAMHSA grant.

CHRIS TONNIGES: Yeah, so if you think of the populations that Lutheran Family Services serves, there's a lot of individuals that don't carry either personal insurance or--

ARCH: Sure.

CHRIS TONNIGES: --are covered under Medicaid. We don't want to turn away anybody from receiving any sort of care. So we talked about what we call open access, which is the ability to see somebody that same day or within that same week. Oftentimes, those are not billable hours, but it allows us to see that individual up front. Again, try to, if they're in crisis, mitigate that crisis and/or move on to whatever that next mode of care might be for that individual.

ARCH: OK. Good. I don't see any other questions. Thank you very much for your testimony.

CHRIS TONNIGES: Yeah, thank you.

ARCH: Next, we'll call Bob Shueey from South Central Behavioral Health [SIC] Services.

BOB SHUEEY: Good afternoon, Senator Arch, Senator Murman. It's wonderful to be here today. My name is Bob Shueey, B-o-b S-h-u-e-e-y, and I'm the CEO of South Central Behavioral Services, providing services in the greater Hastings and Kearney areas. Thank you for the opportunity to speak to you today. As a recent, as a recent recipient of a federal CCBHC planning and implementation grant, we are excited for the opportunities this model will provide. The catchment area for our initial CCBHC implementation will include Adams, Clay, Webster, and Nuckolls Counties. The heart of the CCBHC model is a push to break down the barriers faced when trying to access behavioral healthcare services. A key criterion for establishing a CCBHC is a commitment to

serving everyone who needs our services, regardless of their ability to pay for the care they need. This is a very straightforward way to improve access to care. Another barrier that is often faced when individuals seek behavioral healthcare is the fact that under our current system, many providers are very specialized. This can make accessing a provider that offers the specific level of care a patient needs an extremely time consuming and difficult process for an individual to navigate. This can delay people getting to the level of care they need. These delays often escalate the issues that people are facing and could put additional burdens on our crisis systems and on law enforcement. Since a CCBHC is mandated to provide a complete spectrum of services, this burden can be reduced. As a relatively small rural provider, South Central Behavioral Services would be hard pressed to directly provide all of the required CCBHC services. But the CCBHC model is flexible enough that it allows us to partner with other local service providers to fill in the gaps in our service array. This means that we don't have to reinvent the wheel or duplicate a service being provided by a non-CCBHC provider, but also requires us to formalize these relationships in order to ensure that our clients don't face any barriers when they need the services of one of our partners in the community and also mandates that we share the data that will help us treat the whole patient efficiently. The CCBHC model also provides funding for care coordinators whose role in, in the CCBHC model is ensuring that the people we serve are able to navigate the system to access all of the services they need, and that all of the providers involved in the client's care, including their physical health providers, are communicating and working together toward the same outcomes. This strengthens our overall system, ensures timely and comprehensive care, and should ultimately reduce costs to our system over time because timely care is the most cost-effective care. At South Central Behavioral Services, we are extremely excited about the opportunities provided by the CCBHC model and would encourage the Legislature to move forward with support for this modern and proven structure for behavioral healthcare delivery.

ARCH: All right. Thank you. Questions?

MURMAN: Well, thanks a lot for-- if I may, thanks a lot for the service you provide in south central Nebraska. You do collaborate, I see with even physical-- the other providers of healthcare also.

BOB SHUEEY: Absolutely. That's a key component. Those, those care coordinators are out there trying to make sure that we're looking at

the whole patient and that everyone's talking to everyone and working toward the same ends.

MURMAN: OK. And you mentioned that you provide the service regardless of the ability to pay. So you're referring to Medicaid there I assume?

BOB SHUEEY: Well, you know, a lot of folks have private insurance but can't afford their deductibles. I mean, there's a lot of different reasons someone can't afford services or that they might feel they can't afford services. So a key component of the model is we cannot deny services to anyone based on their ability to pay.

MURMAN: So because of the grant that allows that.

BOB SHUEEY: Right.

MURMAN: OK. Thank you.

BOB SHUEEY: Um-hum.

ARCH: So it, it talks about partners and other private providers. How, how-- whether you've-- I don't know that you've set them up yet, you, you just received this.

BOB SHUEEY: We did.

ARCH: OK.

BOB SHUEEY: We're working on--

ARCH: So how do you, how do you think you'll negotiate rates with private providers?

BOB SHUEEY: Well, we've already been in some talks with some local providers because we're, we're definitely not going to even attempt to provide all the services--

ARCH: Sure.

BOB SHUEEY: --internally. And, you know, it's, it's just a negotiation, you know, a good faith negotiation based on the current rates that Medicaid and the regional system are able to provide. You know, we want to be in line with, with what they need to stay in business.

ARCH: OK.

BOB SHUEEY: You know, so we don't--

ARCH: So you've got, you've got flexibility under your grant to negotiate the rate.

BOB SHUEEY: Right. Well, and under the current status with Nebraska not being yet involved with the PPS system, our partners are just going to bill Medicaid directly for their services for people that are eligible. So we will only help cover the cost for people who don't have another payer source.

ARCH: So you'll, you'll handle uncompensated care?

BOB SHUEEY: Right.

ARCH: OK. All right. Great. Any other questions? Seeing none, thank you. Thank you for your testimony. I don't have any other scheduled testifiers, so I would open it to the public if anybody wants to comment on LR366. All right, I don't see anybody. So with that, Senator Wishart was not able to stay for close, so with that, we will close LR366. And we will open LR397. Well, I might, I might say for LR366 we, we did have a letter that was submitted from the Department of Health and Human Services, and that will be, that will be available as well. Senator McDonnell, you are welcome to open on LR397.

McDONNELL: Thank you, Senator Arch, members of-- member of the committee. You just don't have quantity here, but you have quality, I guess.

ARCH: That's right.

