CLEMENTS: Good afternoon, everyone. Welcome to the Appropriations Committee hearing. My name is Rob Clements. I'm from Elmwood. I represent Legislative District 2, which is Cass County and Eastern Lancaster County. I serve as Chair of this committee. We will start off by having members do self-introductions, starting with my far right.

DORN: Myron Dorn, District 30.

McDONNELL: Mike McDonnell, LD 5, south Omaha.

VARGAS: Tony Vargas, district 7, downtown in the heart of south Omaha.

LIPPINCOTT: Loren Lippincott, District 34.

ERDMAN: Steve Erdman, District 47.

CLEMENTS: Assisting the committee today is Tamara Hunt, our committee clerk. To my left is our fiscal analyst, Mikayla Findlay. Our pages today are Malcolm, from [RECORDER MALFUNCTION] testifier sheets. If you are planning on testifying today, please fill out a green testifier sheet and hand it to the committee clerk when you come up to testify. If you will not be testifying, but want to go on record as having a position on a bill being heard today, there are white sign-in sheets at each entrance where you may leave your name and other pertinent information. These sign-in sheets will become exhibits in the permanent record after today's hearing. To better fill-- facilitate today's proceeding, I ask that you abide by the following procedures. Please silence your cell phones. Move to the front chairs when you are ready to testify. The order of testimony will be introducer, proponents, opponents, neutral, and closing. When you come to testify, please spell your first and last name for the record before you testify. Be concise. We request that you limit your testimony to 5 minutes or less. Written materials may be distributed to the committee members as exhibits only while testimony is being offered. Hand them to the page for distribution when you come up to testify. If you have written testimony, but do not have 12 copies at this time, please raise your hand now so the page can make copies for you. And now we will begin today's hearing with LB46. Senator Dorn.

VARGAS: It's Dorn day.

CLEMENTS: Senator, you're welcome to open.

DORN: Thank you. Thank you, Senator-- Chairman Clements and the rest of the Appropriations Committee. And, no, I did not schedule these five bills at a time, so I don't know why. But we are here and we're glad to have them all at the same time. Also, because many of these, there's a lot of interest by similar type people back here and stuff. So, thank you very much for doing this. My name is Myron Dorn, M-y-r-o-n D-o-r-n, and I represent Legislative District 30. I am here to open on LB46. This bill would appropriate $250,000 to the Department of Health and Human Services for a Medicaid reimbursement rate study of home healthcare, skilled nursing services, and private duty nursing services. To remind committee members, home health is typically the lowest cost option that we have for delivering healthcare services to a wide range of Medicaid beneficiaries. There are members of the state association here to testify about that. I also believe that most Nebraskans prefer to receive as many of their healthcare services while remaining at home rather than being in a hospital or other types of facility care settings. There are types of skilled services that home health agencies provide, including cardiac care, respiratory care, physical therapy, everything except surgery or maternity services can be provided in the home. But delivering those skilled services in the home for Medicaid beneficiaries required skilled caregivers. Most of the time, those skilled caregivers are nurses. We all understand that there is a nursing shortage in Nebraska, and that competition among healthcare providers for nursing services exist. The testifiers behind me will speak to this in detail, but what they have conveyed to me is that they simply can't hire nurses to provide home healthcare services for anything close to what Medicaid reimburses for their services. The result of this is that many hoth helm-- home health agencies simply don't take Medicaid referrals for home health services. In other words, the state isn't able to offer the cheapest form of care to many Medicaid beneficiaries because home health agencies can't hire the nurser-- nurses they need for the reimbursement they receive. LB46 is the first step in determining a solution to this problem. The bill asks for $250,000 for the Department of Health and Human Services so the department can hire a consultant to examine the home health, skilled nursing, and private duty nursing reimbursement rates for Nebraska Medicaid beneficiaries, and determine whether they are meeting providers' annual cost of service. If the study shows that rates need to be increased, it would be a future decision for this committee to determine whether we want to appropriate the money for any future increases. Thank you for considering this bill. Be happy to answer any questions. But just a side note, when you look at the fiscal note, there is a line in there

that says this study would most probably qualify for federal funds, and that this could then be half federal funds and half general funds. So if you look at it that way, and if the study ends up costing $250,000, it's actually $125,000 general fund request. So.

CLEMENTS: Are there questions from the-- Senator Erdman.

ERDMAN: Thank you Senator Clements. Thank you, Senator Dorn. So if this study, it could cost $500,000.

DORN: That we don't know, yes. What we're asking for is $250,000 here in--

ERDMAN: But it says a 50/50 match. So we're, we're appropriating $250,000. And if the feds do $250,000, that's $500,000.

DORN: Oh, then it'd be $500,000. Yes, that could be also.

ERDMAN: So you may not know the answer to this, but what in the world would take $500,000 to do a study. So even at $250,000 at $50 an hour, that's a significant amount of money. And you know what's going to happen when you put this out for an RFP? And they already see that we've appropriated $250,000, how much things are going to cost?

DORN: When we-- when we-- I'll be honest with you and tell you, when we brought the bill, we thought the whole study was going to be $250,000. And that's what it was going to take, and that's what it should be bid out for. Now, after that, I don't know if we have much say or control, but--

ERDMAN: If you ask-- If you ask for $50,000, I think that'd be a lot.

DORN: That would be a lot.

ERDMAN: I think this is a joke, but every time we hear all this-- every time somebody comes for a study, it's $250,000, $500,000 for a study. I want to some time see the billable hours that went into that study, why it cost $250,000. If you only had somebody employed in $100,000 a year, that's two and a half employees for a year. And that's quite a lot.

DORN: And then if there's-- and then if there's extra money left over in there, I think we ought to be able to see where that extra money is at, or if it should come back to us.

ERDMAN: Yep.

DORN: I agree with you. Thank you.

CLEMENTS: Other questions. Just one.

DORN: You bet.

CLEMENTS: I believe, if you determine that there is federal cost share, we'd like to see an amendment--

DORN: OK.

CLEMENTS: --here to reword this--

DORN: All right.

CLEMENTS: --with $125,000 general funds and $125,000 federal funds.

DORN: OK.

CLEMENTS: Will you research that?

DORN: We will research that and have that ready for you when we have-- when we start discussing bills. We will have that ready by then, yes.

CLEMENTS: All right.

DORN: Thank you.

CLEMENTS: Thank you.

DORN: No, thank you for that.

CLEMENTS: We will welcome proponents. Will the first proponent come forward? Welcome.

CARRIE EDWARDS: Hi. My name's Carrie Edwards, C-a-r-r-i-e E-d-w-a-r-d-s.

CLEMENTS: Go ahead.

CARRIE EDWARDS: I'm the Director of Home Care at Mary Lanning Healthcare in Hastings, and I'm president of the Nebraska Association for Home Healthcare and Hospice. Our association represents Nebraska's personal care, home care companies, home health agencies, and hospice

agencies. We would like to thank Senator Dorn for introducing LB46. Home healthcare is provided for Nebraskans ranging in age from infants to the elderly. Aside from delivering babies and performing surgery, home health agencies can provide a variety of skilled care and services in the patient's home and community. This includes cardiac care, respiratory care, disease management, wound care, well baby visits, the physical, speech, and occupational therapy for patients recovering from surgery, hospitalizations or strokes. It is important to note that home health is the lowest healthcare cost option for patients to remain safe, comfortable and independent in their homes. When you ask Nebraskans where they prefer to receive healthcare services and supports, a majority indicate they prefer to remain at home. Nebraska's home health agencies are partners with hospitals, skilled nursing facilities, assisted living facilities, behavioral health, social workers, and other professionals in the healthcare continuum. A key component in the value of home health services is the long term cost savings to our state. Although it is difficult to measure what the number looks like, there are situations every week when home healthcare nurses intervene to help patients prevent and avoid emergency room visits and rehospitalization. In 2020, the need and demand for home health services was forecasted to grow by an anticipated 35 percent by 2030. Medicaid expansion in Nebraska and the COVID 19 pandemic added further to the growing need. In the past three years. Nebraska's hospitals have been at or near capacity, and discharged patients to their home with more complex healthcare needs. Nursing facility closures placed further strain on Nebraska's healthcare delivery system, and has also contributed to the increased need for home health services so that patients can remain in their local communities. The COVID 19 pandemic created further challenges for home health agencies to offer a competitive salary and benefits for nurses and other staff. Traveling nurses are earning at least twice the amount that home health agencies are able to pay. Hiring and retraining trained nurses to provide skilled nursing and private duty home health services has become very difficult. The handout we distributed reflects some initial analysis by an industry partner that has conducted reimbursement rate studies for home healthcare in other states. The handout references that the increase in Nebraska home health discipline costs per visit from 2020 to 2021, based on CMS cost report data, is 9.58 percent for skilled nursing care. That does not take into account inflation since that time, nor the rising cost of fuel for nurses to drive to patient homes. Our agency alone in Hastings recently decreased our service area to 40 miles, effective March 1st, due to the expenses being paid for staff's travel time,

mileage and the inadequate reimbursement rates. We previously served a 60 mile radius, serving parts of 13 counties, and reduced to now serving parts of seven counties. Many of those counties we served previously will have no other home healthcare option. Our association has discussed with the Nebraska Department of Health and Human Services that it has been at least 20 years since a home health reimbursement rate study has been conducted. Our home health agencies have indicated that they have stopped serving Medicaid home health beneficiaries, or have had to limit the number of beneficiaries they can serve. Two years ago, an informal cost report review was conducted looking at a cross-section of Nebraska home health agencies represented rural and urban areas. That review identified Medicaid home health, skilled nursing, and private duty nursing as the areas with the largest gaps of reimbursement rates as compared to actual care delivery costs. We believe that performing a rate study is a more prudent and data driven method for addressing these challenges. As part of this study, our goal will be to determine the true cost of care for home health providers in Nebraska. Home health agencies would be surveyed and asked to provide the amount spent in each of these outlier categories. This information will then be correlated with CMS claims and cost report files to determine total costs and expenses to deliver services. Often, when Medicare and Medicaid rates are determined, they are not based-- I ran out of time.

CLEMENTS: Thank you. That's your time. Are there questions from the Committee?

WISHART: Thank you, I have questions.

CLEMENTS: Senator Wishart?

WISHART: So, what I'm understanding is that, through your own analysis, or through a consultant, you have done a rate study. I'm looking at this, that you do have a sort of a comparison to look at what rates should be.

CARRIE EDWARDS: There's other states that have done great studies.

WISHART: OK. There are other states, this is-- you're utilizing the other states' information--

CARRIE EDWARDS: Yes.

WISHART: -- and data. OK. Thank you.

CARRIE EDWARDS: Yep.

CLEMENTS: Other questions? I had a question about-- you have three different types of providers, home, skilled, and private. Could you tell me what qualifications that differ between-- what type of provider does those three, are they different?

CARRIE EDWARDS: Yes.

CLEMENTS: Does it have to be an RN in each case? Or can there be other--

CARRIE EDWARDS: No. So the skilled home healthcare requires a skilled service for a nurse or a licensed therapist. That could be like the wound care that was mentioned, or disease management, education, IVs in the home. The private duty side, that can be a contract with a patient to get personal care and support services. Some of those require nursing. It depends on the agency and what they're licensed to provide for those members.

CLEMENTS: That didn't answer my question.

CARRIE EDWARDS: Well, I'm sorry.

CLEMENTS: Does it have to be a registered nurse in any of these?

CARRIE EDWARDS: You can have a registered nurse or an LPN.

CLEMENTS: All right.

CARRIE EDWARDS: For the skilled home health.

CLEMENTS: In, in each of these three categories?

CARRIE EDWARDS: Yes.

CLEMENTS: Very good. Thank you. Any other questions? Thank you for your testimony.

CARRIE EDWARDS: Thank you.

CLEMENTS: Next proponent for LB46.

RYAN BEETHE: Senator Clements and fellow members of the Nebraska Legislature Appropriations Committee. My name is Ryan Beethe, R-y-a-n B-e-e-t-h-e. I'm the director of business operations at Maxim

Healthcare Services in Omaha. Testing-- testifying on behalf of members of the Nebraska Home Care Association, as well as Maxim Healthcare. Our members employ nurses, nurse aides, and therapists that deliver medic-- medical care and support at home for your Nebraska constituents. We're asking for support of LB46 would appropriate-- which would appropriate funds for a comprehensive Medicaid home health rate study. Home health agencies are struggling to compete with hospitals and nursing facilities for qualified RNs and LPNs because of the competitive pay facilities are offering compared to home health agencies. Home healthcare is the most cost effective level of care for Nebraska Medicaid beneficiaries, but currently is the lowest funded, resulting in a lack of qualified staff to care for Nebraskans in their homes. Currently, patients who are deemed ready to discharge home by medical professionals are having to wait months, sometimes even years, to discharge home because home health agencies aren't able to hire qualified nursing staff quick enough. At Maxim Healthcare, we specialize in caring for Nebraskans who need around the clock care. Most of our 130 Nebraska Medicaid beneficiaries are pediatrics who have ventilators, tracheostomies, and G tubes. Without nursing support in the home, these patients would be forced into facility level care that would also be paid for by the state, just at a higher cost. A competitive Medicaid fee schedule would allow Maxim and other home health agencies to attract qualified RNs and LPNs so these kids can be at home with their families and loved ones. And I'll add that-- I mean, these are the kids that are born, they're usually at Children's Hospital for about three, six months, and that's when the doctors deem them eligible to go home. And then the process starts we're trying to-- the, the biggest delay right now is nursing. So, if we can hire nurses at a higher clip, we can get them home. And then the cost savings-- I mean, it's-- it is just that-- that's really the smallest component, because you get these little kids home with their families, siblings. And we see it all the time where these kids are ready to go home, and only thing holding them back is just the three or four agencies that provide the private duty nursing for these kids that we just can't hire nurses quick enough. So that's where this rate study's going to show the rate increase that we need. So then basically we can get these kids home. There's-- It, it, it's crazy how many kids that we see just in Nebraska that are born each month that have-- need this level of care. But most of them it's-- you can picture, it's a hospital setting at home. Mom and or dad, grandma, grandpa, they're the primary caregivers, and then our nurses are supporting them. We're confident this study is going to show the gap between current Medicaid fee schedules compared to current-- the

market landscape. The study is going to help the state allocate appropriate funds so home health agencies can hire and retain qualified caregivers, so our fellow Nebraskans can remain at home rather than in facility level of care. Any questions?

CLEMENTS: Senator Wishart?

WISHART: Ryan, thank you for being here, and thanks for, for what your company does for kids. All right. The previous testifiers said that there are other rate studies that have been done in, in states, and so they were show-- able to show us some comparable, sort of, information on where we are and where rates need to be. Why not just use that other states' data and, and, you know, have the department just look at what other states have done. Can it be that different in Nebraska than it would be in another state for these types of services? Or do you--

RYAN BEETHE: We--.

WISHART: --want me too-- should I ask somebody else?

RYAN BEETHE: No, you can ask me. We've actually-- I've sat here and had this same testimony for years. In-- a lot of times there's just not the money to invest, right? That would be the easier approach. But that approach hasn't worked in the past. But we're this-- it would be the $250,000, and if the federal match it would be $125,000 approximately that we filled in, then that would be-- it would be the concrete data showing how far off the rates actually are. So I guess to answer your question, in the past, that didn't work.

WISHART: OK. But you-- there are other states. Would you-- could we argue that there-- would it be fair to say that other states' data could be used for us to look at for comparable needs in Nebraska?

RYAN BEETHE: Absolutely.

WISHART: OK. Thank you.

CLEMENTS: Senator Armendariz.

ARMENDARIZ: Thank you. Thank you for being here. Can you tell me, does your company hire and provide traveling nurses, what they call traveling nurses to these facilities?

RYAN BEETHE: We don't. This is just home healthcare. So we hire RNS and LPNs that care for these kids that only live in Nebraska. So they could be in Kearney, Omaha, any, any small town. But we only hire nurses. We don't do any travel nursing.

ARMENDARIZ: Similar to what the VNA--.

RYAN BEETHE: A VNA--.

--did?

--would do more of, like-- you consider like the Medicare. I mean, they do all different fundings but it might be like that acute need coming out of the hospital, maybe grandma broke her hip and then needing a 60-- 30 to 60 day help. These kids sometimes are-- they come out of the hospital hopefully at six months or a year, and they might have this level of care until-- a lot of times these kids do get their trachs out. So it might be four or five years old, these kids get their trachs out, they're going to school. We actually follow these kids at school, too, and that's paid for the-- by the Department of Education. They get their trachs out, and then they don't need us anymore, usually. Obviously, if they pass away, sometimes these, these kids have this level of care for years.

ARMENDARIZ: OK. So you don't-- you don't contract with any organization. You are your own organization, that you--

RYAN BEETHE: Yeah, we hire our own nurses. We have 250 RNs and LPNs who work for us, and then they staff the hours for the 130 patients that we currently serve. And any hours we can't staff at the home, then the parents are-- help out with.

ARMENDARIZ: OK. Thank you.

RYAN BEETHE: Does that answer your question?

ARMENDARIZ: Yeah.

RYAN BEETHE: OK.

CLEMENTS: Other questions? Seeing none, thank you for your testimony. Next proponent. Good afternoon.

SEAN BALKE: Good afternoon. So, Senator Clements and members of the committee, thank you so much for having me today. My name is Sean

Balke, spelled S-e-a-n B-a-l-k-e, and I am president of private duty nursing for Pediatric Home Service. And, of course, I'm testifying today in favor, and asking for your support of LB46. You know, my agency specifically is a specialist in this, this area of service. We only provide service to the most medically complex, most sick pediatric children that need to come out of an acute care hospital or a rehab hospital. And we do so-- we're really the only agency that does so across the entire state of Nebraska. So we cover a very wide territory. So we see kind of what the circumstances, environments are in, you know, metro areas like Omaha, and then all the way out by Sydney. Right? We get to see kind of everything across the board. And I wanted to thank Senator Dorn, for introducing this, this bill. And I really would like to, to talk a little bit, based on my, my peer's testimony, and I'll deviate a little bit. We do only hire RNs and LPNs, and we, we do not contract with any of the traveling nurse agencies. We can't. They charge way too much, with what we get reimbursed there's no possible way we could make it work. And Senator Wishart, to the point that you brought up earlier. So my organization provides services across ten different states. So we do see different environments, and we've seen rate studies in other states. The one comment I would say that Nebraska is a little bit unique if you look at the demographic data and the supply demand data for Nebraska, there are more RNs from a ratio standpoint than there are LPNs in a very-- a much dis-- a very disproportionate ratio. Right? So another state, for example, I provide services in Missouri, and in that state, the large majority of nurses we employ are LPNs, and a small percentage are RNs. In Nebraska, it's a large percentage RNs, small percentage LPN. So that's going to skew the data a little bit, because Missouri has a blended rate, right? It's one rate for-- doesn't matter if it's an RN or an LPN. In Nebraska, it's distinguished between an RN level, LPN level, high tech, low tech. So there are different ranges for those. So I could-- and to your point earlier, Senator Erdman, you can take my word based on what our candidates are coming to. It's like we get hundreds of applicants, and the nurses are looking for alternative employment settings, because they don't necessarily want to stay where they're at. And so I have data that shows here's what they're asking for. And in my testimony, it says, you know, they're asking for exactly, basically, what we get reimbursed for from the state right now. So we are at --and to answer your question earlier, Senator Clements, we are a CMS certified Home Health agency. So we have significant cost and oversight to be able to be licensed and certified to provide this service. It's not an easy thing to get. So there is overhead and we have to have funding to be able to support that. If we

paid the nurses what they're asking for, we could not survive. It's impossible. So, I can provide data that shows this is what it would take. We're trying to provide an informed way for the state to allocate funds, to say this is what it would cost to adequately fund this, rather than just using our data. I mean, we can do that, and I would be happy to supply that to the committee. But, so that, that is one option. But I think a study would be effective in showing what it actually costs. The one point I will make is that we currently, as an agency, have 28 referrals, this is 28 medically complex children, that are ready to come home, they've been ready to come home, and they cannot come home. And this is to all different areas of the state, because we cannot hire nurses. And the main reason we get rejected by candidates is rates for-- pay rates. But we can't offer them because they have options. So that just illustrates the point that it is-- it's a significant deal, because these, these children are not-- there's not a lot of them, but they're extremely complex and extremely expensive. So if we can't get them out of the hospital and those-- it's about $4,000 to $5,000 on average dollars a day in acute care. If we can't get them out of those settings and get them home to a much lower cost setting, you can start doing the math. We have cases that have been in, in the hospital ready to come home for more than a year, more than two years in some cases. So you add the number of days, times that amount, you start to think, wow, that that costs-- starts to make some sense why we might want to do a study and look at how we can pay appropriately. So with that, I think that's-- I deviated a little bit, but I wanted to hit on some of the points that were brought up in questions, and I'll be happy to stand for questions.

