HANSEN: All right. Well, good morning. Welcome to the Health and Human Services Committee. My name is Senator Ben Hansen and I represent the 16th Legislative District in Washington, Burt, Cuming and parts of Stanton Counties and I serve as Chair of the Health and Human Services Committee. I would like to invite the members of the committee to introduce themselves, starting on my right with Senator Ballard.

BALLARD: Beau Ballard, District 21, northwest Lincoln and northern Lancaster County.

M. CAVANAUGH: Machaela Cavanaugh, District 6, west-central Omaha, Douglas County.

RIEPE: Merv Riepe, District 12, which is southwest Omaha and the good folks of Ralston.

HANSEN: We're missing a couple of senators today because last night was a little rough so I think they may still be recovering. So also assisting the committee is our legal counsel, Benson Wallace, and our committee clerk, Christina Campbell. And our committee pages for today are Krista [SIC] and Mataya. I always feel like I'm going to pronounce that wrong, so. OK, a few notes about our policy and procedures today. Please turn off or silence your cell phones. We will be hearing four bills this morning. We will be taking them in the order listed on the agenda outside the room. On each of the tables near the doors to the hearing room, you'll find green testifier sheets. If you are planning to testify today, please fill one out and hand it to Christina or one of the pages when you come up to testify. This will help us keep an accurate record of the hearing. If you are not testifying at the microphone, but want to go on record as having a position on a bill being heard today, there are white sign-in sheets at each entrance where you may leave your name and other pertinent information. Also I would note if you are not testifying, but have an online position comment to submit, the Legislature's policy is that all comments for the record must be received by the committee by noon the day prior to the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. We would ask if you do have any handouts that you please bring ten copies and give them to the page. We use a light system for testifying. Each testifier will have five minutes to testify. When you begin, the light will be green. When the light turns yellow, that means you have one minute left. When the light turns red, it is time to end your testimony and we will ask you to wrap up your final thoughts. When you come up to testify,

please begin by stating your name clearly into the microphone and then please spell both your first and last name. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters of the bill, then those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given the opportunity to make closing statements if they wish to do so. And on a side note, the reading of testimony that is not your own is not allowed unless previously approved. And we have a strict no-prop policy in this committee. So with that, we will begin today's hearing with LB451 and welcome Senator Brewer to open. Good morning.

BREWER: Good morning. Thank you, Chairman Hansen. Good aft-- good afternoon-- good morning-- seems like afternoon-- fellow senators of Health and Human Serv-- Human Resources Committee [SIC]. I'm Senator Tom Brewer. For the record, that is T-o-m B-r-e-w-e-r. I represent 11 counties of the 43rd Legislative District of western Nebraska. I'm here today to introduce LB451. I'm introducing this bill on behalf of rehabilitation hospital clinics across Nebraska. I also have some firsthand experience with these facilities. LB451 provides a direct appropriation for Madonna to pay for capital reconstruction improvements. To give a little background, I was first, I guess what you'd say, connected with Madonna just after being wounded in December 16, 2011. I was in Afghanistan and was injured by a rocket-propelled grenade. Because of the nature of a grenade, you have many injuries and when the military looked at a place to send me that could deal with the loss of hearing, loss of eyesight, partial loss of the use of my legs, injuries to the entire right half of my body and having my left thumb partially disconnected, they determined that Madonna was one of those choices because it had the ability to do occupational therapy, physical therapy, speech therapy. Oh, yeah. You also get a traumatic brain injury thrown into that mix. And it had the ability to deal with the vision, the hearing, all of that. It was, it was one-stop shopping and when the military looked at across the country, they determined that, that Madonna was going to be the best place for me to go to, to go through treatment. And that started about a two-year process to essentially get rebuilt. So there were days that you would have four or five different encounters with different folks within the facility itself. The result of those injuries caused multiple surgeries. So the beauty of Madonna was as soon as you went through that particular medical procedure, you would come back and then they would start the next phase of either occupational or physical therapy. And then they could also follow on tracking the

traumatic brain injury and your, your progress there. And for those that, that aren't familiar with it, you hear the term speech therapy. Speech therapy, you assume that has to do with, with speaking. It was really more about memory loss and memory confusion, all that that comes with, with the traumatic brain injury. So hopefully you understand why after two years of time in a facility, you become to feel kind of like part of the, the team, part of the, I guess, family there. I kind of would compare it to Cheers and when Norm walked in, everybody knew your name. So that, that was refreshing when you're going through that kind of trauma. So that's the connection to Madonna and that's why when I was approached about this bill, I didn't hesitate to embrace it because I had enough personal experience. And, you know, my injuries really weren't that great compared to many that are in Madonna. You walk through there and see those that have been in traumatic car accidents, those that have had really harsh strokes, things like that, and you, you appreciate that your injuries really were something that were fixable and you could return to a relatively normal life. There are those that struggle, struggle immensely. And, and that's more what I want to stress today in this opening was that there are, there are those that need specialized care in a nursing home and, and certain facilities are able to provide specific needs. The other part of that is many of the patients don't have private insurance and Medicaid pays a lot of the bills. Madonna treats everyone equally. Madonna is the only nonprofit nursing facility, nursing home facility that provides specialized care for patients on ventilators. They work hard to wean those on ventilators off, obviously-- for obvious reasons. Rehab at Madonna is not easy. There were days that I dreaded going in to see a physical therapist or occupational therapist because many times, your injuries-- you want to return to normal, but in order to do that, it means a lot of work, a lot of time, a lot of effort. As a state senator, I'm concerned about saving money for, for the state. Madonna loses over $4 million a year on long-term nursing care. If Madonna is unable to afford to continue to provide these complex specialty care, especially as an acute hospital care, they will be forced to, to not provide this and the, the reimbursement rate for Madon-- is higher for Madonna. And so as we go through today and you have a chance to have folks kind of better explain the ins and outs of why this is critical-- and I believe that CEO of Madonna will be here today also-- ask questions. Try and better understand it. But what I'm here for is, I guess, to, to share a little experience that I had at Madonna and why I felt this bill was important and wanted to be the sponsor for it. So at this time, I'll take questions. And I, and I do plan to stay for the close.

HANSEN: Thank you, Senator Brewer. Are there any questions from the committee? Yes, Senator Riepe.

RIEPE: Thank you, Chairman Hansen, and Senator Brewer, thank you for being here. I don't know whether people know it or not. I've lost count of how many Purple Hearts you have, but I think it was around eight or so, something in that neighborhood. So you were walking on target obviously and a hero in my mind. One of the concerns that I do have is-- and you can respond to this question is that my experience is one will get a person ten, you know? I mean, so providing some carveout for Madonna creates a lot of other wannabe needs that will come forward either this-- not maybe this session because we're not there, but in future sessions. And at the same time that organizations are asking for this-- and like this one, the $30 million, they're also asking for Medicaid rate increases. I don't know--

BREWER: Well, I mean--

RIEPE: --if it's a choice between the two.

BREWER: --they are unique in, in this umbrella they're under with the nonprofit part and in some of the specialized care they provide. But I think as far as getting into that, that area, I'm going to reserve that for the ones that actually watch the checkbook and understand it because I think I start tiptoeing in a place where I'm not an expert. I, I'm-- I guess I'm more here to validate the, the facility, the care and, and what I personally experienced.

RIEPE: Let me-- one more question?

HANSEN: Yes.

RIEPE: How was the food?

BREWER: Food was good.

RIEPE: OK.

BREWER: Food-- compared to army food, it was great.

RIEPE: OK. Thank you, sir.

HANSEN: Any other questions from the committee? I have, I have one. I saw the fiscal note and they need-- to implement this, which I wouldn't think, you know, to go through the application process,

support the program, $57,000 the department said as a fiscal note on top of $30 million. They say it's going to take $57,000--

BREWER: Well--

HANSEN: --to the employee to operate this.

BREWER: --keep in mind, the, the fiscal notes sometimes are kind of difficult to understand the logic behind them. So I-- that's a fair question. But again, understanding what goes into the decision on what number they put on a fiscal note I have yet to sort out.

HANSEN: Yeah, I just thought that was quite a bit of money on their end, I thought, so. All right, you going to stay to close?

BREWER: Yes.

HANSEN: OK. All right. Well, with that, we'll take our first testifier in support of LB5-- LB451. Welcome.

PAUL DONGILLI: Thank you, Chair Hansen and distinguished members of the committee. My name is Paul Dongilli, D-o-n-g-i-l-l-i, and I am president and CEO of Madonna Rehabilitation Hospitals. I know yesterday was a very long and difficult day for you so thank you for letting me be here today and allowing me to speak to you about Madonna and the importance of this legislation. Before I continue, I would like to offer sincere thanks to Senator Brewer for introducing this legislation, LB451. As you all know, he's a proud veteran and a former patient with multiple inpatient stays at Madonna after sustaining the injuries he described serving our country. He's a great ambassador for Madonna's mission and vision. Madonna is a not-for-profit rehabilitation hospital with an attached long-term care nursing facility. That's very unique. We're the only such entity in Nebraska. We were founded by the Benedictine sisters in 1958 as a nursing facility. In 1985, Madonna partnered with DHHS to increase the medical complexity of individuals admitted to the nursing facility with a program to care for individuals with complex medical needs on a ventilator. In 1985, Madonna's nursing facility was the first facility outside of an acute care hospital to provide care for individuals on a ventilator and today is only-- one of two institutions in the state that provide this chronic ventilator care program. In addition, Madonna is the only nursing facility in Nebraska with a special needs unit in contract with DHHS to care for clinically complex patients. Presently, Madonna has a 126-bed nursing facility and 30 beds have

been dedicated to these levels of care. We serve the highest number of ventilator-dependent residents in the state of Nebraska and using DHHS's CMI, which is a measure of severity of illness, for our ventilator-dependent residents at Madonna, they have the highest CMI of any nursing facility in the state. Without Madonna, these patients would need to be treated in an acute care hospital. We've long focused on meeting community needs and accepted patients regardless of payor source. Seventy-six percent of our long-term residents in the nursing facility pay for their medical care through Medicaid. Despite the challenges associated with this clinical population, we have received accolades from the state, from CMS, and in 2020, received the COVID-19 Heroes Award for exceptional care and low COVID-19 infection rate during the pandemic. The lower Medicaid reimbursement rate for rehab hospitals makes us a more cost-effective option for patients who need this complex care. Over the last nine years, Madonna has prevented medical complications and successfully weaned 40 percent of nursing facility residents on a ventilator, resulting in a discharge to a lower level of care or to the community. This has saved the state nearly $40 million in Medicaid reimbursement over this nine-year period. We have not shared in this cost savings. The high percent of Medicaid reimbursement presents a significant financial challenge to Madonna, putting pressure on facilities like ours to maintain our infrastructure and provide this care. Since 2015, Madonna's nursing facility has experienced a net income loss every year and in 2022, this loss reached a high of $4.5 million. We are willing to shoulder some of this burden, as it is our mission. However, this reimbursement and cost gap has limited capital dollars for facility renovations and infrastructure upgrades. Madonna is not alone with this financial challenge. In the last five years, 15 percent of Nebraska's nursing facilities have been unable to sustain operations and have closed. Madonna's nursing facility is located in a building that was constructed in 1971. Although there have been facility upgrades to portions of the building, much of the infrastructure is original. The $30 million will allow us to renovate and upgrade 61,457 square feet of ancillary treatment space, resident bathrooms, shower facilities and common areas. Existing air handling, HVAC systems and mechanical rooms will be replaced at a cost of $3 million. The renovations cost $27 million. As you know, Madonna recently spent $61 million constructing a new patient tower at our Lincoln campus and $100 million constructing a new hospital in Omaha. No state funding was requested for these projects. Requests for state funding for programs that serve a large Medicaid population are common. And I'll reference the Hospital for Special Care, a chronic disease facility in New

Britain, Connecticut, provides care similar to Madonna's. They recently received a $10 million grant-in-aid Connecticut state funding to construct a new 12-bed unit. Like Madonna, they have 75 percent of their inpatient population funded through Medicaid. We're requesting your support for LB451. We view it as an investment in our facilities so that Madonna can continue to provide a high level of cost-effective care for years to come. Thank you.

DAY: Thank you, Mr. Dongilli, for your testimony today. Let's see if we have any questions from the committee. Yes, Senator Ballard.

BALLARD: Thank you, Senator Day. Thank you for being here. Can you talk a little bit about some of the challenges of Madonna, maybe just long-term healthcare in general?

PAUL DONGILLI: Right. Well, I think one of the key ones right now is the rising costs that we see associated with our workforce and the inability for rate increases coming from federal programs like Medicare and Medicaid that are inconsistent with the rate of increase that we see in order to provide that care. Seventy-six percent of our costs at Madonna are tied to our employees. We have a large employee base to provide the kind of care that we do. And so the workforce challenges and the costs for maintaining employees is out of pace with reimbursement rates. And so as a result, we don't have dollars often to funnel back into infrastructure improvements.

BALLARD: Thank you. And then, if I may, Senator--

DAY: Yeah, of course.

BALLARD: --and then can you talk a little more about-- I know Madonna does a great job of private investment. Can you expand on that a little bit, from just private, private donors?

PAUL DONGILLI: I'm sorry.

BALLARD: So private donors--

PAUL DONGILLI: Yes.

BALLARD: --can you expand on that? I know Madonna does a great job of, of having--

PAUL DONGILLI: Uh-huh.

BALLARD: --partnerships with private donors. Can you expand on that a little bit?

PAUL DONGILLI: Sure. We've long had the support of the community to provide the work that we do. And I think most of our donors recognize that there are aspects of care that we provide that are not funded through reimbursements, through either insurance companies or through Medicaid or Medicare. For instance, our pediatric program. We have special education teachers that work to help transition kids that we serve back into the school system. Insurance companies say we're not going to pay for that; that's the responsibility of the school system. The school systems say that's not our responsibility; that service is provided within a hospital. That's part of your insurance package. So no one pays for that. I think a lot of our donor base recognize the specialty services that we provide and give us dollars to help support those aspects of our program that have a huge benefit to the people that we serve.

BALLARD: Thank you.

HANSEN: Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here. We have a letter of opposition from the Department of Health and Human Services, which I don't necessarily see that they're going to testify. So I want to give you the opportunity to speak to their opposition, which is basically that they haven't done a grant like this before. That coupled with the fiscal note, which I would echo some of Chairman Hansen's statements, seems a bit high on the administrative side of things. I previously worked in nonprofit fundraising and that's more than you would pay somebody to be a full-time grant writer. So to administer a grant, that seems pretty high, steep. And I just wanted to give you the opportunity to speak to that. And I also had some questions about maybe some alternative pathways and how we could work on this. Perhaps have a cap on what the department can spend and then perhaps the remaining part would go-- be paid for out of the grant. So if we said that the department can expend $25,000 to pay somebody-- an employee to do this work and if they had to pay more than $25,000, perhaps the remainder of that would come from the $30 million. Is that something that would be workable for Madonna and just, like--

PAUL DONGILLI: Yes, it would.

M. CAVANAUGH: I just loaded a lot on you, but.

PAUL DONGILLI: Yeah.

M. CAVANAUGH: Go.

PAUL DONGILLI: No. Well, I don't understand or have a good handle on the scope of DHS's [SIC] involvement in terms of administering it. But we've always been such good partners with DHHS and I'm confident that the scenario that you outlined, that we could somehow work to absorb that within the $30 million grant-- or request-- funding request.

M. CAVANAUGH: So that there's possibilities moving forward to help adjust and address that fiscal note--

PAUL DONGILLI: Yes.

M. CAVANAUGH: --outside of the $30 million.

PAUL DONGILLI: Yes.