McDONNELL: Thank you. My name's Mike McDonnell, M-i-k-e M-c-D-o-n-n-e-l-l. I represent LD 5, south Omaha. I'm here to introduce LR397. The purpose of LR397 is to examine the needs in the current state of Nebraska's mental health system. This includes the workforce and funding streams for the mental health across Nebraska. Experiencing a global pandemic has shined a light on mental healthcare and, I believe, somewhat dissipated the negative stigma related to mental health. With more awareness to mental health, now is the time to examine our commitment to mental healthcare funding needs and workforce across the, the state. This is an issue that impacts all Nebraskans and all levels of government across our state. We need to collaborate with our counties, schools, providers, regions, DHHS, and others to make sure we are all pulling in the right direction to tackle the mental health needs and care for Nebraska. Also last

session, I introduced LB909 to address an issue with mental health practitioners and individuals in emergency protective custody. I've asked a proponent of that legislation to speak to this committee today to provide you with background on this important issue. Following my testimony, we will hear perspectives from counties, providers, regional administrators, and workforce development. Just want to thank you for, for being here today. And, and the people behind me that will be testifying, they are, are subject matter experts. As we all know, we probably have a friend, a family member, a neighbor that is struggling with mental health. And I think it's our responsibility as senators to try to bring people together, which you will, you will hear from different people, as I mentioned, behind me today, but at all levels of government to work together to try to solve this issue. I'm here to try to answer your questions. And thank you for listening.

ARCH: Thank you, Senator. Any questions? I see none. Are you going to stay for closing?

McDONNELL: Yeah, I'm staying. Yep.

ARCH: OK. All right, great.

McDONNELL: Thank you.

ARCH: First invited testifier is Commissioner Mary Ann Borgeson. Welcome and thanks for coming.

MARY ANN BORGESON: Hi. Good afternoon, Chairman Arch and members of the-- member of the Health and Human Services Committee. My name is Mary Ann Borgeson, M-a-r-y A-n-n B-o-r-g-e-s-o-n. I have proudly served on the Douglas County Board of Commissioners since 1995. I currently serve as chairwoman of the Douglas County Board and of our Region 6 Governing Board. First, I'd like to thank Senator McDonnell for introducing LR397 and this committee for holding this interim hearing. Second, it is important to recognize the recent work done by the Legislature with respect to provider rates, mental health workforce, and facilities. I am hopeful those investments will provide a great return in healthier communities across Nebraska. With that being said, there is still a lot of work to be done to improve Nebraska's mental health system. As this committee and the Legislature continues to work on the funding of mental health needs, I'd like to share the trends, a few programs and service examples and challenges that Douglas County continues to face. At the Douglas County Correctional Center, there are currently 1,303 incarcerated

individuals, and the average daily population is 1,130. Of that population, we had 929 incarcerated individuals diagnosed with mental illness, which equates to a 41.9 percent of our jail population with mental illness. You can compare that to November of 2021, where we had 901 incarcerated individuals with mental illness at a 38.03 percent rate of population with mental illness. So unfortunately, this does make Douglas County Community Corrections Center the largest mental health facility in the state. And, of course, these individuals in our facility come in with a variety of reasons, but a large driver of the intakes is mental illness. Another priority area for mental illness or mental healthcare for Douglas County is at our community mental health center. This center serves those in our community who were unable to find care. In 2021, we served 573 individuals in our inpatient unit, 152 in our intensive care unit, 1,061 individuals which equated to 4,611 APRN and medic-- and MD visits, and 2,029 therapy sessions in our outpatient program. We served 72 individuals for 750 days of care in our day treatment program and 693 individuals in our voluntary detox unit and 939 individuals in our involuntary detox unit. These two departments working together, we actually have established an array of services such as our mental health diversion program, intensive care management for incarceration transitional age youth, a long-term injectable pilot program, a Familiar Faces program, Reasoning and Rehabilitation educational groups, and an intensive outpatient program in our community corrections facility area just to name a few. In 2015, I brought the Stepping Up Initiative to Douglas County in Region 6. Stepping Up is a partnership between the National Association of Counties, the Council of State Governments Justice Center, and the American Psychiatric Association Foundation. They came together to basically provide this initiative to counties so that we could focus on reducing the number of individuals with mental illness in our county jails. Yet with so many good things happening, we still face a number of challenges. And just to name a few: we need additional alternative placements to county jails; long waits for individuals at the LRC; robust transitional supportive housing for individuals; regulatory constraints; funding for psychotropic medications for those not on Medicare, Medicaid, or private insurance; working with individuals that have co-occurring disorders along with medical issues, we find the services to be fragmented and funded siloed. So you see, Douglas County has stepped up to the challenge of addressing the ever-growing needs of our citizens experiencing mental health issues. Douglas County invests $19.8 million just between Corrections and community mental health center. Add to that our nursing home, youth center, sheriff's, and human resources department,

that figure jumps to $22.5 million. Unfortunately, in Douglas County and across the state, we continue to see mental health needs increasing and still have challenges before us. Douglas County, the Region, and our community mental health providers are here today to express our ongoing need and our plea for your assistance and partnership. We need more resources to address the ever-increasing calls for mental health/substance abuse services, and we need to continue to add investment to the behavioral health system. One thought on funding is that if we could potentially look at our sales tax structure and see if a portion of that can be given to counties and earmarked for mental health services. I thank you for this hearing today and I hope outlining our great work as well as our continued challenges will be helpful in working with you to address and alleviate the mental health issues for Nebraskans. And after all, we must remember that mental health is health. And I'm here to answer any questions that you may have.

ARCH: Thank you. In the, in the case of someone who is being held in Douglas County Correctional Center that has an identified mental illness, what, what kind of treatment care is available to those, to those people incarcerated?

MARY ANN BORGESON: An individual that enters our jail is screened, if you will, when they come in for mental health issues. And then they're seen by our medical, which is a, a contracted service with Wellpath. We actually increase the number of mental health providers within the jail so that they can do a full screening and assessment of that individual's mental health needs, as well as any psychotropic drugs that they currently are on or may need. And then they are monitored and placed-- some are placed in our medical infirmary for continued observation. We do have a number of "mods" where those individuals are placed together, but we do have a medical team within inside our jail that serves individuals with not only just medical needs but mental health needs.

ARCH: So is it, is it active treatment? Would you call it active treatment for the-- for that--

MARY ANN BORGESON: Yes, so--

ARCH: --mental illness?