CLEMENTS: Are there questions from the Committee? Senator Armendariz.

ARMENDARIZ: Thank you. Thank you. So how would you-- how would you anticipate you would compete with those traveling nurses' rates?

SEAN BALKE: We can't.

ARMENDARIZ: So.

SEAN BALKE: We can't.

ARMENDARIZ: Health systems are even losing nurses to that.

SEAN BALKE: Correct.

ARMENDARIZ: How would-- how would you think you could stomp that out and pay a normal nurse's rate?

SEAN BALKE: That's a wonderful, wonderful question. We don't expect to compete exactly with traveling nurse jobs, or even with acute care, like Children's Hospital, for example. Home care nursing is unique. There are, there are pros and cons to it. Right? A nurse that wants to work in home care, they typically want to do so because they get to work with one patient instead of 12 on a given shift. We have flexible scheduling. They can help kind of change their hours and flex their hours in a way. They get to work in a, in a home setting rather than a hospital setting. So there's kind of like these features and advantages of the job that make it something that a nurse would say, I can, instead of making $50 or $60 an hour in a hospital, I can come work for you for a fraction of that, but not $20 an hour or, or $25 an hour. So they're willing to take a cut in compensation to come do this work, but not to the extent that they're asked-- they're being asked to take now. So we have to get closer. We're never, we're never going to match those rates, but we have to be able to at least be competitive for maybe 50 percent of the nurses that are out there, that are willing to do this work. So we're, we're trying to get there.

ARMENDARIZ: Have they told you what they want?

SEAN BALKE: Yeah. In my testimony, I, I in here I don't if I hit it. I apologize if I didn't. Our rates are ranging anywhere from the upper thirties to the mid-forties right now, where we get-- that's what we get reimbursed from the state. So that's what's being asked for. They're asking for the 30ish to low forties.

ARMENDARIZ: By these nurses.

SEAN BALKE: In most cases.

ARMENDARIZ: So if we already know, why do we need a study?

SEAN BALKE: I agree. I mean-- we have data.

ARMENDARIZ: OK.

SEAN BALKE: We can present data as an agency.

ARMENDARIZ: Fair enough.

SEAN BALKE: I know my, my counterparts could as well, to say we can look at what our recruiters and what they're telling us that candidates are asking for. And so that certainly is one way. Our mindset was we want to provide an informed, a way for the state to

make an informed decision based on data. I'd be happy to provide. I mean, I have hundreds of examples of candidate requests that I could provide, so that would be an option.

ARMENDARIZ: I appreciate that.

SEAN BALKE: OK. Sure.

CLEMENTS: Other questions? Senator Erdman?

ERDMAN: Thank you, Senator Clements. Thank you for coming.

SEAN BALKE: Absolutely.

ERDMAN: Your last comment stirred a question then. So if you can figure it out, what it should be, why does it cost $250,000 for somebody else to figure it out?

SEAN BALKE: I do not disagree with you.

ERDMAN: OK, So here's my, here's my analysis right? $250,000 at $100 an hour. That's 2500 hours of work, right? 2500 hours divided by four people, that's 625 hours, or 15.6 weeks, four people work on this for $250,000.

SEAN BALKE: Right.

ERDMAN: And you just described pretty explicitly, and simple how you figured out what you should pay. I have no clue why we have to spend a quarter of $1,000,000 to discover what you've already discovered.

SEAN BALKE: Yeah, I would agree with your sentiment. I think that if, if the-- if agencies can provide data that that the committee would feel is valid and is accurate, there would be no need for that study.

ERDMAN: Right.

SEAN BALKE: I think the, the association's intent was to provide a method so that we wouldn't just come to you and say, please take our word for it, that we have a way to validate that.

ERDMAN: I'm not I'm not opposed to the study.

SEAN BALKE: Yeah.

ERDMAN: OK? I'm not opposed to having people getting paid more, so we have people--

SEAN BALKE: Sure.

ERDMAN: --that need to do the job.

SEAN BALKE: Sure.

ERDMAN: My point is we continue to get these that are requesting exorbitant amount of money. And I never figure out for what.

SEAN BALKE: Sure.

ERDMAN: That's what-- that's my point. Thank you.

SEAN BALKE: Sure. OK.

Further questions? Senator Wishart?

WISHART: Would there be a way for your agencies to come together and get us a dollar amount and percentage, and I don't know if there may be even a bill that's addressing that later on, of what we would need to do to get you at that competitive level?

SEAN BALKE: In my opinion, the answer is yes. I think there's a-- collaboration between agencies is really good in Nebraska. I think there's, there's mutual shared interest. No one's asking for anything different than what, you know, Ryan with Maxim provides the exact same service that my company does. So we want to work together to make sure that these kids and families have these options of care. So I think that's absolutely a possibility.

WISHART: And second question is, could you get that to us by the next week?

SEAN BALKE: In the next week?

WISHART: Yeah.

SEAN BALKE: I could. My agency could, yes.

WISHART: OK. Thank you.

SEAN BALKE: Yes. I can't speak for the others.

CLEMENTS: Other questions? I have a question.

SEAN BALKE: Yes.

CLEMENTS: Do you know what percent of your patients are Medicare, Medicaid, and private? Percentages?

SEAN BALKE: Yeah. Large, over 80 to 90 percent Medicaid. And then the rest are going to be-- there's going to be some commercial insurance in there. No Medicare.

CLEMENTS: No Medicare?

SEAN BALKE: No.

CLEMENTS: Oh, right. Well, yeah, you're a pediatric home service--

SEAN BALKE: Correct, Correct

CLEMENTS: -aren't you?. Very good.

SEAN BALKE: Yep.

CLEMENTS: And you are a member of the Home Health Care Association?

SEAN BALKE: Yes. Correct.

CLEMENTS: All right. Very good. Thank you for your testimony.

SEAN BALKE: Thank you so much.

CLEMENTS: Are there other proponents for LB46? Seeing none, is there anyone here in opposition? Besides Senator Erdman.

ERDMAN: I'm not-- I'm not-- I'm not in opposition.

Sorry, that was-- I apologize. Is there anyone here in the neutral capacity? Seeing none, Senator Dorn, your're welcome to close.

DORN: Thank you. Thank you for the hearing there. But I also want to comment one to Senator Erdman, and this comes more from a lifelong learning process. We had a neighboring feed yard about 20 years ago. They needed to have a permit because they had the lagoons and stuff. They needed to be certified by the state. The owner, he wrote it out. He wrote the specs up, exactly what was required, turned it in, and they said you needed a stamp, you needed an engineer stamp. They went

and got an en-- and went and talk to an engineer. It was going to cost $12,000, and they said, no, they're not going to pay that. So he rewrit-- rewrote some of it, turned it in, still didn't qualify. So then they told him without that engineer stamp on there, we won't pass it. So they went and paid the $12,000 to the engineer. He went over the thing, changed about three lines in it, submitted it and got approved. So that's part of your-- when you talk about cost, sometimes there's cost that we, the Legislature, sometimes probably have a part of imposing. So thank you. I'll take any questions. I'll do otherwise.

CLEMENTS: Any other questions? Seeing none, thank you, Senator Dorn.

DORN: Yep.

CLEMENTS: And we have position comments for the record. Five proponents, no opponents, and none in the neutral capacity. And that concludes the hearing for LB46. We'll now open the hearing for LB128. Senator Dorn.

DORN: Thank you again. Good afternoon, Chairman Clements and members of the Appropriations Committee. My name is Senator Myron Dorn, M-y-r-o-n D-o-r-n, and I represent District 30 in the Nebraska Legislature. I'm here today to introduce LB128, a bill to increase the rate paid to Nebraska's hospitals when providing inpatient or outpatient care to Medicaid patients. This bill will increase the Medicaid provider reimbursement rate to 9.6 percent in July 2023, and 7.7 percent in July 2024. Hospital costs are rising. Workforce costs have risen 26.8 percents-- cent since, since 2020. Medical supply costs are up 25.4 percent, and drug costs have risen 42.5 percent. But reimbursement for patients on Medicaid have not kept up, with the average loss for Medicaid care of 60 percent. Last year, this committee and the full legislature increased reimbursement rates for a number of Medicaid providers, giving many of our-- many providers a much needed 15 percent increase. However, no additional increase was given to hospitals at that time. Instead, in 2020, 2021 and 2022, hospitals received just a 2 percent increase, well below the actual cost-- increase in cost to provide services. This bill is intended to allow our committee to discuss the appropriate rate increase to be included in the budget as we move the budget forward. As we know, the Governor's budget did not include any Medicaid rate increase. There will be those behind me with more information as to the consequences of moving forward without any increase, and the importance of our committee determining what rate of an increase we should provide and why 9.6 percent and 7.7 percent may be the right amount. I'm offering

an amendment, which you will see here on the next page in this-- in your hand out to include physician clinic services. We missed this during the drafting stage of this bill. Thank you and happy to answer any questions. I also will note that there was-- we've had several visits with some of the people from Bryan Hospital. They did include some of their information. I did ask them to include some information about what their Medicaid reimbursement and what their dollar amounts and some of the losses that they are and stuff. And then another article there. So. But be happy to take questions.

CLEMENTS: Any questions? Seeing none, would-- we'll have the first proponent.

DORN: Woke me back up. Yeah.

CLEMENTS: Right. Welcome.

JEREMY NORDQUIST: Good afternoon, Chairman Clements, and members of the highly esteemed Appropriations Committee, maybe the most esteemed committee in the Legislature. 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, here today, representing Nebraska's 92 hospitals and 50,000 hospital employees. We strongly support, and thank Senator Dorn for, LB128. This is absolutely critical to preserving hospital services across the state of Nebraska, especially in rural communities. The first slide I have on the PowerPoints coming through, will give you numbers on what's happened with our costs during the two years of COVID, our current year, and projections of-- our best projections that we have available for the next year. During the-- during the fiscal year 2021-2022, which would basically be the two years of COVID, we saw a combined 20 percent increase in those, those-- that time period. In the current fiscal year that most of our hospitals are operating in, our CFOs are reporting a budgeted 6.1 percent increase in costs. And then our CFOs gave us the best numbers they could looking at what would be the second year this biennium in the future. And they project about a 4.2 percent. Good news is the rate of growth is coming down. The bad news is the growth is still growing substantially. So if you combound-- compound the two years of COVID, where we are this year and where we project to be next year, you're looking at over those four years, a 32.8 percent cost increase in hospital services. That's how much the cost to provide healthcare has gone up. The sec--, the third page has why we came up with 9.6. And as Senator Dorn mentioned, we received a 2 percent a year increase in each year of the last biennium. We took those percentages from our CFOs, the 6.1 and 4.2,

and we said, well what-- we, we can't continue to carry the heavy load that we lost in the last biennium without any make-up on that. So we, we really thought hard what, what would that be? And it landed at 3.5 percent a year additional adjustment. When you compound the 2 percent-- the 2 percent with the 9.6 and 7.7, that gets you to 22.8 percent. Again, our costs during those four years would have grown 32.8 percent. So we would still be 10 percent below where we were with provider rates going back to the beginning of COVID. The graph shows you a 21 year history of provider rates compared to hospital costs. Never before has the legislature enacted a zero or negative provider rate unless we're in a state budget crisis. So a 0 percent would be certainly out of-- out of the history of provider rates. The average cost over these 21 years of hospital care grew 5.6 percent. That's, that's a fairly big growth. But is-- it is over a percent below the national average of growth during that time period. But our provider rates in Medicaid, the average annual increase was 1.56 percent. That, that is why if you turn to the next page, we see Medicaid reimbursements for services that are so far below the cost of providing care. A hip replacement in Medicaid costs, and these are audited costs that are submitted to CMS on cost reports, $23,400, and we are getting reimbursed from Medicaid only 38 percent of costs, or $8,800. So what's that mean for hospitals? The growth of costs certainly has been the biggest factor in tough bottom lines for hospitals. It means services are being reduced and we already saw it in 2022. We lost a l--. You'll see the list of services, inpatient geriatric psych unit in central Nebraska, nursing homes in northeast, southwest, and north central Nebraska, orthopedic and nephrology services lost in north central Nebraska, obstetrics services in southeast Nebraska and west central Nebraska. Home Health Services eliminated in northeast and north central Nebraska. A long list of services that have been cut already, and hospitals will continue to have to make those changes. Lastly, I just wanted to-- there was some muddying of the water on provider relief funds, the money that came in from the federal government. All of that had to be utilized for two purposes, COVID costs, or lost revenue. Most of our hospitals had to use it for lost revenue. One hospital system alone, when the state shut down services three times over a two year period, lost $340 million of revenue. They got $80 million in total provider relief funds from the state. So those federal funds didn't even make up a quarter of the lost revenue they ended up having. Those funds have all been expended and all of those reports are public documents that have gone to the federal government. So if anyone has any follow ups on those, happy to answer. Thank you.

CLEMENTS: Are there questions from the committee? Senator Erdman.

ERDMAN: Thank you, Senator Clements. Thank you, Mr. Nordquist for being here. On the fiscal note, can you tell me how the termination is between the state's contribution and the federal funds, is it a percentage, or how do they figure that?

JEREMY NORDQUIST: Yeah, so it depends on the population mix. And the department would utilize the data working with the fiscal office. So if it's, you know, the expansion population, every service we're providing to that population, the federal government is picking up 90 percent of that cost. If it's for a child, the federal government is picking up about 70, 65, 70 percent of the cost. If it's somebody who was already at the pop-- the disabled population, or other populations, the federal government, it's closer to a 50/50 mix. So it depends on the population mix. But ultimately it comes out to almost a 2 to 1 federal match on those-- roughly on those dollars. So every dollar the state would put in in general funds for provider rates, $3 would go into local economies to pay nurses and healthcare workers at our hospitals.

ERDMAN: So are these federal funds, is that are ARPA money.

JEREMY NORDQUIST: Nope. That's, that's just the Medicaid match.

ERDMAN: OK.

JEREMY NORDQUIST: That, that is in statute and will be in statute until Congress changes the law.

ERDMAN: Thank you.

JEREMY NORDQUIST: Yep.

CLEMENTS: Other questions? Speaking of the fiscal note, I assume it does not include the physician clinic services.

JEREMY NORDQUIST: That's right.

CLEMENTS: Is that right?

JEREMY NORDQUIST: Yeah.

MIKAYLA FINDLAY: [INAUDIBLE]

JEREMY NORDQUIST: Yeah. Yes. So the department--

CLEMENTS: This does not include emergency room or dialysis either.

JEREMY NORDQUIST: Yeah. So if you look at the second-- Mikayla filled me in, if you look at the second page of the fiscal notes, the department's estimate-- the department's estimate did include dialysis and emergency room. Those should have been spelled out in the bill draft initially. So as the committee makes this consideration, we certainly would want to make sure emergency room is treated the same as-- for increase as other-- the inpatient and outpatient hospital services.

CLEMENTS: OK.

JEREMY NORDQUIST: Yeah. You might need to get some new numbers from the department on the physician clinic side.

CLEMENTS: OK. Excuse me, I need to make a note on that.

JEREMY NORDQUIST: No, that's all right.

CLEMENTS: Do you know, in your association, what your Medicare, Medicaid and private pay percentages are.

JEREMY NORDQUIST: For the association as a whole, I don't have that number, but I can tell you I have a list of it for every hospital. And the vast majority of our hospitals fall in between 60 and 80 percent, Medicare and Medicaid together. Medicaid is the smaller, certainly the smaller part of that. It can be as high, you know, as 18, 19 percent for a very high Medicaid hospital. It can also be single digits. But in general, the average that most hospitals in our state fall between 60 and 80 percent government paid. And if you're interested, the Medicare increase for the year overall is 3.8 percent. But there's a factor on that for wages, and because we're a lower wage state, that gets ratcheted down. So our increase for hospitals, for Medicare for this year is 3.2 percent.

CLEMENTS: And Medicaid expansion is winding down Have you analyzed how that's going to affect you?

JEREMY NORDQUIST: We've certainly talked to the department, and had a lot of conversations with them about the process. You know, I think if people come in for services, our hospital folk, our hospital social workers and support teams do what they can to check to see if they're eligible for benefits, or if they fall off now, maybe they requalify in the future. You know, at the end of the day, because we-- hate to

say it this way, but because we lose dollars on Medicaid patients, you know, you don't make it up on volume when your margins are negative per, per case. So, you know, we certainly want people to get access to coverage and be covered, and we will help them enroll in Medicaid. That's certainly better than having them be uninsured. But in terms of the fiscal impact, you know, it isn't-- having more people on Medicaid isn't a net plus for hospitals.

CLEMENTS: All right. Let's see. All right.

MIKAYLA FINDLAY: He said Medicaid expansion is ending.

JEREMY NORDQUIST: Yeah, not expansion, but the redeterminations happen in--

CLEMENTS: The Medicaid expansion is here to stay.

JEREMY NORDQUIST: Yeah, right.

CLEMENTS: I'm sorry, yes, right.

JEREMY NORDQUIST: Right. Yeah.

CLEMENTS: The public health emergency--

JEREMY NORDQUIST: Yeah.

CLEMENTS: You understood what I meant.

JEREMY NORDQUIST: Yeah. Yeah, absolutely.

CLEMENTS: And I believe that's all the questions--

JEREMY NORDQUIST: OK.

CLEMENTS: -- we had. Anybody else?

JEREMY NORDQUIST: Always happy if anyone has any follow ups with specific questions. And we have a few hospital folks to talk about their specific situations. Thank you.

CLEMENTS: Thank you, Mr. Nordquist. Next proponent.

PAT CONNELL: Good afternoon. My name is Pat Connell, P-a-t C-o-n-n-e-l-l. I serve as a health policy advocate for Boys Town National Research Hospital. I've been a long term member of the

Nebraska Hospital Association Public Policy Committee. I was asked to testify today to talk about the history and the parallels between what we had in the late seventies and early eighties with inflation and how it impacted hospitals and healthcare. I've been in healthcare for 45 years now. I didn't start when I was 16. I did not. But I've been in, in, in administration for over 45 years. There's a lot of similarities. I put a graph on the top of the page-- I mean in the bottom of page one. It shows the inflation rates for that period. We we breathe a sigh of relief after 10 percent in 1975. Creep creep down to 5.7. And then, then it really took off, and we had a 11 percent, a 13 percent, and then another 10 percent. The biggest problem we had was is that a lot of people were in denial of inflation. They thought of it as a transitory phenomenon, and then they didn't understand the cumulative impact of inflation on cost and revenues and et cetera. If you go to-- so, so if you look at this, this, this deal with inflation, hospitals had really only three options in order to be able to respond to this. Well, actually, four, the fourth one we don't talk about. That is we cost-shifted to the commercial insurance industry because what happened was Medicaid did not keep up. We got very small increases in Medicaid and we had bigger increases in inflation, so we had to make up for the difference. But the three major things that hospitals did was one, is we tightened our belts, and we cut cost. And we have still-- that-- this has become a culture for hospitals. There's not cost anywhere that we can just come back and say, tighten your belt, make up the 20 percent of inflation by cutting your-- by cutting costs. The second thing that we did is that low margin programs, programs that required a lot of subsidy by hospitals. Those were the first ones to go. And the rural hospitals were the most fragile. They had the-- they had a lot of programs who were very fra-- very low margins. So what ended up happening is those hospitals closed programs or reduced capacity. Well, then the people in those rural areas said, hey, I need to go for healthcare. I call my hospital or I call my clinic and I find out I have to wait 6 to 8 months to get an appointment. Meanwhile, at the same time, the urban hospitals are doing the same strategy. They're cutting programs, they're reducing the size of those programs. They're doing this quietly. And those patients from the rural area are now trying to come into Omaha and Lincoln to gain appointment, said they can't get out in central Nebraska and western Nebraska. So what ended up happening is things would be pushed out 6 to 8 months. I had some really good ranching friends of mine in Valentine, Nebraska. They called and begged me to help go find a cardiology appointment in Omaha for their father. And I asked, well, what-- would you-- what do you hear? 6 to 8 months before

they can get in for a, a consult. The third thing is, is that we start to see hospitals and clinics close. They reduce the number of clinic locations so patients had to travel farther. And one of the other things that hit the rural community was instead of having to drive 50 miles or 100 miles for an appointment, they had to drive 300 miles. So to get you to your doctor, you had to waste a day going there, seeing your doctor and waste a day getting back to there. So you lost two days of, of, of work. The last thing is, is that I detailed out on the-- one of the last pages, the hospitals that took dramatic action in the Omaha area. I don't-- I can't recall the hospitals that closed out in the rural areas. Maybe somebody else can. But, but the problem with the inflation was it was a cumulative effect. And so, for instance, Saint Joe's Hospital and Saint Joe's Center for Mental Health, they had to sell out to American Medical International because they only had 21 days in cash on hand. That was a program that was disproportionately taking care of a lot more Medicaid patients. But all these hospitals and programs that are listed in these bullet points had to have significant-- either closed, or they, they, they cut their, their programs and services. So the last two things I would leave you with is, you can't kick this thing down the road. It just ain't going to work. You've got to take some action now because that inflation of 20 percent is going away, those cost increases. You're going to have to do something to make up for it. And then the second thing is, is healthcare is an investment and it's local. And, and talk to your pe-- talk to your people. They'll tell you it's-- healthcare is a local and it's an investment. You can't get people to come and move to Nebraska and take a job if they don't know-- not going to get the level of care that they think they need to get for their, their family. So I've kind of gone through that rather quickly. I appreciate your-- this opportunity to talk about what happened 45 years ago or 40 years ago. But there sure is a lot of parallels.