M. CAVANAUGH: OK. So yeah, their opp-- their opposition struck me a little bit more as this is more of an observation as perhaps neutral testimony, but they did submit it in opposition and so I wanted to make sure you had a chance to address that.

PAUL DONGILLI: Yeah. We've been such good partners and like I said, this program was developed with strong input from them and recognized by them as being critical.

M. CAVANAUGH: OK.

PAUL DONGILLI: Yeah.

M. CAVANAUGH: Well, thank you.

PAUL DONGILLI: Thank you. Um-hum.

HANSEN: Senator Riepe.

RIEPE: Thank you, Chairman Hansen. You noted that in 2022, you had a $4.5 million loss.

PAUL DONGILLI: Yeah.

RIEPE: My question would be is what's your current bond rating?

PAUL DONGILLI: Our current bond rating--

RIEPE: Say for the $100 million that you-- I assume you didn't pay cash for that in Omaha.

PAUL DONGILLI: Correct. We did not pay cash. We just had our latest Standard and Poor's review and we were rated A-minus, stable.

RIEPE: A-minus.

PAUL DONGILLI: Stable.

RIEPE: OK so that's a good rating.

PAUL DONGILLI: Yes.

RIEPE: OK. The other question that I had was what percentage of your patients are Medicaid? And then if you could, what percentage are Medicare? Do you have that breakdown at the tip of your tongue?

PAUL DONGILLI: The-- I do for in the nursing facility. The days, reimbursed days for care that we provide in the nursing facility, 76 percent are Medicaid.

RIEPE: Seventy-six percent.

PAUL DONGILLI: Seventy-six percent are Medicaid.

RIEPE: That's good.

PAUL DONGILLI: Uh-huh. I don't have the-- out of the remainder 24 percent, the majority of it would be Medicare and there's a small commercial mix for the nursing facility.

RIEPE: Do you think that a higher percentage of Medicaid is due because of pediatrics?

PAUL DONGILLI: No.

RIEPE: No. OK. I guess that one of the things that the hospital industry and things talk-- or at least some that I've talked to, some administrators, is that one of the biggest ways the state can help is for provider rates, which would then maybe-- particularly to nursing homes--

PAUL DONGILLI: Um-hum.

RIEPE: --to alleviate so that you don't-- they don't get the responsibility of keeping patients in their facility after the funding has stopped. I don't know-- I know that happens with Medicare. I don't know whether that happens with Medicaid. We're pretty generous with Medicaid so maybe we continue to pay anyway. But my point gets to be is can we do the hospitals like your own more by helping nursing homes? You see what I'm saying? Trying to move--

PAUL DONGILLI: Uh-huh.

RIEPE: --people through the system to get them placed.

PAUL DONGILLI: Right. That was just on the news yesterday. The Nebraska Hospital Association talked about the backlog of individuals in acute care hospital because of the inability to place those folks in post-acute settings or nursing facilities. We've long been committed to this level of care. We do have challenges with staffing right now.

RIEPE: Sure.

PAUL DONGILLI: And even though reimbursement rates might go up, those reimbursement rates really only allow us to pay our staff a salary that keeps them. You know, nursing assistants make just as much money as fast food workers. And when you look at the scope of the work that they provide, most folks will say, I'll go work at Amigos, fast food, versus provide or support the care in our nursing facility. We really view this request as an investment in the infrastructure. Regardless of increasing reimbursement rates, the difference between what we're paid and what it costs us to provide service is not going to allow us the dollars that are needed in order to improve the infrastructure of the facility. And like I said, we did not ask any state dollars when we did this for the hospital portion of Madonna. We recognize that's part of our hospital business. It's reimbursed differently and the mix of payment is different. The nursing facility is another-- is, is another business line or consideration. If we did not do this, we have currently in-house in the nursing facility 90 residents who would-- the state would have to find placement for somewhere else and, and a significant number on ventilators and they would wind up back in acute care hospitals. So we're just asking for an investment in the infrastructure, the first time we've done this in the 60 years that we've been in operation.

HANSEN: Yes, Senator Riepe.

RIEPE: One more question. What would you suggest we tell other healthcare facilities? Because there will probably be a lineup that say why we selected Madonna to receive, let's say $30 million, you know?

PAUL DONGILLI: Right.

RIEPE: Because we're going to-- we will have to-- one will get you ten. We will have to answer that question--

PAUL DONGILLI: Yeah.

RIEPE: --if not this session and next session, there will be a line out in the parking lot.

PAUL DONGILLI: Right. I can understand that. I think how I would respond is that we provide a service to the state, to state Medicaid. We do. If we didn't do this, they would have to find it someplace else. We viewed this as a long view to what happens in our nursing facility and specifically for our ventilator-dependent program as a partnership. The state was well aware of what we were doing and supported us doing it. So we view this as a partnership with the state and providing them a needed service. We think that is different than the majority of other healthcare facilities that might come to you requesting similar funding.

RIEPE: The Med Center might argue with that, but OK. I'll accept your answer.

PAUL DONGILLI: Yeah.

RIEPE: OK. Thank you, Mr. Chairman.

HANSEN: Any other questions from the committee? All right, seeing none, thank you for coming and testifying.

PAUL DONGILLI: Yes, thank you.

HANSEN: We'll take our next testifier in support of LB451. Welcome.

JANE PICKEL: Good morning.

HANSEN: Good morning.

JANE PICKEL: My name is Jane Pickel, spelled P-i-c-k-e-l, and I've been a resident at Madonna for approximately six years. When I was 18

years old, I had a spinal cord injury resulting from a car accident. And despite this, I was determined to have a full life and as long, long-- I've lived in Lincoln all my life. And I earned my bachelor's degree in counseling from the University of Nebraska and lived independently. However, years later, a second car accident left me with additional health challenges, challenges which required me to be on a ventilator with a tracheotomy. I need special care and long care-- term care. I'm at Madonna because of mission, expertise and how well they treat their patients. Thanks to Madonna's exceptional staff, I'm stronger than I was when I first arrived and I only need ventilator support at night. Other facilities do not have the activity programs and acute nursing care that Madonna offers. Madonna goes beyond just healthcare. When my mother passed away last year, Madonna made it possible for me to go see my mother before she died. I also enjoy several of Madonna's groups outing in the recreation department and that includes outings to go shopping or go to movies. And I'm very involved in all the activity programs. And I'm also the president of the residents council, which is a group of residents who provide feedback to Madonna staff. If we have any complaints or problems, we address them at that time. The proposed additions, including new bathrooms, would be a welcome improvement for the residents who each need specialized equipment and accommodations. Madonna is my home. I consider it very homey there and have lots of friends and people that I'm pretty close to. I'm grateful for the tremendous care and the activity that they provide. Do you have any questions--

HANSEN: Thank you for coming.

JANE PICKEL: --anybody?

HANSEN: Thank you for coming to testify.

JANE PICKEL: Thank you.

HANSEN: Are there any questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for testifying. You're the president of the residents council so you're kind of a politician then.

JANE PICKEL: Well, not really.

M. CAVANAUGH: You're in the, you're in the right building.

JANE PICKEL: I'm not very good at that.

M. CAVANAUGH: I don't know. You're here testifying in front of the Legislature. If Madonna weren't able-- were to close, where would you go?

JANE PICKEL: That's a good question. The only other nursing home in town is called the Ambassador.

M. CAVANAUGH: And do they--

JANE PICKEL: They have a ventilator system unit as well, but they do not offer extensive recreation, the support that Madonna offers, and the individualized care that's needed for each person. So I was at the Ambassador at one time--

M. CAVANAUGH: OK.

JANE PICKEL: --and they're at-- they don't do very many activities. They don't have in-house activities and they do outings once every three months. So Madonna does activities, outings every month. And also individual-- they'll work with you individually in your room. Particularly during the pandemic, they came to the unit when we were isolated from other units and they helped me pass the time by doing-- playing cards and doing other activities that I like to do, so.

M. CAVANAUGH: Thank you.

JANE PICKEL: Um-hum.

HANSEN: Any questions for the committee? All right, seeing none, thank you for coming.

JANE PICKEL: Thank you.

HANSEN: We'll take our next testifier in support.

SCOTT WURDEMAN: Thank you for allowing-- or my name is Scott Wurdeman, S-c-o-t-t W-u-r-d-e-m-a-n. Thank you for allowing me to speak today on behalf of Madonna's nursing facility. I have been a Madonna resident for roughly 17 years. A car accident in 1992 left me with a spinal cord injury. For several years after, I lived with my parents in Columbus, Nebraska. Then in 2006, I came to Madonna for its assisted living services when my dad developed Alzheimer's. My mom couldn't take care of both of us. A family friend who worked at Madonna at the time recommended a program to me and I'm so glad he did. The staff here are wonderful. There are like, like another family. I've gotten

close to quite a few of them over the years. I'm also appreciative of the specialized ventilator care at Madonna. Also, many of Madonna's staff are wound care experts who focus on preventing-- prevention and the long-term management of wounds. They are right on top of any skincare issues, which could be a big problem for people in wheelchairs. Plus, they have a physician assistant on the unit. You can talk to them about anything. The planned addition, including new heating and air conditioning, common areas and bathrooms, are needed for the quality of life for each resident. In closing, I like the outstanding care they provide at Madonna.

HANSEN: All right, thank you for coming and testifying. Are there any questions from the committee? All right, seeing none, thank you.

SCOTT WURDEMAN: Yeah.

HANSEN: All right, we'll take our next testifier in support of LB451. Is there anybody else wishing to testify in support? All right, so with that, is there anybody wishing to testify in opposition to LB451?

RIEPE: You're on your own.

HANSEN: I was waiting to hear from you, Merv. Anybody wishing to testify in opposition? All right, seeing none, is there anybody wishing to testify in a neutral capacity? All right, seeing none, with that, we will welcome Senator Brewer to close. And for the record, we did have one letter in opposition from the department, from DHHS and no other in support.

BREWER: All right. Well, thanks to those who came to testify. I want to start by saying I think that Senator Cavanaugh is right about a technique that is used by the executive side of the house to kill bills that they don't like. And I, and I, I say that because I've seen it in, in Ag. I've seen it in Natural Resources. And it's really kind of a sad way of doing things because it isn't about whether the bills are right or wrong; it's an inconvenience or something they don't want to deal with. You put a big enough price tag on it, I don't care how good or how bad the bill is, it won't have life. And that's a technique that I think we-- at some point we're going to have to take a look at and figure out why that is allowed to happen because I think they're, they're using a technique to kill legislation because of their need or convenience. And, and that, that's a fight for another day. But if you stop and think about the discussion that was just had-- reference Madonna-- and ways you can compare that to the

decision that was made with our mental health system, the decision was made to collapse that system, thinking that we could do that in other ways. And many of those ended up in the Nebraska State Penitentiary and, and we're dealing with it there. And I, I'm not so sure that if we were to sit down and look at the investment Nebraska has to make because of that and had we had that mental health system continue, we would have been money ahead and we would have had a situation that was a whole lot more tolerable with our Nebraska State Penitentiary. Now, with that said, we, we're dealing with a very unique group of folks that don't have many options. And some of these injuries are at a level that their care is, is something that has to have special consideration. Now, I wish I was a health expert when it comes to some of the questions. I unfortunately am someone who's, who's been a patient of the care and not someone who has had to manage the systems and understand the complexities and difficulty. I came here today because I think their voices needed heard. Someone needs to champion their cause and that's why I came here today. And I'm asking you to support LB451. Open for questions.

HANSEN: Thank you. Yes, Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Senator Brewer. First, I'd like to say I would love someone to cross-stitch Senator Brewer's quote of Senator Cavanaugh is right. Just put-- just putting that out into the universe. I discussed with the director about the opportunities for addressing the fiscal note in creative ways. Would you be willing to work with the committee on that?

BREWER: Yes, And I think I would also probably say the same thing that I've told the Department of Ag under the previous director and the Department-- or with Game and Parks and that is these agencies need to come in in neutral and then they need to provide information, detailed information justifying why they see a particular concern. To purposely come in knowing what-- knowing full well that that position could very well doom the bill, it's not fair. It's not fair to our, our committee process. And so, yes, I would do whatever I could to help.

M. CAVANAUGH: I would say that there-- I, I stated this before. I believe that their opposition letter is more neutral. It, it more stated that they haven't done something like this before, which is not a reason to not do something. And, and I think we could continue the conversation about if there's a more appropriate department. I, I understand why we would have DHHS doing the grant awarding, but I know other agencies have done grant awards and so we could probably look at

fiscal notes of how they've done that and the cost. And, and what I'm saying is I look forward to working with you on this.

BALLARD: And it's in the public record that I agree with you.

M. CAVANAUGH: Marking my calendar.

HANSEN: All right, any other questions from the committee? All right, seeing none, thank you.

BREWER: All right, I'm off to do interior design.

HANSEN: Good luck with that one. OK All right, well, that will close our hearing for LB451 and then we will now open it up for LB433 and welcome Senator Jacobson. This your first time in front of HHS?

JACOBSON: It is, it is.

HANSEN: We've been waiting for it.

JACOBSON: Is this chair on the floor? I feel like--

WALZ: I know.

HANSEN: I don't know. Complain to Senator Brewer.

JACOBSON: I've never felt this short.

HANSEN: It's all for a reason.

JACOBSON: I gathered as much. Wow. Boy, you guys, you guys have a way of really intimidating somebody right out of the gate. Well, good morning, Chairman Hansen and members of the Health and Human Services Committee. My name is Senator Mike Jacobson, M-i-k-e J-a-c-o-b-s-o-n, and I represent the 42nd Legislative District. Today I am introducing LB433, a bill that I believe is absolutely necessary and would seek to provide budgetary flexibility to the six regional behavioral health authority regions across the state. LB433 adds needed budget flexibility for regional behavioral health authority regions to allow local needs to be met. It requires that any appropriation to the regional behavioral health authority's region via the Division of Behavioral Health be allowed to be used within approved annual budgets or by activities identified through need, as demonstrated by the region throughout the year. A regional behavioral health authority may move up to 20 percent within a service category to address emerging

needs. If the amount exceeds 20 percent, a regional behavior health authority may request a transfer and a director of the Division of Behavioral Health shall grant it upon-- unless it violates state or federal law. If a denial is issued, the region may appeal the decision through the Administrative Procedures Act. Last summer, I met with the governing board of Region II Behavioral Health in North Platte. The governing boards of the other-- of our regional behavioral health authorities are comprised of one county commissioner from each of the counties within a region. Region II is comprised of 17 counties in west-central Nebraska. During my meeting with them, they expressed concerns about the lack of flexibility that the Division of Behavioral Health provided them to meet the needs of our region. My office began researching this issue and discovered that there was not much flexibility provided to the Behavioral Health Services Act for the regional, regional behavioral health authorities. Further, we discovered through additional conversations with Region II that even with the Appropriation Committee intent language in the 2023-2024 budget, which is similar to LB433, there still had not been much desire on the part of the division to make-- to be flexible to meet the region's needs. I'm a fiscal conservative. You all know that. That's why I'm in passing this, I'm passing this legislate-- think passing this legislation makes sense. This legislation allows for those folks who are on the frontlines in our regional behavioral health authorities' regions to work to maximize the dollars we have provided to them to provide the maximum amount of services within their geographic area. This bill does not expend any new money. It provides flexibility to them to move money to specific target areas. In testimony after me, you will hear from representatives from three of the six behavioral health regions, including Region II, VI, and V. Each of them have stories of how the lack of ability to move resources around has caused major issues in their region. Two, you will hear from providers who have experienced the frustration of the lack of responsiveness to needs in both rural and urban Nebraska. I encourage you to listen to them and to join me in supporting a bill that makes a lot of sense and allows for these officials whom our voters have elected to make the decisions they need to make on budget priorities. I can tell you listing specifically at Region II, we had a significant amount of conversation about the amount of budget dollars that were-- they were not able to expend while they had overwhelming needs in the area. I want you to focus on the fact that one size should not fit all. And I want you to also focus on the testimony that you're going to hear from the opposing-- those opposing. It's the agency in particular. And I'm going to, I'm going to re-- I guess I'm going to

agree with Senator Brewer and Senator Cavanaugh. You're going to get a two-for-one today so you can put me on record as agreeing with this as well. This is a situation where our needs are different, OK? And one thing I think you've heard on the floor from me is we've got to look at the entire state and our needs across the state do differ. And I want you also to focus on the idea that three years ago, this wasn't a problem, OK? Three years ago, there was ability to move money around and now it's changed. I find it appalling, appalling that there's a fiscal note the size that's on this bill. It's disgraceful and appalling to me that to go back to doing it the way we did three years ago is going to cost $1.4 million. So with that, I'm going to stop and ask for any questions. And would refer to that-- the fact that we will have testifiers that will get you into the weeds on the issues that they've had. With that, thank you.