MARY ANN BORGESON: Yes and no. So jails, you know, are, are not long term so we do--

ARCH: It's not a hospital.

MARY ANN BORGESON: Right. And so we can provide as much as possible in terms of if there are, again, psychotropic drug needs, those can be ordered and administered. But we first have to find out what they are on, if they are on anything, and then go from there. But yeah, it's, it's kind of active, but it's very short term. So we do, we do have discharge planners that work with our individuals once they enter our jail, they're social workers. And so they'll work with that individual upon admission to get ready for discharge. And that does include getting them set up with appointments to not only their medical needs but their mental health needs once they're discharged.

ARCH: OK. Thank you. Any other questions? Senator Murman.

MURMAN: Talking a little more about treatment while they're in the Douglas County Jail. So I assume that that treatment, other than what's paid for by the federal government, is, is property taxes of Douglas County to pay for those treatments there.

MARY ANN BORGESON: All of it is paid by property taxes. Once an individual is-- steps foot in our jail, even if they have Medicaid, that's not covered. We did get a bill passed a few years ago that we could collect from a private insurance, but there is a federal regulation that terminates or suspends someone's Medicaid while they are in custody. Going back and looking at the testimony, it actually was supposed to be for prisons, but jails got thrown in there because they didn't understand the difference between a jail and a prison. So we are stuck with again, once they enter, that all falls on your local taxpayer to pay for their medical needs.

MURMAN: I, I assume you're always full in the jail. I mean, is there potential for-- I guess because of the waiting list, like at Lincoln Regional Center, potential for more treatment, especially if you get state assistance at the Lancaster-- or I mean, Douglas County Jail?

MARY ANN BORGESON: So they sit-- yes, so why they're sitting in our jail-- and that was one of the things that, that we struggled with a little bit as a board of commissioners, because we didn't want to become a mental health facility. But when you have individuals that are in need of help while they're there, you have to provide that help. And so we did have, over the course of the years, an increase in staffing for mental health. So we increased the psychiatrist-- excuse me, hours, we increased the number of therapists, the APRNs. And

again, we look at the whole of what that assessment brings and what medications, that psychotropic medications they may need, along with some of the other programs that I told you about. It's not just all about meds, but it is the therapy and the programs that we can give. But again, it's sometimes on a very short time. But if they are waiting, they continue to get their services while they're in our custody or in our jail.

MURMAN: And are the inmates in Douglas County Jail typically all from the Omaha area, or you don't have extra capacity to take inmates from surrounding counties?

MARY ANN BORGESON: We, we do at times, if, if asked and if we do have beds, yes, we have done that. But for the most part they are Douglas County.

MURMAN: And that's more of an expense than an income to the county, I assume.

MARY ANN BORGESON: It's all expense, really.

MURMAN: OK. Thank you.

ARCH: Thank you very much--

MARY ANN BORGESON: OK.

ARCH: --for your testimony.

MARY ANN BORGESON: Thank you.

ARCH: Next, call on a representative from the Nebraska Hospital Association.

JEREMY NORDQUIST: Good afternoon, Mr. Chairman and members of the Health and Human Services Committee. I am Jeremy Nordquist, J-e-r-e-m-y N-o-r-d-q-u-i-s-t, president of the Nebraska Hospital Association and here today representing our 92 member hospitals across the state of Nebraska. I was here last Friday, and we discussed post-acute placement challenges that our hospitals were seeing. And this hearing today certainly ties in as behavioral health is a significant barrier to moving patients out of the hospital to the appropriate level of care. First, I'd like to thank you, reiterate Commissioner Borgeson's thank you for the investments that this Legislature made last year in behavioral health. Certainly, important

steps with ARPA funding to help boost our behavioral health workforce capacity and working on provider rates. Our hospitals-- Nebraska hospitals often serve as the front door to needed behavioral health services for Nebraskans. Over the last 12 months, and I've provided a handout, there have been over 34,000 behavioral health visits to the emergency room, or about 93 a day, every single day throughout the year. And in the handout, you can go in a little greater detail about the specific categories of patients for the reason. The overall number is up slightly from the previous, the previous year. Although the number of patients who have then gone from the emergency room to inpatient admissions has come down just a little bit. And if you're interested in longer term data on that front, we're happy to provide that to you. But these individuals enter through our emergency rooms when they cannot access or are not accepted into community services. And I think the hearing you heard before certainly is a pathway to addressing the shortages of community services throughout the state. For patients needing inpatient care, wait times in our emergency departments can be extensive. One system reported delays of over 72 hours in the emergency room for about 10 percent of the behavioral health patients coming through the door. Another health system reported that their average can be up to 19 hours, and that's, that's the average number for patients sitting in their emergency departments. Obviously, lack of inpatient beds is a significant concern. One of the issues that we would like to look at and, and take on in the next session is the reimbursement for inpatient beds. I've handed out a example from Bryan Medical Center looking at their inpatient and outpatient costs versus reimbursement for inpatient and outpatient beds. But just going back from 20-- 2021 and 2022, if you look on the back on the, on the chart side rather than the graph side of that handout, you'll see that total cost per cases went up 2 percent in 2020, 13 percent in 2021, and 10 percent in 2022, all while reimbursement per case went down 5 percent in 2020, went up 5 percent in 2021, but then down another percent in 2022. And that, that leaves you that gap on the front that, as you can see from the blue line, doesn't even cover the variable cost per case, let alone the total cost per case for inpatient visits. So that's an issue that is important to our hospitals that provide inpatient psychiatric care and is essential for us to build the inpatient capacity that we need. Another major concern we hear about from our members is the lack of capacity at the Lincoln Regional Center. Adding to these delays, according to the Department of Health and Human Services, the average wait time right now at the Lincoln Regional Center is 83 days for those that ultimately get admitted. And often this can be a challenge

on the back end, too, if a patient does get discharged from the Lincoln Regional Center, but their symptoms worsen, maybe their commitment has been dropped, there aren't beds available at the Lincoln Regional Center for them to go back to if their situation gets worse. And often then they're stabilized in our hospitals and, and waiting for very extended periods of time to find appropriate placement. And then just wanted to circle back to an issue we talked about last week and that was on post-acute placement in the specialty units for long-- for skilled nursing, long-term care, but in particular for behavioral health patients. We know that we have a high number of these patients sitting in our hospitals waiting for care. But again, it's very challenging to send behavioral health patients to nursing facilities that aren't designed to care for them. They don't need inpatient care, but they certainly need the appropriate psych care. And we need to look at models to create those specialized units of post-acute care that also meet their behavioral health needs. So happy to answer any questions or if the committee as they dig deeper into this would be interested in additional cuts of information from our hospitals, we're happy to provide that.