CLEMENTS: Thank you. That's your time. Are there questions from the committee? I had one question I forgot to ask the previous person. You've given us some cost study information about your association. Did it cost you $250,000 to get it?

PAT CONNELL: No, but later on today, I will be talking about another bill about rebasing of behavioral health inpatient, and I think I'll have some good answers for your question at that time. So stay tuned.

CLEMENTS: Thank you. I would ask, maybe, Senator Nor-- Mr. Nordquist, later. Thank you for your testimony. Oh, Senator Dover.

DOVER: When you talked about rural hospitals, what's your definition of rural hospitals, or where would they be located?

PAT CONNELL: I think of rural hospitals as anything outside of Omaha, Lincoln, and some of the major cities along the I-80 beltway, I mean, I-80 Interstate.

DOVER: Are those reimbursed any differently than hospitals in Omaha that you consider non-rural?

PAT CONNELL: Yes, they are. But I think one of the speakers after me will give more-- better qualified to answer that question.

DOVER: Thank you.

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

PAT CONNELL: Thank you.

CLEMENTS: Next proponent for LB128. Welcome.

PATRICK AVILA: Thank you for the time, today. Good afternoon, Chairman Clements and members of the Appropriations Committee. My name is Patrick Avila. That's P-a-t-r-i-c-k A-v-i-l-a. I'm president and CEO of Merrick Medical Center, located in Central City, Nebraska. Merrick Medical Center as part of Bryan Health. It's a locally owned and governed Nebraska hospital system. We believe in keeping healthcare local, banking with local banks and investing in communities to ensure that rural Nebraska continues to thrive. I've been working in healthcare administration for more than 20 years. I come to you today on behalf of the Nebraska Hospital Association and the Nebraska Rural Health Association in support of LB128. Our hospitals are the lifeblood of our local communities, often serving as one of the largest local employers and providing quality care close to home. For every dollar invested in rural hospitals, $2.30 of economic activity is generated. Concurrently, projections place between two and six rural hospi-- two in six rural Nebraska hospitals are at risk of closure over the next year. When a patient in rural Nebraska comes to their local hospital for care and is deemed in need of a higher level of care, they are transferred to one of Nebraska's tertiary care centers. If patients are not able to transfer to this next level of care, or that care is delayed due to further travel, their care may be negatively impacted. At Merrick Medical Center, our patients can quickly be transferred to Grand Island Regional Medical Center, or CHI Saint Francis for this higher level of care. If those hospitals close

service lines, if they reduce bed capacity or they close altogether because of financial constraints they're under, the patient's next option for a higher level of care is coming to Lincoln or going to Kearney, which is more than an hour either way. For patients in Scottsbluff and Alliance needing a higher level of care, the distance and impact can be even greater. A healthy healthcare system in our state is reliant on every hospital from critical access hospitals to large metropolitan medical centers being reasonably reimbursed for the high quality lifesaving care they provide. The cost of providing care continues to rise as prices of supplies, drugs and staffing increases. The Bryan health system continues to see the proportion of commercial to government insurance shift to a majority of government insurance. In 2022, Bryan Medical Center relied on 29 percent of patients who are privately insured to cover the gap for the 71 percent who are covered by Medicare and Medicaid. This is a tax on every business and privately insured person in the state of Nebraska. Increasing provider rates is essential to our ability to care for Nebraskans of today and Nebraskans of the future. If rates remain where they're at, hospitals will close and services will be reduced. This is bad for every Nebraskan. I want to thank you for the opportunity to share the importance of provider rates for the health of all of Nebraska's hospitals. As you hear from myself and my colleagues today, I ask that you move-- are moved to take action in support of LB128. Friends and neighbors that we mutually serve are relying on you to ensure their access to healthcare. Thank you for your time, and I welcome any questions.

CLEMENTS: Are there questions from the committee? Senator Lippincott?

LIPPINCOTT: How short staffed are you folks, Bryan, in general, on nurses?

PATRICK AVILA: I know as a system it's something that we continue to talk about. So it's, it's a significant reliance on contract staff. I don't have the number for the whole system. I can tell you for Merrick Medical Center right now, and we have 120 employees, eight of those employees are contract staff. So that's about 6 percent of our staff is, is we're relying on travelers to support that need.

LIPPINCOTT: And how much-- do they get paid more, or you pay the agency?

PATRICK AVILA: You look at to two and a half times the salary of those employees, and sometimes more. Yeah, it's a, it's a significant

expense. So for us right now, our volumes are up, our ER volumes are up almost 20 percent this year. Our inpatient or swing bed volumes are up probably about 18 percent, and our outpatient demand is up. So we really don't have an opportunity to cut for our community. There's not-- there's not floors that we have in our critical access facility that we can shutter and continue to provide that care. So it's just basic services to our community. But yeah, about 6 percent of our staff is, is travelers.

LIPPINCOTT: And also what's the vacancy or the occupancy right now of the hospital?

PATRICK AVILA: We-- as a critical access hospital, we vary. Multiple times, just this month alone, we've had more patients needing a licensed bed than we have licensed beds. We do try to transfer those patients when we can. What we hear back from our community when we do transfer, and oftentimes they're in a gurney in an emergency room waiting for a bed at that facility. So we feel like we can offer better care closer to home for those situations. However, based on our bed licenses we offer, we, we usually hit a reduced rate or we're not getting reimbursed for keeping those patients if we need to keep them in our hospital for that care, and we're exceeding that. So we've had a total of, I think, four days just this month where we've exceeded that capacity.

LIPPINCOTT: And one additional. What is the percentage of people that are-- come there and use Medicaid services versus not.

PATRICK AVILA: For Medicaid? We run about 15 percent.

LIPPINCOTT: One five15?

PATRICK AVILA: Yes, sir

CLEMENTS: Other questions. Senator Erdman?

ERDMAN: Thank you Senator Clements. In, in your testimony you mentioned somebody from Scottsbluff or Alliance has a long ways to travel. Most people in my area? They're not going to Kearney. They're going to Colorado. Because it's 200 miles to Denver, and it's almost 275 to Kearney. So we know the eastern part of the state may get those people. But the western part of the state, we go south. We don't come here.

PATRICK AVILA: Right. And the point-- I think that's a great point, so thank you for that. The point is, that's a long ways to go for care. And so depending on your ability to get there, the timing to get there, that can impact your ability or willingness to go to that next stop.

ERDMAN: Yeah, it's easier, of course to go to Colorado.

PATRICK AVILA: And I know there's a lot of reliance on, on air flight to get to those locations, which in itself is a very costly endeavor.

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

PATRICK AVILA: Thank you.

CLEMENTS: Next proponent. Good afternoon, sir.

DEREK VANCE: Good afternoon. Chairman Clements, members of the Appropriations Committee. My name is Derek Vance, D-e-r-e-k V-a-n-c-e. I'm the president of CHI Health St Elizabeth Hospital here in Lincoln, and I'm representing the CHI Health and Nebraska Chamber of Commerce and Industry in testimony today. I appreciate the opportunity to express support for LB128. In my 24 years of hospital administrative experience, I have experienced many turbulent times in healthcare. None more so than today. Most recently, the COVID 19 pandemic pushed our staff to the capacity-- pushed our staff and capacity to the brink. Yet we've remained steady in our resolve to care for our communities. Central to our mission is caring for those who are vulnerable, which in our case is nearly one in five patients who come in our door, about 19 percent have coverage through Medicaid services. Hospitals in Nebraska, however, as you've been hearing, are facing some of the strongest financial headwinds in decades. Our hospitals cannot weather the current inflation crisis without adequate payments from public programs like Medicaid. The reimburse-- for 2023, Centers for Medicare and Medicaid Services increased the Medicare inpatient payment rate to 3.2 percent, or by 3.2 percent. And the state of Nebraska increased Medicaid reimbursement 2 percent. So as a result, Nebraska hospitals will receive minimal payment increase, while costs have soared, as you've heard, over 20 percent in the last two years. So from fiscal year 2020, costs are up 27.4 percent, reimbursement is up 6.1 percent. It's in this context that we find the proposed state budget very concerning. It currently proposes, of course, no increase in Medicaid reimbursements to providers over the next two years, which would place the healthcare community even further behind. We know that

you have many interests to consider when compiling the state budget, and we aren't trying to compete with those interests. We do request that healthcare providers are given consideration so that we can maintain the partnership that we both count on to care for the well-being of Nebraskans throughout our state. Hospitals are the anchor in many communities, providing well-paying jobs and providing essential healthcare to the residents who choose to live, work, and raise their families in Nebraska. We're proud of the fact that we cared for over 187,000 Nebraskans on Medicaid just last year. We will continue to do our part to reduce expenses and cut costs through sound financial practices. But we need your partnership to continue to prevent direct impacts to access service delivery and patient care. We welcome the opportunity to work with this committee, the governor, and our partner health systems in assuring reasonable Medicaid rate increases that will allow our health systems to keep caring for our communities. Thank you, Senator Dorn, for introducing the bill, and to the Appropriations Committee for your consideration. Happy to answer any questions that the committee has.

CLEMENTS: Are there questions from the Committee? Seeing none, thank you for your testimony. Next proponent. Welcome.

CHAD BANCLEAVE: Thank you, Senator Clements. And thank you for allowing me to speak today and also for the committee as well. I want to thank Senator Dorn for introducing this bill on behalf of hospitals. My name's Chad Bancleave, spelled C-h-a-d B-a-n-c-l-e-a-v-e. I am the CFO and vice president of finance at Columbus Community Hospital in Columbus, Nebraska. I have over 26 years of healthcare experience, half of that being with a Medicare fiscal intermediary. I used to do the Medicare audit and reimbursement, and the other half has been on the-- on the-- on the provider side. What I've been passing out today as my testimony today, is to kind of give a quick overview of how the recent inflationary times has impacted our hospital. Our hospital is a 50 bed facility nonprofit located in Columbus, Nebraska. We have over 52 physicians, active medical staff. Standing behind me today would be 930 employees, physicians, clinicians, people who support our staff and also for our clinics and our community. They're also independent. We have over 230 volunteers. Our primary service areas is Platte County, Nebraska, but we also have a secondary market, including Colfax, Butler, Polk, Nance and Boone Counties. We have a 24/7 level three trauma center in our community, which is important. I think the key thing is what we want to provide today from a Columbus Hospital standpoint, we retired our debt in 2012. We're rated in the nation as one of the top 20 hospitals

for rural and community hospitals, and those are based on eight metrics: inpatient market share, outpatient market share, quality, outcomes, patient perspective, cost, charge and financial efficiency. So what you have in front of you as it's being passed out on the first page, which show our last fiscal year, which ended in April of 2022, that was a full 12 months. Our net operating revenue that year is $128 million. Our net operating expenses was $119 million. That was an $8.7 million net income of a 6.8 percent margin. Again, we prided ourselves over the years of, of this simple-- this simple methodology. You take care of your physicians, you take care of your, your staff. They will in turn take care of your patients. And the financials usually take care of themselves. What we've seen in 2023, ten months in through February is that we've seen a significant decline in the net income of our facility. That impact has been solely from the fact that our inflationary cost to both labor and our supplies and purchases, items has brought us down to a 0.1 percent margin and on $114 million, almost $115 million so far this year, $131,000 net income that comes on the heels of an 8 percent increase last year of our charges and another 8 percent midyear that we implemented January of 1 of 2023 just to get ourselves above water. This was the first time in my 14 years that we've ever had a negative margin up to this point. What I want to point out I think is important as well, is that operating expenses, I think people look and, and drive by our hospital systems and say, where's all the money being spent? If you look at our-- at least I can speak to us, is depreciation, amortization, that includes all of our buildings, all of our major medical equipment is, is 7 percent of our total, total operating budget, 1 percent being utilities, but about 63 percent of that, and the majority, is spent on people, our labor. The men and women that come to work each day that care, 24/7/365, morning, night to care for the patients in our community. I know it came up before, I put it here, because I knew it'd be a question, is the number of employees. We have 707 FTEs. Currently today we do have travelers, 13. It's about 1.8 percent. I think we're probably one of the lowest in the state for travelers, and our expense shows that as well. One of the main reasons we've been able to keep travelers so low is because of our ability to pay, attract, and our culture to keep, keep nurses in, in, in our-- in our community. On the next page, you're going to see our statistics. I want at least point out, you can see this is a-- this is a six year look-back based on the first ten months of fiscal year, and it goes from left to right. I want to basically show that we have not seen a decrease based on the number of, of, of statistics in our-- in our volumes going down. Last but not least, I want to show the financial

position up until this point, 14 years running until 2021, our average price increase was 4.39 percent. In the last three years, we've actually raised that price 8 percent, 8 percent and 8 percent to make up for the shortfalls on our commercial payers. Those are self-funded plans, those are individuals out in the community paying commercial, and those are individuals who don't have health insurance at all. And we are proposing another 8 percent. cumulative, that will be a 36 percent increase in the matter of three years onto the backs of the consumers. The last slide, I'm a skip ahead since my time is running short, is that the state of Nebraska actually calculates out what our Medicaid shortfall is. We actually submit information to qualify for special payment under disproportionate share adjustment. We've received that adjustment, at least in my history, since 2008. This last year was $6.8 million in uncompensated care. And I think on the last page that I have in front of you, you can see from 2008 it was a 1.7 per-- or $1.7 million shortfall. That shortfall has increased to $6.8 million over the last 13 years. More importantly, we are taking care of more and more patients under the Medicaid expansion. But you can see the percentage is 36 percent of uncompensated care has now grown to 55 percent. That's a 20 percent increase, so--

CLEMENTS: All right. That's your time. Are there questions? Senator Vargas.

VARGAS: I just wanted to give you the opportunity to finish your thought. I didn't know if you had any more that you wanted to say.

CHAD BANCLEAVE: Yeah. What I want to say is that, and with respect to the NHA, for our hospital, a 9 percent increase next year and a 7 percent increase doesn't get us closer to covering the costs of our salaries and wages. If you think back, 63 percent of what we spend is on our labor and right now, as of 2021, the last year it was audited by the state of Nebraska, they are reimbursing 45 percent of our cost of care for Medicaid patients. 85 percent of the inpatients that we see in our hospital, we have twice as many inpatients than any other hos-- or the average in the state, is related to birthing service. This is basically most of the inpatients that we see is OB. And I know that it was asked for me to say, well, what, you know, what services would you give up? What would you, you know, cease to provide? And, and I hate that question because the fact that we don't want to see any of our services decline, and definitely not OB, but that would be where probably where most of our Medicaid losses are seen. And I, I also I presented in the packet, I gave you a copy of a-- of our calendar. We do this as a kind of a-- from our marketing department

does a great job. But it also is to reach out to our community and I wanted you to see it as well. When we talk about Columbus Community Hospital, I know that the other hospitals can speak to this as well. It's not the building, it's not the equipment. This is Columbus Community Hospital. It's the people, it's the men and women, it's our physicians, our nurses, our clinical staff, our support staff that are there 24/7, waiting for, for, for, our, our community who needs us in a time of need. And if I could, one personal story. I was there working late one night as a CFO, I'm in my office, usually working with numbers, but I heard the call over the the ra- or the, the, the, the intercom and it was code blue Broselow. It's not a common code. It's a-- it's a pediatric cardiac arrest. And so I went downstairs and one of our health supervisors has already responded to this. It was a child, a two year old child, that had been brought in by their mother to one of our offsite on campus locations. That nurse started proceed to, to deliver CPR to save that child's life. And unfortunately, the child had brought in, it was already too late. What I witnessed is something that you probably have heard about, but until you actually see it physically, the amount of, of delicate-- the physician, the nurses, the social workers that had to work with that family as the father came in, and as the grandparents came in, and as the relatives arrived, it went from what I saw is extreme grief and sorrow and wailing to where you couldn't even pick them off the floor, to a moment of anger and misunderstanding that their-- that their child had died. I think what the piece that was missing is not just those-- the technical skills that is made available through these highly skilled individuals in our E.R., but also the house supervisor, because that house supervisor, what I witnessed, is that her first call was to her husband, and she brought in her three kids just so she could give them a hug for about 3 to 5 minutes until she had to get on with her-- the rest of the day. I think that's the piece that's missing in a lot of this, is that we can look at numbers, you can have the balls, you know, CFO come in and talk to you about losing money. But in the end, what I'm advocating for is this increase in Medicaid spending is necessary for the front line technical skill workers.

CLEMENTS: All right. Thank you for that story. Senator Vargas?

VARGAS: I was just going to say thank you. And I have-- I have been to your hospital because my family members have been there, so I visited them when they were receiving care. So I just appreciate you coming.

CHAD BANCLEAVE: Thank you.

CHAD BANCLEAVE: Thank you for your testimony. Next proponent.

LIPPINCOTT: It's the doctor of the day today.

CLEMENTS: Welcome.