HANSEN: Thank you. Are there any questions from the committee? Senator Riepe.

RIEPE: Thank you. Thank you, Senator. Senator, I appreciate you being here and I have a keen interest in the mental health piece. What problem specifically initiated this legislative act? I assume there were some sentinel event that precipitated all of it that finally, it just blew the lid off of it.

JACOBSON: There is and I'm going to, I'm going to ask for Kathy Seacrest to give you the specifics--

RIEPE: OK.

JACOBSON: --who's the Region II director. But I will tell you that when I met with them, my understanding there was there was $1.2 million in budgeted dollars for Region II that were frozen and could not be spent because their need-- what the-- what it was targeted for wasn't a need that we had. We had other needs and we weren't allowed to move the funds. That's when I contacted DHHS through a letter to say, can we sit down and talk? And the answer was basically they, they weren't going to be flexible. So we've had crickets since that time. I bring a bill, suddenly I get some communication with nobody understanding, well, gee, what's wrong? What possibly could be wrong? So there really have been no serious effort to really try to resolve this and that's why this bill is here today.

RIEPE: The next question, if I may, Chair, it seems to me that this is not a bill specifically about Region II, but rather a major move to

totally decentralize the existing statewide mental health delivery planning process or system and so ramifications on this can be somewhat significant.

JACOBSON: I think the goal here is to be able to allow a portion of the budget to be moved around. And I think that, that, that's really what we're aiming at and, and I think that's where the focus is. You know, I understand that there's various funding mechanisms and we don't want to interfere with those. But I can just tell you that the system the way it is isn't working. And I think after you hear the testimony from the other three regions in-- or the three regions and hear what they're saying specifically, I think you'll probably get a better idea of just exactly what we're seeing there.

RIEPE: Did I hear you say earlier 20 percent?

JACOBSON: Yes, that's what's in the bill.

RIEPE: OK. OK. Thank you. Thank you for being here.

JACOBSON: Thank you.

HANSEN: Senator Cavanaugh.

M. CAVANAUGH: Thank you. Man. I just-- I'm feeling the love this morning.

JACOBSON: I'm afraid you're going to hold it against me. I'm just, I'm just-- I was really, I was really hesitant to say this this morning.

M. CAVANAUGH: Never. You did mention something that I wanted to ask you a little bit more about. So you said that this wasn't the way things were three, three and a half years ago. And according to our wonderful legal counsel's memo, there's no specific past legislation on this issue. What changed?

JACOBSON: The contract changed between DHHS and the region.

M. CAVANAUGH: OK and so this is seeking to codify how it was done before the contract changed.

JACOBSON: Essentially, yes.

M. CAVANAUGH: OK and I do have questions about the fiscal note as well, but I think I'll save those for some of our regions that are going to testify.

JACOBSON: Thank you.

M. CAVANAUGH: You're welcome.

HANSEN: Any other questions? I have one. Is there any concern that we might jeopardize federal funds?

JACOBSON: Well, I think that's the question we've got to work through. I guess my question is, what changed, you know? I mean, did our funding change that significantly from the federal level from three years ago? And why did this, why did this all of a sudden become a change in the most recent contract, but what-- none of this was included in the previous contracts.

HANSEN: OK. All right. All right, seeing no other questions.

JACOBSON: I will stay for a close.

HANSEN: All righty.

JACOBSON: Thank you.

HANSEN: OK. Good. All right, we'll take our first testifier in support of LB433.

KATHY SEACREST: We'll see how short I feel.

HANSEN: Thank you for coming. If you could please spell first and last name and compliment Senator Cavanaugh.

KATHY SEACREST: Good morning, Chairman Hansen and members of the Health and Human Services Committee.

HANSEN: Welcome.

KATHY SEACREST: I'm Kathy Seacrest, K-a-t-h-y S-e-a-c-r-e-s-t, and I'm the regional administrator in Region II, comprised of 17 counties in west-central Nebraska. We would like to thank Senator Jacobson for bringing this bill. Historically, the regions were created to keep service delivery local and to have local elected officials determine budget and services. The erosion of that role is why I and other leadership from the other five regions are here today to support this

bill. Over the last decade, the behavioral health regions have been so tightly controlled by the Division of Behavioral Health that we cannot provide the services needed. The cookie-cutter approach that the division is using keeps us from creating what is needed in our own areas and hampers our work with Nebraskans in need. In previous years, we had the flexibility to move dollars where we needed them, up to 20 to 25 percent. Again, within the last decade, that was taken away. Now every dollar must be preapproved for shifting, even though the regional governing board, comprised by locally elected county commissioners, has already approved that shift. This kind of state control keeps us from achieving the best outcomes for our consumers. For the first time in my 34-year career with the region, there is money available to us within our budgets to address needs and I find that a miracle, but we cannot utilize it. In Region II, it took us over 14 months to create a couple of services that our community forums made up of providers and consumers requested. The money was there, but the hoops that we had to jump through it made it almost impossible. The division has virtually destroyed a program that we created over 20 years ago that a-- someone calling can see a counselor within 48 hours to determine what they need and to access that service. Region II created this program and two years ago, the division decided we could only provide it on a unit basis and that each person had to meet all criteria. And our original idea was get the person in, see them, take care of them and then we can figure out the logistics. We wanted to make that connection with the person who needed services quickly and help them access what they needed with a minimum of paperwork. Under the current requirements, we must collect all the information upfront. We get paid a fraction of what the program's actual costs are. The division took over $300,000 away from this program. They told us that we could use it for something else, but the things that we have tried to implement were delayed or denied. We need the flexibility this bill allows. My governing board has met with the division and has tried to make things work, but it goes nowhere. When we asked how to appeal a decision, we were told to email the director of the division who made the decision in the first place. Thus, we also want a way to appeal decisions. My board has requested that we continue expense-based reimbursement. The answer was no. My board asked for a rural rate and they were told that the division might look at that in a year or two. In closing, mental health and substance use disorder services are needed now more than ever. We want to meet those needs, but our autonomy and flexibility have been eroded. Please pass this bill to help us utilize our dollars as

effectively as we can and for the good of those in need. I'm happy to answer any questions you might have.

HANSEN: Thank you for your testimony. Are there any, are there any questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here. Do you feel comfortable talking about this fiscal note?

KATHY SEACREST: Would you say that--

M. CAVANAUGH: Do you feel comfortable talking about the fiscal note? I wanna make sure I'm asking the right people about this fiscal note.

KATHY SEACREST: I-- you know, I only saw it yesterday, but--

M. CAVANAUGH: Oh, OK.

KATHY SEACREST: --yes, I'm happy to talk about it.

M. CAVANAUGH: Well, I just-- you know, as Senator Jacobson said in his opening, that this is how it was previously done and this fiscal note is for over-- it's $1.4 million to go back to how it was previously done. I guess I just want to give you the opportunity to share your thoughts or perspective--

KATHY SEACREST: Thank you.

M. CAVANAUGH: --on that.

KATHY SEACREST: I am flabbergasted by the fiscal note. We-- when we put this in, we did not see it costing anything. Now, potentially, if we had to appeal a decision, that appeal might cost the state something. But in fact, it would cost the division less work because they wouldn't have to be approving every single dollar that we need to shift. So I, I, Senator, can't really account for the fiscal note.

M. CAVANAUGH: So-- sorry-- if--

HANSEN: Yep.

M. CAVANAUGH: --this is how you previously did things and then three and a half years ago or so, that changed and Senator Jacobson--

KATHY SEACREST: Yeah, a little, a little more than that and it kept getting tighter and tighter.

M. CAVANAUGH: And was that through the contract?

KATHY SEACREST: Yeah.

M. CAVANAUGH: --with the state--

KATHY SEACREST: Yes.

M. CAVANAUGH: --that kept getting tighter and tighter?

KATHY SEACREST: Yes. And in-- let me just grab it here--- in 2016-17 and '17-18, it literally says we can move 20 percent-- 25 percent actually-- here and there. So why that had to change, I don't know. And federal funds have come up. This is usually State General Funds. The federal funds we clearly understand have to be used for what they are intended for. And, and all of the regions understand that perfectly.

M. CAVANAUGH: So the funds we're talking about are state funds to kind of go back to Chairman Hansen's question.

KATHY SEACREST: Most-- I can't think-- the only time it would be federal funds is the substance abuse dollars and prevention. And then we're not moving them out of prevention. We're moving them amongst the categories. And we used to be able to do that with-- just do it. Now we have to have permission to do that as well.

M. CAVANAUGH: OK. Thank you.

KATHY SEACREST: Thank you.

HANSEN: Senator Riepe.

RIEPE: Thank you, Senator Hansen. I have a couple of questions. One is do you perceive that the change-- I think you said, what, two years, three years ago?

KATHY SEACREST: Well, it's been over the course of the last ten years--

RIEPE: Oh, OK.

KATHY SEACREST: --but more significantly in the last five.

RIEPE: Was that due to a change in DHHS policy or in DHHS leadership, sort of different leadership style?

KATHY SEACREST: You know, I wish I knew.

RIEPE: OK.

KATHY SEACREST: I know the contracts changed. I know our network operations manual change. But whether that was from leadership or what, I don't know, Senator.

RIEPE: And you said the feds are pretty uncompromising. I mean, what they say is what you have to do.

KATHY SEACREST: Right. And we under-- all the regions understand that and follow the federal guidelines to the letter.

RIEPE: So if you're giving then 20 to 25 percent latitude/flexibility, do you have an oversight audit plan? I mean how do you--

KATHY SEACREST: Oh, we have--

RIEPE: --make sure that it's--

KATHY SEACREST: --we have audits all the time.

RIEPE: OK, OK.

KATHY SEACREST: Yeah, we do a CPA audit and the division audits us and ,and we audit our programs so, I mean, there's lots of checks and balances for those funds.

RIEPE: OK. Thank you very much. Thank you for being here. Thank you, Mr. Chairman.

HANSEN: Yep. Any other questions from the committee? All right, seeing none--

KATHY SEACREST: Thank you.

HANSEN: --thank you. And we'll take our next testifier in support.

PATRICK KREIFELS: Good morning. Chairman Hansen, members of Health and Human Services Committee, my name is Patrick Kreifels, P-a-t-r-i-c-k K-r-e-i-f-e-l-s. I am the administrator for Region V Systems Behavioral Health Authority. I am here today on behalf of the Nebraska Association of Regional Administrators and on behalf of Region V Systems Governing Board. Region V is comprised of 16 counties in southeast Nebraska, including Butler, Filmore, Gage, Jefferson,

Johnson, Lancaster, Nemaha, Otoe, Pawnee, Polk, Richardson, Saline, Saunders, Seward, Thayer and York. I want to begin by offering my profound appreciation to the senators and Governor for the commitment, sacrifices and contributions to our state, ultimately helping make Nebraska a great place to live. Thank you for your service. Social determinants of health have a major impact on people's health, well-being and quality of life. Examples of social determinants of health include safe housing, transportation, education, job opportunities, income, access to nutritious foods and physical activity. When Nebraskans experience a major mental health or severe substance use condition, oftentimes there's interference with their daily living activities and therefore impacting social determinants of health and quality of life. The regional behavioral health authorities are committed to system and service improvements and as a public safety net for Nebraskans who are oftentimes marginalized because of a major mental health and substance use condition. In order to accomplish these improvements, there is the need to have flexibility in our funding and reimbursement systems and the authority to manage local services. The flexibility that was afforded to the regions in years past has been gradually eroded away, much like the topsoil in our agricultural fields being blown away year after year. This erosion in the behavioral health system has resulted in restricted decision-making with flex funds, lack of or slow responses with approvals for expanding services and adding new innovative services, ineffective, restrictive policies/procedures, attempts to have the behavioral health system mirror Medicaid's fee-for-service environment and questioning that delays approval processes. This lack of engagement, collegiality, commitment, collaboration, understanding that all system partners are needed to fulfill the system needs directly and negatively impacts the people with the most vulnerabilities in our community. With the expansion of Medicaid eligibility rules and enrollment starting in October of 2020, adult Nebraskans with income up to 138 percent of the poverty level, a household of one who makes approximately $18,000 annually are eligible for Medicaid. This means more Nebraskans are gaining access to healthcare to meet their needs and supporting their social determinants of health and there are fewer people using-- utilizing regional behavioral health funding. This has created a unique opportunity for the behavioral health continuum of care in Nebraska to leverage existing funds to be reinvested in our system, covering the gaps and fragmentation and to enhance, expand and improve services across Nebraska. Examples of how we have been able to leverage and maximize funding are two projects with Lancaster County. Community

Corrections is contributing American Rescue Plan Act funding of approximately $2 million to assist with locating the building and Region V Systems is allocating $1.2 million for behavioral health services such as crisis stabilization and mental health respite to serve adults in the community experiencing a behavioral health crisis. This service offers people in our community somewhere to go when experiencing a behavioral health crises versus going to the emergency rooms or filling up the jails. This service has been released for a request for proposal in our community. Additionally, Lancaster County is contributing ARPA funds and allocating up to $6 million to assist with locating a building and Region V is committing another $1.2 million for behavioral services such as a family resource center to serve families and youth in a community experiencing behavioral health crises. Referral sources will be law enforcement, 988 help line, mobile crisis response and families. This service also offers families and youth in our communities somewhere to go when experiencing behavioral health crises versus going to the emergency room, waiting for hours and only to learn that their youth are not going to be admitted and then being turned away with minimal supports. Extremely frustrating for the families. This service continues to experience delays in response from the Division of Behavioral Health since December 7, 2023. As regional administrators, we work closely with county commissioners from our respective counties in our geographical service area, ensuring they're contributing county match funds for services and listening closely to constituents from rural and urban citizens, taxpayers and persons of interest to aid in identifying the gaps and fragmentation in our behavioral health system.

HANSEN: Mr. Kreifels, your red light went on.

PATRICK KREIFELS: Oh.

HANSEN: [INAUDIBLE]

PATRICK KREIFELS: Thank you.

HANSEN: If you want to just wrap up your final thoughts really quick?

PATRICK KREIFELS: I certainly can. I just-- you know, when I was listening to Senator Brewer, LB451, testifying about the jails and the mental health problems in our community, I mean, I think that's what we're talking about. Some of our services are here to support the people so they don't have to go to the jails. I just ask respectfully that you support LB433.

HANSEN: All right, thank you.

PATRICK KREIFELS: Thank you.

HANSEN: Any questions from the committee at all? Senator Riepe.