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

JEREMY NORDQUIST: Thank you, Senator.

ARCH: Next, I would invite Patti Jurjevich from Region 6.

PATTI JURJEVICH: Good afternoon, Chairman Arch, Senator Murman, members of the committee. My name is Patti Jurjevich, P-a-t-t-i J-u-r-j-e-v-i-c-h. I'm the administrator for Region 6 Behavioral Healthcare. I'm here today on behalf of the Nebraska Association of Regional Administrators. For your reference, information about the Regional Behavioral Health Authorities is attached to this testimony. I want to begin by offering our appreciation, as you've heard others today, your commitment that the Legislature and the Governor made to behavioral health needs across the state. And so between the significant provider rate increase of 15 percent in the budget, intent language to provide flexibility to the behavioral health regions to move dollars between budget lines, and the millions of ARPA dollars committed to infrastructure needs within the behavioral health system, you made an important commitment to the system that will assist in meeting the needs of many providers across Nebraska. So we thank you for that. There's two items I would like to bring to your attention today. First, is to confirm the Regional Behavioral Health

Authorities' commitment to system and ser-- service improvements. The attached Recovery Oriented System of Care document developed by the Regional Behavioral Health Authorities provides information on the proposed system changes as we have the unique opportunity to redirect and reinvest funds to enhance, expand, and improve services across Nebraska. Second, in order to accomplish these improvements, there is a need to have flexibility in our funding and reimbursement systems and the authority to manage local services. I will note that that attached document is the subject of ongoing discussions between the Regional Behavioral Health Authorities and the Division of Behavioral Health that began in August. The Regional Behavioral Health Authorities envision a system that is well-resourced, has adequate service capacity, provides services across the continuum of care, and ensures care to support individual recovery regardless of payer source. An important principle of a Recovery Oriented System of Care is adequate and flexible financing. Based on apparent changes in the working relationship with the department, the Regions have experienced the loss of flexibility and authority needed to effectively manage the behavioral health system to address the needs in our communities. As a result, there has been a steady reduction of the Regional Behavioral Health Authorities' ability to respond to individual community and system needs in a timely manner. Slowly and methodically, the ability to serve as the safety net of Nebraskans who experience a mental illness and/or substance use disorder has been diminished. The once collaborative, productive partnership between the Regional Behavioral Health Authorities and the department that we experienced during the behavioral health reform, unfortunately, does not appear to exist. It is important to remember that Regional Behavioral Health Authorities have statutory authority and responsibility to develop and coordinate the publicly funded behavioral health services within the Region. It was the Legislature's intent in the 1970s, with the legislation establishing the regional system, that mental health needs were best determined and decisions best made at the local level. The expansion and requirement of the fee-for-service environment has crippled our ability to be innovative and responsive to needs, both present and emerging. This fee-for-service reimbursement method alone without the opportunity for supplemental financial support to help cover operational costs also endangers access, especially in rural areas where providers cannot sustain service capacity. You may be aware that a portion of last year's appropriation to the behavioral health system was unspent. This is in no way indicates that there isn't a need for more behavioral health services. It is much more a symptom of the systemic delays and constraints experienced through the department. We

respectfully request your consideration of legis-- legislative language that provides the Regional Behavioral Health Authorities with the necessary flexibility and authority to make timely budget and service decisions in response to needs in our communities. We recognize the issues facing schools, hospital emergency departments, psychiatric inpatient units, county correctional facilities, criminal justice, law enforcement, and access to care concerns of our citizens. Regional Behavioral Health Authorities are working to move forward plans to reinvest dollars in order to expand capacities and develop new services to address many of these needs. But the process can be a slow one. I assure you that the regional administrators are ready, willing, and able to collaborate with the department for the betterment of our system. To conclude, the Regional Behavioral Health Authorities envision a system that is accessible, effective, efficient, innovative, and flexible in order to meet the current and emerging behavioral health needs of Nebraskans. As always, we appreciate your continued support of the behavioral health system. I appreciate your commitment to this. Thank you for your, for your time. Happy to answer any questions.

ARCH: Are there questions? Is there a, is there a philosophical difference between the department and the Regions? Is that, is that what is-- I guess, I'm-- just listening to your testimony, it sounds as though that you're not, you're not on the same page?

PATTI JURJEVICH: I think that's probably a fair statement that we're not on the same page. I think we ask ourselves that question sometimes. What is the difference? What has changed over time? That it seems like it is becoming more and more difficult to be able to respond to local needs. I can, I can tell you in Region 6, we have been working for probably over a year to try to develop some new services, some residential services. You know, we clearly see the challenge with folks coming out of the Lincoln Regional Center, folks trying to discharge out of acute care. There's some gaps there. We know that. So we've been trying-- we've attempted to develop some new residential services and that process, I, I, I can't tell you why it's taking this long. We respond to the questions that come to us. We've done crosswalks, we've done analysis. We've tried to answer every question that exists, and yet we still don't have approval to move forward and, and we have the dollars to do that. And so it is, it is confusing to us why it is that we can't seem to get some swifter response and approvals to be able to move forward to meet those needs.

ARCH: So it's not funding.

PATTI JURJEVICH: Well--

ARCH: You say you have the dollars to do, to do [INAUDIBLE].

PATTI JURJEVICH: I do for this particular situation, yes, we have the dollars to invest.

ARCH: OK. All right. Any other questions? Seeing none, thank you very much for your testimony.

PATTI JURJEVICH: Thank you for your time.

ARCH: And Lindsay Kroll. Good afternoon.