DANIEL ROSENQUIST: Thank you. Chairman Clements and members of the committee, my name is Daniel Rosenquist, D-a-n-i-e-l R-o-s-e-n-q-u-i-s-t. I'm a family physician from Columbus and the current president of the Nebraska Medical Association, which represents nearly 3,000 physicians in the state. The NMA supports LB128. A significant increase in reimbursement for hospital services is greatly needed. These facilities are vital to the health of Nebraskans, and many are struggling to continue to provide services that Nebraska can't afford to lose. The focus of my testimony today is on the need for an increase in reimbursement rates for physician clinics. I want to thank the Nebraska Hospital Association, and Senator Dorn for supporting an amendment that would add physician clinic services to the reimbursement rate under LB128. Physician clinics across the state are facing many of the same increases in costs that you've heard about today from our hospital partners, including increases in staff wages due to the competitive market-- labor market, increases in supplies and other expenses. The significant increases in cost is not just anecdotal. NMA survi-- surveyed a number of independent physician clinics to get a sense of how their operating costs have increased since 2020. And what we've seen is that staffing costs have increased 17 percent, supply costs 25 percent and insurance costs another 15 percent. While the cost of operating a physician clinic has seen a significant increase, net patient revenues have simply not kept up, and in some cases have decreased. Physicians saw a 2 percent Medicare payment reduction for 2023. Meanwhile, increases in Medicaid rates for physical healthcare have been slow. The incremental 2 percent increases between 2020 and 2022 came on the heels of two years with no increase. The-- these increasingly thin or negative margins disproportionately affect small, independent and rural physician practices. When reimbursement rates do not keep up, what you see is physicians limiting the number of Medicaid patients they can take in order to stay viable. It is common to hear about ac-- access to care issue from Medic-- Medicaid patients for this very reason. Recently here in Lincoln, there was no pediatrician clinic willing to-- south of, of O Street, accepting new Medicaid patients. As physicians' practices limit the number of Medicaid patients they see, we see increased utilization of ER for routine healthcare and minor illnesses, resulting in increased costs

and further fragmentation of care. Increasingly, we see clinics interested in moving to a direct primary care model due to these payment challenges. And while these may be an attractive option for physicians who choose to cut out third party payers, this further limits access to care for individuals on Medicaid. Finally, we see consolidation, private equity, and absorption of clinic by health systems as it becomes increasingly attractive to move to an employed and salary mod-- phys-- model. This may help some clinics stay viable, but it also reduces competition and has some concerns about the increased costs of healthcare. In 2022, researchers at the University of Nebraska Medical Center reported that 25 out of 93 counties either have no family physician or have physicians that have more than 2000 individuals under their care. When reimbursement rates are low, this makes it even more difficult for physicians to practice in these underserved areas. The result is individuals delaying care because they can't get an appointment or can't make the time to travel to another county for their health-- their mel-- medical needs. As a family physician, I can tell you that delayed care inevitably leads to worse outcomes, higher costs and unhealthy patients. Nebraska needs to invest in healthcare. We need to keep rural hospitals alive. We need physicians practicing in large and small communities across the state. And increasing Medicaid rates will make a difference in the bottom line for physicians and hospital clinics-- and hospitals. It will increase access to care and help hospitals and physicians continue to provide the care that Nebraska needs. Thank you for your time. I'm happy to answer any questions.

CLEMENTS: Are there questions from the Committee? Senator Lippincott?

LIPPINCOTT: Obviously, we know that we've got a shortage of workers here in the state. And can you tell me, with the personnel shortage in offices, in the hospitals, how does that impact the services you can offer?

DANIEL ROSENQUIST: It's been very difficult. We've, we've struggled to find staff across the board, fronts, fronts, people answering phones, people, receptionists, people doing billing, nursing personnel, ancillary personnel. Everybody is out there. We, unfortunately, have to compete with hospitals and other systems for many of these same workers. Some people are just burned out. They just don't want to be in the healthcare arena because they can get paid to the same-- a pretty good wage at a-- at a fast food facility. And so we have to-- we have to make sure that our wages are very competitive and we have something else to offer these people. It's very difficult.

LIPPINCOTT: And also, you've been a volunteers doctor of the day in the Legislature several times.

DANIEL ROSENQUIST: A few times, yes.

LIPPINCOTT: It's a voluntary thing, doesn't pay anythin--

DANIEL ROSENQUIST: Yes. Yes.

LIPPINCOTT: --and we appreciate your service that you offer.

DANIEL ROSENQUIST: Thank you.

LIPPINCOTT: Thank you.

CLEMENTS: Any other questions? Seeing none, thank you, doctor, for your testimony. Are there other proponents for LB128. Seeing none, is anyone here in opposition? Seeing none, anyone in a neutral capacity. Seeing none, Senator Dorn, you care to close?

DORN: Again, thank you for listening and I'll just kind of waive closing. Probably, there's been enough comments made that many of those people have made more than I can possibly do. So thank you.

CLEMENTS: Very good. Seeing no questions, we'll go to position statements, or position comments on LB128. Two proponents, two opponents, and none in the neutral capacity. That concludes LB128. We'll just add one and go to LB129. Open the hearing for LB129, Senator Dorn.

DORN: Thank you. Thank you again. Good afternoon, Chairman Clements, and fellow--

CLEMENTS: Just wait one minute--

DORN: Yes.

CLEMENTS: --there's people coming and going here. Another minute. We need to get the door closed. All right. Senator Dorn, you're welcome to open.

DORN: Thank you. Thank you, Senator Clements, Chairman Clements, and fellow members of the Appropriation Committee. My name is Senator Myron Dorn, M-y-r-o-n D-o-r-n, representing District 30, which comprises all of Gage County and a portion of Lancaster County. I'm here to introduce LB129, to state the intent regarding appropriations

for the Department of Health and Human Services for Medicaid nursing facilities. LB129 would appropriate funds for Medicaid nursing facility services under program number 348. The amount is not specified in the bill. However, in conversing with stakeholders, the total Medicaid amount requested for the biennium would be $40 million, which would rough-- reflect roughly $8 million in state general funds for each of the next two fiscal years. Those of you who've served on the Appropriations Committee previously may recall former Chairman Stinner's intent with a nursing facilities appropriation last session. Nursing facilities received a significant increase in appropriation for the purpose of offering competitive wages. Based on his ana-- analysis, Chairman Stinner clarified that last year's funding was not sufficient to make nursing facilities viable over the long term. Chairman Stinner's intention was to close this gap over a three year period with a plan to appropriate, appropriate an additional $20 million towards Medicaid nursing facilities services each year. I have heard from members of my constituency that operate skilled nursing facilities about the tremendous increase in costs these facilities are facing. These costs, coupled with staffing shortages, unfunded federal mandates, and inflationary costs, are crippling to facilities, not only in my district, but across the state. You will hear from a few of these this afternoon. We have an opportunity this year, due to the cost of living adjustments for Social Security recipients with which the state is able to utilize its Medicaid nursing facility savings to aid in funding this proposal. There will be testifo-- testimony following my introduction to provide more information. And basically that part will be that each resident of a nursing home, that their Social Security check goes towards the nursing home. They're allowed to keep so much of that. They will tell you about the dollars that they keep. I think Senator Holdcroft has a bill out there this year to increase that rate. But because Social Security rate increase, or Social Security payment increase was approximately 9 percent, in that neighborhood, now, that additional funding that went up that level, unless Senator Holdcroft's cross bill passed, that level will stay the same amount for the residents. So that other amount, instead of going to the state, that's the proposal in this year, that would now go to the nursing facilities. So there will be more people later that will be able to clarify and talk more about that part of it.

CLEMENTS: Questions. Seeing none, thank you. We welcome the first proponent for LB129. Good afternoon.

JALENE CARPENTER: Good afternoon, Chairman Clements and members of the Appropriations Committee. My name is Jalene Carpenter, J-a-l-e-n-e

C-a-r-p-e-n-t-e-r. I'm the President and CEO of Nebraska Health Care Association. On behalf of our 184 nonprofit and proprietary skilled nursing facility members, I'm here today to testify in support of LB129. I thought it best to start simple and define a nursing facility. They're commonly referred to as skilled nursing facilities or nursing homes. Nursing home care is provided by licensed nurses and nurse aides under the supervision of a registered nurse. Nursing homes care for those who typically have complex medical conditions, multiple chronic illnesses, and those who need assistance in performing their own basic care. These are individuals who cannot usually be cared for safely in their own home. For a Nebraskan to qualify for Medicaid to pay for their nursing home care, an individual must meet the financial criteria, essentially being low income and having no more than $4,000 in assets. And then the individual must be determined to meet medically necessary requirement. It is critical to understand that nursing home residents who receive Medicaid benefits are hardworking Nebraskans who supported their families and contributed to their communities. They truly believed they planned responsibly for their future. They simply outlived their resources. According to the department, in January of 2023, 60 percent of the nearly 10,000 Nebraskans in nursing homes relied on Medicaid to pay for their care. Simply put, for every ten nursing home residents, six depend on Medicaid. Because nursing homes serve a highly vulnerable population, they are heavily regulated by the federal government. The COVID 19 pandemic brought an onslaught of unfunded mandates and overly burdensome restrictions that did, and continue to, require additional staff. For a state with historically low unemployment, and an underfunded industry that was already experiencing staffing challenges, these restrictions only exacerbated the problem. The result? Nursing home closures. The last 11 closures have been all in rural communities. Many facilities are now turning away residents, and families are driving great distances to find available beds for their loved ones. You have in your handout a map of the care desert that now exists in Nebraska. As a solution focused association, we identified a way to fund LB129. We believe there is a Medicaid savings as a result of the Social Security cost of living increase that requires nursing facilities to pay-- excuse me, requires nursing facility residents to pay a larger portion of their nursing facility payment, and that Medicaid or the state to pay less. An example of this is on page three of my handout. We have been in conversations with the department since December of 2022 regarding this cost of living increase, and we appreciate the collaboration, and although they have told us that this increase would be included in the nursing facility rate, we are still

unclear how the calculation is made. Therefore, we believe in order for the savings to be included in nursing facility rates, there needs to be an appropriation for additional dollars. I would like to thank Senator Dorn for his introduction of LB129 and I would be happy to answer any questions.

CLEMENTS: Are their questions? Seeing-- Senator Erdman.

ERDMAN: Thank you, Senator Clements. Thank you for your testimony. Didn't, didn't the Appropriations Committee appropriate extra money last year for nursing homes?

JALENE CARPENTER: Yes, they did.

ERDMAN: Did they-- did they spend all that?

JALENE CARPENTER: There was two-- are you talking about the ARPA funding or the Medicaid rate increase?

ERDMAN: All of it.

JALENE CARPENTER: All of it. Yes. So the ARPA funding was distributed by the states to the facilities that they have reported in their cost report. It was very specific. It was only allowed to be used for recruitment and retention of staff. And so went solely towards those incentives. As far as, if you're asking me if they-- if the amount of the provider rate increase covered their cost of care. No, it does not continue to cover the costs that are-- of the care that is required for a nursing home resident.

ERDMAN: So you're saying they used all the funds that we appropriated?

JALENE CARPENTER: Correct.

ERDMAN: Thank you.

CLEMENTS: Are there other questions? Looking at your sheet here, you're showing a $150 million difference in the payment. That could be a savings. Times-- that's times 6,000 potential residents.

JALENE CARPENTER: Correct.

CLEMENTS: That's $954,000.

JALENE CARPENTER: So when we did the analysis, maybe I didn't look correctly. Based upon conversations we've had with the department and

with a third party consultant, they estimated it to be roughly $10 million. Again, what we gave you was an average, and that would be per month. And then if you take it over the course of 12 months. Yep.

CLEMENTS: Times 12.

JALENE CARPENTER: Yep. There we go.

CLEMENTS: $11.4 Million.

JALENE CARPENTER: And that would be state and federal funds.

CLEMENTS: That's not just state funds?

JALENE CARPENTER: Correct. That will not just be general funds. The savings would be the cumulative.

CLEMENTS: That's the combination of state and federal.

JALENE CARPENTER: Yes.

CLEMENTS: All Right. Other questions? Senator Lippincott?

LIPPINCOTT: What type of attrition rate do you have?

JALENE CARPENTER: When you're talking about-- are you talking about for residents the length of stay or--

LIPPINCOTT: Nurses.

JALENE CARPENTER: For nurses. And there's operators behind me that can speak directly to that. I can get you with total turnover ratios. I don't have that. I can tell you in the handout on the second page, it talks about-- excuse me, on the first page there, it has our percent of openings that we still have based on the Bureau of Labor Statistics. That would be all staff. I think it is important to understand that nursing facilities, a large portion, is RNs and LPNs, but their greatest portion of their workforce is CNAs; CNAs, housekeeping, dietary. That is the largest portion of their workforce.

LIPPINCOTT: Thanks.

CLEMENTS: Senator Erdman.

ERDMAN: Thank you, Senator Clements. Thank you. I have one more question. This document you handed us--This document here, in the

center of the page it says nursing home residents times number of changes in acuity, by-- December to January it's $1,826 and then it's $1,985. Is that a difference between how much the Social Security payments went up?

JALENE CARPENTER: Correct.

ERDMAN: OK. So it's about 170 bucks.

JALENE CARPENTER: Yeah, roughly. Senator Clements, may have done that exact math.

CLEMENTS: $159.

ERDMAN: OK. Oh one fif-- That's it. OK. I couldn't understand what your question was. Thank you.

JALENE CARPENTER: Yep.

CLEMENTS: And let's see. Other questions? Yeah. I do want to ask about Senator Holdcroft's proposal been mentioned. Does this take into account that adjustment?

JALENE CARPENTER: It does not. And I believe, Senator Holdcroft's bill would have an appropriation amount to it of what that would cost the state.

CLEMENTS: And does your association support that bill or not?

JALENE CARPENTER: Yes, we can-- we sent a letter here.

CLEMENTS: Do you know the bill number?

JALENE CARPENTER: I d-- I apologize, I don't.

CLEMENTS: We can find it.

MIKAYLA FINDLAY: OK.

CLEMENTS: Right. All right. Very good. Thank you for your testimony.

JALENE CARPENTER: Thank you.

CLEMENTS: Next proponent. Welcome.

CHAY INDRA: Thank you. Hello. Hi. My name is Chay Indra, C-h-a-y I-n-d-r-a. I am the secretary of a five person volunteer nursing home board in Clarkson. I have been on the board for 12 years. I have been involved with the facility for over 20. I've been an employee, a family member to grandparents that were residents, and an outpatient receiving therapy after a surgery. Clarkson Community Care Center is rated a five star facility on CMS's Nursing Home Compare. Nursing Home Compare ranks all nursing homes, as well as other healthcare agencies, on a scale of 1 to 5 stars, five stars being the best. It is based off of survey results, staffing metrics and quality measures. Our community depends on us to provide respite care, short term rehab, long term care and therapy services. Prior to COVID, we had also had community members that would come in for baths, blood pressure monitoring and just general nursing questions. We also provided Meals on Wheels. Clarkson is a town of a little over 650 people, and it has a strong Clarkson Czech heritage. Many residents of the facility were business owners, farmers, teachers and clergy in the community. The grade school kids have field trips to the nursing home to play bingo or to do crafts. The high school kids walk through on prom to show off their dresses, or to drive through the parking lot in their tractors during FFA week. There are many high school kids that get their first peek at the healthcare profession by working as CNAs, and as dietary aides. I would like to share some of our metrics with you. We employ about 50 team members and serve 36 residents. Financially, I am not sure what the future holds for us in the next 1 to 3 years. We are having a loss every month. It is simply that it costs more to care for the residents than what we are being reimbursed. Currently, 50 percent of our residents utilize Medicaid to cover their stay. Financials from July 1 to December 31 show a loss of $94,174 for those six months. Our average expense is $267 per day, per resident, with the average revenue being $257 per day per resident. This means that we have a loss of $10 per resident per day. We do have staffing challenges. We utilize the agency nursing. Our administrator covers many different roles within the facility, from cooking to laundry to managing supply and stockroom. Our dietary manager not only cooks meals, but also does transportation to get residents to their appointments. As I think about my time in front of you, I think it's very valuable to tell you a story about one of the elders that we serve. This is about a couple that I know very well. He recently moved into the nursing home. He and his wife have been married for more than 60 years. He was a business owner in town, born and raised in our area. He is very well known and gets many visitors to help pass his day. Because of his illness. He cannot communicate well, but he does understand. People visit him to

tell him about what's going on with the farmers, what's happening in church, and all the preparations for our Czech days. His wife goes to see him every morning and every evening. While it's not home, he is adjusting well. If the facility were not to be here any more, she would not be able to see him every day. I'm not sure she'd even be able to see him every week. It would be a lot harder for his friends to stop by and visit. His quality of life would decrease significantly if the people that he worked with and served in the community were not able to visit and tell him about all the things that he loves and values. I've been around healthcare my entire adult life. The facility does amazing things. We employ passionate people and we care for our elders in our community. We want to continue to be able to do this for years to come. I get it. You have a really hard job. Everyone's asking for funding. But as you go back and start making a decision, I just ask that you think about all of the nursing homes in Nebraska, all of the Clarkson's of Nebraska. It's a very tough decision, but we're worth it, and the elders of Nebraska are worth it. Thank you for your time. I'd be happy to answer any questions.

CLEMENTS: Are there questions? Seeing none, thank you for your testimony.

CHAY INDRA: Thank you.

CLEMENTS: Next proponent. Welcome.

BOB TANK: Hi. My name is Bob Tank. B-o-b T-a-n-k. And thank you, Senator Clements and the Appropriations Committee for-- I'm a proponent of the LB129. I-- like I said, my name is Bob Tank, and I am-- I have been administrator at Bethany home for 15 years. And I've been a long term care administrator for 26 years. And I've worked in long-term Care for 42. We had a-- our, our accountants do a cost analysis of between fiscal year 2017-2018 and fiscal year 2021-2022. And our, our expenses, our costs went up 41 percent in them-- in that time frame. So that was a difference of $90 per day. And so if we've-- each one of them years, the first year that our costs went up 7.19-- 7.15 percent, and most of that cost was due to raises of staff. The next year, our costs went up 1.66-- 1.66 percent, and we did no increases that year. We did a 25 cent across the board increase. And so in-- for 2019-2020, from 2020-2021 fiscal year, our increase-- our, our, our rate increase, our costs increased 9.32 percent and that was due to increases staffing agency. And my assumption is we didn't do rate increases enough or didn't do wage increases enough the year before. So we lost several staff, and because of COVID. And so the

next year, from 2020-2021 fiscal year to 2021-2022 fiscal year, our costs went up 18.11 percent and that was due to increased-- we increased wages and we increased in-- an increase in staffing agency. For-- we increased wa-- we did an increased wage scale February of 2022 and, and July of 2022. And the difference between the end of the-- the difference between seven to-- or July of 2021 and July of 2022 was a 21.48 percent increase in wages that we did in one year. So that was about a $1.18 percent, or a dollar, $1.18 an hour for non-- and that was for non-managerial, managerial employees, which did assist us in recruiting new employees. Our facility had gone from all agency, agency in housekeeping to no agency in housekeeping, and agency utiza-- utilization in nursing has decreased in the last three months from $180,000 to-- a month to about $65,000 March 2023. Thank you for your time, Senators. Is there any questions?

CLEMENTS: Are there questions? Where are you located?

BOB TANK: Minden.

CLEMENTS: Minden. Just the one location.

BOB TANK: Yep.

CLEMENTS: That it? All right. Thank you for your testimony. Next proponent?

LORI DANNAR: Good afternoon. How are you guys? I'm a little nervous, just to let you know. I'm from western Nebraska out in the middle of Scottsbluff and Alliance, a little community called Hemingford, Nebraska. About 800 people total. They've all done such a wonderful job talking about finances and where we sit.

CLEMENTS: Could you give us your name and spelling?

LORI DANNAR: Oh, I'm sorry. Yes, My name is Lori Dannar. L-o-r-i D-a-n-n-a-r. I'm from Hemingford, Nebraska. We-- I serve the Hemingford Community Care Center. So Hemingford, 35 years ago, sent people down here on three bus trips to get the certificate of need to even build our, our center. Alliance is 20 miles away. They had two, and Hemingford did not need one. But we felt like 20 miles was too far for a family to drive. And my mom drove down on those-- rode down on those buses 30 years ago. It has been in our family ever since. My mom has since passed in that nursing home. My dad has passed in that nursing home. 20 miles for me to drive to Alliance to see my mom and dad every day doesn't sound like far. I come to Lincoln, Nebraska, and

I have all the stop-- we don't even have one stoplight in our town, so I get nervous when I'm coming down here. But that's how we live. We are rural Nebraska. We have farmers and ranchers that have put every dime back into their farm and their family to live and to think about-- my mom bought long term care insurance, thank God, but there's very little education on it. I think a big plus for future would be education on this, because most people that I talked to, well Medicare will pay for that. I have Medicare. I have Medicare and a supplement. Education needs to be a prime thing looking forward into the future. But that's future. And we're here today. We have 36 bed nursing home, 13 bed assisted living. I just worked really hard on a lady that lives 60 miles away. She was in Colorado at the hospital. We helped her get onto Medicaid so that she could come to our facility 60 miles away from her family because she's on dialysis. Her family did not know we even existed. And now they can't believe the compassion that our staff has. Through COVID, we had contracted labor, we had agency. We were paying one RN $80 per hour, and my D.O.N. makes $35 per hour. We financially couldn't sustain as a independent facility anymore, so we have since went with a leasing company, which I have support here today from Jeremy. He's with the VITAS Foundation. They are helping us find our way to, to remain sustainable because Medicaid dollars are not supporting us enough to keep our loved ones close to home. And that's what every facility is built on. Each one of you are going to have a parent or grandparent or wife or husband that someday will need a nursing home. And stop and think, if you have to drive 60 miles to hold their hand while they're dying and you have to be away from your other family, your job, how hard is that going to be? So look into the future. Today we have an opportunity to help within the next couple of years. But this is going to be an ongoing problem, because we are just getting more and more with the elderly. There's more of us. I'm going to be one here before too long, and I want the staff that I have at my facility. My staff-- we have not given my staff a raise in three years because they choose to care for the, the families of the residents that are there. But they're getting burnt out. And you, you guys have the opportunity to help not only the staff, the facilities and our communities, but if my facility closes, my community could close because they also get supported from my facility to stay open. So my community of 800 may not exist in five years down the road if my facility isn't. Thank you.