RIEPE: Thank you, Senator. Could you help me with-- share with me an example of your interest in a program that's not allowed by DHHS? Say if you had this 25 percent flexibility, is there a specific program that you would say, this is where our Region V community needs that's different than urban Omaha or Lincoln?

PATRICK KREIFELS: I'm going to try to answer that, Senator.

RIEPE: That's all I ask.

PATRICK KREIFELS: So I-- what I can say is we want to continue to have a collaborative and collegial relationship with Health and Human Services.

RIEPE: Sure.

PATRICK KREIFELS: And in doing so, we do need their partnership to continue to make sure that the funds are expended in appropriate ways and that we are following the federal guidelines or local or state--

RIEPE: Of course, you have to.

PATRICK KREIFELS: --and laws. And so I cannot think of a specific example for you today. However, it's the-- it's that slow response time. I mean, when we're looking at on average 78 days to get a response to help move services out in the community a-- the longest time we waited was 288 days to get a response from Health and Human Services. So this is-- this challenges that we are experiencing that ultimately affects the people that are vulnerable in our communities.

RIEPE: OK. Thank you.

PATRICK KREIFELS: Thank you.

HANSEN: Any other questions from the committee? Senator Ballard.

BALLARD: Thank you, Senator. Thank you for being here. Kind of piggybacking off of Senator Riepe's question, looking back at your last fiscal year, where would you have moved money with this flexibility?

PATRICK KREIFELS: There are lots of opportunities for us to move money. So looking back over since 2021-- April of 2021, we have submitted over 30 requests to the Department of Health and Human Services to shift funds for proposals and that is on the low side. We have-- we monitor the entire array of services, whether it be an acute stay in a hospital or a residential for substance use or mental health or outpatient. And when there is under production or overproduction by providers within the network, we need that flexibility to shift quickly for them so that they are being reimbursed in an appropriate time frame. And, you know, waiting on average 78 days to respond is not a quick response and that's the concern that we have and our constituents have. Increasingly concerned about the, the bureaucracy and the delays that are occurring in our relationship with Health and Human Services.

BALLARD: Thank you.

HANSEN: Any other questions? All right, seeing none, thank you.

PATRICK KREIFELS: Thank you for the opportunity.

HANSEN: Is there anybody else wishing to testify in support?

DALE SCHROEDER: You're right, Senator Jacobson, and I'm pretty short to start with. Good morning, Chairman Hansen and members of the Health and Human Services Committee. My name is Dale Schroeder, D-a-l-e S-c-h-r-o-e-d-e-r. I am a commissioner in Keith County and I represent District 1 there. And as a result of that, I'm a member of the Region II Human Services Governing Board. I have served on this board since January of 2021 and I'd like to thank Senator Jacobson for bringing this important legislation. I appreciate the opportunity to appear before you today in support of LB433. Problems have been building for Region II over the past seven years we've debated that, whether it was ten or three or five or seven, but I'm going to say seven now. We as a governing board have experienced an extreme loss of control, which has in-- and which has resulted in an inability to get dollars moved to meet the needs of patients in our region. My time on the Region II board has allowed me to gain a tremendous amount of respect for the abilities and knowledge of our administrator-- our regional administrator, Kathy Seacrest, and her staff. Thus, I am certain that their methods for maintaining care within our budget are well-planned and completely transparent. They have gone above and beyond the requirements that, that the Division of Behavioral Health has demanded of them. However, the Division of Behavioral Health continues to put

up roadblocks that prevent Region II's ability to deliver services that we know work in our area. The division wants to use a cookie-cutter approach to provide services and in our rural area, that just doesn't work. Our board asked the division to consider a rural rate table and we were told that they may look at that in a couple of years, but we need to have this happen now if we're going to be forced to bill that way. We need the flexibility that LB433 gives us to manage our dollars effectively and efficiently. As a board, we've tried working with the division, but they continually refuse to acknowledge our role in the system and our ability to define the needs that Region II has. This resulted in the division mandating an external audit, which we complied with, and the third-party audit findings indicated that Region II was perfectly in compliance with requirements and regulations. The division's leadership determined that these findings were not to their liking. Thus they simply overlooked the audit and continued to throw up roadblocks. We, the governing board and our administrator, asked to appeal the decision of the director. We were then informed that the appeals process was to go directly back to the deputy director's office, thus rendering us helpless in an appeal process. This is simply not acceptable. I know that you are all familiar with the United States Constitution and in Article I guarantees its citizens the right to petition the government for a redress of grievances. There must be a fair process of appeals put in place. Region II's administrator, her staff and our governing board have been good stewards of the state dollars and use every dollar we can for service delivery to those who need help. I simply ask that you help pass LB433, which will help our region and other regions continue to do just exactly that. I appreciate your time and attention to the issue and I'll try to answer any questions that you might have. And I do mean try.

HANSEN: Thank you for your testimony.

DALE SCHROEDER: Thank you.

HANSEN: Are there any questions from the committee? You lucked out.

DALE SCHROEDER: I'm glad the regional administrators took care of some of that. Thank you. Thank you. I appreciate the opportunity.

HANSEN: We'll take the next testifier in support. Good morning.

PATTI JURJEVICH: Good morning. Chairman Hansen, members of the committee, my name is Patti Jurjevich, P-a-t-t-i J-u-r-j-e-v-i-c-h.

I'm the administrator for Region VI Behavioral Healthcare. I'm here today on behalf of the Nebraska Association of Regional Administrators and also on behalf of the Region VI Governing Board. For your reference, Region VI is comprised of Cass, Dodge, Douglas, Sarpy and Washington Counties. We too appreciate the introduction of LB433 by Senator Jacobson. There are two items I'd like to bring to your attention today. First is to confirm for you the regional behavioral health authorities' commitment to system and service improvements. In November, I appeared before this committee and provided the attached recovery-oriented system of care document developed by the regional behavioral health authorities. The document provides information on the proposed system changes, as we have the unique opportunity to redirect and reinvest funds to enhance, expand and improve services across Nebraska. Second, in order to accomplish these improvements, there is a need to have flexibility in our funding and reimbursement systems and the authority to manage local services. I do want to note that that attached document, we've had ongoing discussions with the Division of Behavioral Health leadership since August of 2022. The regional behavioral health authorities envision a system that is well resourced, has adequate service capacity, provides services across the continuum and ensures care to support individual recovery regardless of payor source. At the hearing in November, I indicated in my testimony that an important principle of a recovery-oriented system of care is adequate and flexible funding. Based on apparent changes in the working relationship with the department, the regions have experienced the loss of flexibility and authority needed to effectively manage the behavioral health system to address these needs in our communities. As a result, there has been a steady reduction of the regional behavioral health authorities' ability to respond to individual community and system needs in a timely manner. Slowly and methodically, the ability to serve as the safety net of Nebraskans who experience a mental illness and/or substance use disorder has been diminished. The once collaborative, productive partnership between the regional behavioral, behavioral health authorities and the department that we experienced during behavioral health reform unfortunately does not appear to exist. It is important to remember regional behavioral health authorities have statutory authority and responsibility to develop and coordinate the publicly funded behavioral health services within the region. It was the Legislature's intent in the 1970s with the legislation establishing the regional system that mental health needs were best determined and decisions best made at the local level. The expansion and requirement of the fee-for-service environment has crippled our ability to be innovative and responsive to needs both

present and emerging. This fee-for-service reimbursement method alone, without the opportunity for supplemental financial support to help cover operational costs, also endangers access, especially in rural areas when providers cannot sustain service capacity. You may be aware that utilization of the appropriation from the Legislature to the behavioral health system is low. This in no way indicates there isn't a need for more behavioral health services. It is much more a symptom of the systemic delays and constraints experienced through the department. We respectfully request your consideration of the proposed language in LB433 that provides the regional behavioral health authorities with the necessary flexibility and authority to make timely budget and service decisions in response to needs in our communities. We recognize the issues facing schools, hospital emergency departments, psychiatric inpatient units, county correctional facilities, criminal justice, law enforcement and access to care concerns of our citizens. Regional behavioral health authorities are working to move forward plans to reinvest dollars in order to expand capacities and develop new services to address many of these needs. But the process can be a slow one. I assure you that regional administrators are ready, willing and able to collaborate with the department for the betterment of our system. To conclude, the regional behavioral health authorities envision a system that is accessible, effective, efficient, innovative and flexible in order to meet the current and emerging behavioral health needs of Nebraskans. As always, we appreciate your continued support of the behavioral health system. I thank you for your time today and would-- I'll try to answer any questions you have.

HANSEN: All right. Thank you for testifying. Are there any questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman Hansen. First a comment and then you can respond to this. It seems to me that this-- or it appears to me that this is a coup d'etat, if you will, by the regional behavioral health systems because it sounds like virtually all of you are here to testify in support of this greater flexibility.

PATTI JURJEVICH: Well, it--

RIEPE: Is that fair to say?

PATTI JURJEVICH: --it, it is an ongoing concern that we have about how we can reasonably and in a timely manner respond to those local needs. It is the regions and our staff that get those phone calls from law

enforcement, from the hospitals, from the school systems. They have needs that need to be met. And if we can't respond, if we have the dollars-- and we have the dollars to invest in those things-- if we can't do that in a timely manner, then we're not being effective at, at our mission.

RIEPE: OK. The second question, if I may Mr. Chairman, was with the demise of the state mental health hospitals in the '70s, with the intent that it was supposed to be replaced by community mental health centers-- and of course, the nice idea; never happened. Were these regional centers set up to be those-- that answer to the absence of the state mental hospitals of Hastings and-- oh, I forget-- Omaha-- Lincoln had-- Lincoln, Omaha-- or Lincoln--

PATTI JURJEVICH: Norfolk.

RIEPE: --Hastings, Norfolk?

PATTI JURJEVICH: Correct. Yes. You know, I was involved in that behavioral health reform effort. And I, I-- there was a great deal of planning, a great deal of collaboration that went on between the regions and the Division of Behavioral Health. We all put together plans on what we needed to be able to serve individuals in our community so they could return from the state hospital system and perhaps not need to go to the state hospital system and could be served closer to home and families. The unfortunate thing was that there wasn't sufficient dollars to do everything that was identified that was needed. So everybody did the best they could with the dollars that we had, but unfortunately, we have, you know, continued to see ongoing needs, probably much related to that inadequate funding of that behavioral health reform effort.

RIEPE: You may have known Dr. Frank Menolascino.

PATTI JURJEVICH: That name is familiar to me, yes, you bet.

RIEPE: Because he was instrumental in all the--

PATTI JURJEVICH: Yes, he was.

RIEPE: OK, great. Thank you. Thank you.

HANSEN: Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thanks for being here. The fiscal note talks about needing to hire additional staff to basically make sure that the regions are in compliance with the federal regulations. And since I don't know if the department is testifying today, I'm going to ask you and if you don't know the answer, that's totally fine. But do they currently check to make sure that the regions are in compliance with federal spending--

PATTI JURJEVICH: Absolutely.

M. CAVANAUGH: --guidelines?

PATTI JURJEVICH: Absolutely. That is a role that they have. And we are in regular communication when there is a question that we have about whether-- potentially, you know, a budget shift that might impact federal dollars or any of the maintenance of effort kinds of situations that go on with federal dollars. We could communicate regularly with them and they can give us an indication whether that's a concern of theirs.

M. CAVANAUGH: OK. I just-- it's not your responsibility to address their fiscal note, but it seemed to me that there probably were people that work at the agency that make sure that you're in compliance-- the regions are complying currently.

PATTI JURJEVICH: That is the current statement, yes.

M. CAVANAUGH: OK. Thank you.

HANSEN: Senator Walz.

WALZ: Thank you, Chairman Hansen. Thanks for coming today. Mr. Kreifels said that he had asked for over 30 requests to shift funds. Do you-- over the last year-- I don't remember if it was the last year or how-- over a time period, but can you give us an idea of how many requests you've--

PATTI JURJEVICH: How many budget shift requests?

WALZ: Yeah.

PATTI JURJEVICH: I'm afraid I don't have that at my fingertips today. I certainly can follow up with you. And I would say probably our greatest concern is the timeliness of-- I can give you an example. We-- a concern that we've had in-- with individuals leaving Lincoln

Regional Center. These are individuals that probably have very complex and complicated needs. And we have not-- we don't really have anything in our community that best meets those needs. So we started a process in August of 2021, alerted the Division of Behavioral Health we need to develop something. We don't think anything else exists like this. We want to develop something. So the conversation started. So, you know, you kind of, you kind of pitch this is our, our idea about how this service might look. And it was clear after some conversations with division staff that they weren't going to approve that. So, you know, the conversation continues month after month after month, trying to figure out what is it that we can create that meets those individual needs that will get approved by the division? So that process really took until probably late last calendar year before we were finally able to settle on a service definition that the division would approve. Then we have to submit to the division our request for proposal document and then that takes time then for them to review and get approval on that. So a process that started in August of 2021, we just in January-- late January were able to have a bidder's conference to get the ball rolling to find out if we have providers that can do that service. In the meanwhile, people are not getting services that they need. We know that. That's where-- you know, we have a sense of urgency to try to move things forward, right? It's a little different situation than a budget shift necessarily, but these are the-- some of the, the major issues that, from a, from a time perspective, are creating problems for us.

WALZ: And so you wouldn't have had that issue three and a half years ago or prior to the contract being changed. You would have been able to define and start a service that was needed?

PATTI JURJEVICH: It may have been just a little bit of a different situation with a new service that doesn't exist already. The shifts are a little easier made between existing services. Maybe you're expanding a service. It is-- if you're bringing in a new service definition, it may make it a little more complicated in that process.

WALZ: Yeah. Thanks.

HANSEN: Any other questions? Seeing none, thank you for coming.

PATTI JURJEVICH: Thank you.

HANSEN: All right. We'll take our next testifier in support of LB433. Welcome.

ANNETTE DUBAS: Thank you. Good morning, Senator Han-- Chairperson Hansen and members of the Health and Human Services Committee. My name is Annette Dubas, A-n-n-e-t-t-e D-u-b-a-s, and I'm the executive director for the Nebraska Association of Behavioral Health Organizations, otherwise known as NABHO. NABHO represents 52 organizations statewide that include community behavioral health providers, hospitals, regional behavioral health authorities, and consumers. We work to raise awareness and build alliances that support access to behavioral healthcare for everyone across our state. We thank Senator Jacobson for his support of our behavioral health regions and for introducing LB433. Our members, as well as many behavioral health providers across our state and country, rely heavily on public payors for reimbursement. Medicaid is the single largest payer for mental health services. The Division of Behavioral Health and the six regions are one of those public payors that our members engage with regularly. Medicaid is a federal program, which brings with it federal regulations and requirements. There's very little, if any, flexibility when it comes to services and reimbursement from CMS. Providers understand that and some will even make the decision because of the complexities of the program not to serve Medicaid clients. But the Division of Behavioral Health and the regions are a very different program. Our six region partners with their local county governments. Each region has a board with one commissioner or supervisor from each county. Counties contribute financially as well, with $1 for every $3 from the general fund. Regions also seek input from consumers through advisory committees and provider meetings. Regions were established specifically to meet those local needs, not a one-size-fits-all like Medicaid. Regions contract and work with the local providers to meet the needs of their communities. Our members sincerely appreciate the flexibility in how responsive that system can be to meet the needs of their clients. Regions are a great example of local control and responsiveness. You've heard more specifics from the region testifiers today, but I want you to know from a provider and a consumer perspective, we truly do appreciate the ability of regions to work with us and support services that meet our community's needs. One of the objectives of LB1083 that was passed in 20-- 2004, which was mentioned earlier, was the closing of those regional centers and the intent to move those resources into the communities through the regions and again, their ability to assess the needs in specific areas, in specific areas of their communities. For whatever reasons, the flexibility provided with regions were-- the regions were established has been slowly eroding. NABHO supports LB433 because our members and the people they serve benefit from that flexibility. I've

been in conversations where it was discussed that perhaps we need to more closely align DBH with Medicaid. And while we agree there may be some places that that can happen, it's more important to recognize that these are two very different types of programs and payors, each with their own purposes and benefits, and really strongly believe it should remain that way. LB433 adds needed budget flexibility for regional behavioral health authorities to allow local needs to be met by allowing that any appropriations to behavioral health regions be used within an approved annual budget or by activities that are identified through needs, as demonstrated through the regions. If there ever was a time to make sure that all resources that are available be directed to services, it, it truly is now. And I know in the past, we've come in and supported the regions when they simply asked for intent language to be included in the budgets. Just trying to, to make that point of, you know, we need this flexibility. We understand the needs of our community. And if the resources are there, you know, let us direct them to where they need to go. So I, I truly thank you for your attention and hope you will see the merits of LB433 and advance it to General File.