LINDSAY KROLL: Good afternoon. Good afternoon, Senators and the HHS Committee. My name is Lindsay Kroll, L-i-n-d-s-a-y K-r-o-l-l. I represent the Omaha Police Department. I am the mental health coordinator and a licensed independent mental health practitioner with over 16 years of experience working in the mental health field in administrative roles, creating and overseeing programs, practitioners, providing direct therapeutic services and nonprofit community-based settings and correctional facilities in three different states. As a mental health professional, we all want to be able to provide the most effective, accessible, low or no barrier support and treatment in the least restrictive settings to those that we serve. Our ability to do this is effectively impacted in several ways. We all seem to work in silos to serve the same communities. Often we-- the experience of consumers feels a bit like a hot potato and no one is aware of what resources one is connected to. Often they are already referred to a resource working with an agency or on a waitlist somewhere and this often causes confusion for the consumer. Case management and getting people connected to services is a time-consuming process, and every agency wants to ensure that they have a piece of that pie. Many of the issues around improving access, removing barriers, reducing wait times could be solved by having improved information-sharing ability and community collaborative communication that is HIPAA and FERPA compliant. This connects service providers, support workers, hospitals, probation officers, all entities who may be working with the same individuals that can real-time connect the dots for that person they're trying to serve. There's already been a precedent set for systems like this to include Safe2Help, which is a statewide sharing information of connecting those involved in school-related issues such as bullying and suicide. The Stepping Up initiatives, including the Familiar Faces Project to reduce recidivism for those

with severe mental illness in the jails has been an effective process by information sharing as well. The Advanced Mental Health Directives that was another great initiative to serve-- for those who self-advocate for their treatment, the question is who is aware that they exist to enact those? Something that could also be shared in a community collaborative system that could be available to law enforcement in order to start that process to recovery immediately would be beneficial. Those are just some examples of how information sharing can improve collaboration to save lives. The second way our ability to effectively serve those in need includes the limitation of not being recognized as a mental health professional in state statute. In an effort to continue to destigmatizing or decriminalize mental illness, the Omaha Police Department is committed to improving mental health access and trying to alleviate potential dangerous situations. We offered LB909 as a suggestion a few times now, but each time it was opposed by the department and some mental health providers. We at the police department have successfully implemented our co-responder program to help our officers assist individuals in a mental health crisis by employing licensed mental health professionals with education and experience to best meet the needs of those in that behavioral health crisis. This education and experience comes with a lot of responsibility to do no harm, therapeutically treat our clients while balancing informed consents, limits to confidentiality around assessing for risk factors of suicide, homicide, relapse potential, safety planning to mitigate risk, provide means, restrictions, and, of course, treating individuals in the least restrictive level of care required to meet the need. All of this done-- is done in a therapeutic, recovery-oriented, trauma-informed manner as guiding principles to our licensure and practice as mental health professionals. This year, from January to September, the Omaha Police Department alone enacted 1,173 emergency protective custody placements. The co-responder team responded to 974 calls in the Omaha community. When a crisis correspondent or a mental health professional was on scene, there were only a total of 104 EPC placements that occurred to those 911 calls. This demonstrates an 89 percent diversion rate from hospitalization when a mental health professional was on site with law enforcement providing an expert assessment ensuring those who were in need of that higher level of care received it in an efficient manner. We are advocates for our clients. We want them to succeed. We see the traumatic impact of unnecessary hospitalizations that can disrupt it and create-- that can create for someone. Therefore, by allowing those who have received the education training and experience and proposed certification doing the work with those

who have mental health struggles to determine involuntary commitment would ensure the most appropriate individuals receive the right level of care. This would free up space in emergency departments, decrease wait times to be assessed for acute levels of care, decrease bed utilization, and allow alternative options from only law enforcement driven response to a mental health crisis which aligns with other initiatives such as 988. Allowing the ability for these trained professionals to determine involuntary commitment based on mental illness is most logical. Counterarguments to this effort include transportation, custody, and creating barriers for consumers to reveal challenges due to providers having the ability to temporarily take custody for the safety of the patient and the public. This is an old way of thinking. Current state statutes already allow for mental health professionals, psychologists, and psychiatrists in an outpatient setting to temporarily take custody of a patient for these reasons. This is not disrupted to therapeutic relationship for patients to not share those details. Transportation can still be assisted by law enforcement. In many other states, emergency medical services or medical transportation is often utilized for this medical mental health related evaluation and transportation. This interim study being proposed needs to also examine the national and best practices related to improve coordination and collaborative information sharing and involuntary commitments. In an area-- era where we are creating more nonlaw enforcement responses to meet the needs of those in mental health crisis with efforts such as 988 and mobile crisis only team considerations, we need to create an alternative option aside from law enforcement for individuals to receive required interventions for their safety and determine the necessity of involuntary level of care to treat their mental health related needs. Law enforcement officers are not mental health professionals, yet they're often put in a position to act as one. And this is counterintuitive. There are times this is a necessity, but there are also effective alternatives that should be considered. Thank you for your time and efforts with this resolution, and I'm more than happy to answer any questions.

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

MURMAN: You mentioned HIPAA compliance could be an issue. Could you expand on that a little bit?

LINDSAY KROLL: Sure. So there are concerns around information sharing with covered entities with more of a community collaborative software or platform. We've seen many communities very successful in setting up

a, a software collaborative system to connect providers or people working with different individuals so that they're all kind of aware if they're plugged into a service. So there are ways to get around HIPAA or FERPA by what information is shared in those kind of systems and who has access to it. So it's not a risk of, of sharing information that doesn't need to be shared.

MURMAN: OK. So that's something that can be mitigated by, I guess, the terminology maybe or the-- what type of communication is used.

LINDSAY KROLL: Yeah, what information is entered into that, and then who has access to it based on different criteria and licensure.

MURMAN: OK. Thank you.

LINDSAY KROLL: You're welcome.

ARCH: Yeah, I think some, some states have even gone into the definition of a treatment team and who's on, who's on a treatment team. And of course, if it's, if it's for the purpose of treatment, then you, you have HIPAA compliance with that. But I appreciate that. Well, seeing no other questions, thank you very much.