Are there questions? Senator Erdman.

ERDMAN: Thank you, Senator Clements. Thank you for coming. I would assume you came yesterday.

LORI DANNAR: Yeah.

ERDMAN: And you probably won't go home till tomorrow.

LORI DANNAR: Right.

ERDMAN: So it took you three days to come and testify for 5 minutes?

LORI DANNAR: Correct.

ERDMAN: I appreciate it.

LORI DANNAR: And I am very honored. Let me tell you.

ERDMAN: I appreciate that. So you have 36 beds.

LORI DANNAR: Yes.

ERDMAN: How many residents do you have?

LORI DANNAR: We right now have 19 residents.

ERDMAN: OK. So why don't you have more residents? You have not enough help to do that or what's, what's the situation?

LORI DANNAR: Help is one reason. We were low on staff. With VITAS Foundation's help, we just became Medicare certified. We were only-- I won't say only because it's a very important part, but we were a nursing home, we were not skilled, so we couldn't accept Medicare patients. We now are, as of February 1st. So that's going to help us because 90 percent of those that need help come from the hospital, they need rehab, or they need a skilled care, maybe short term, maybe long term. But where we didn't have that component. So we're just now getting into the Medicare aspect of it and a large learning curve there, too. But it's exciting. You guys are, are doing an awesome job and healthcare is exciting. Helping the elderly through that next transition into the next life, death. Not-- very few come into a long term care facility that are going to leave. And we're the last people that they see. And to be able to be caring, kind and know that you all understand what we go through every day and are willing to put that money out there to help us is a godsend. So thank you.

CLEMENTS: Senator Erdman.

ERDMAN: Thank you, Senator Clements. Is there-- is there a list of people you have options, people waiting to get in?

LORI DANNAR: We've had four referrals that we are looking at, but three of them are, as they said before, it's a 56 year old that's a meth and cocaine. And to put them into long term care with an 80 year old farmer might not be conducive. And so there are some issues that we just can't help some. Being in a small community, Crawford, Chadron, Alliance, we all have long term care, so we're all vying for the same people from a few hospitals. And home health has helped keep people home a lot longer. So they're not coming to the nursing home as soon. COVID scared a lot of people. I don't want to be locked up. If I go to a nursing home, our regulations are, you get COVID, they have to stay in their room. Do you guys want to stay in your room and not come out for 14 days? We bring you your meals and still today, that's what's happening. We have to-- we have to hold them in their room per ICAP for 14 days to ensure that we don't. So why would you want to come to a long term care facility? So they are looking at that whole aspect a little bit closer as far as, can I keep mom and Dad home just a little bit longer before-- maybe COVID is going to go away May 11th, maybe magically we won't have to do that anymore. So those are some of the issues.

ERDMAN: So how many employees do you have.

LORI DANNAR: We have 43 employees.

ERDMAN: So I would say, next to a school, you're probably employing more people than anybody else in to town.

LORI DANNAR: A school and our co-op, Westco, we have a grain elevator there that employs. But yeah, we are the next largest.

ERDMAN: Are you familiar how Crawford's getting along?

LORI DANNAR: They are still struggling. They had looked at closing. In fact, they had VITAS also go there and visit with them. I just visited with someone from there. They are hopefully on a better track, but they are struggling also.

ERDMAN: Did they not sign an agreement with the company to manage that?

LORI DANNAR: No.

ERDMAN: They didn't.

LORI DANNAR: No, they did not. They stayed. I think Rural Health is still helping them, Rural Health Development. But Synex of Nebraska's been our-- or VITAS Foundation has been a, a Godsend, to help us get going. We are also applying for the Veteran's Administration for Box Butte County, so hopefully that will help too, because our veterans deserve awesome care.

ERDMAN: How long you been working with Synex?

LORI DANNAR: In May, it will be one year.

ERDMAN: Good.

LORI DANNAR: Yeah.

ERDMAN: They are in Bridgeport as well.

LORI DANNAR: Yes. Yup.

ERDMAN: Outstanding group.

LORI DANNAR: Yeah. So.

ERDMAN: They do a good job. Thank you.

LORI DANNAR: You're welcome. Thank you, guys.

CLEMENTS: Senator Dover.

DOVER: And I'm not familiar with who VITAS is.

LORI DANNAR: VITAS Foundation. Their main offices are in Colorado and Florida. They will either come in with a management contract or we chose-- we were village owned. The village chose to sign a ten year lease agreement. So the building and property are still the village's. But the business aspect, Vitus has now. And so they're in charge of finances. You know, taking care of all of that. The billing problems and all of that good stuff, we just get to focus on residents. So they're hopefully taking over, or not taking over, but they're going to be assisting other facilities, too. They have a lot of knowledge, a lot of fortitude. If you get the facilities working together as a team, I think it helps. We're all in the same business. We're not here-- I'm not trying to steal residents from Alliance. I'm trying to-- let's work together, because they may have a knowledge that I

don't have. And that's what VITAS brings to the table, because they're helping other facilities so we can share ideas.

CLEMENTS: Is VITAS a nonprofit?

_____: For profit.

LORI DANNAR: For profit, Yes.

CLEMENTS: And you know what your Medicaid resident percentage is?

LORI DANNAR: We are approximately 85 percent.

CLEMENTS: 85 percent?

LORI DANNAR: Yeah, because we are a rural farming area. You know, my mom and dad qualified for Medicaid when we were growing up, but didn't take it because they were proud. They were going to do it. And a lot of families just don't have the funds put away.

CLEMENTS: Well, with Medicare eligibility, you may lower that percentage, I would hope.

LORI DANNAR: Yes. Hopefully soon in the future.

CLEMENTS: Did you have to hire staff to-- more staff to become Medicare skilled?

LORI DANNAR: Yes. And that's a problem because we don't have very many RNs in our little area. The RNs that are there-- of course, I mean, our RNs we're paying $32 to $37 per hour, and then go to the hospital 20 miles away and make more. Or another facility that's been Medicare longer and can afford to pay more. But it's our smiling personality that keeps them there.

CLEMENTS: Very well. Thank you for your testimony.

LORI DANNAR: Thank you very much.

CLEMENTS: The next proponent. By the way. Good job. You didn't seem too nervous.

LORI DANNAR: Well thank you.

CLEMENTS: Welcome.

MICHELLE PLOEGER: Hello. Welcome. Good afternoon, Chairman Clements and members of the committee. My name is Michelle Ploeger, M-i-c-h-e-l-l-e P-l-o-e-g-e-r, and I am testifying on behalf of Quality Living Inc, a specialized nursing facility in Omaha. Many of you are familiar with QLI, and the one of a kind rehabilitation and residential care services we provide to individuals who have suffered a brain or spinal cord injury. QLI's care continuum includes a licensed, specialized extended rehab nursing facility whose reimbursement rate is determined in part by the application of the inflation factor. Though not the classification of nursing facility that will be more widely impacted by this bill, we too have a stake in its outcome because our Medicaid reimbursement rate is-- reimbursement is allocated from the same source. QLI has not historically taken a position to advocate for rate increases. Rather, our focus has been on providing incredible care as effectively and cost efficiently as possible, even volunteering rate cuts at times. For over 30 years, we've been able to produce outstanding outcomes for individuals, families and the state of Nebraska, while saving Nebraska millions of dollars. Since the inception of managed Medicaid, however, we have been forced to chase-- change our stance on advocacy due to the financial impact of managed care. QLI's short term rehab nursing facility has fallen under the purview of managed care, Heritage Health, since the most recent expansion. Our experience with managed care is that the MCOs focus on short term cost management at the expense of the best long term outcome for members and the state. This impacts QLI especially because we serve members with complex, lifelong medical needs. Despite our patients high needs, the MCOs have cut off funding for continued inpatient stays in shorter and shorter time frames. This has left QLI in an ever more frequent position of providing necessary care to achieve a safe and successful transition without getting paid for it. Since 2017, the total cost to QLI for these unfunded services is nearly $1 million. QLI also incurred costs during this time for the increased overhead in appealing inappropriate denials, including approximately $100,000 in attorney fees since 2020. We've been able to absorb this degree of revenue loss due to sound management and a healthy payer mix. But the impact is great, and it's not sustainable. Because the MCOs apply utilization management and reimbursement practices similar to commercial insurance, which is an-- inefficient at best, QLI has also had to increase spending on payroll by adding more staff to our team to meet reporting and claims processing requirements. Within the past five years, we've added eight full time staff to meet these demands, resulting in approximately $650,000 in increased spending annually. Given that managed Medicaid

is not going away, and the likelihood of expansion to long term care, we foresee significant financial struggles for nursing facilities, faced with the same challenges we have experienced on top of the financial strains that others who have testified about today are experiencing. The rate enhancement proposed in LB129 would provide much needed support to QLI and every other nursing facility who accepts Nebraska Medicaid now and into the future. Thank you and I'd be happy to answer any questions.

CLEMENTS: Are there questions? Seeing none, thank you for your testimony. Are there additional proponents for LB129? Seeing none, is anyone here in opposition? Seeing none, is anyone in the neutral capacity. Seeing none, Senator Dorn, you may close.

DORN: I want to thank you again for allowing us to introduce that bill, and thank you for some of the testifiers and stuff. So I haven't been doing that in the past, for some people to come from Hemingford down here, it takes a commitment. Just ask Senator Erdman how often he drives that stuff. So, with that, I'll take questions. Otherwise I'll waive my closing again, I think there were some really good comments.

CLEMENTS: Any questions? Seeing none, thank you. We have position comments for the record, on LB129. 20 proponents, no opponents, none in the neutral capacity. And that concludes the hearing for LB129. In just a minute as the--

DORN: Yes.

CLEMENTS: --we rearrange the room. Right now, we're ready for LB130. Senator Dorn.

DORN: Good afternoon, Chairman Clements, and the-- and the-- and also members of the Appropriations Committee. My name is Senator Myron Dorn, M-y-r-o-n D-o-r-n, represent District 30, here to introduce LB130. LB130, as introduced, was similar to LB340 brought by former Chairman Stinner in 2021 to create a separate Medicaid nursing facility budget program. This bill will give a committee-- this bill was given a committee priority. However, time ran out in that session, and with the end of the legislative session, the bill was indefinitely postponed. I'm here to bring it back into the spotlight with proposed amendment in an effort to capture a current practice in statute and eliminate the need to repeatedly add this language to each biennial state budget. We understand the department's opposition to the previous bill and concerns about the original draft of this bill as

that it would create a new and separatary but-- separate budgetary program. AM899 will eliminate that barrier. The amendment will become the bill and will be put into statute. The language this committee is-- [RECORDER MALFUNCTION] for the past three years. This bill, as amended, specifies that the total amount appropriated to the department for Medicaid nursing facility services be utilized in the calculation of rates and used as the base for funding for the following fiscal year. AM899 would also require the department to continue to file its two annual reports with the Legislative Fiscal Office and Clerk of the Legislature. The bill does not appropriate funds or require that funds be appropriated, identifying funding would continue to be the responsibility of our committee through our usual, usual budgetary process. To be clear, this bill, as amended, would continue what the department is already doing. It simply would put these practices into statute. And I think we've had a time or two we've talked about it, I think, I know Keisha was there when we talked about it, we put this intent language in the budget every year. All this is doing is if we put it in as a statute, it, however, has to come to the floor and be passed which I think everybody knows what's going on this year and if-- it might sit there again. But we did have a conversation with the people from DHHS last week or the week before, we've had several visits with them since then, and out of that has come the white copy or the white amendment which is going to be the bill. So other than that, I would take any questions.

CLEMENTS: Are there any questions? And the-- so the amendment changes, just the wording so that they're more comfortable with how the process works, is that--

DORN: Yes. Yes. We did have a visit with them. We've had several visits with them, some other people on my staff and me, I did have with the first time. We've since talked to them again, they are going to be here to testify probably in opposition to the green part but in neutral to the white part because it is something that they wanted to have some input as we brought that forward so that when that could maybe become a statute that, you know, they were involved in the process.

CLEMENTS: Very good. All right. Well, let's invite proponents for LB130. Welcome.

CINDY KADAVY: Welcome. Good afternoon, Chairman Clements and members of the Appropriations Committee. My name is Cindy Kadavy, C-i-n-d-y K-a-d-a-v-y, and I represent the Nebraska Health Care Association. On

behalf of our 184 nonprofit and proprietary skilled nursing facility members, I am here today to testify in support of LB130 as amended by AM899. As-- so some of you may recall that former Senator Stinner introduced a similar bill, Senator Dorn mentioned that as well, and what that did, his effort was really to continue the transparency and the accountability that this committee worked really hard to develop around the nursing facility rate calculation process. So five years ago, any increase in the nursing facility appropriation was indicated as a percentage in the budget and that inadvertently caused a misunderstanding in the calculation of the nursing facility rates as the department was starting with-- from-- with a different number than the Legislature intended. So to remedy the situation in collaboration with our association, the department, and the Fiscal Office, the committee added language to the state budget to earmark a specific dollar appropriation for nursing facilities services, required the full appropriated amount to be used in the rate calculation, and require an annual reporting of how the rates were calculated and any unspent funds back to the Legislature. And these were small changes, but they made a significant difference in the nursing facility rates and in building trust between providers and the department. So as Senator Dorn referenced, initially LB130 would create a separate budgetary program, but that was the concern of the department. So when we met with Senator Dorn's meeting, which he hosted with us and the department, we talked about possible alternatives. So based on that discussion, we feel like AM899 does address the department's concerns. So as amended, the bill would simply place the budget language in statute so it would no longer create a separate budget program. It would just take that language out of the budget and put it in statute. The department is already providing those two annual reports, it would not add any additional reporting. The department has also consistently told us they appreciate the appropriation being identified as a dollar amount in the budget and the guidance on how the Legislature wants the rates calculated because that means the legislative intent is clear to everyone. The bill, as amended by AM899, would simply codify the current practice. We'd like to thank Senator Dorn for his introduction of this bill and happy to answer any questions.

CLEMENTS: Any questions? Seeing none, thank you for your testimony. Additional proponents? Are there opponents? Good afternoon.

JEREMY BRUNSSEN: Good afternoon. Good afternoon, Chairman Clements and members of the Appropriations Committee. My name is Jeremy Brunssen, J-e-r-e-m-y B-r-u-n-s-s-e-n, and I am the deputy director for Finance and Program Integrity in the Division of Medicaid and Long-Term Care

within the Department, the Nebraska Department of Health and Human Services. I am here on behalf of the department to testify on LB130. The department opposes LB130 as originally introduced which would create a separate DHHS budget program for Medicaid nursing facility services. The department's position is neutral with respect to the drafted AM899 language shared with us. LB130 as originally introduced would significantly alter the way we do business, add, add a number of complexities, and add administrative costs without bringing forward any known direct positive impacts for providers or beneficiaries. Separating these funds would limit Medicaid's ability to manage the budget should there be changes or increases in utilization that could create situations where we would need to request deficit funding in order to continue to pay nursing facility claims. We've been able to manage these within our budget in the past without needing to take such, such action. The department generally does not support the concept of codifying business processes or methodologies in statute, but does acknowledge that the language in AM899 reflects the language that is and has been in recent budget bills. Therefore, we do not anticipate any operational impacts to the department with the language we've had the opportunity to review. The department values the ongoing working relationship that we enjoy with the long-term care provider community and associations. We greatly appreciated the opportunity to meet with Senator Dorn and the Nebraska Health Care Association to share our concerns with the original language in LB130 and the thoughtfulness that has gone into the proposed amendment to mitigate our concerns. Thank you for the opportunity to testify and I'd be happy to answer any questions.

CLEMENTS: Are there questions? Senator Erdman.

ERDMAN: Thank you, Senator Clements. Thank you for being here. Are you, are you familiar with what Senator Stinner tried to do last year?

JEREMY BRUNSSEN: I would say yes, sir. Thank you for the question, Senator. I've, I've been very involved in the nursing facility budget. I've been a part of many of the conversations with Health Care Association and with the Legislature in the past.

ERDMAN: So, so was it, was it true that Senator Clements or Senator Stinner was worried or concerned that all the money that was appropriated wasn't actually spent? Wasn't that his concern?

JEREMY BRUNSSEN: So I would, I would say there's a lot of history. I don't know that that was a concern last year. I can say when I joined

the department in 2017 or the fall of 2016, you know, some of the very first meetings that we had were with the Health Care Association and really just trying to drive out transparency in the process. You know, being new I was able to come in and take a fresh perspective. And what I evaluated was, you know, there was just a-- I would say there was friction and misunderstanding between the department, the association, and providers because, you know, we were in a position where we, you know, we're using prior year information to develop, you know, prospective rates and try to estimate what utilization was going to be in a future period. And, you know, so the department had a process that had been being used for years. It wasn't changed. But I think that the way that the budget was intended to be built, you know, didn't reflect that process. It reflected kind of a different understanding going and I can't speak to what it was specifically so I think there was a disconnect initially that, you know, hasn't existed for the last few years.

ERDMAN: So what was your opposition to the green copy?

JEREMY BRUNSSEN: So our opposition is really creating a separate budget program doesn't actually solve any problem that exists today. We do not, you know, pay out of budget programs based on a facility type or type of service. It's based on the member's eligibility. So we would have to go in and recode our MMIS. You know, it creates a level of complexity. You know, nursing facilities not only bill for just the normal standard nursing facility payments, but they also have hospice and therapies that they bill. So it creates a lot of complexity and I think would probably cause some errors and, and really doesn't bring a lot of value if it's not going to increase what we're paying.

ERDMAN: So, so then you're neutral on the amendment, is that correct?

JEREMY BRUNSSEN: Correct.

ERDMAN: So then you shouldn't be concerned at all if we pass this bill.

JEREMY BRUNSSEN: We, we came in a position as a bill, you know, our opposition was truly to the introduced copy of LB130, the original copy.

ERDMAN: But the original copy LB130 is no longer here, it's AM--

JEREMY BRUNSSEN: Well, I don't believe it's actually been, the amendment's been introduced yet.

ERDMAN: So we've sat here for several days and listened to people having issues with the way the department does the appropriations and distributes funds and, and I can see why these people are concerned about having it in the statute. It's been difficult listening to some of these people's testimonies so I think, I think the amendment looks good to me.

CLEMENTS: Any other questions? I think we, we have been unclear as to why it's so hard to just account for something separately so that we can see it split apart and you're, you're talking about with Medicaid. Would you refresh us again on why it is hard to separate that?

JEREMY BRUNSSEN: So there's a-- it's-- there are a lot of considerations that go into why the department would be in opposition to a separate budget program. You know, one, one example would be while the intent is for, you know, very, you know, clear transparency around exactly how much of the money that the department, you know, spent of the appropriation, I, I understand the intent, but there are consequences tied to that. You know, in a given year, if we have utilization, if we have more members in the nursing facility that receive services than what, you know, anyone projected, which has happened, we would actually run out of money in the budget program where today we continue to pay because in the Medicaid broad budget, you know, utilization shifts occur. Maybe one year we have more people getting hospital services, the next year more nursing facility. It allows us to manage the budget without, you know, in the scenario where it's in its own budget, our claims would fail. We couldn't actually process payments unless we had a deficit approved for that specific budget program.

CLEMENTS: Oh, I see, so you-- if it was a separate program, you would be limited to those dollars where all combined you could shift from one type of service to another.

JEREMY BRUNSSEN: Right. Correct.