HANSEN: Thank you for your testimony. Are there any questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thanks for being here. You said in 2004 there was a bill passed.

ANNETTE DUBAS: That was the, the big-- one of the big reform bills, LB1083.

M. CAVANAUGH: LB1083. I didn't catch the bill number. Thank you. Do you have any, any comments you'd like to make to address this fiscal note?

ANNETTE DUBAS: [INAUDIBLE] by fiscal note. I have, have had personal experience with that as well.

M. CAVANAUGH: Yes, I know.

ANNETTE DUBAS: And I haven't had to deal-- I haven't looked in depth--

M. CAVANAUGH: OK.

ANNETTE DUBAS: --at the fiscal note, but--

M. CAVANAUGH: One of the things that it, it's-- it talks about is needing additional FTEs to main-- ensure federal compliance. And that's something you heard me probably ask already. It just feels like they should already be doing that.

ANNETTE DUBAS: They are. And I mean, I've heard from my members all the time about the, the amount of information that they're required to provide to the region so the regions can then in turn, you know, submit, you know, their reports and the audits. So I can't think of anything and I've never heard any of my members say anything that--

M. CAVANAUGH: OK.

ANNETTE DUBAS: --would make that requirement necessary.

M. CAVANAUGH: OK. Thank you.

HANSEN: Senator Riepe.

RIEPE: Thank you, Chairman Hansen. Welcome back, Senator.

ANNETTE DUBAS: Thank you.

RIEPE: One of the questions-- and I know we've, we've sort of targeted DHHS on this, but are they getting additional federal pushdown from them for changes that they're just simply the go-between and-- but they're catching the flack on it?

ANNETTE DUBAS: I-- you know, I can't speak to that specifically. I, I have not heard anything to that, that degree. Again, there's, there's a-- truly an understanding of these are the federal dollars and these are how the federal dollars have to-- my, my members understand that as well. So they're always on top of it. So as far as would there be pushback from the federal government, I, I can't imagine that, that there is.

RIEPE: We might get a chance to hear one of them coming up. I don't know, but thank you very much.

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

ANNETTE DUBAS: Thank you.

HANSEN: Is there anybody else wishing to testify in support of LB433? All right, seeing none, is there anybody wishing to testify in opposition? Good morning.

BO BOTELHO: Good morning, Chairman Hansen and members of the Health and Human Services Committee. My name is Bo Botelho, B-o B-o-t-e-l-h-o. I am general counsel for the Department of Health and Human Services. I'm here to testify in opposition to LB433 on behalf of the department. DHHS administers and coordinates the state's public behavioral health system. This includes prioritization and approval of expenditures of behavioral health funds and coordination and oversight of regional behavioral health authorities. DHHS takes these responsibilities seriously and works throughout the year with the regions to ensure the budget and subsequent budget changes are supported by revised budget information service utilization and other data. Approved budgets and expenditures are based on the annual budget plans submitted by regional governing boards. The budgets are reviewed by HHS for alignment with the state's strategic plan. Budget guidelines are provided to the regions each January for use during budget plan development. HHS monitors and ensures compliance with federal maintenance of effort, match requirements and the funding proposed-- proposals set by the Legislature and federal entities. Without this oversight, the state risks failing to meet its maintenance of effort obligation, resulting in the loss of federal funds. While DHHS supports full expenditure of allocated funds, the complexities of multiple funding sources and the requirements must be weighed in all decisions. Automatic reassignment of funds could lead to audit findings and federal disallowance of funds. Changes to approved budget plan can be proposed throughout the contract period and are evaluated based on budget justification and demonstration of need. In fiscal year 2022, the first six months of fiscal year 2023, the regions asked for a combined $5.6 million in budget changes. All but a few thous-- all but a few thousand dollars-- I think it was around $4,000 was approved. DHHS works diligently to review and approve the requests within four days, consistent with the agreement in the-- with the regions. The bill would also grant the regions the right to request an administrative hearing if a budget request is not-- it is an inappropriate-- it is inappropriate to use the Administrative Procedures Act, the APA hearing process for matters relating to intergovernmental funding agreements. A decision regarding the requested budget change for grant funds doesn't rise to the level of a contested case involving individual rights. The hearing officer and the district court are not the right places for these decisions to

be made. DHHS understands the need for government to be flexible and responsive. HHS will continue to carry out the intent of the Legislature and the federal government and be a good steward of public funds. We ask that the committee not advance LB433 and I'll try to answer any questions the committee may have.

HANSEN: Thank you for your testimony. Are there any questions? Senator Riepe.

RIEPE: Thank you, Chairman. I'm accustomed to having DHHS come generally in a neutral capacity so you obviously feel very strong in coming in, in an opposition position. And my question, I guess, would be is I briefly looked here at the fiscal note, correct me if I'm wrong here, it says the addition of ten FTEs would be used for contract subaward management and monitoring the agreements. That seems like a-- kind of a concrete block to make the person down, if you will, makes it-- the fiscal note then kills-- tries to kill it, as, as the senator pointed out. I hope that's not the case. You're telling me it's going to take ten FTEs to administer this redistribution of 20 percent?

BO BOTELHO: I think what the Division of Behavioral Health is, is saying that if we're going to manage each region independently, they're not staffed to, to manage multiple-- basically separate and distinct-- almost like a confederacy of, of behavioral health districts. They're staffed to manage a statewide enterprise and that's how they're operating. If intent is to separate them all and now we're managing them all individually, then these FTEs is what they're saying they would need to set up basically independent units.

RIEPE: Aren't you managing them independently at this time?

BO BOTELHO: There-- as I-- the way behavioral health works is they're almost like a traffic-- air traffic control tower with, with the funds. We have a maintenance of effort, which is different than a match requirement. So the state is required to spend so much state dollars annually for specific purposes in order to maintain federal funding, these, these block grants. So what they're doing is they're ensuring that the overall spend is meeting this maintenance of effort match to preserve the block grants. And they're doing it as a collective, which is-- when we're shifting money around, they have to ensure that they're maintaining their, their, their maintenance of efforts for the totality for the state. But they're not seeing each region as sort of, like, an independent entity where they would have

their own maintenance of effort. They're looking at it collectively is how I understand the process. And I'm not--

RIEPE: Yeah.

BO BOTELHO: --in the Division of Behavioral Health, but that's my understanding of the process.

RIEPE: So you wouldn't be comfortable if the executive director of each unit attested to the fact of how they spent their 20 percent. It almost gets to a trust factor.

BO BOTELHO: It, it does and the, the accountability in the federal government is always with the state because the money is given to us and, and we are then awarding it to the regions. So when they come back for the money, they're coming back to us, state level. They're not going into the regions and saying you've failed to meet maintenance and that's not how we're set up. We're set up that when the feds look down on us, they see one state enterprise. They're not necessarily seeing it dividing into regions. So ultimately the responsibility falls on us to ensure that maintenance of effort is, is met to ensure future federal grant funds and any match requirements are being matched to ensure funds.

RIEPE: It seems to me that the feds might have more flexibility than you're having at DHHS.

BO BOTELHO: It's-- yeah, when it's their money, it's their rules and, and we're just complying with their rules.

RIEPE: OK. Thank you, Chairman.

HANSEN: Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Mr. Botelho, for being here. In your testimony, you said that you, the department at-- the regions asked for a combined $5.6 million in budget changes and all but a few thousand dollars was approved. Not to get too much into semantics, but what is a few thousand because a few--

BO BOTELHO: $4,000 is the number--

M. CAVANAUGH: $4,000?

BO BOTELHO: --yeah.

M. CAVANAUGH: OK so we have a kind of a conflict here in testimony because we had the very first testifier in support, Kathy Seacrest, said that they had over $300,000 that they were seeking approval on that they haven't been able to use.

BO BOTELHO: So the numbers I was speaking about are budget shifts, which would be shifting within approved budgets is how I understand that works, Senator.

M. CAVANAUGH: OK.

BO BOTELHO: I'm not sure what the first cut-- it may have been original budget or it may have been new services--

M. CAVANAUGH: OK.

BO BOTELHO: --which one of the previous test-- testifiers spoke about that as well.

M. CAVANAUGH: Sure. We can probably circle back on that off line.

BO BOTELHO: Yes.

M. CAVANAUGH: That was-- just, just stuck out to me. The fiscal note and this insurance of federal compliance-- I know you just kind of discussed this with Senator Riepe. I just-- I am having a difficult time understanding what it is you do now and how this would be different because it seems like now you have to-- correct me if I'm wrong here-- have federal compliance and you have to ensure that the dollars that they're spending are federally compliant. How would this require ten additional people? Did you have-- did-- I guess let's go back to before, three years, seven years, whenever it was that this shift came in the contracts. Did the department eliminate ten FTEs at that point in time? If you previously allowed the flexibility to do this 20 percent shift in spending, when you eliminated that from the contracts, did you also eliminate ten FTEs from the Department of HHS?

BO BOTELHO: I, I don't know, Senator, to be honest with you. I'm not sure. My understanding of the changes in the contract that's been testified to are changes to ensure compliance with our federal block grants, so--

M. CAVANAUGH: OK. I think--

BO BOTELHO: --I don't think there was an elimination of FTEs that I'm aware of.

M. CAVANAUGH: OK because there, there seems to be a disconnect in, in how the department is presenting this versus how the regions are understanding it. And part of this disconnect seems-- and again, I would like you to speak to this-- to be a lack of communication. It sounds like from what they have said, that they have tried to have communication with the department and even Senator Jacobson has tried to have communication with the department. And there wasn't clear lines of communication, which has brought us to this point today. Can you speak to that?

BO BOTELHO: To the extent I-- Senator, actually, what I know is what Senator, Senator Jacobson has told me in conversations and what he testified to here today so I don't know all the history. The communications you're talking about it between the regions and behavioral health. And Director Green was not able to be here today, but I know that he has met briefly with Senator Jacobson and has committed to meet-- to continue to meet with and try to resolve these issues. But I agree with you that there appears to be a communication failure between the division or the department and these independent-- and these individual regions. But I don't know the genesis of that and I don't know what the obstacle is.

M. CAVANAUGH: OK. So-- sorry, bear with me for just one more minute- so you've spoken with Senator Jacobson--

BO BOTELHO: I have.

M. CAVANAUGH: --in advance of this. And has this fiscal note been discussed and how we could address the fiscal note? Because the fiscal note, as far as I can tell from all of this testimony, is, is a lack of communication in what, what the intention of the bill is, what the intention of the regions are and what the expectations are, both federally in compliance and just the state generally. There seems to be a lot of lack of communication. And to Senator Riepe's point about departments coming in in opposition, I think Senator Riepe and I served our first four years in a very different environment. I am very used to the department coming in opposition, unfortunately, but it would be great if we could have less of that and more upfront communication. So is that something that happened and there just couldn't be an agreement or is that something that has not happened?

BO BOTELHO: I have not spoken with Senator Jacobson about the fiscal note.

M. CAVANAUGH: OK.

BO BOTELHO: But I think the fiscal note is, is based on what the department is-- the department is not sure how we would manage this under this bill or what the expectation of the Legislature is, how you want us to manage these regions under this legislation. So they're asking for-- they're assuming that they're going to be independent and now we're basically going to have a division of behavioral health for each region almost to that, that, that fact. And so I think that's--

M. CAVANAUGH: Sure.

BO BOTELHO: --the basis of the note.

M. CAVANAUGH: My note, my, my note to the department would be to, perhaps before you formulate the fiscal note, to have a conversation with the introducer to find out the intent and see if there is some work that can be done in advance so that we don't have these conversations, but thank you.

HANSEN: Any other questions from the committee? Senator Walz.

WALZ: I have a question. Thanks for coming today. So if we would remove the federal funds and appeal would you come in support of the bill then?

BO BOTELHO: I, I'm sorry, Senator. I didn't understand that question. If we would remove the federal funds?

WALZ: Yeah, I thought--

BO BOTELHO: So a lot of this has to do with the, the maintenance of effort, which--

WALZ: Right.

BO BOTELHO: --we have to use state dollars. Now, if you're going to say that we're going to forego any of these block grants and we're basically going to say we're not going to seek federal funding for any behavioral health services in the state of Nebraska, then that would shift a lot of money over to general funds and you're going to have a huge general fund--

WALZ: Right.

BO BOTELHO: --impact.

WALZ: Right.

BO BOTELHO: But I don't think that's what you're asking, is it, Senator?

WALZ: No. No, it's OK. I can-- I'll, I'll circle back with you on that. Can I ask one more question, though, please?

HANSEN: Yep.

WALZ: Thanks. Here's another silly question because I don't know: when you are preparing fiscal notes, is there a consideration on the overall state budget? Like, when you're coming up with these fiscal notes, how, how are you considering how it will affect the overall budget? Does that make sense?

BO BOTELHO: So when we do a fiscal note or a fiscal impact statement, we look at the, the legislation and we look at what cost that would be or new cost-- especially if it's new work, right-- which in this bill, it's unclear if we're going to be having to do new work under this legislation. So we look at what the cost is to implement the bill and we put it in the fiscal impact statement. We have to look at each individual bill separately and do a fiscal impact [INAUDIBLE] statement.

WALZ: Right.

BO BOTELHO: You will see lots of impact statements where we say that we can-- we try to quantify the work and then say, you know, this bill, we can absorb this, this cost because-- but then the concern is if a lot of these bills drop that we're saying we can absorb the cost, then we may have costs now that we can't absorb. But that's the way the fiscal note works; you have to look at the legislation in a vacuum. What is the cost to implement this bill? And we estimate that cost.

WALZ: OK. I understood-- OK.

BO BOTELHO: Because we don't know which bills at the end of a session are going to be enacted in, into law.

WALZ: But you're saying you can absorb this cost.

BO BOTELHO: No, we're-- well, we're saying that if-- we're unclear on how we're being asked, if this bill passed, to implement this. But what the Division of Behavioral Health is saying is that if they have to, in essence, manage each region separately, I believe-- almost like independent behavioral healths-- then they're going to need additional staff because they can't do that with their existing staffing. They can't do all the monitoring if they're all a separate individual entity. And we're not looking at one strategic statewide plan or managing a statewide system of services. We're now managing multiple individuals, basically splitting the division of behavioral up into regions as well. I-- and again, I'm not in the Division of Behavioral Health, but reading the fiscal note, that's what I think they are preparing to do with this legislation.

WALZ: OK. Thanks.

HANSEN: Senator Ballard.

BALLARD: Thank you, Mr. Chairman. I want to get away from the fiscal note for a little bit. You said in your, your testimony that review of approval and requests take about four days. That's your goal.