LINDSAY KROLL: Thank you for your time.

ARCH: I have no other scheduled testifiers and so I would open up to the public if there's anyone that wants to, wants to speak to this issue.

MICHELE BANG: Senator McDonnell, Senator Arch and members of the committee, my name is Michele Bang, M-i-c-h-e-l-e B-a-n-g, and I'm currently the deputy director of Project Harmony, which, as many of you probably know, is the Child Advocacy Center located in Omaha. Prior to that, I spent 29 years with the Omaha Police Department, where I recently retired as a deputy chief. Today, I'm not speaking for OPD as a-- but as a deputy director at Project Harmony with law enforcement experience. I also want to thank the state and the county representatives that are here and have done a lot of work in improving these systems. And I do recognize that that has occurred. What I've learned over the last 29 years, however, is that we either pay to help people access quality mental healthcare early on or we are going to pay later through poor outcomes. As a deputy chief, I had many opportunities to work on collaborative partnerships to study the relationships between untreated or undertreated mental health concerns, and the entry into both the juvenile and adult justice

systems, increased suicide risk, and even the increased risk of victimization. Some of those programs have been mentioned here already, and so I'm very excited to hear about the successes of our CCBHCs and hopefully you will approve those as well. You may not, as Mary Ann Borgeson just mentioned, you now know that Douglas County Community Corrections treats more people with severe and persistent mental illness than any other agency in the county. At that time, there is-- what you did not get to hear is that there was numerous studies to indicate that persons with serious and persistent mental illness will spend more time in jail than those who do not have a serious and persistent mental illness. And there's many reasons for that. And when I left the department, the experience in Douglas County was consistent with those national studies. And while again, we have done much, we continue to ask law enforcement and Corrections to deal with folks who are suffering. Oftentimes, those people who struggle with serious and persistent mental illness have lost family or friend support due to their ongoing behavior. They experience homelessness and are no longer welcome in shelters. Again, this leaves that law enforcement officer responding to disturbances with little other options than jail or emergency protective custody, custody, which is not ideal. Again, the advent of the co-responder program and crisis response teams have improved that, but there's still much work to be done. And as you heard from Mr. Nordquist, this puts undue pressure on our hospital systems. The problem is it will stabilize the crisis, but the cycle happens over and over again. Research shows that adults with a high number of adverse childhood experiences or have a high ACE score are more likely to have poor health outcomes. As kids, they are more likely to struggle in school, and if they deal with their trauma through example, through the example of outbursts or fighting, they are often referred to the office or worse, get arrested or drop out. The kids who deal with their trauma by disappearing might not cause problems, but they are not reaching their potential and they may disengage from school completely. In 2021, Project Harmony developed the anti-trafficking program, which consists of an anti-trafficking coordinator, a high-risk use specialist, and a newly highly family support specialist. The program works primarily with OPD to identify youth who are at high risk of being trafficked and the goal is to get both the youth and the family into services. OPD identify at-risk youth by reviewing all missing youth reports and using criteria developed by the National Center for Missing and Exploited Children, which includes three or more missing reports, currently a state ward, a history of child abuse and neglect, a history of sexual abuse, and a history of substance abuse. In a 2020 initial review, 521 at-risk

youth were identified, many of which are 13 and 14 years old. Some of these kids are not being trafficked, but they are still on the streets and most are engaged in high-risk behavior that can lead to other victimization or arrests. We know that there are not enough trained providers and facilities able to work with this population. So when the youth are found, CPS is struggling to find a place that can manage their behaviors, behaviors that are often a result of unresolved trauma. The sad fact is that OPD recently shared with our Project Harmony board that on a daily basis, 200 to 400 ads for sex work are posted in the Omaha area alone. We can do better. There are many lessons that Project Harmony has learned in collaboration with law enforcement, Department of Health and Human Services, schools, and other community partners providing mental health services. In a minute, you're going to hear from two Project Harmony professionals about the importance of not just having high-quality mental health professionals, but the need for mental health coordinators and advocates who work with families to navigate systems to match the family to the right kind of therapist. You will hear also about the work they do to mitigate those barriers to entry. There are many tasks that therapists do with complex clients that are asked to-- that are, that are done outside of the therapy session, tasks that are not reimbursed. This might include preparation for court, doing additional assessments. If these tasks are reimbursed or they're not reimbursed at a level sufficient to maintain their business model, these funding gaps must be filled through grants and private foundations or by having a high client caseload. This leads to burnout. Often the seasoned providers stop working with the people who need the most support, leaving the newest providers to handle the most complex cases. Project Harmony believes that our lessons learned can help to inform the state on the steps that can be taken to help improve access to care for kids and their families. And we would be happy to share that information as part of the study. Because of that, I hope you vote yes on LB397 [SIC--LR397] and thank you and I can answer any questions.

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

MICHELE BANG: Thank you.

COLLEEN BRAZIL: Good afternoon. My name is Colleen Brazil, and I'm the director of children services with Project Harmony. C-o-l-l-e-e-n B-r-a-z-i-l. I am a licensed independent mental health practitioner and a master's level social worker. I have been a forensic interviewer

for 24 years. I have also provided mental health services to youth and families. Project Harmony provides services to Douglas, Sarpy, and Dodge Counties in Nebraska and 16 counties in Iowa. Children who are evaluated at Project Harmony for allegations of sexual and physical abuse often have a need for ongoing therapy and support for both themselves and their families. The psychological impact on children who have been abused and neglected is tremendous and impacts not only the youth, but their families. Individuals who do not receive appropriate and timely mental health services often struggle in work and personal lives. Many of these families face barriers, both financially and with access to receiving therapy services. Access to therapy is difficult for families due to several factors. Location of therapy services is a challenge for families. Many families do not have the ability to travel for ongoing therapy services outside of their neighborhoods. The number of therapists who work with complex trauma utilizing evidence-based practices is not enough to meet the needs of children and families in the Omaha metro area and certainly not in rural Nebraska. With a shortage of trained therapists, there's also a shortage of time slots after school, evenings, and weekends to accommodate families' needs. There's a lack of trained therapists to provide trauma-informed, evidence-based treatment to children and families. These cases are complex and time consuming for therapists and take additional time beyond weekly sessions. Therapists may need to complete multiple assessments with children and families and could be called to court. Therapists are not paid for additional assessments, travel time, and time spent preparing for and testifying in court. Families often need additional case management services to assist with the many needs that families experiencing abuse face. Families are dealing with abuse within their family, and at times they do not have strong support within their own families. Financially, transportation is also a barrier. They often do not have the resources to go to the therapist's office. Therapy for complex trauma cannot be dealt with in the school setting. Providing trauma therapy in the school is not best practice for children, as it can be difficult focusing when returning to the classroom setting after receiving therapy. There is a need for satellite locations that allow families to access services within their own neighborhoods. Financial barriers include lack of insurance, high deductibles or copays, and/or insurance that does not cover mental health services. Due to the nature of abuse, many families are already suffering financially to even address their own basic needs. And therapy can be a financial burden that families are unable to manage on their own. The research shows that as many as 50 percent of those referred for mental health