CLEMENTS: Well, that is helpful. Other questions? Thank you for your testimony. Are, are there other opponents? Seeing none, is there anyone here in the neutral capacity? Evidently, no. So, Senator Dorn, do you care to close?

DORN: Thank you. Thank you for having that conversation. Just wanted to reiterate that we did visit with them a couple of weeks ago and we've had several visits since then. And they knew before they came in

here that we were going to replace the green copy with the white copy. That was part of what the conversation had been and we'll continue to have that as we go forward with our budget. Thank you.

CLEMENTS: All right. Thank you. We'll be joining LB130. We have position comments: four proponents, no opponents, none in the neutral. That concludes LB130. We will now open the hearing for LB131. Senator Dorn.

DORN: And I believe this is my last one today, I think.

CLEMENTS: It is.

DORN: Yes. Thank you. Thank you for listening to all of them. And, and I appreciate sometimes how the schedule is put out so that we kind of have a theme day or whatever. I'm very thankful for that. And also, as you visit with many of the people that sometimes are here for the different bills that they're able to come in one or two days, especially if they're from farther away. Good afternoon, Chairman Clements and fellow members of the Appropriations Committee. My name is Senator Myron Dorn, M-y-r-o-n D-o-r-n, representing District 30, here to, here to introduce LB131. LB131 would appropriate funds for Medicaid waiver assisted-living facility services under Program 348. The amount is not specified in the bill. However, in conversing with stakeholders, the total Medicaid amount requested is the amount necessary to increase rates to the amount determined by the department's contractor. We roughly estimate this amount for the biennium to be approximately $13.5 million, which would reflect roughly $4.9 million in state General Funds for state fiscal year '23-24 and roughly $1 million for '24-25. We will work with the department to get these exact numbers. Those of you who served on the Appropriations Committee last session may recall that former Chairman Stinner introduced LB988 to appropriate funds to the department to carry out a former Medicaid waiver assisted-living rate study. The bill was advanced to General File but time ran out on the session and LB988 was not taken up for debate. In the meantime, the department opted to contract with a third party to carry out their own rate study of Medicaid waiver services by conducting a detailed cost analysis and rate comparison with other states. LB131 would appropriate the funding necessary to increase the Medicaid waiver assisted-living rates to the recommended level in the study's preliminary report, which identified a significant gap between the current payment for those services and the actual cost of care. Based on speaking with assisted-living produce-- providers in my district and other parts of the state, it is

important that Nebraskans, especially those who rely on Medicaid, are able to access assisted-living services when they need assistance but don't require 24-hour nursing care. Those speaking after me will be able to provide additional information on the study and how an increase in rate, rates would increase access to assisted living for Nebraska, Nebraskans reliant on Medicaid to pay for their care.

CLEMENTS: Oh, that's it. Are there questions? Senator Erdman.

ERDMAN: There is. Thank you, Senator Clements. Senator Dorn, it's interesting at the bottom of that statement it says the department contract with a third party to carry out their own study for Medicaid waiver. Can you find out how much that cost?

DORN: I don't know, maybe some of the late, the ones speaking after me. If not, we will try to gather that information. That would be interesting to know so, especially since we had a bill asking for--

ERDMAN: Thank you so much.

DORN: --a study. Thank you.

CLEMENTS: Other questions? Seeing none, proponents. Welcome.

JALENE CARPENTER: Good afternoon, Chairman Clements and members of the Appropriations Committee. My name is Jalene Carpenter, J-a-l-e-n-e C-a-r-p-e-n-t-e-r, and I am the president and CEO of Nebraska Health Care Association. I am speaking on behalf of our 232 nonprofit and proprietary assisted-living community members, and we are here today to testify in support of LB131. I want to clarify, we are talking about assisted living, so I am going to again start kind of simply. In Nebraska, an assisted-living facility is a residential setting where shelter, food, and personal care assistance with services such as social activities, housekeeping, laundry, medication assistance, and transportation services are provided. Assisted-living facilities are regulated at the state level. An assisted-living facility is not a nursing home and cannot provide ongoing care by licensed nurses. Nebraska seniors in an assisted-living facility may qualify for services that fall under Nebraska Medicaid waiver program, which was established in the late 1990s. It is our understanding that there had never been a formal rate study of the assisted-living rate prior to the one conducted last year. Since the establishment of the program, the provider rate increases received have not kept up with the cost of care. In 2022, the Department of Health and Human Services contracted

with Optumas and Myers and Stauffer to complete a-- excuse me to conduct a rate study of services provided under the Medicaid waiver program. The goal of the study was to analyze the cost of providing care and determine reasonable Medicaid rates. Although the formal report has yet to be released, in October of 2022 a preliminary recommendation was issued. I have provided you with a copy of the Optumas assisted-living facility rate recommendations. They recommended parity for urban and rural rates because there was no cost difference. LB131 requests the Legislature appropriate the funding necessary to implement the department's recommended rate of $83.84 per day as identified in the study. I have to clarify, it wasn't the department's recommendation, it was the third-party's study that recommended the rate. I urge the committee to include LB131 within the mainline budget to assist communities across Nebraska in the continued care of our aging demographic. There are testifiers after me that will speak directly to their individual operations. I would like to thank Senator Dorn for his introduction of LB131. I would be happy to answer any questions. I do not know how much the rate study cost.

ERDMAN: Thank you.

CLEMENTS: Other questions? Do you know what the current rate is per day?

JALENE CARPENTER: I do. Maybe I do. I will get that information for you.

CLEMENTS: All right.

JALENE CARPENTER: Sorry.

CLEMENTS: That's all right. All right, thank you for your testimony. Are there additional proponents?

MARV FRITZ: Thank you, Senator Dorn and Senator Clements and Appropriations Committee for listening to our testimony. My name is Marv Fritz. I'm from-- M-a-r-v F-r-i-t-z, from O'Neill, Nebraska. My wife Dee and I own and operate a small assisted living-- stand-alone assisted living in O'Neill. You have a more detailed version of my testimony in your packet. I'll try to highlight our positions. I'll use the acronym AL for assisted living and, and SNF for a skilled nursing facility. I'll try to show you why this bill could potentially, I think, be revenue neutral. Failure of this bill has a potential to end Medicaid waiver for assisted living in Nebraska, most

of Nebraska. We're currently subsidizing the state about $1,385 per resident waiver-- per waiver resident per month in our facility today. Last year, you gave us $20 a day to help with labor costs and it was a one time and it covered about half of the deficit from the cost study. Labor accounts for about 66 percent of our cost, and we cannot compete in the hiring market when we're getting so much less than you provide the SNFs and other health services for those, for the nursing and, and the care, care staff that we need. I'm sure they needed the money, but I don't know why you left AL completely out of the mix. Even at the requested rate, we are still going to be underfunded because those study numbers are already two hours-- two years out of date and the highest inflation we've had in 40 years. We saw a DHHS program on Monday about reporting requirements, not supposed to be required now but it will happen. We're already keeping all the records they are requesting, but would have to have a different format just for waiver. If you pay us for this, we can accommodate it, but you probably won't. The extra recordkeeping was not included in the cost numbers. AL was conceived as a social model and it worked very well as that. Every effort you make to move it into a medical model is destroying it, quite frankly. The bottom line is more reporting is not going to improve the care. It's just going to improve the cost. We believe this bill could end up saving the state money and this is why, if the rates were more fair, we believe that a lot more assisted-living facilities would take waiver residents versus they have to go to nursing homes now because they can't stay in one nowhere. Assisted living won't take them because the rates are so low. Half of the, half of the assisted livings in the state are tied to a SNF so they can move them over in their own facility, the other half don't take any at all or the other half, half that are left and that leaves us small people out there that are in a rural area and only have one facility having to take care of both people at the same levels. It costs the state an average about $100 a day more, more to do in a SNF than it does in, in an AL for the same care and about 15 or 20 percent of the lower end of those residents could be put in an assisted living if they would accept them and that would essentially be enough money-- save the state enough money to pay for the other $40 a day that we need to keep our end of it going. The alternative is going to be pretty soon we'll have to send most of those 1,700 people into a SNF and that's going to cost you about $50 million a year. So we're, and we're in that group of small ALs. We, we don't want to force people to move when they run out of money. It's a huge physical and mental handicap to the residents, and we believe that we can successfully care for these people for the remaining days. We do-- we've, we've introduced physical therapy and a

few other things into our facility, speech and occupational. We keep, I know it sounds morbid, but we keep a lot of our people of within 30 or 45 days of, of end of life now. If we can do this in a social setting, and, and we think we can, it will cost the state much less overall. And our last point was, as Jalene had mentioned, that the real costs in the study were shown to be as high or higher than urban, and we would sure like to at least fix that. We can't continue to subsidize the state much longer, even without the new reporting requirements. But for-- so if you ask us to do more for the same money our decision is going to have to be pretty easy, they're just going to have to go to, they're just going to have to go to skilled facilities. For $50 million a year, you can get all the reporting you want. We'll move on to something else. We don't want to, but we'll have to, we'll just have to, but, and, and it will hurt us. There's no doubt it will hurt us, but it will be doing a lot more disservice to your, to your constituents. And I think-- if you do this correctly, I think it could be close to revenue neutral. It's an opportunity to make a, a good thing better and just instead of being more expensive. Thank you for your time and I'll take any questions.

CLEMENTS: Questions? Senator Erdman.

ERDMAN: Thank you, Senator Clements. Thank you for coming all the way. So how many, how many available beds do you have? How many people will you, will you house at your facility?

MARV FRITZ: We, we have 53 units, currently have 45 residents in AL.

ERDMAN: So how many people do you employ?

MARV FRITZ: I write 33 checks in a month. We have 20 full time and the, and the balance are part time, evening, dinner help, that sort of thing.

ERDMAN: And I would assume most your residents are local people? Most of your local-- residents are local people?

MARV FRITZ: Pretty much, not-- either that-- the only exception is we have some people that their kids live in town. Parents were from someplace else so the kids brought them to O'Neill.

ERDMAN: Thank you.

CLEMENTS: And do you know what percentage you have of Medicaid right now?

MARV FRITZ: Twenty percent. It's run runs pretty close, 17 to 23 it runs, stays pretty steady through the years. And what happened, most of our residents, most of it is people that come in, run out of money, we don't kick them out.

CLEMENTS: OK.

MARV FRITZ: And being rural, it's so hard to do.

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

MARV FRITZ: Thank you.

CLEMENTS: Next proponent. Welcome.

LISA NIELSEN: Thank you, Chairman Clements, and members of the Appropriations Committee. Good afternoon. My name is Lisa Nielsen, L-i-s-a N-i-e-l-s-e-n. I'm the vice president of Ray Brown and Associates, and that's a development company for long-term care facilities. In addition to my role as a developer, I'm also a shareholder in four assisted-living facilities: O'Neill, the gentleman that just spoke, his facility in O'Neill, Ord, Gothenburg, and Doniphan. And all of these facilities were built with, with private money from local investors. And like many assisted-living facilities in our state, they're small in size. They range from 25 to 65 apartments. The buildings are locally owned and governed, and they were developed out of consumer desire for a less restrictive alternative to nursing home care. They've been home to many people and they play an integral role in supporting the local economies that they're in. Generally, the Medicaid person that we serve has lived in the community all their lives. They've worked hard and they've saved, but they have limited income and minimal assets. And unlike many facilities, we don't require that a person pay privately before they can come in or pay privately for a certain number of years. If we're able to meet their needs, they're generally accepted for residency. Assisted living is required to provide for Medicaid residents a furnished private apartment, including all utilities, maintenance, transportation, three meals a day plus snacks, medication administration, and assistance with personal care 24 hours a day. In addition to these services, there are more Medicaid regulatory requirements than for our private-pay residents. We have greater background checks for staff and more reporting requirements for resident status reporting to their, to their caseworkers. So our administrative cost is higher for a medicaid resident than for our

private-pay resident. And last year, DHHS commissioned a rate study. I, I hesitate to mention that, but the, the study concluded that based on cost analysis that the Medicaid portion of the 2022 waiver assisted-living rate should have been $83.84 per day rather than the actual payment of $59.38 per day. So that's the rate that we're getting right now, $59.38. This is a difference of $24.46 per day for $8,928 per resident each year. Based on the department's study, the facility, like the ones that I've mentioned averaging 20 Medicaid residents, lost approximately $178,560 in 2022. The department rate study that was issued or completed in 2020, they used 2021 financial information from Nebraska assisted-living providers to arrive at the recommended rate. And according to Social Security Administration, the cost of living increased by 5.9 percent in 2022, 8.7 percent so far in 2023. So according to inflation, the study that was commissioned in 2022 is now outdated and the proposed rate is already behind by another 15 percent. For assisted-living facilities to continue providing care to Medicaid recipients, the rate must be increased. As you're all aware, the labor market is much more challenging than ever and the cost of doing business is much greater. This is not a matter of it would be nice to have a reasonable Medicaid rate, but it's imperative the rate be increased so we can take proper care of our seniors. And I just appreciate all of your work and what you're doing and, and thank you for taking time to hear my testimony today and I'm happy to answer any questions.

CLEMENTS: Are there questions? Senator Erdman.

ERDMAN: Thank you, Senator Clements. Thank you for coming. So if they did a rate study that's supposed to be $83 a day and they're paying you $59, why don't they pay you the $83? Do you know what the answer to that is?

LISA NIELSEN: I don't know. I would like to know.

ERDMAN: We're going to try to find that out.

LISA NIELSEN: Yeah. Yeah.

ERDMAN: That's crazy. Thank you.

LISA NIELSEN: Thank you.

CLEMENTS: Are there other questions? Do you know how many are on Medicaid and assisted living in Nebraska?

LISA NIELSEN: I don't have that answer.

CLEMENTS: Do you know what percentage your facilities run?

LISA NIELSEN: In our facilities it ranges depending on the location from 10 percent to up to 45 percent Medicaid.

CLEMENTS: That's a big difference.

LISA NIELSEN: Um-hum. It is.

CLEMENTS: Very good. All right. Thank you for your testimony.

LISA NIELSEN: Thank you.

CLEMENTS: Are there additional proponents for LB131? Seeing none, is anyone here in opposition? Seeing none, anyone here in the neutral capacity? Seeing none, Senator Dorn, you may close.

DORN: Well, I, I thank you very much. I thank you for a lot of the questions today and I thank you for putting these all together at one time. It was quite a challenge on part of it, but it was also very nice to have different people that can comment on, on different things today here. If there's any questions, I sure would take them otherwise thank you very much.

CLEMENTS: Any questions? Seeing none, we do have comments for the record on LB131. We have 19 proponents, one opponent, and none in the neutral. And that concludes the hearing for LB131 and Senator Dorn is done for the day here. Our next bill, we'll open the hearing for LB149. Senator Jacobson.

JOE MURRAY: Well, he is probably in a different state by now--

CLEMENTS: All right.

JOE MURRAY: --because he has business with the federal--

CLEMENTS: Oh, yes.

JOE MURRAY: --state board that he was supposed to be at all week and had to be here for some votes.

CLEMENTS: All right. Welcome.

JOE MURRAY: We good?

CLEMENTS: Yes, go ahead and open.

JOE MURRAY: Good afternoon, Chairman Clements and members of the Appropriations Committee. My name is Joe Murray. That's J-o-e M-u-r-r-a-y, and I am the legislative aide appearing here on behalf of Senator Jacobson from District 42. Senator Jacobson introduced LB149 at the request of the Nebraska Hospital Association and his local hospital, Great Plains Health in North Platte. This bill is part of a package of bills brought on behalf of the Hospital Association to address the great need for specific level treatment beds such as psychiatric and rehabilitation beds. Hospitals are struggling to move patients to the appropriate level of care, losing much needed bed space as these patients wait to be moved to the next level of care. This bill is one way in which it can help. Most importantly, LB149 directs the Department of Health and Human Services to rebase their per diem rates paid to behavioral health providers, providing inpatient care and psychiatric facilities, hospital-based psychiatric units, and psychiatric residential facilities. This simply requires rebasing the base amount using more recent claims data, cost reporting data, and other relevant reimbursement information. A rebasing of these behavioral health rates has not taken place since 1993. That's nearly 30 years. The bill also directs the similar rebasing of inpatient per diem rates for rehabilitative facilities and hospital-based rehabilitative units. As you can see from the language of the bill, the amount of the appropriation itself is not spelled out. In discussions with the department, we understand this rebasing can be done budget neutrally with any rate increasing-- increase that your committee includes with the budget. Even a budget-neutral rate, rebasing would be important to determine today's cost rather than continuing to use 1993 figures. It is our hope then that with a more accurate recognition of today's cost to provide these specific services, we can stem the loss of psychiatric and rehabilitation beds across our state. Since I won't be closing, I believe we are going to hear from the department that they have some changes they want and Senator Jacobson would certainly be open to those. And the judicial branch has also approached the senator asking that they be included in the language of this bill so that the rates that probation pays are equal to the rates paid by Medicaid. And Senator Jacobson would be agreeable to those if you decide to do it. Senator Jacobson also was baffled again by the bureaucratic math of HHS on its fiscal note. Roughly half a million per year for what is basically redoing a mathematical formula and then applying to what is already being done with the current formula it seems excessive. I mean, there's almost

$100,000 a year for one new employee. By legislative standards, that's a huge increase. And then maybe we need to be in the-- reconsider careers for rebasing consultants. They want $400,000 a year for a consultant. That seems excessive. Our tax dollars, none of this is about the actual provider rates. This is where our tax dollars should be focused on the ratings, not the bureaucracy of appointing them. This is an important update to our budget language and Senator Jacobson asks that it be included in the budget package that you move forward in the coming weeks. Thank you and there will be others to answer questions.

CLEMENTS: Any questions? Seeing none, did you say you're, you're not staying to close?

JOE MURRAY: No, I'm not.

CLEMENTS: All right. Thank you. First proponent for LB149. Good afternoon.

JEFF FRANCIS: Good afternoon, Chairman Clements, members of the Appropriations Committee. My name is Jeff Francis and I am vice president of finance and CFO for Methodist Health System. As mentioned earlier--

CLEMENTS: Would you spell your name.

JEFF FRANCIS: J-e-f-f F-r-a-n-c-i-s.

CLEMENTS: Thank you.

JEFF FRANCIS: Thank you. As mentioned earlier, Senator Mike Jacobson introduced LB149 at the request of the Nebraska Hospital Association. This is one of many bills submitted on behalf of NHA to support our hospitals. This particular legislation will move the reimbursement to healthcare facilities for patients needing psychiatric or rehabilitative services more in line with the costs to care for these patients. LB149 would direct the Department of Health and Human Services to rebase the per diem rates paid to behavioral health providers when providing inpatient care in psychiatric facilities, hospital-based psychiatric units, and psychiatric residential facilities. The behavioral health rates have not been rebased since 1993, 30 years ago. A rebasing would update that amount to reflect recent claims data, cost report data, and other relevant reimbursement information. The bill would do the same for inpatient per diem rates for rehabilitative facilities and hospital-based rehabilitative units.

It's my understanding that the department could rebase in a budget-neutral fashion, and if the committee would provide a rate increase the rate increase could be incorporated. The rebasing would make a difference for aligning the reimbursement we receive closer to our cost to care for patients at the 20-bed behavioral health unit at Methodist Fremont Health and the 20 beds for inpatient rehabilitative services at Nebraska Methodist Hospital. In summary, I would ask that you include this bill language in the budget package that will be moved forward in the next few weeks. Thank you and I'll take any questions.

CLEMENTS: Are there-- Senator Dover.

DOVER: Yeah, could you explain what rebasing means? I mean, my limited understanding would assume and I'm sure it's incorrect, but you can correct me, just so I, just so I know my starting point is. The base was established in 1993 and, and basically it wishes-- so that's a, that's a, that's your base point you're going to reference from and that things are added based on 1993?

JEFF FRANCIS: Correct, and hasn't been reflective of updated and cost changes in care that would be provided in a more recent review with cost reports and related information.

DOVER: Could you explain how changes in care would affect the base?

JEFF FRANCIS: Could be additional costs associated with a higher nursing census to care for the psychiatric patients or for the rehabilitative supplies that would be required to take care of those patients in either of those settings.

DOVER: OK. Thank you.

JEFF FRANCIS: Um-hum.

CLEMENTS: Other questions?