BO BOTELHO: That's the goal, yes, Senator.

BALLARD: We've heard from multiple testifiers that that's not the case, that this isn't-- I think Region V said they've averaged 78 days. So it's not-- it doesn't sound like a one-off. So can you take me through the process of how you review those requests and taking into consideration the director or the CEO came in a few weeks ago, talked about innovation. That's not very innovative, in my opinion, not very businesslike. I know I'm just a humble pastry chef, but if I ran my business like-- where I waited for customers for a long time, then I won't have a lot of customers. Can you talk a little about that process and what you can do?

BO BOTELHO: I'm not sure what to behavior-- what the behavioral health's process for these requests. So I know there are different types of requests. In my testimony, I was speaking about requests for cost shifts, which I think are very different than some of the requests that the regions are asking, like bringing up some new services. So there's a-- there, there are different variety of types of requests that may require different levels of approval. But I

really don't know, Senator. We-- I'd have to get back to you on that. I can get that information from the division and provide it to the committee.

BALLARD: OK. Thank you.

HANSEN: Any other questions from the committee? All right, seeing none, thank you.

BO BOTELHO: Thank you.

HANSEN: Is there anybody else wishing to testify in opposition to LB433? Seeing none, is there anybody who wishes to testify in a neutral capacity? All right, seeing none, we welcome Senator Jacobson up to close. And the record, we did have six letters in support of LB433.

JACOBSON: Thank you, Chairman Hansen and members of the committee. I'm trying to figure out where to begin here on the close. I think what you heard was you heard what was happening on the ground. I think you heard what was happening from the standpoint that we've got people trying to serve people within the various regions of the state to do what they were set up to do originally and yet there's roadblocks. I'm not quite sure on this last testimony in terms of dollars that have been approved. But I can tell you last September, Region II was not able to expend $1.2 million and they had to forego those funds. I would like an explanation from the last testifier why that happened; $1.2 million. I'm going to go back to Senator Cavanaugh's question. Thank you for the question. Why did we need ten people now when we didn't get rid of ten people back in 2015? Because I'm looking at the budget--or the contract that was signed with the department with Region II back in 2015 and it said, with the exceptions identified in section-- is section (e) paragraph 2 and 3, the region is permitted to reassign funds within service categories up to 25 percent of the funds between service categories without, without prior approval of DHHS. We did it back then. We did it back then. I'm insulted that DHS came in here and testified in opposition. That's inappropriate. They should have been here in a neutral capacity sharing their information. Very frustrating how this is working. I know they've got a tough job. I appreciate the job they have to do, but I'm sitting on the ground watching the actual providers struggling to try to curb the, the, the mental health issues that we're dealing with across Nebraska. We listened last year in LB920 trying to look at prison reform. What do you think's beating our prison system? We got to get on the front end

of these things and 78 days for a response is unacceptable. We can't do that. This flexibility is needed to make that happen. This is not a coup d'etat. This-- we're not trying to overthrow anybody. We're trying to get flexibility within the funding that the state is putting into this program. And they're notifying DHHS of what they're doing so they can run their numbers. Again, the fiscal note, insulting. Absolutely insulting. Let me also give you just one piece of the track record. This conversation I had, the letter I sent email back-- or the letter back and forth is back in September, I was told no flexibility because of the contract, no flexibility. Communication since that time, zero, zero. When did I have a conversation with DHHS? A week ago. When did I get the fiscal note? This morning. Is that cooperation? Is that trying to solve the problem? I don't think so, not how I interpret it. I've got a good memory. I'm going to remember this day. Thank you and I hope you'll move this bill forward. Do the right thing. And I'd stand for questions.

HANSEN: All right. Thank you. Are there any questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Senator Jacobson. Not so much a question as more of an observation. When the department comes in with fiscal notes like this, it is not constructive and it is not helpful to future fiscal notes to be taken seriously. So it does make it difficult for our jobs in any state agency. I appreciate very much your frustration. For four years, I think every bill that had anything to do with the Youth Rehabilitation Treatment Center had a $4 million fiscal note because they interpreted that we wanted to bulldoze buildings and anything that touches CMS had a-- was a $40 million fiscal note because we need a new computer system. So it's-- it, it does make our jobs difficult and I very much appreciate your perspective on this. I do think that there are a lot of questions that we couldn't get answered in this hearing as a result and it would be helpful if you could give us copies of those contracts to look at the history of it. So thank you for bringing this bill and I'm sorry for this frustration.

JACOBSON: And by the way, we agreed on this issue. Now, we aren't going to agree on all issues, but I just--

M. CAVANAUGH: Again--

JACOBSON: --but you've got this one.

M. CAVANAUGH: --I hope somebody is cross-stitching everything from today, so.

HANSEN: All right, any other questions? Senator Riepe.

RIEPE: And just for the record, I wanted to clarify a little bit. I'm not in opposition of coup d'etats.

JACOBSON: That's good. That's good to note.

RIEPE: They have their place.

JACOBSON: They do. Thank you, Senator Riepe.

HANSEN: Any other questions? All right, thank you for coming. Thank you for closing.

JACOBSON: Thank you.

HANSEN: And that will end the hearing on LB433. And we'll move on to LB219 and welcome up, welcome up Senator Ibach.

IBACH: I feel like I have to adjust my glasses because I'm sitting--

WALZ: We need to get some books--

HANSEN: Yeah.

WALZ: --pillows--

IBACH: Or--

WALZ: --that chair.

IBACH: --maybe just one that--

HANSEN: Or just taller senators.

IBACH: Well, that ain't going to happen.

HANSEN: All right. Well, welcome to HHS and you are willing-- or ready to open whenever you'd like.

IBACH: This one will be much easier. Good morning, members of the Health and Human Services Committee. My name is Senator Teresa Ibach, T-e-r-e-s-a I-b-a-c-h, and I represent Legislative District 44. Today

I'm here to introduce for you consideration for LB219. LB219 is a simple bill which directs the Division of Medicaid and Long-Term Care to rebase in-patient interim per diem rates for critical access hospitals using the most recent audited Medicare cost report. As of now, there are 63 critical access hospitals in Nebraska. For background, the critical access hospital designation was designed in 1997 to keep access to healthcare viable in rural areas across the United States by reducing the finite-- financial vulnerability of rural hospitals. To be eligible for the designation, hospitals must meet the following criteria. They must have 25 or fewer acute care inpatient beds. They must be located more than 35 miles from another hospital. They must maintain an average-- annual average length of stay of 96 hours or less for acute care patients and they must provide 24/7 emergency care services. There are six of these hospitals in my district, District 44: Chase County Community Hospital in Imperial, Cozad Community Health Systems, Dundy County Hospital in Benkelman, Gothenburg Health, Lexington Regional Health Center, and Perkins County Health Services in Grant. The Nebraska Hospital Association recently released a report that stated that 53 percent of our critical access hospitals are currently facing financial stress. While there are numerous reasons for these hospitals to have this financial stress, I believe that by enacting LB219 into law, we can help alleviate one of these pressure points. Critical access hospitals are reimbursed based on their cost of providing services. Currently, the average patient cost for Medicaid recipients who receive services in a critical access hospital is between $3,000-- $3,300 and $4,500. Medicaid then will pay a per diem between $1,800 and $2,600, which only covers about 50 to 60 percent of that cost. This is the part that the bill would direct to be rebased. This per diem payment is artificially low and should be updated to better reflect today's costs. Additionally, these critical access hospitals then have to wait 18 to 24 months for full payment of the remaining costs already incurred to provide that care. When the states only pay 50 percent upfront, then these small hospitals are stuck holding the bag on the remaining 50 percent for up to two years. We can help our rural hospitals simply by retiming these payments. Paying a greater amount of the Medicaid costs upfront allows those hospitals financially struggling to retain existing services and staff and may allow those that are in a stronger position financially to expand their services, which then keeps our rural communities strong and healthy. After discussion with the Department of Health and Human Services, I am submitting for your consideration AM33, which will amend LB219 to require the department rebase the interim per diem rates every two

years, as opposed to the every-- every year, annually that was proposed in the bill. And this is due to the complexity and increased workload needed to rebase these rates every year. With that, I'm more than happy to address any questions. However, I do have some testifiers that are more proficient with the answers than I will be. So thank you very much.

HANSEN: Thank you for your opening. Are there any questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: Thank you. I just want to know, how did you get such a pretty fiscal note? I'm kidding.

IBACH: Pretty or--

M. CAVANAUGH: Well, I mean, it didn't-- it doesn't require-- it's, it's reasonable.

IBACH: It's really just for additional staff--

M. CAVANAUGH: Right.

IBACH: --to rebase.

M. CAVANAUGH: Yeah.

IBACH: And I think somebody-- someone will testify, but currently I think the fed rebases every four to six years maybe.

M. CAVANAUGH: And this would be annual?

IBACH: Yeah.

M. CAVANAUGH: Thank you.

IBACH: Well, this would be-- actually be biannual.

M. CAVANAUGH: Biannual.

IBACH: So that they would rebase every two years.

M. CAVANAUGH: OK.

IBACH: We requested three-- or we requested one, they proposed three and we compromised at two--

M. CAVANAUGH: OK.

IBACH: --so--

M. CAVANAUGH: Thank you.

IBACH: --sorry.

HANSEN: Any other questions? All right, seeing none--

IBACH: Thank you.

HANSEN: --see you at the close. All right, we'll take our first testifier in support of LB219.

MANUELA BANNER: Good morning and I am short. Good morning, Chairman Hansen and members of the Health and Human Services Committee. My name is Manuela Banner, M-a-n-u-e-l-a B-a-n-n-e-r, and I'm the president and CEO of Memorial Community Hospital and Health System in Blair, Nebraska. I'm here today to testify in support of LB219 on behalf of CHI Health, the Nebraska Hospital Association and the Nebraska Rural Health Association. When critical access hospitals are not reimbursed in a timely manner, it can have negative impact on the financial stability of the hospital. We have operating expenses such as salaries, supplies and equipment that need to be paid on a regular basis. When our reimbursement is delayed, it can put a strain on our cash flows and make it difficult to meet ongoing expenses. It can also lead to decreased morale amongst our employees in an already very tough labor market currently, affect the overall stability of the hospital and the reputation of the hospital in the community. There are 63 critical access hospitals in the state and more than half of them report that they've been operating with a negative margin for several years. I have a personal example from my days in a previous role in Nebraska. At that facility, every morning our CFO and I would meet and look at our receipts from the previous day and our bills that we had to pay for the month and we would decide, based on our receipts, what we could pay in the morning. And every month when payroll came around, we weren't sure whether we would be able to meet those obligations. All this happened at a time when we were paid a lower than necessary per diem for Medicaid and then we would have to wait 12 to 24 months to off-- or often longer to receive our end-of-year settlement. As in many other industries, our costs have skyrocketed, but the Medicaid per diem has not been adjusted. Specifically in the last two years, we've seen an average increase in

costs of about 33 percent, much of it related to labor costs and supply chain issues. Today, I'm not here to ask you that you pay us a higher reimbursement. I'm not looking for a raise. I'm here to ask for support that the critical access hospitals in Nebraska receive timely payments from Medicaid. Your support could help in providing a quicker availability of these funds that already show in our books as a receivable and in your books as a payable. Let me explain. Currently, critical access hospitals receive a per diem rate within about eight weeks after a patient's stay. This per diem rate actually reflects only about one-third to a half of the actual amount due to Medi-- from Medicaid. Annually, there is a drawing up of charges. This is generally done at the end of the fiscal year and the hospital report the difference between the actual cost and the payment received. Medicaid then is supposed to settle up with us with the remaining payments. The main and most driving issue is that currently the settlement takes between 12 and 24 months and sometimes longer. These are long months that especially puts the 53 percent of hospitals that are currently already operating at a financial risk at even higher severe stress. Critical access hospital payment is difficult to understand for many. Even our CPAs on our board sometimes don't understand the cost-based reimbursement so please forgive me if I make this really simple here in a, in a different example. If I were to get the engine replaced in my car and paid the repair shop the same amount it costs to replace an engine five years ago, let's say $1,000, and at the end of the year my car mechanic would notify me that I owed an additional $1,000 to $2,000. If I handled it like Medicaid drew up, it could take up to 24 months for me to pay the rest of the cost of the repair. If this is how repair shops work, we would have a hard time finding a place to fix our car. I'm here to support this legislation to reset the base amount received by critical access hospitals from Medicaid based on the actual cost of the facility from the prior year. Hospitals file a Medicare cost report annually. This report reflects the current and actual costs to the rate set, based on this cost report would reflect the most up-to-date cost of care for each patient. This is already in practice by our Medicare payors. If this was done annually or biannually for Medicaid based on actual cost in the prior year, hospitals would receive reimbursement in a much more timely manner and better yet, at no additional cost to the state. The money is already out so timely payment only reflects a much more realistic payment timeframe. Quick turnaround of appropriate Medicaid reimbursement may mean the difference between remaining open and solvent and closing their doors for some critical access hospitals in the state. It's important for critical access hospitals to receive

timely reimbursement from Medicaid to ensure that they can do what we like to do the best and that is provide high-quality care to our communities. Do you have any questions?

HANSEN: Thank you. Manny [PHONETIC] and her husband always beat us in trivia night once a week so if anybody has any really difficult questions to ask her--

MANUELA BANNER: It's my husband and I didn't bring him.

HANSEN: --now would be the time to do it No, are there any questions from the committee? Yes, Senator Riepe.

RIEPE: Sounds like you're a person that has a lot of knowledge if you can beat the senator at any game, I guess. My question is this: what is your percent of Medicaid?

MANUELA BANNER: Our percent in our facilities, only 6 percent.

RIEPE: What?

MANUELA BANNER: Six.

RIEPE: Six? I would have guessed higher. OK. The other thing I'd like to have you define, you've talked about an untimely reimbursement. And I think you said 24 months so you want that to go to what? Not tomorrow, but--

MANUELA BANNER: Absolutely. If we got an appropriate base, then it wouldn't be so important for that rebase-- for the, for the cost report settlement to come in within a month or two. But it would be nice if we could get it within a few months of the end of the year in time to file our reports.

RIEPE: OK. And I think you mentioned in your testimony that critical access hospitals aren't on a cost-plus basis. Now, I assume maybe there are some costs in there that don't apply, but for people that aren't on a cost plus, they're probably not too sensitive. And I hope that-- I see the hospital association is here. I have a question for them that-- if they-- if Mr. Hale does testify. No, he says he's not going to. I have been told by a credible source, a former state legislator, who of course never exaggerated or lied, that in the Ogallala area, there are two critical access hospitals within 15 miles.

MANUELA BANNER: I can't speak to that.

RIEPE: That's why I wanted-- I'll catch him in the hallway later. If it is, that to me is a concern because this is like many things. Once established, takeaways are next to impossible. Policies, payment methodologies, you name it. Once given, that's why we have to be very prudent about what we do give away. Thank you.

HANSEN: Any other questions from the committee? Seeing none--

MANUELA BANNER: Thank you.

HANSEN: --thank you for your testimony. And we will take the next person to testify in support of LB219.

HANSEN: Welcome.

RIEPE: I hope I bullied you.

ANDY HALE: I think you did. Chairman Hansen, members of the committee, my name is Andy Hale, A-n-d-y H-a-l-e, and I'm vice president of advocacy for the hospital association. I do want to thank Senator Ibach for bringing this, this bill and having Manny come and testify. We do have Wade Eschenbrenner, who is from Lexington who is a CFO who can answer probably some more pertinent money questions. But, Senator, to your question, Ogallala, Nebraska, is with, with Banner Health and they are not-- there's not another hospital located within 15 miles. It would follow the regular hospital.