services do not follow through. When families are assisted with setting up services, removing some of the barriers, there is an increase in engagement. There is a need for engagement specialists to continue to follow the family addressing these potential barriers and to provide education and support to the family while they are awaiting therapy services. At the time of the forensic interview, the family may not even realize some of the potential barriers their family may face. So this follow-up is critical to promote this engagement. The engagement specialists have knowledge of community mental health providers to assist with an appropriate match for the family and therapist. They can provide basic communication and coping skills to caregivers while waiting for therapy services. This helps to ensure continued engagement for the family with the therapeutic process. Currently, private insurance and Medicaid do not reimburse an engagement specialist's services, and there is not another funding source to cover this cost. We know that having family engagement specialists work. In children services at Project Harmony, each family is assigned a family advocate who educates the family about the impact of trauma. The family advocate works with the family to identify potential barriers to treatment and helps plan how to overcome those barriers. Currently, Project Harmony has a $30,000 enrichment fund donated by a generous donor. However, these funds often do not carry us through the year and this year were depleted by the beginning of October. In addition to the family advocate, a mental health navigator works with the family to identify a therapist that will be the best fit for the family and then does same-day scheduling. The evidence shows that by having a mental health navigator assist with getting that first appointment scheduled and ensuring there is a good therapist match, the actual attendance at the first appointment increased from 60 to 65 percent to 80 to 85 percent. Project Harmony is only able to provide mental health navigator services because of the support of generous donors. Thank you for listening today and I will take any questions that you may have.

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

MURMAN: Yeah, I think you mentioned that it's difficult to provide mental health services in school. What is your suggestion for children, youth or children to get mental health services while they are still in school?

COLLEEN BRAZIL: Well, what I want to clarify is that it's difficult for children who have experienced the type of trauma that physical or sexual abuse brings to the table. School-based therapy for children

with other behavioral or mental health concerns that don't contain complex trauma works very well. And you'll hear from one of my coworkers about how well that works. The children that we see for sexual and physical abuse, that complex trauma is not dealt with well in school. And so having satellite locations, having additional resources to help families with transportation, with the cost of therapy, additional trained therapists would open up those slots for children and families to access therapy after school, evenings, weekends, things like that. We just don't have enough trained therapists dealing with the complex trauma of abuse.

MURMAN: Well, when they have the, the youth or the children have that much complex trauma, are-- what is the-- I mean, typically, I assume they wouldn't have a family that would get them to the services. Do you have an answer for how that can, you know, how that can be done?

COLLEEN BRAZIL: Often-- yeah, often, children do have either a family member, the kinship placement, foster home placement that they may be placed in that would be able to get them to the services. But many of our families, due to financial barriers, either can't afford therapy. We have therapists at Project Harmony that we actually try to prioritize those families that have no insurance or insurance that won't pay because there's no charge for our services. We just can't handle the numbers of children that we see. And so we're trying to partner with community agencies to get families to those therapy sessions. Get-- having people to provide the transportation is not the issue, it's the paying for the services that insurance doesn't pay and having enough therapists that are trained to deal with that type of trauma.

MURMAN: Thank you.

COLLEEN BRAZIL: Yes.

ARCH: Thank you. I don't have any questions, but thank you for your testimony.

COLLEEN BRAZIL: Thank you.

JORDAN GRIESER: Good afternoon. My name is Jordan Grieser. That's J-o-r-d-a-n G-r-i-e-s-e-r, and I am the director of Connections at Project Harmony. Prior to my work at Connections, I was a Deputy Douglas County Attorney in the Juvenile Division. Connections began in 2015 with the mission of connecting children and families in need of

mental health services with trained and experienced therapists. We receive the majority of our referrals to the program from school partners, but also have a referral line so that families can contact us directly for help. Last year, Connections received nearly 2,000 referrals for children in need of mental health services and provided them access to both individual and group therapy. In the nearly eight years that Connections has been working to help metro area children access high-quality, affordable, and timely mental healthcare, we have learned many things. Perhaps one of the most important lessons we have learned is that while it is vital to ensure a strong pipeline of trained mental health profession-- excuse me, mental health therapists, it is equally as important to ensure that there are proper supportive resources and professionals in place to connect families in need of those services with the help. We have seen time and again that even when a community has trained and experienced mental health therapists available to provide services, it is of no use if the family does not have the means to access the services initially and continue to regularly attend sessions. Oftentimes when a caregiver is seeking therapy for a child, they are in the midst of a crisis, the child has been through a trauma. Behaviors at school or in the home have become untenable or a child is showing signs of self-harm. These stresses alone can make it difficult for someone to have the presence of mind to call multiple agencies trying to find an open appointment while also navigating the often confusing landscape of insurance coverage and Medicaid reimbursement. And the reality is that finding mental healthcare for a family member is usually only one of many complex issues a caregiver is navigating at one time. The research tells us that parents who are dealing with their own mental illness are more likely to have a child who also needs mental health services. Moreover, we know that factors such as poverty, community violence, and other environmental stressors contribute to a child's need for mental health therapy. However, these same factors make it more difficult for those children to access the mental healthcare they need and deserve. The research bears out that children with the most serious presenting issues and the most complex social situations are the ones most likely to either never access services and to drop out of services early. At Connections, those are the kids and families we serve, the ones very much in need of mental health therapy and simply lacking the ability to access that care. We contract with over 100 trained and experienced mental health therapists in the metro area. We have found that key to our ability to serve these families and ensuring that they are able to successfully complete mental health treatment is our utilization of engagement specialists that are the