ARMENDARIZ: Senator.

CLEMENTS: Can you explain how the-- oh, excuse me. Senator Armendariz.

ARMENDARIZ: Thank you. Thanks, Jeff. It's nice to see a friendly face today. Can you tell us for 20 years not having that rebased, what that might mean to your health system in particular?

JEFF FRANCIS: Yeah, over the last 30 years that hasn't been--

ARMENDARIZ: Thirty years.

JEFF FRANCIS: --rebased. What that does is it keeps expanding the difference between what it costs us to care for those patients versus what we receive through Medicaid on a per diem rate. And that rate continues to grow with-- without a rebase.

ARMENDARIZ: So the, the gap keeps getting larger.

JEFF FRANCIS: The gap does keep getting larger. Yes.

ARMENDARIZ: OK. I appreciate it.

CLEMENTS: And the comment is that it's revenue neutral. How is-- or budget neutral, how has that happened? How can that be?

JEFF FRANCIS: For us, what it would mean is that we would have a rebase, so we would get paid more in the psychiatric or the rehabilitative, and likely there would be an adjustment to some other types of services that are provided or are covered through the same DHHS budget.

CLEMENTS: A reduction in something else.

JEFF FRANCIS: Correct, unless there would be additional monies approved or passed through a budget from this committee.

CLEMENTS: Senator Lippincott.

LIPPINCOTT: Is this multiple locations?

JEFF FRANCIS: This would be facilities throughout the state of Nebraska. Yes.

LIPPINCOTT: OK.

CLEMENTS: Senator Dover.

DOVER: Just again, so are you-- so as far as-- are you-- what-- is what you're saying is that if you get the increase because they're just budgeted so much that they would be forced then to cut someplace else?

JEFF FRANCIS: That would be my interpretation. Yes. I have not spoken with the department specifically about it, but there is such a difference between what we're getting paid on a per diem rate versus what our costs are because of not rebasing that we would like it to at least address it for the psychiatric and inpatient rehabilitative settings.

DOVER: Could you just use an example of-- I mean, those numbers don't have to be relevant necessarily, but could you just tell me that if the base was done back then it was this number, but if we rebase it, it would be at this number and how it might affect you?

JEFF FRANCIS: And I know NHA has put out some information on it and they had an example from one of the sister health systems where the base is at a little over $3,000 and their costs on a per diem for-- or per case basis was $6,700. So reimbursement was at 40 percent of the cost in that example.

DOVER: So are you simply then asking us to adjust to the $6,700?

JEFF FRANCIS: Up to, yeah, closer to that number. Yes. I don't know if the actual rebase would get to that cost to provide it because in most cases Medicaid doesn't cover-- doesn't reimburse to cover total cost--

DOVER: OK.

JEFF FRANCIS: --of services but it would get closer.

DOVER: Thank you.

CLEMENTS: Senator Armendariz.

ARMENDARIZ: Thank you. Thanks, Jeff. I don't know if you can share this broadly, but it'd be really important for the senators to understand how the health systems recover these losses if the state doesn't reimburse at the level of cost.

JEFF FRANCIS: As explained in other testimonies today, it really then becomes a burden on to the commercial payers that the rates continue to go up because at the end of the day we will have a very thin margin. And to the extent that the costs aren't covered from a governmental program that's becoming a larger portion of our-- of the care that we provide and the patients that we care for, it does then go on to the commercial rates and going on to the employers and the employees within the state of Nebraska.

ARMENDARIZ: Thank you.

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

JEFF FRANCIS: Thank you.

CLEMENTS: Next proponent. Good afternoon.

PAT CONNELL: Good afternoon. My name is Pat Connell, P-a-t C-o-n-n-e-l-l, and I'm here on behalf of LB149. I've been a longtime member of the Nebraska Hospital Association Public Policy Committee. I probably been on that committee probably for 15, maybe 20 years now. I've also been a very active member with the Nebraska Association of Behavioral Health Care [SIC] Organizations over the last 33 years. I have been president four times and served in a variety of different capacities. At one point in time back in the '80s, I was a chief financial officer for St. Joseph Center for Mental Health. And, and then in the early 1990s is where I was at the first rebasing conference that the state of Nebraska had. This was in about 1992. They hired a consultant, the consultant came in, they gave him a bunch of reports. The reports back then were called FA-20s. FA-20s were-- I don't know what ever happened to them, but every hospital that had an inpatient program or an RTC had to produce annually this FA-20 and swear under blood that this was accurate and complete. And this gave the department an understanding as to what the cost was for providing those services. So what happens over a period of time is The Joint Commission, who does our accreditation, add standards on, and then also if the state of Nebraska revises its Medicaid regulations or licensing regulations, and sometimes those add cost. And so what has happened over-- so what happened was we had a director of HHS, who has long who left the state, decided to have this rebasing. The first report that they got back, based on our cost report, said that the state would have to alter and increase our rates substantially. Well, that wasn't going to be acceptable because that's not budget neutral, but it portrayed the difference between cost and the rate. We went through seven different renditions of that report and somebody in the department gave us a copy of those reports. They were 36 inches tall for those seven renditions of those reports. And finally, it's like Goldilocks and the Three Bears, they came up with a report that was just right. Well, that matched, the rate matched what was there for budgeted dollars. What ended up happening was that was about 50 to 70 percent of the actual cost of what it, what it was costing us on operating cost alone for providing that, that, that service. We seriously objected to that. We, we laid it out and said this is going

to decimate the mental health system over a period of years, by shortchanging to that we're going to have to depend upon our med search hospital brethren to support the costs of the mental health services. You have seen and in details on the end of my testimony, there's a whole bunch of providers that have closed their doors since 2000, and, and those programs used to be supported by these hospital inpatient programs because they wanted the patients when they went to go home, we wanted continuity of care. We-- and so that's why we were supporting these rural hospitals, I mean, rural mental health centers and, etcetera. The reason this is, this is sort of a solely a problem of inpatient and, and the RTCs is that we don't get mental health region dollars like the mental health centers do and, etcetera. Our money comes from commercial insurance, Medicare, Medicaid and some self-pay. And from time to time, maybe child welfare or juvenile justice. But it's a, but it's a very small amount. So the director said, well, we're too late, this is June, the, the new budget year starts in July. We'll fix that in the future. We've been waiting 33 years for fixing this. So what the mental health community has done is we have commissioned reports on our own. I wish Senator Erdman was here because I would love to tell him about the cost methodology that we use. We gathered those FA-20s, we turned them over to Simon Johnson an accounting firm in Omaha that's a national healthcare accounting firm. And they took those reports and we've come before the Legislature in the past and asked for some increases. Our, our typical increase is anywhere from 1.96 percent to about 2.3 or 2.4 percent. We are extremely grateful for the 15 percent rate increase we got last year because that's the difference between survival and closing our doors, at least on a temporary basis because our costs were going up 20 to 20-some percent. So the reason we are proposing this and the reason we want to move forward with this is we got to do, we got to do an open and transparent process. Let's get the information on the table. Let's resume these FA-20 reports. Let's see what it really costs us for to provide inpatient and PRTF services and then, then figure out a way to reimburse accordingly. And it's probably going to take some additional money. But you can't increase mental health services if you're not going to be-- and nobody's going to open new programs when the cost difference between the rates and the costs are, are such a big spread. Sorry for running over.

CLEMENTS: That's OK.

PAT CONNELL: Thank you.

CLEMENTS: Thank you.

PAT CONNELL: I hope it's helpful.

CLEMENTS: Are there questions? Senator Dover.

DOVER: You might have already said this, but what is the current spread?

PAT CONNELL: I'm sorry, what?

DOVER: What would, what would you consider an average of the current spread?

PAT CONNELL: Oh, from, from discussion with my peers, it's, it's still probably 50 to 70 percent of the reimbursement is-- our, our cost-- our, our reimbursement is 50 to 70 percent of our cost.

DOVER: OK.

PAT CONNELL: And it all depends upon which, which kind of inpatient or PRTF program.

DOVER: All right. Thank you.

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

PAT CONNELL: Thank you. Appreciate the opportunity.

CLEMENTS: Next proponent.

JEREMY NORDQUIST: Good afternoon again, members of the Appropriations, the highly esteemed Appropriations 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. Be real brief. Just want to on, on the point of budget neutrality, we certainly would appreciate this being considered in your provider rate increase. I know you had hearings already this week on behavioral health. Certainly that, that is where we want to go. I think, you know, when we talk to our hospital executives, obviously base rates and the issues we talked about earlier today are, were, were priority number one. But right behind that is behavioral health capacity because it is having other impacts on our hospitals. We started doing a report every month of how many patients are sitting in our hospitals unnecessarily. It ranges at any given time. It's a snapshot report between 250 and 290 patients, and a significant portion of those are behavioral health patients that we can't get placements for. So we need inpatient capacity, we need to support it,

we need to nurture it. We need to create an environment where we preserve and even expand inpatient behavioral health capacity in the state. And it comes down to being able to operate and for Medicaid patients operating at those numbers are, are right. It's about a 50 percent loss right now because you go back to 1993, you make that year your point in time, well, your costs since 1993 have grown faster than, than the rate of, of increases provided through the state budget. So we're asking to make progress on that. But we also think the rebasing is important just to kind of reset the decks in terms of the costs of providing behavioral healthcare to make sure that the pie, however big you decide to make the pie, that the pie is distributed reflective of the costs of providing that care, so. Take any questions.

CLEMENTS: Any questions? Seeing none, thank you for your--

JEREMY NORDQUIST: Thank you.

CLEMENTS: --testimony. Are there additional proponents for LB149? Seeing none, is there anyone in opposition? Seeing none, is anyone here in the neutral capacity?

KEVIN BAGLEY: Don't feel like I can get away without answering questions about this one.

CLEMENTS: All right. Good afternoon.

KEVIN BAGLEY: Good afternoon, Chairman Clements and members of the Appropriations Committee. My name is Dr. Kevin Bagley, K-e-v-i-n B-a-g-l-e-y. I'm the director of the Division of Medicaid and Long-Term Care within the Department of Health and Human Services here to testify in a neutral capacity for LB149, which would require our division to annually rebase several services using the most recent Medicare cost report as its basis. LB149 would bring a significant amount of new work to the division by requiring the department to rebase the following rates on an annual basis: inpatient psychiatric facilities, hospital-based psychiatric facilities, psychiatric residential treatment facilities, rehabilitative facilities, and hospital-based rehabilitative units. I want to take a second here to, to talk a little bit about what rebasing implies. As, as we've heard in previous testimonies, what it really reflects is an effort to evaluate the underlying basis on which we set a rate. So looking at things like the direct care cost components, the overhead cost components, if there's technology involved in certain services,

looking at the relative risk of a service, and then what the implications for malpractice insurance might be, all of these factors come into play when we look at what rate should be set for a service. And so when we talk about a budget-neutral rebase, what we're really saying is we, we take a, an amount of money spent on these services. And, and for sake of math, because I'm not ready to do a whole lot of really complicated math on the fly, if it's $1 million total that's paid for these services, we take that pie of $1 million and shuffle it up or down on a relative basis based on the new underlying basis developed in that rebase. So a budget-neutral rebase implies increases in some service rates, but decreases in others to offset those increases. So when we talk about that as a budget neutral, I, I want to be clear that doesn't change the size of the pie. It just shifts the relative size of individual service rates. Rebasing rates is more complex than simply applying a percentage increase or decrease to rates. It requires evaluating payment categories, like I mentioned, relative to each other and adjusting the basis for calculating those payment amounts. There is a substantial amount of analysis necessary. When Mr. Connell talked about 36 inches of paper in 1993, those cost reports have not gotten more simple or less complex in that amount of time. I can tell you, having worked with a lot of those in order to do some of this rebasing work, if you printed those all off today, it, it would probably be a lot more than three feet high. It would fill this desk three feet high and you still wouldn't touch it. So it is a considerable amount of work. And part of that would also include incorporating those changes in that reimbursement methodology in new authority from our federal partners, as well as incorporating that into our capitation rates that we pay to our managed-care plans in order to ensure that those changes are reflected in the payments that they make. Given the volume of work necessary and significant complexities involved in implementing, implementing the new rebasing process, the bill imposed deadline of July 1, 2023, does not allow for the Department to adequately do so by that date. We would not recommend an effective date for those newly rebased rates until at least July 1 of 2024 in order to incorporate the amount of time needed to really have that discussion with providers as well as our federal partners. The bill also requires the department to produce an annual report containing information regarding behavioral health bed capacity. This information would be incredibly valuable in identifying service gaps, as well as providing better insight into service availability throughout the state. However, we would need to create some internal infrastructure and reporting instructions for providers in order to promul-- and as well as promulgate regulations in order to

have all of that information at our disposal. That also takes time. One other thing I'll mention is the, the bill requires this to be done on an annual basis. Given the amount of work and the fact that those underlying cost factors don't typically change dramatically from year to year, while sometimes they do, that's atypical, we would request more flexible language to the tune of something like once every five years or at least once every five years.

CLEMENTS: That's your time but we're--

KEVIN BAGLEY: That's my time.

CLEMENTS: --interested in the department's information so please continue.

KEVIN BAGLEY: So I, I will wrap it up quickly by just saying that we appreciate all of the opportunity to collaborate with partners across the state, with Senator Jacobson's office, in order to kind of have these conversations and, and really work through this. We recognize the need for improved behavioral health service delivery across the state. And so we want to be clear, these changes we're recommending are not in an effort to delay or put off, but rather to ensure that this gets done right in a way that's sustainable moving forward.

CLEMENTS: Are there questions? Senator Dorn.

DORN: Thank, thank you, Senator Clements. And thank you, Director Bagley, for being here. You mentioned in here that Medicaid is generally supportive of rebasing rates on a periodic basis. They don't require anything, then?

KEVIN BAGLEY: You know, if there is statute that does require it, we can follow that. So there are other bills, for example, in our critical access hospitals that this year would require that to be done on a periodic basis. That makes sense, frankly, for us to do. And we do that with relative periodicity depending on the nature of the service. So we're supportive of doing those rebasing, whether it's in statute or not. It certainly doesn't require statutory language for us to do it.

DORN: Well, then my follow-up question will be, you know, I know you visit with other states and you talk--

KEVIN BAGLEY: Yeah.

DORN: --a lot among, amongst your peers or whatever. Do other states do it more often or how have-- what do you hear from some of them?

KEVIN BAGLEY: You know, it varies quite a bit. There is a significant amount of work associated with doing these, these types of rebasing and so generally you will see this come about as a result of statute. And the reason why is because it often requires an increased appropriation in terms of resource to, to do the work. So if, if states don't have that resource readily available, there's usually some legislative action that has to take place in order to facilitate that.

DORN: Thank you.

CLEMENTS: Senator Armendariz.

ARMENDARIZ: Thank you. Thank you, Director, for being here. So this, the rebasing hasn't been done in 30 years,--

KEVIN BAGLEY: Yes.

ARMENDARIZ: --what do you, what do you think is an appropriate amount of time that we could set as a standard to rebase, every three years, every five years?

KEVIN BAGLEY: So the, the language I think I might recommend would be at least once every five years. And I'll give a little bit of explanation as to that. The-- at least ensures that it has to be done at least that often. But it also gives us an opportunity to be flexible in years like the last several where we've seen dramatic shifts in costs. We may not want to use the previous year's costs to rebase rates for the first year of the pandemic or, conversely, we may want-- may not want to take the last year of the pandemic's costs to be the basis for moving out of the pandemic rates. And so it would give us the flexibility from a statutory perspective to work with stakeholders in the community to, to say what does make sense. It also alleviates part of that resource burden on the state. But I think we're open to having a discussion as to what the industry and other stakeholders think makes sense.

ARMENDARIZ: OK. So you're, you're fairly new to your position. Correct?

KEVIN BAGLEY: Yeah, I've, I've been here about two and a half years. Yeah.

ARMENDARIZ: Yeah. So do you think putting it in statute would be a good motivator since it hasn't happened in 30 years, we'd want to actually put that in the statute to make sure that it happens? And are you thinking that you want it at least every five years because it could benefit the state or would you do it at the direction of, say, providers that find that they're being underpaid again, would you do it at the direction of them as well?

KEVIN BAGLEY: So I'm, I'm, I'm going to try and answer that in a couple of ways and feel free to follow up if I don't adequately answer them for you, Senator. I think whether or not it's in statute we're supportive of, of doing these periodic rebases. The fact that it hasn't been done in 30 years, I don't know that I can speak to kind of the why or any of that, but it does make sense to reevaluate these. I think one of the, one of the barriers that states run into in doing that work is we do sometimes come to the conclusion that costs have outpaced appropriation, and that puts us as state agencies in a difficult position because we, we don't manage the purse string. Right? That is the role of the Legislature to make those appropriations decisions. And so it puts us in a position that can be sometimes difficult in saying we see here in the data that we're covering, say, 50 percent of your costs, but we're not in a position to change what percentage of your costs are being covered short of an appropriation from our legislative partners. And so in, in that difficult spot of I don't necessarily want to try and come and tell this committee how money should be spent. But at the same time, I, I, I think it's helpful to have that data so that everyone is starting from the same position and understands the current state of, of the market.

ARMENDARIZ: Yeah, I, I would say speaking for myself, I would appreciate knowing with my eyes wide open--

KEVIN BAGLEY: Yes.

ARMENDARIZ: --and not having blinders on so I'd rather know exactly what it is instead of just kind of letting it sit there without looking at it.

KEVIN BAGLEY: And I agree. I, I, I would prefer to err on the side of transparency. The reason I share that is, is really just that, that is, I think, the sensitivity that, that you find with a lot of state agencies nationwide, right, is we can't necessarily just come to a legislative body and say you're going to have to pay more. But

starting with kind of eyes wide open and being clear about the current state of the market, having this in statute allows for everyone to kind of come together and say we see what is going on--

ARMENDARIZ: Be clear.

KEVIN BAGLEY: --and we can make decisions based on that.

ARMENDARIZ: Thank you.

KEVIN BAGLEY: Yeah, thank you.

CLEMENTS: Senator Wishart.

WISHART: Thank you for being here, Director.

KEVIN BAGLEY: Thank you.

WISHART: I may be way off on this, can you, can you correct me? Would TANF funds be able to be utilized for any shortfall that would come should you find that in rebasing there needs an additional amount of dollars to support this type of aid?

KEVIN BAGLEY: So I will caveat this with saying I am not an expert on TANF funding. That being said, generally speaking, we're not able to leverage federal funds to offset our Medicaid dollars because that ends up kind of being a, a position where we use federal funds to pull down federal funds. And so we wouldn't likely be able to do that, whether that could be done completely separately from Medicaid reimbursement, I don't know. I, I would probably have to defer to someone who has more expertise on TANF funding requirements.

WISHART: OK. I'm not an expert either so appreciate your candor there. The one other question I have is picking up with what Senator Armendariz was saying. If the Legislature were to know that a rebasing were to be happening within the next couple of years, would it work for us to set aside a certain portion of dollars that then should that rebasing result in an additional need that we would have set some dollars aside for then you to be able to utilize for, for, for that need?

KEVIN BAGLEY: You know, I think-- I'm not sure--

WISHART: OK.

KEVIN BAGLEY: --the best way to answer that. But I, I think what I would say is we would be happy to sit down with anyone here in, in this committee, as well as stakeholders in the community, to try and work through what makes the most sense in terms of planning for the future.

WISHART: OK. Thank you.

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

KEVIN BAGLEY: Thank you.

CLEMENTS: That was a neutral capacity afternoon.

WISHART: He was lucky Senator Erdman wasn't here.

CLEMENTS: Yeah. Anyone else in the neutral capacity? Seeing none, he's not going to close. So we have for LB149, we have six position comments: six proponents, no opponents, and none neutral. That concludes the hearing for LB149. We'll open the hearing for LB525. Senator Fredrickson.

FREDRICKSON: The grand finale.

CLEMENTS: Good afternoon.