RIEPE: So this legislator lied to me.

ANDY HALE: That I can't comment on because I think he's my boss. So I don't know, maybe if there was some misinformation--

RIEPE: No, no, no.

ANDY HALE: --I wasn't privy to that conversation.

RIEPE: It was a different one.

ANDY HALE: Oh, a different one. OK. So to my knowledge, no, and I would-- I'd be willing to meet with you and that certain individual as well.

RIEPE: We'll get you under oath.

ANDY HALE: I have not sworn under oath today, nor am I going to as of yet. But no, I can, I can tell you that is not the case.

RIEPE: OK.

HANSEN: All right, any other questions from the committee? Yes, Senator Riepe.

RIEPE: Do you feel that we-- thank you, Mr. Chairman. Do you feel that we, as the Legislature, have the authority to establish the timeliness of reimbursement? I'm concerned about that. It seems that that goes to the federal level as much as it does to the state level in terms of who can, who can say you have to pay within 30 days.

ANDY HALE: I think if you worked with the state Medicaid department, I think they can help you with that. I, I agree. We're not forcing someone to pay, but in reality, these payments usually occur, as Manny stated and I think Wade will too, 18 to 24 months. And so, again, this isn't new money-- or that's coming out of the state. The state has this money. In my understanding, it's coming here to the state and they're holding onto it instead of moving it. So when you asked a timeframe, I think anything would be better than they currently have.

RIEPE: I think in your response, you're delegating up. I would say-- I would push back and say as a hospital association, you need to be in the mix on that and negotiate that, not us as a legislative body. I mean, we're not in the business of doing that.

ANDY HALE: We've had conversations with Medicaid. I don't believe they are here.

RIEPE: You can say anything now.

ANDY HALE: I think I'm-- we're still on TV and being recorded. We've had conversations and we've worked with them on this. Again, that, that's probably something we can talk to together on how that procedure works and--

RIEPE: How long have you been at that?

ANDY HALE: The communications with them?

RIEPE: Yeah, I mean, it doesn't sound like you'd say within the last 30 days, you've had that discussion.

ANDY HALE: Oh, we've had this-- we had this discussion, I believe the summer or the fall with them. They knew that we were--

RIEPE: For the first time?

ANDY HALE: In-- yeah, in my time there, that was the first time we, we talked about it.

RIEPE: And this is unique to all of the 63 critical access hospitals?

ANDY HALE: Correct.

RIEPE: OK. Thank you. Thank you, Mr. Chairman.

HANSEN: Any other questions? All right, seeing none, thank you.

ANDY HALE: Thank you, Senator.

HANSEN: All right. We'll take our next testifier in support. Welcome.

WADE ESCHENBRENNER: Good morning. Good morning, Chairman Hansen and members of the Health and Human Services Committee. My name is Wade Eschenbrenner, W-a-d-e E-s-c-h-e-n-b-r-e-n-n-e-r. I'm the chief financial officer for Lexington Regional Health Center. I'm here today to testify in support of LB219. As kind of previously described, the Medicaid reimbursement model is based on a cost-based reimbursement system. And as you had mentioned, it's, it's not necessarily 100 percent, right? Ninety percent of our costs are considered allowable, 10 percent typically aren't. So that's kind of our starting point from a cost-based perspective, which reimburses our CAHs for reasonable and necessary costs incurred in providing care to Medicaid beneficiaries. The amount of reimbursement a CAH can receive is determined by various factors, such as hospital operating expenses and amount of Medicaid patients served. The aim of the reimbursement model is provide adequate funding to CAHs to help ensure their financial stability and continued operations. We are currently carrying, as Lexington Regional Center, nine days of operating cash and Medicaid receivables waiting for settlement. That approximately $1 million of Medicare or Medicaid receivables going back multiple fiscal years. We are still working with one HMO on a pre-pandemic settlement in 2019. Reducing the Medicaid receivables a CAH hospital carries will allow us to better plan equipment, supplies and other operating purchases instead of trying to coordinate it in the timing of settlements. If a CAH is building of their cash river-- reserves for future equipment and repairs, the lost opportunity of that investment income could be more

than $40,000 annually for a CAH. As we continue to see high inflationary pressures, our costs of today are much higher than they were 18 to 24 months ago, particularly in a time of nurse shortages, respiratory therapist shortages-- we heard Paul Dongilli talk about their Medicaid. You know, it's respiratory intense and we have the same issues in CAH hospitals. These shortages are reflecting this increase. Rebasing is one way to help alleviate these pressures. It is important for CAHs to receive timely reimbursement from Medicaid to ensure that we can continue to provide high-quality care to the-- to our communities. So it's not asking for more money. It's just the timing of the money. So we get interim rates for-- from Medicaid, which are not reflective of the true cost. So as Manny kind of described, we go through the fiscal year. At the end of the fiscal year, we submit a cost report to Medicare five months after the fiscal year ends and then that's how we determine the cost for the year. That gets settled with Medicare and with Medicaid. Any questions?

HANSEN: All right, thank you for your testimony.

WADE ESCHENBRENNER: Sure.

HANSEN: Are there any questions from the committee? Senator Riepe.

RIEPE: Thank you, Senator. What's your percentage of Medicaid?

WADE ESCHENBRENNER: It depends on what service, but generally overall, we're 15 percent. And we're one of the higher Medicaid--

RIEPE: OK.

WADE ESCHENBRENNER: --population CAHs in the state and we have the lowest Medicare percentage in the state.

RIEPE: On your community benefits report, which you're required to file, how much of that is charity and how much is bad debt?

WADE ESCHENBRENNER: We're actually a district hospital, a political subdivision, just so you're aware, so we don't--

RIEPE: Do your counties support too?

WADE ESCHENBRENNER: We do not levy any taxes.

RIEPE: OK.

WADE ESCHENBRENNER: So we do a--

RIEPE: Do you have a feel for what you're given? You know, charity, we always said the ones that would like to pay but can't--

WADE ESCHENBRENNER: Yes.

RIEPE: And bad debt are the ones that could but choose not to.

WADE ESCHENBRENNER: True. We, we approximately have $250,000 to $300,000 annually in charity care and approximately $2 million in bad debt.

RIEPE: OK. Thank you. Thank you very much, Chairman.

HANSEN: Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thanks for being here. In your testimony, you made a comment that I'd like to dig in on a little bit more. You currently have a 2018 HMO settlement?

WADE ESCHENBRENNER: 2019.

M. CAVANAUGH: 2019. Can you tell me a little bit more about that?

WADE ESCHENBRENNER: It's one of the plans that exited previously. So I think just in discussions, it took a long time to figure out who to talk at that plan--

M. CAVANAUGH: OK.

WADE ESCHENBRENNER: --and so we're currently working through that. They kind of were unaware, I think, that this happened.

M. CAVANAUGH: So you have, so you have a settlement with a previous HMO?

WADE ESCHENBRENNER: Correct.

M. CAVANAUGH: Can you share any of the details about that?

WADE ESCHENBRENNER: Wellcare exited, Healthy Blue came in and took their place.

M. CAVANAUGH: OK.

WADE ESCHENBRENNER: So it's, it's with Wellcare.

M. CAVANAUGH: And for how much?

WADE ESCHENBRENNER: It'll be hard to determine. I can't give you an exact number because it will be based on their records--

M. CAVANAUGH: OK.

WADE ESCHENBRENNER: --in essence. It's probably for the last-- they exited in January. Our fiscal year is June 30 so there's a six-month period. It could be $50,000 approximately.

M. CAVANAUGH: $50,000.

WADE ESCHENBRENNER: Approximately. That's just my guess.

M. CAVANAUGH: OK. OK, so-- thank you.

HANSEN: Any other questions from the committee? All right, seeing none, thank you for coming.

WADE ESCHENBRENNER: Thank you.

HANSEN: Is there anybody else wishing to testify in support of LB219? All right, seeing none, is there anybody who wishes to testify in opposition? Seeing none, is there anybody who wishes to testify in a neutral capacity? All right, seeing none, we will welcome up Senator Ibach to close. And for the record, there were four letters in support of LB219.

IBACH: Good. Well, this will be really short. Thank you again for your attention. I would just note that the bill really does just address the rebasing, but we did meet with Mr. Bagley and he agreed that they could adjust the timeliness of their payments. So we're going to follow up with him and stay on that, so--

HANSEN: OK. Any questions?

IBACH: --that's all I have.

HANSEN: You were brave to start off your opening saying this is a simple bill. I've learned never do that.

IBACH: So that's your advice?

HANSEN: Yeah. It's just a simple bill. All right, so with that--

IBACH: Don't say that.

BALLARD: Yeah, I'm just crossing that out on my testimony.

HANSEN: That will conclude our hearing for LB219 and we will welcome up Senator Ballard to open up on LB458.

IBACH: It's a simple bill.

BALLARD: I crossed that out, don't worry. I can still say good morning.

HANSEN: Welcome.

BALLARD: All right. Thank you. Good morning, Chairman Hansen and members of the Health and Human Services Committee. My name is Beau Ballard. For the record, that is B-e-a-u B-a-l-l-a-r-d. I represent District 21 in northwest Lincoln and northern Lancaster County. I'm here today to introduce LB458. LB458 eliminates regulatory barriers in healthcare and increase-- that increase the costs and decrease efficiency. LB48 [SIC, LB458] provides clarity in the existing definition of central fill pharmacies. Central fill pharmacies preparing and packing prescriptions on behalf of dispensing pharmacies, allowing pharmacists at the dispensing pharmacy locations to spend more time focusing on providing direct patient care. LB458 proposes two changes: the first to provide clarity that when a central fill pharmacy and a dispensing pharmacy are under common ownership, the central fill pharmacy can deliver prescriptions to the patient on behalf of the dispensing pharmacy. Right now, the regulatory interpretation of the existing definition, definition of central fill requires that prescriptions that are filled in a central fill pharmacy be delivered back to the dispensing pharmacy location before it can be delivered to the patient. For patients who wish to have their medication delivered to them via mail or courier, this extra step requires additional resources and time without adding any, any value and improving patient safety. It also adds a delay in patient receiving their medication. The updated central fill definition proposed in LB458 will eliminate the requirement to return the prescription first back to dispensing pharmacy before delivery to the patient if the delivery, if the delivery is what the patient prefers. The second change proposed in LB458 is to remove the requirement that the central fill pharmacy number be included in the prescription

label. Since the dispensing pharmacy maintains a primary patient facing responsibilities, it can add confusion for patients by including the phone number of both the dispensing and the central fill pharmacies on the prescription label. By removing that requirement for inclusion of the central fill pharmacy's phone number, it will provide clarity for the patient that the dispensing pharmacy is pharm-- pharmacy is a number that they can call for questions and needs. This bill is brought to me by Nebraska Medicine and they intend to clarify some, some additional testimony to move this simple bill forward to General File.

HANSEN: All right, any questions from the committee? All right, seeing none, we'll see you at close. We'll welcome up our first proponent testifier. Welcome.

SARAH KUHL: Hello. Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. I am Sarah Kuhl, S-a-r-a-h K-u-h-l. I'm director of community-based pharmacy services at Nebraska Medicine, which is a nonprofit integrated healthcare system. Our healthcare network includes two hospitals, Nebraska Medical Center and Bellevue Medical Center, and nearly 70 specialty and primary healthcare centers in the Omaha area and beyond. The healthcare sector is experiencing significant staffing shortages and the pharmacy workforce is stretched thin. Nebraska Medicine is working hard to identify ways to utilize resources as efficiently as possible while maintaining our high standards of care for patients. One of those opportunities for greater efficiency is the addition of our central fill pharmacy. The Nebraska Medicine central fill pharmacy prepares and packages prescriptions for patients, which allows our health system to more efficiently deliver prescriptions to our patients. Our central fill pharmacy allows pharmacists at our patient-facing pharmacy locations to spend more time focused on providing direct patient care. The automation utilized in our central fill pharmacy can fill about 250 prescriptions per hour, which is about the number of prescriptions that a handful of pharmacy employees can fill in an entire day. Central fill allows us to take the human resources that are no longer required to fill prescriptions and focus those efforts on providing patient-facing support such as medication counseling, injection training, triage of acute medication needs, disease state management and vaccinations. Here's how a central fill pharmacy works. Prescriptions are sent to the patient's pharmacy by providers or a patient requests a refill. The prescriptions are clinically reviewed by pharmacists for appropriate dosing, indications and potential drug interactions. After review, the prescription is assessed for

eligibility to be filled at our central fill pharmacy. A prescription is eligible for central fill if there's adequate time for the medication to be filled and delivered back to the patient's pharmacy prior to the available pickup time chosen by the patient. If eligible, the prescription information is transmitted from the patient's pharmacy to the central fill pharmacy. Technicians at the central fill pharmacy fill the prescriptions with the assistance of the automation equipment and an onsite pharmacist reviews the filled prescription for accuracy. After that, the prescription is packaged and ready to be delivered to the patient. The existing statutory definition of central fill defines central fill as where preparation occurs in a pharmacy other than the pharmacy dispensing to the patient. The regulatory interpretation has been that central fill pharmacies cannot, cannot directly deliver to the patient. For patients who have chosen to have their prescriptions mailed or delivered via courier, this means that the prescription is packaged at the central fill location and has to be delivered back to the patient's pharmacy before it can be put in the mail and delivered or delivered by the courier. This leads to prescriptions filled late in the afternoon, having a whole day delay getting to the patient because they are filled after the courier has taken prescriptions back to the patient's pharmacy for the day. In our case, Nebraska Medicine has had to hire an additional delivery driver and purchase a larger delivery van to meet the requirements to deliver the prescriptions back to the patient's pharmacy before being delivered to the patient. For our Nebraska Medicine couriers, often the same driver is responsible for loading the prescription from the central fill pharmacy, then unloading the prescription at the patient's pharmacy only to reload the same prescription to deliver it to the patient. LB458, LB458 will remove this burdensome regulatory requirements, which require the prescription to be delivered back to the patient's pharmacy location before it can be picked up by a courier service or put in the mail for delivery to the patient. The updated central fill definition in LB458 will help eliminate potential delays in delivery, while allowing us to maximize the opportunities of central fill pharmacy and meet the needs of our patients. This bill reduces regulatory burden and cost and helps address workforce shortages and improves the focus on patient care. Thank you for your consideration. I'd be happy to answer any questions.

HANSEN: All right. Thank you. Are there any questions? Senator Riepe.

RIEPE: Thank you, Mr. Chairman. My question would be is this the Med Center's response to many of the health plans now promoting pharmacy by mail?

SARAH KUHL: Not-- no, not really. We aren't using central fill to increase the mail that we are doing. Our goal is to eliminate as many barriers to care for our patients. So when a patient does need a medication mailed, this allows us to do it more efficiently. But we also need the central fill location just to get those prescriptions for patients who want to pick up. So the central fill is just an efficiency. It's not a way for us to actually increase the mail volume we are doing. It's just to address--

RIEPE: I think we all read about the problems that CVS and Walgreens are having cutting back on hours. Just again, the same problem, the stamp. I also have a concern-- maybe you can respond to this too-- is I understand that the incoming class for the school of pharmacy has been-- like, 100 [INAUDIBLE] that are open, but it's that-- they're reading or understanding what's going on in retail pharmacy and they want no part of it. Is that fair to say?

SARAH KUHL: Pharmacy is absolutely a challenging profession to join. And it's rewarding, but also, yes, we are having staffing shortages right now, especially with technicians and with the lower class sizes that we're seeing. We're working hard to address--

RIEPE: Thank you.

SARAH KUHL: --future pharmacist shortages.