first point of contact when a family is referred to the program. They reach out to determine at the outset what the mental health needs of both the child and the caregiver are and what barriers might stand in the way of the family being successful in therapy. Those barriers might include payment for services, transportation, or lack of childcare. The engagement specialists are-- use the information that they gather to match children not just with any therapist, but with the right therapist who has the education and experience needed to treat their particular mental health concerns. And they start to work with the family right away to problem solve some of the barriers that could make it difficult for them to attend sessions and be successful in therapy, as well as building their capacity for change and growth. We have found that these engagement specialists have made all the difference for the families we serve. While most therapists expect clients will cancel or simply no show to 30 to 40 percent of their sessions, with the use of engagement specialists, children in our program consistently attend 86 percent of their scheduled sessions, and this translates to their success in therapy. One study from 2010 found that in the United States, up to 80 percent of children drop out of care before receiving the appropriate therapeutic dosage. At Connections, 84 percent of the children we serve successfully complete treatment. What's more, studies show that trained engagement specialists who can start a family psychoeducation even before the first therapy appointment actually help children get better faster. I commend this committee for taking the incredibly important issue and-- for taking on this incredibly important issue and I urge you to consider the importance of funding for not only the well-trained mental health professionals needed to serve Nebraska children and families, but also the engagement specialists that are vital to ensuring that all families have access to quality care. Without these supportive roles, we know that most-- that those most in need of mental healthcare will simply have no way of getting it. Thank you.

ARCH: Thank you. Any questions? Thank you for your testimony and thank you for your work.

JORDAN GRIESER: Thank you.

ARCH: That Connections program sounds very important.

JORDAN GRIESER: Thank you.

ARCH: Good afternoon.

ANDREA SKOLKIN: Good afternoon, Chairman Arch, Senator Murman. Thank you for allowing me to be here today. 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 as well here today representing the seven federally qualified health centers in Nebraska to express our support for this study and a little bit about the workforce needs and our role in providing mental health. Nebraska's health centers serve an incredibly diverse and complex patient population. Over 95 percent of our patients fall at or below 200 percent of federal poverty, 70 percent are racial and ethnic minorities, and 37 percent of our patients are uninsured. Last year, the health centers served over 113,000 Nebraskans across 72 locations, providing primary medical, dental, behavioral health, pharmacy, and wraparound services regardless of insurance status or ability to pay. Over the past five years, Nebraska's health centers experienced a 34 percent increase in patients, nearly double that of the national average for health centers. This rapid increase in the patient population resulted in significant increase in our staffing. Health centers now employ over 1,100 Nebraskans, and yet we know there's still significant barriers to equitable access to care. According to the CDC, over 12 percent of Nebraskans have delayed or decided to forgo care because of inability to pay, and over 20 percent lack the usual source of care. And then we came-- then came COVID. COVID-19 not only exacerbated existing barriers in accessing healthcare, it intensified the need for behavioral health services across the state. Statewide, Nebraska health centers experienced a 20 percent increase in behavioral health visits from 2020 to 2021. At OneWorld, that percent increase was 34 percent. However, the need for equitable access to behavioral health services has long been a standing issue for our patients. Lower income individuals are twice as likely to struggle with mental health issues and illnesses than the nonpoor. The stress of struggling to make ends meet leads to higher incidences of illness, such as depression and anxiety, and we see increasing numbers of co-occurring illnesses. Moreover, research shows that these linkages are cyclical. Poverty leads to higher incidences of mental health illnesses, and it is more difficult to pull oneself out of poverty when suffering with mental illness. So the cycle continues. Workforce shortages across the state are also a barrier to care. An aging population, insufficient numbers of providers, and the provider-to-patient ratios are a problem. Lack of diversity among the provider workforce all impact our ability to access-- to expand access to services. In behavioral health in particular, there is a significant lack of diversity among providers. In order to adequately understand cultural perceptions about accessing

behavioral health services and address centuries of systemic barriers that lead to distress, we must build a workforce that is representative of our patients. It is imperative as a state that we look at providing healthcare in new and innovative models and ensuring those models create a healthcare system that is accessible to all. Increased use of mobile facilities, expanding school clinics, expanding telehealth are ways to address these healthcare barriers and increase access, especially in rural communities. Expanding training programs that afford individuals the ability to learn where they will live and practice and in developing pathway programs that increase diversity in the workforce will enhance our ability to increase access to behavioral health services across the state. Equitable access to behavioral health services is essential to the overall health of our state. And I'd like to thank Senator McDonnell, though he had to leave, for introducing LR397 and the committee for your ongoing efforts to improve access to healthcare. And I'm happy to answer questions.

ARCH: Thank you. That's quite, that's quite a bit of growth.

ANDREA SKOLKIN: It is quite a bit of growth and we struggle--

ARCH: Will you have to handle that with staffing?

ANDREA SKOLKIN: Pardon me?

ARCH: Was staffing an issue for you because others are really struggling with that?

ANDREA SKOLKIN: Senator, staffing is an issue for everyone.

ARCH: Sure.

ANDREA SKOLKIN: In behavioral health, we have additional challenges because of language issues, and it's even harder to recruit. But yes, staffing is an issue, though I think our staff would say it's a bigger issue than what I see because compared to others, we have done quite well.

ARCH: Good.

ANDREA SKOLKIN: Um-hum.

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

ANDREA SKOLKIN: Thank you.

ARCH: --for your testimony. Is there anyone else that would like to testify on LR397? Seeing no one wishing to testify, there-- I want to indicate that there were two letters that were submitted, one from the Nebraska Association for Marriage and Family Therapy, and one from the Department of Health and Human Services. Senator McDonnell was not able to stay for closing. So with that, we will close the hearing on LR397 and the hearings for the day for the committee.