FREDRICKSON: Good afternoon. All right. Good afternoon, Chair Clements and members of the Appropriations Committee. I'm John Fredrickson, J-o-h-n F-r-e-d-r-i-c-k-s-o-n. I represent District 20 which is in central west Omaha and I'm happy to be here today to introduce LB525 which provides a 15 percent increase in provider rates for psychiatric diagnostic evaluation and for evaluation and, and medication management follow-up visit services. It was brought to my attention by substance use treatment and mental health providers that a critical service paid for by Medicaid was at an extremely low rate making it more and more difficult to provide the service. That service, which enables providers to conduct a diagnostic assessment evaluation and to monitor and adjust medications, is known as a psychiatric diagnostic evaluation and management or more, more generally known as just medication management. I passed out the service definition for you today for additional information. A medication prescribing healthcare professionals, so like a, like an APRN or a psychiatrist or physician assistant must be the one directing this care, which can make it more costly than just talk therapy. The service is provided in both inpatient and outpatient settings, and it allows more patients to be

moved out of expensive inpatient settings while also allowing them to receive continued support as their conditions improve. I know as a mental health provider myself how important psychiatric care and follow-up services are to an individual's recovery in management. Appropriate provider rates are necessary to allow more individuals to be served especially in our ongoing mental healthcare crisis. I also bring to you today AM909, which also appropriates dollars to the Supreme Court to allow for increased provider rates for these same services. The Administrative Office of the Courts asked me to bring this amendment to ensure we would not have different rates for DHHS than for the Supreme Court. My staff followed up with the Fiscal Office to ensure we were proceeding as per usual course with this amendment. I also want to make mention to the fiscal note, so there has been a little bit of confusion with that. So the figures included are substantially higher than the actual costs. So this is because there was confusion about the intent of what would actually be covered in this bill and who would be covered under this bill. So multiple codes cover the service of psychiatric diagnostic evaluation. But our intention with this legislation is to cover the initial diagnostic interview and follow up with established patients afterwards. There are actually only six codes that we intended to cover with this legislation. So providers covered include: medical doctors, doctors of osteopathic medicine, physician assistants, and advanced practice registered nurses. So my staff has been in contact with the Fiscal Office and Fiscal is getting new estimates to DH-- from DHHS based on the intent of this bill. So they have that request up to DHHS currently. So we'll continue to work with them and we'll hopefully get that worked out as quickly as possible. We have others here today who will testify as to the details of the service and the costs associated with it. And they will talk in more detail about who will, who this will actually cover. With that, I'd be glad to answer any questions you may have.

CLEMENTS: Are there questions? Seeing none, will you stay to, to close?

FREDRICKSON: I will be here to close. Yes.

CLEMENTS: All right.

FREDRICKSON: All right.

CLEMENTS: All right. Thank you, Senator.

FREDRICKSON: Thank you.

CLEMENTS: We'll welcome the first proponent for LB525. Good afternoon.

TAMI LEWIS-AHRENDT: Good afternoon, Senator Clements, members, members of the Appropriations Committee. 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, a private nonprofit corporation doing business in Nebraska with service locations in Lincoln and Omaha. I'm here today to testify on behalf of CenterPointe and the Nebraska Association of Behavioral Health Organizations in support of LB525. LB525 increases rates by 15 percent for the services that are identified as psychiatric diagnostic evaluation management, or simply put, medication management. These services are provided in outpatient settings where the prescriber conducts an evaluation of the individual's need for psychotropic medications, provisions of prescription, and ensures an ongoing medical monitoring of these medications. These appointments are provided by a prescriber, a doctor, a PA, nurse practitioner, or DO, and require the support of a nurse or medical assistant who check vitals, review the overall health of the individual receiving the service. Medication management services are critical to keeping individuals out of hospitals, emergency rooms, Corrections, and other law enforcement encounters by ensuring they have access to effective medications and that those medications are working or by providing an adjustment to those medications if they aren't. Because these appointments are related to the prescribing of medication, they must be provided by high-level professionals. The current Medicaid rate for the service falls short of covering the cost of the appointment by 18 to 20 percent at CenterPointe. The service requires not only provider time, but includes nursing support, coordination of care and access to medications, medication education, and assessment of other health-related issues necessary to ensure safe and effective care for the people we serve. Provider time plus these added and necessary expenses means a loss on each and every service we provide in this array. The requested 15 percent rate increase would allow us to further bridge the gap between our costs and the reimbursement. We've appreciated the support of the Legislature over the last few years. Most recently passing a 15 percent rate increase last year. This saved us. Our personnel costs are the biggest single expense, and the rate increase helped us attempt to meet those increased costs. We're asking you to please pass the emergency funding increase of 15 percent for medication management so we do not have to turn away people for the lifesaving care and access to the medications that allows them to live

their lives. Thank you for your consideration, time, and commitment to serving Nebraskans. I'm happy to answer any questions I can.

CLEMENTS: Are there questions from the committee? Senator Armendariz.

ARMENDARIZ: Thank you. Thank you for being here. Can you tell me when you have a patient, an ongoing patient that regularly is seen, how many, how many months does, does he or she have that prescription available--

TAMI LEWIS-AHRENDT: So it would depend--

ARMENDARIZ: --for refills?

TAMI LEWIS-AHRENDT: Yeah, sure. It would depend on the individual and the medication of the severity and complexity of the issue that's being treated. Mental illness is oftentimes a chronic issue like heart disease and diabetes and takes ongoing care. So a number of the patients that we serve at CenterPointe we've been serving for the last, well, I've been there 15 years and I know there are folks that have been coming to see our psych providers for at least that long. Oftentimes, those medications diminish in effectiveness and so they have to start new medications which takes more frequent visits until they're stable and then maybe they're seen once every six months to validate and ensure those medications are still functional. So initially, if somebody comes in for a diagnostic appointment they may be seen that time and then maybe a two to four week follow up depending on the medication and then maybe a two to week-- two to four week follow up after that. And then it might be six months before they need to be seen again if that medication is deemed effective for them. They can call and say it's not working or I'm having side effects, just like any medication that we take and be seen sooner if needed. Does that answer your question?

ARMENDARIZ: So if, if you're trying to regulate the medication right off, do you, do you have them come in each time or do you just bump it up or bump it down over the phone?

TAMI LEWIS-AHRENDT: We try to-- no, we try to see them in person. We try to have them come in for evaluation. I guess it would depend on what they're reporting. And I'm not a clinician, so this is based on my knowledge of working with the staff that we work with and seeing the frequency of visits. But it would depend on the, the side effect that was being reported. But typically we try to see them if they're

complaining that the medication is ineffective or that they're experiencing something negative, if they're asking for a, a titration or a change to the medication.

ARMENDARIZ: OK. Thanks.

CLEMENTS: Other questions? Excuse me. Let's see, just a minute.

TAMI LEWIS-AHRENDT: No worries.

CLEMENTS: Was the intent of this for medical management only or also when other services are provided?

TAMI LEWIS-AHRENDT: My understanding is that the intent is just for the diagnostic interview and then the five visit codes that follow. So it's a limited array of visit codes related to the evaluation and management of medication support for psychotropic medications.

MIKAYLA FINDLAY: [INAUDIBLE]

CLEMENTS: I'm being told that are codes for epilepsy and sleeping disorders included?

TAMI LEWIS-AHRENDT: My understanding is that this is just for mental health provision. So I don't-- we don't contemplate that, including epilepsy, unless it's an individual who has a co-occurring issue. So they may have both a, a mental health concern and epilepsy, in which case they may be treated in the same appointment because the medications may encounter with each other but they wouldn't be exclusive for an individual who has epilepsy, to my understanding.

MIKAYLA FINDLAY: [INAUDIBLE]

CLEMENTS: Yeah, I'm being told the codes are the same and the fiscal note is based on the language of the bill which-- or an analyst may need to fine tune or the bill may need to be fine tuned to carve out things that are being including in the fiscal note.

TAMI LEWIS-AHRENDT: For sure.

CLEMENTS: I had a question about do you know with CenterPointe what percent of Medicaid patients you have?

TAMI LEWIS-AHRENDT: Yeah, currently in our, in our psychiatric programming so that the, the, the program that is impacted by this specific bill we have about 61 percent Medicaid.

CLEMENTS: And then some Medicare?

TAMI LEWIS-AHRENDT: We do have some Medicare.

CLEMENTS: And then some private?

TAMI LEWIS-AHRENDT: Some private and some Division of Behavioral Health so those region paid folks.

CLEMENTS: And the-- this would be the Medicaid portion that this bill would cover.

TAMI LEWIS-AHRENDT: Yes, sir.

CLEMENTS: All right.

TAMI LEWIS-AHRENDT: Yeah.

CLEMENTS: Other questions?

TAMI LEWIS-AHRENDT: Just to clarify, Medicaid pays these services differently than Division of Behavioral Health and that's where a lot of the disparity comes in. The Division of Behavioral Health has just a set rate for medication management, and it's paid on a, a 15-minute increment. So if an appointment is 15 minutes, it's, it's one-fourth of that rate or it's the rate and then if it goes longer it's times 15-minute increments where Medicaid pays on a CPT code basis. So they're coded services billed not necessarily based on time, but on severity and complexity of the services provided within that appointment. So that's sort of where Medicaid gets out of proportion compared to other payers because of, of how those CPT codes work.

CLEMENTS: All right. That sounds complicated.

TAMI LEWIS-AHRENDT: Sorry, if I made it overly complicated.

CLEMENTS: No, analyst says it is.

TAMI LEWIS-AHRENDT: It is, it is. Yeah.

CLEMENTS: Seeing no other questions, thank you for your testimony.

TAMI LEWIS-AHRENDT: Thank you.

CLEMENTS: Are there other proponents for LB525?

HEATHER NIELSEN: Hello.

CLEMENTS: Welcome.

HEATHER NIELSEN: Thank you for having me. Good afternoon, Chairperson Clements and members of the Appropriations Committee. My name is Heather Nielsen, H-e-a-t-h-e-r N-i-e-l-s-e-n. I serve as the medical director at Lutheran Family Services. Today, I'm testifying on behalf, behalf of LFS in support of LB525. I want to say we're grateful for Senator Fredrickson's leadership on this issue and appreciate the Appropriations Committee's long-standing commitment to providers across the state as they work to serve some of the most vulnerable Nebraskans. Since 1892, LFS has served children and families, beginning as orphanages in Fremont and Omaha, has now become one of the largest nonprofit health and human services agencies in the state, with locations across the state of Nebraska, as well as an office in Council Bluffs, Iowa. As the needs of the individuals, families, and communities have changed over the years so have our programs. We provide comprehensive behavioral services for children, families, and special populations, which includes veterans and refugees. Our psychiatric medication management teams provide services out of offices located in Lincoln, Omaha, and Fremont at this time. Each of the core treatment teams within this program is comprised of one psychiatric prescriber and a medical assistant or, or a licensed practical nurse. Both of these individuals possess specialty expertise required for the populations we serve. Those populations are largely comprised of persons with complex treatment needs, including those popu-- excuse me, including those with severe persistent mental illness, substance use disorders, dual diagnoses, and mental health board commitments. This service position-- provision requires not only psychiatric assessment, prescription of psychotropic medications and monitoring over time, but also a significant amount of coordination of care, psychoeducation and support for the individuals and families to ensure that they're understanding the process needed to access and navigate the system adequately. Over 61 percent of the clients seeking services from LFS utilize Medicaid funding, and the expansion of Medicaid has certainly served to improve access to care for individuals and families within our communities. Unfortunately, that reimbursement doesn't entirely cover the costs of service provision. We're now consistently seeing a six-figure loss in our psychiatric

medication management program, which we mitigate by conducting fundraising and donations, as well as limiting the number of clients to whom we can provide services at times, unfortunately. Lack of access to psychiatric medication management services can lead to serious health and social impacts for individuals, families, and communities at large. The lack of adequate reimbursement makes it difficult to build and maintain capacity within the specialty medical program at LFS where we strive to ensure that all community members are served in a person-centered, team-based, and holistic health model of care. To sufficiently ensure that LFS can meet the growing needs of Nebraskans an 18 to 20 percent reimbursement rate would be needed. The 15 percent increase proposed in LB525 would make a significant impact on the financial stress that our providers face and ensure the continued ability to serve Nebraskans who are the most vulnerable. I agree with the, the last testimony that this decreases hospitalizations and unnecessary use of higher levels of care. I'd like you to please incorporate LB525 into this year's budget package and I'd be happy to answer any questions.

CLEMENTS: Are there questions?

HEATHER NIELSEN: Can I offer-- I'm sorry, I could speak to the CPT coding a bit if you wanted.

CLEMENTS: I had one question first. Do you know what percentage of Medicaid you provide?

HEATHER NIELSEN: Sixty-one percent.

CLEMENTS: All right, and then, yes, you're welcome to speak to the codes.

HEATHER NIELSEN: OK. So the codes that we're talking about that, that go across the spectrum, are called evaluation and management codes or E&M. And those are actually the same CPT codes, the numbers for each one that are utilized across a number of medical services for follow up for established patients. So it's based on medical decision-making and/or time of care spent with the client. It's not limited to psychiatric practices or, or provision of psychiatric services so I'm assuming that the, the wording in the bill must speak to the practitioner who's providing it or the, the location of the service. Does that make sense?

MIKAYLA FINDLAY: [INAUDIBLE]

CLEMENTS: All right, her understanding is the code is for both psychiatric and other types of care and it's hard for us to isolate the cause separately.

HEATHER NIELSEN: OK.

CLEMENTS: Reject it.

HEATHER NIELSEN: That makes sense.

MIKAYLA FINDLAY: The fiscal note shows more than the [INAUDIBLE].

CLEMENTS: All right, so the fiscal note is really more than what the actual cost would be.

MIKAYLA FINDLAY: [INAUDIBLE] that the language is broad.

CLEMENTS: Oh, OK, right. The, the language is broad and it's not sure, we'll have to see if the senator can work on that.

HEATHER NIELSEN: Well, in the intake code or the PD with medical services, that's specific to psychiatry. So it's just the E&M codes that you're going to need to clarify.

MIKAYLA FINDLAY: OK, that helps.

HEATHER NIELSEN: Good.

CLEMENTS: All right. That helps. Thank you for your testimony.

HEATHER NIELSEN: Thank you.

CLEMENTS: Did I miss any questions? No. Other proponents?

PAT CONNELL: Good afternoon, my name is Pat Connell, P-a-t C-o-n-n-e-l-l. I'm here as a proponent for LB525. I've been asked to speak on behalf of Boys Town, Boys Town National Research Hospital, and Nebraska Hospital Association. Well, first of all, I'd like to thank the senator for introducing this bill. I just would like to just put this into some sort of real-life context as what's going on here. About 20 years ago, and I'm going to do it from the perspective of Boys Town, about 20 years ago, Boys Town was having children in our RTC and our skilled family homes and, etcetera, and they would be returning to their home community. And we would-- and if they were on psychotropic medications, we would try to get an, an appointment with a psychiatrist back in, in the rural area. And what we found is, well,

first of all, there's a, there's a severe shortage of child psychiatrists. But when we called them and, and it was their kid in the first place, sometimes it's like 6 to 8 to 10 to 12 months away. You can't, you can't do that with psychotropic medications for children. You got to have that follow up because their, their bodies are changing. They're growing. So I went to our leadership at the hospital and then we went to our board of directors and said we have to do something about this at Boys Town, we have to figure out a way of creating that continuity of care. And so I got permission, in my old job I was the vice president of behavioral health, this started about 20 years ago, started recruiting child psychiatrists kind of from all over the country. And we now have the largest number of clinical child psychiatrists in the midwest is in Omaha, Nebraska at Boys Town. Now the, the thing that we're trying to do here is, is that we're trying to do two things: one, is we, we get referrals from all over the state of kids that have been put on multiple psychotropic medications by family practice doctors, pediatricians, other people that may not have as much experience as a child psychiatrist. So we have gotten at least 600 kids that have been referred to us by Health and Human Services that are on these medications and we take them off the medications, we evaluate them, we recommend back. And, and in, in the vast majority of cases, they're on substantially less medications when they leave. Now we still have that problem with what do we do with these kids that are being discharged from Boys Town and they're going back to their home community. In Omaha, it's a pretty simple deal, they just drive out to Boys Town or down to the Boys Town hospital. But out in the rural area, it's a bigger problem. So a couple of years ago, we partnered up with Bryan Health and because Bryan's got this telehealth program and, etcetera, and it's in a lot of locations and like, for instance, we're out talking to Box Butte Hospital. We've been out to talk to Scottsbluff hospital, and North Platte, Sidney. All these areas where they're underserved and the hospitals are, are very much welcoming us there. Now let's talk about the economic realities. Right now, the E&M codes that are, that are for that evaluation and management are-- I, I truly if I did a cost report today, I would say there's probably about 40 percent of what it act-- our actual direct cost. Boys Town is subsidizing this program. It's more than six figures, but we see is, is a very valuable fix for the continuity of care. We would like the codes to be high enough that we could get those doctors that are out in those rural areas to take our patients as, as well as we can provide telehealth services. So I hope you keep this conversation inside here. I don't want anybody getting mad at me out in, out in the rural areas, but it's, it's

reality. We, we need to fix these codes so we can get more people that would be willing to see Medicaid patients. And, and then we can, we can-- hopefully will improve care for, for our kids. So that's what I wanted to offer today. And that puts this into context. We don't think this is going to fix it, 15 percent is not going to fix it, but it's going to go a ways just reducing the amount that have, we have to go back and subsidize this every year. Thank you.

CLEMENTS: Are there any questions? Seeing none-- excuse me.

MIKAYLA FINDLAY: [INAUDIBLE]

CLEMENTS: If we were here to do clinical rates, would that include these codes?

PAT CONNELL: Yes. Yeah, these would be the, the same six or nine E&M codes that, you know, relate to what psychiatrists do, DOs do, APRNs do, think those-- and PAs do, there's a few PAs, and that's their evaluation of these-- of, of medications.

CLEMENTS: Does that answer it?

MIKAYLA FINDLAY: Yeah.

CLEMENTS: Thank you.

PAT CONNELL: Thank you. Appreciate it.

CLEMENTS: Thank you for your testimony. Are there any other proponents for LB525? Is anyone here in opposition? Is anyone here in the neutral capacity? Seeing none, Senator, you may close.

FREDRICKSON: All right. First of all, I just want to thank all the testifiers for being here today and I also want to thank the committee. I know this is the last hearing of the day so I appreciate you all asking questions and, and being engaged in this discussion. So a couple of things I wanted to address. So I know Chair Clements you had a couple of questions about the what was actually reimbursable on this so there was some initial confusion with the way the bill was written. My office has been in contact with the Fiscal Office. We're working with them on that. So this is only supposed to actually cover six codes and so those six codes have been sent to DHHS. They're providing updated information on that. So as soon as we have an updated number on that and an updated estimate from Fiscal that will hopefully provide some clarity on that sort of where that lies as

well. The last testifier kind of mentioned, you know, it's interesting because a lot of times we think about, you know, these services being provided obviously on an in-person basis. But, you know, telehealth and telemedicine, I think, is going to be a key component for a lot of this as well, especially with behavioral health. And, you know, we see this a lot, especially in rural parts of the state, where we do have a lack of providers and resources available. So kind of a theme you will probably notice with me this year is telehealth. I prioritized a Senator Brewer bill about telehealth. So I think it's a great way to sort of be able to deliver services throughout the state and across the state and to bring that to Nebraskans. So with that, I would be happy to answer any additional questions the committee might have.

CLEMENTS: Any other questions?

MIKAYLA FINDLAY: [INAUDIBLE]

CLEMENTS: And the question is, if we would go with the increase that Senator Dorn is requesting, would this also want to be an, an additional 15 percent increase?

FREDRICKSON: I would need to familiarize myself with the increase that Senator Dorn's--

CLEMENTS: Well, let me see about coordinating the different bills. I think the Fiscal Office, that's a question that maybe they can answer.

FREDRICKSON: Absolutely. And we'd, and we'd be happy to work with you and, and Senator Dorn on that to sort of figure out what makes sense.

CLEMENTS: If you would continue to work with them, there's some confusion about the details of the codes and what's covered, so. Seeing no other questions,--

FREDRICKSON: All right.

CLEMENTS: --thank you, Senator.

FREDRICKSON: Thank you very much.

CLEMENTS: We do have comments on LB525, position comments: we have 16 proponents, no opponents, and none in the neutral capacity. That concludes the hearing for LB525 and that concludes our hearings for today.