HANSEN: Any other questions? This might be a simple bill.

SARAH KUHL: They told me not to say that.

HANSEN: So really, in essence-- and I think how you explained it to me, which I think was pretty good, is what we're trying to do is just-- is cut out just, you know, a section of the whole process that really makes no sense whatsoever.

SARAH KUHL: Yeah, it's no value.

HANSEN: So you have a central fill to the pharmacy, open up the box and then pretty much shut it again.

SARAH KUHL: Not even open the box.

HANSEN: Yeah.

SARAH KUHL: That's not even required.

HANSEN: So really it makes no sense.

SARAH KUHL: It's literally packaged, taped up, the label is on it, the stamp is on it. We unload it and then we reload it--

HANSEN: Yeah.

SARAH KUHL: --so.

HANSEN: OK. Well, it's almost like how government runs. And just one more thing for clarification sake, so we're looking at taking the phone number off of the labeling, which, which is fine, but there's still an identifying--

SARAH KUHL: Yes.

HANSEN: --marker on there about where it came from the central fill though, right?

SARAH KUHL: Yeah. We want-- we're not-- we want transparency. We want patients to know that this was filled. So the name and address of the central fill pharmacy will continue to need to be on the prescription label. But again, we are doing central fill to open up resources for direct patient care at our pharmacies. And we want our patients to call our patient-facing brick-and-mortar pharmacies for any questions, so.

HANSEN: All right. Cool. And seeing no other questions, thank you very much.

SARAH KUHL: Thank you very much.

HANSEN: Is there anybody else wishing to testify in support of LB458? Seeing none, is there anybody wishing to testify in opposition? Seeing none, is there anybody wishing to testify neutral capacity? Seeing none, Senator Ballard, do you wish to close?

BALLARD: [INAUDIBLE]

HANSEN: Oh, OK.

BALLARD: No, I just want to-- I'll be short. I just want to say this is a great opportunity to promote efficiency and cut some government regulations. As the Chairman said, this is a simple bill to do something great for the-- for an organization that does so many great

things for this state. So I'll be happy to answer any questions or continue the theme of the day and say something nice about Senator Cavanaugh.

HANSEN: Yeah.

M. CAVANAUGH: Go on.

HANSEN: Any, any questions? Yes, Senator Cavanaugh.

M. CAVANAUGH: What would you like to say?

BALLARD: You could see I was just, I was just grasping. I wanted-- no, I just wanted to a-- one of your famous you're loved and seen quotes. That's what I-

M. CAVANAUGH: My what?

BALLARD: You're loved and seen quotes.

M. CAVANAUGH: Oh, thank you.

BALLARD: Of course.

HANSEN: Sounds good. I like that. You should compliment her shoes too while you're sitting there.

BALLARD: She has-- she does have great shoes. Great smile, great shoes.

M. CAVANAUGH: Thank you.

HANSEN: All right, anything else? Questions? All right, thank you very much. That's-- oh, there were-- just to make sure before we close the hearing, there was one letter in support for LB458. So with that, we will close the hearing for LB458 and close the hearing for this morning.

[BREAK]

HANSEN: All right. Good afternoon and welcome to the Health and Human Services Committee. My name is Senator Ben Hansen. I represent the 16th Legislative District in Washington, Burt, Cuming and now parts of Stanton Counties and I serve as Chair of the Health and Human Services Services Committee. I would like to invite the members of our

committee to introduce themselves, starting on my right with Senator Ballard.

BALLARD: Beau Ballard, District 21, northwest Lincoln and northern Lancaster County.

WALZ: Good afternoon. My name is Lynne Wallz and I represent Legislative District 15, which is Dodge County and Valley.

RIEPE: I'm Merv Riepe. I represent District 12, which is southwest Omaha, part of that, and the good people of Ralston.

HANSEN: Also assisting the committee is our research analyst, Bryson Bartels, our community clerk, Christina Campbell, and our pages for this afternoon is Payton and Delanie. A few notes about our policy and procedures: please turn off or silence your cell phones. We will be hearing four bills and we'll be taking them in the order listed on the agenda outside the room. On each of the tables near the doors to the hearing room, you'll find green testifier sheets. If you are planning to testify today, please fill one out and hand it to Christina or one of the pages when you come up to testify. This will help us keep an accurate record of the hearing. If you are not testifying at the microphone but want to go on record as having a position on a bill being heard today, there are white sign-in sheets at each entrance where you may leave your name and other pertinent information. Also, I would note if you are not testifying but have an online position comment to submit, the Legislature's policy is at all comments for the record must be received by the committee by noon the day prior to the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. We would ask if you do have any handouts that you please bring ten copies and give them to the page. We will be using a light system for testifying. Each testifier will have five minutes to testify. When you begin, the light will turn green. When the light turns yellow, that means you have one minute left. And when the light turns red, that means you have to stop immediately or else we're going to yell at you. You're all OK with it I guess. When you come up to testify, please begin by stating your name clearly into the microphone and then please spell both your first and last name. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters of the bill, then from those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given the opportunity to make closing statements if they wish to do so. On a side note, the reading of testimony that

is not your own is not allowed unless previously approved. And as always, we have a strict no-prop policy in this committee. So with it, we will begin this afternoon's hearing with LB286 and welcome Senator Walz to open.

WALZ: Oh, my gosh. This is a tiny chair.

HANSEN: We should have, yeah, changed the chair out, so. I still blame Senator Brewer for that.

WALZ: It's all right. Thank you, Chairman Hansen. And this is a very complex, not simple bill at all. I'm just kidding. This is a great bill. Good afternoon, Chairman Hansen-- I can't even read this thing-- and fellow members of the Health and Human Services Committee. My name is Lynne Walz, L-y-n-n-e W-a-l-z, and I represent District 15, which is made up of Dodge County and Valley. I'm before you today to introduce LB286. The goal of LB286 is to improve and protect mental health and well-being of Nebraska physician-- of the Nebraska physician workforce. I worked with the Nebraska Medical Association to introduce this bill, which will provide confidentiality productions around an existing physical wellness program in Nebraska. Reducing burnout and safeguarding the well-being and job satisfaction of the healthcare workers is an important part of retaining a strong workforce in our state. LB286 aims to start by creating a safe haven for physicians to seek help with issues related to wellness and career fatigue. In 2021, the Nebraska Medical Association established the organization Life Bridge Nebraska. Life Bridge is a physician wellness program which aims to provide access to confidential and voluntary support for physicians seeking help with stress or other issues in a physician's personal or professional life. Those situations might include: workplace conflicts, grief, depression, marriage or financial stress. When a physician calls Life Bridge Nebraska, they are matched with a physician peer coach who is trained and ready to offer support. Any physician in Nebraska can use Life Bridge at no cost. Programs like Life Bridge are important because the environments in which physicians work drive high levels of burnout. Imagine working for hours in a trauma operating room only to have a patient die on the operating table at one in the morning or being a new physician who may be juggling a young family while working 80 hours a week in a busy residency. Or consider physicians who have been practicing for decades, but who are suddenly having to change the way they practice to manage increasing demands of electronic health records. These scenarios are common and unfortunately, they lead to physicians choosing to leave the practice. According to a 2021 report by Mayo

Clinic, one of every five physicians intends to leave practice within two years, while one in three plan to cut back their hours. Despite the immense pressures physicians are under, they are often reluctant to seek help. A major reason, a major reason for the reluctance is the fear that showing signs of fatigue or stress could have negative repercussions for the physician's career. These concerns are real. Physicians, along with other credential holders under the Uniform Credentialing Act, have mandatory reporting obligations. If a physician's peers become aware that a physician has acted unprofessionally, negligently, incompetently or violated other regulatory provisions of the profession, they have a duty to report licensure at DHHS, which could result in investigation and disciplinary action by the Board of Medicine. While symptoms of workplace fatigue are not likely to rise to the criteria of reportable conduct, this fear is a very real barrier to physicians seeking support when dealing with stress and burnout. LB286 provides confidentiality protections around Nebraskans, Nebraskans' physician wellness program with the following provisions. First, it provides that an individual's participation in a physician wellness program is confidential and not subject to discovery, subpoena or reporting-- or a reporting requirement to DHHS unless there is a danger to the public health and safety by the individual's continued practice of medicine. Secondly, individuals would not be required to disclose their participation in the program to any third party as a condition of employment, credentialing, payment, licensure, compliance or other requirements. These changes will create a safe space through which physicians can seek and obtain confidential care in ways that will not have a detrimental impact on their careers. A number of other states have passed safe haven legislation to protect the confidentiality of their physician wellness programs, including in South Dakota, Indiana, Virginia and Delaware. LB286 is modeled after the legislation passed in those states. It also closely mirrors the protections currently in Nebraska statute for the Licensee Assistance Program, which is a substance abuse program for licensing under the Uniform Credentialing Act. It also mirrors the protections in Nebraska Supreme Court rules for the Nebraska Lawyers Assistance Program. There are testifiers behind me who could speak more to the need for LB286. In conclusion, I'll just say that Nebraska needs its physicians, especially as we look at the rural areas where access to care is increasingly difficult. LB286 is a small change that will help keep physicians healthy, productive and practicing here in Nebraska where we need them. Thank you.

HANSEN: Thank you for your opening testimony. Are there any questions from the committee? Senator Riepe.

RIEPE: Thank you for presenting this bill. Do you anticipate that telehealth would be part of this? Because you talked about the rural--

WALZ: Right.

RIEPE: --remoteness of it and, and maybe the confidentiality. I assume that that might be part of it.

WALZ: You know what? Let me, let me find out--

RIEPE: I was just curious.

WALZ: --the answer to that. Sure.

RIEPE: My other question is, is that-- at least my fiscal note shows zero. So this is the legislate-- this legislation is just to protect the confidentiality of it.

WALZ: Yes. It's not starting a new program. We already have a program in place.

RIEPE: OK. The other question that I have, Mr. Chairman, is what about RNs? And I know in the hospital business, you know, we have programs that are-- allow all the-- everyone--

WALZ: Right.

RIEPE: --employed by the hospital. A number of physicians are employed by hospital systems anymore. They would have access to that. So I'm trying to sort out what makes a physician program different than maybe a program where nurses--

WALZ: For nurses.

RIEPE: --participate in.

WALZ: Right. I don't-- let me find out about that one too.

RIEPE: I was just curious. Thank you for being here.

WALZ: Thank you, Senator Riepe.

M. CAVANAUGH: Any other questions?

RIEPE: They don't have this kind of program for administrators, I assure you.

WALZ: For who?

M. CAVANAUGH: For administrators.

WALZ: Oh, I'll write that one down too.

RIEPE: Thank you. Probably need to.

WALZ: Yes.

RIEPE: OK. Thanks.

WALZ: Thank you.

M. CAVANAUGH: Seeing none, thank you. Our first proponent. Just hand your green sheet to the page. Thank you. Welcome.

TODD STULL: Good afternoon. Chairman Hansen and members of the Health and Human Services Committee, I appreciate the opportunity to be here. My name is Todd Stull. I'm a physician. I've been in practice for about 30 years. I've treated physicians for a number of years. My specialty is psychiatry and addiction medicine so I appreciate the opportunity to talk a little bit.

M. CAVANAUGH: Oh, I'm sorry, could I have you spell your name?

TODD STULL: Oh, T-o-d-d S-t-u-l-l.

M. CAVANAUGH: Thank you.

TODD STULL: So I appreciate the opportunity to discuss the matter today at hand, that's LB286. To provide a little context in this bill, I'd like to share some information. And you've heard some of this already so I'm, I'm not going to repeat what's been said or hopefully not. But there's a number of physicians that are really struggling now with burnout. If you look at the data, it's between 40 and 60 percent-- 60 to 65-- depending on the specialty. Emergency medicine is pretty high and they're into the 65 percent range. In Nebraska, contextually, when you think about this, we have about 12,500 licensed physicians and about 5,500 of those live in, in the state of Nebraska. Of the 93 counties, 65 of those counties have less than ten physicians. And so I bring that up because I want to talk about a

couple other issues that are related to why we're supportive of this, of LB286. You've heard a little bit about burnout. Burnout is the idea of being exhausted, demoralized, if you will. It's an element of being disconnected and being less productive, especially in the healthcare setting and with physicians. What compounds burnout are a number of principles that erode kind of within a healthcare system. And so we knew burnout was going on for a long period of time and now when you look at burnout associated with physicians, about one and a half to two times, there's a greater likelihood of physicians leaving practice. And you heard, heard this earlier in the opening kind of testimony. Many physicians are working less hours and about-- if you, if you think about the-- one in five is thinking about leaving medicine altogether. Let, let me give you numbers: 117,000 physicians left practice in 2021 due to what we're talking about and only 40,000 entered practice. So it's a major issue when we're talking about healthcare. This impacts rural communities even more so than some of the other communities because when a rural physician leaves, there's a number of jobs that are created by that rural physician. And to recruit and train and maintain a physician is not only difficult, but it costs the system about $1 million. In family medicine-- so a family doctor out in practice, if you look at burnout rates ten years ago, they were about 47 percent in family medicine. After COVID, they've gone up to about 57 percent. So Life Bridge, the program that I'm the medical director for, is a program that's a wellness program. It is supported by the Nebraska Medical Foundation as well as the Nebraska Medical Association. It was created by physicians and designed by physicians. And the physicians are the ones who are the coaches to help other physicians. Any licensed physician in the state of Nebraska, whether you're in residency or out in Scottsbluff or Chadron or wherever, can use this program. And they-- the way they access it is by calling a confidential 800 number and many times, they will access it to address issues with-- you've heard the burnout, but also maybe system problems, work-life balance problems, communication problems or just wanting to figure out how to grow and expand. And I don't have time to go into more details, but it's clearly a preventative program that's designed to help physicians that are not only struggling but prevent the struggles that they may get into along the way. And when you think about the, the program, others come into it because they are in transition and they may want to transition out of practice or into a new job. So it can be used from that aspect as well. There's some hesitation about physicians using this program or reaching out largely related to stigma or who's going to find out, so the confidentiality piece. And also it adds time potentially on to

what they're doing. So there's concern with, wow, this is going to take up more of my time in this process. We know that many physicians, as they become demoralized within this process of where we're at with healthcare, it's a multifactorial issue. And they feel like if they have to add something else on, that can be stressful. But in the reality-- or the reality of this is if they address some of the concerns and learn new strategies, it can be very helpful to preventing them from deteriorating further or struggling further. Many individuals will call the 800 number, as I mentioned. However, they can call directly into the program and access it by talking to a physician in the program or being paired with a physician in the program.

M. CAVANAUGH: You have the red light. Could you just wrap up your thoughts for us?

TODD STULL: Yep, I sure can. So we know the utilization rate is a little bit lower than what we'd like it to be. And we found that the states that implement the safe, safe haven law, their utilization rates go up. If utilization rates go up, we hopefully will have that preventative strategy to prevent some of the burnout and other issues that take place. So it's really about physician well-being and health.

M. CAVANAUGH: Thank you. Are there any questions? Yes, Senator Riepe.

RIEPE: Thank you. What's your funding source?

TODD STULL: Funding source comes from the foundation at the Nebraska Medical Association and several hospital systems and insurance companies so far.

RIEPE: OK.

TODD STULL: We have pretty widespread support that recognize the importance of this.

RIEPE: I'm going to take a little point of privilege here in the sense that in 2015, I think I introduced direct primary care, which was, quite frankly, the same factors which resulted in physicians getting burnt out with the idea that they could do direct primary care, control their own lives and doctors-- and Strada Healthcare has been very successful and, and I think it's one of the options for state employees.

TODD STULL: It's been very successful. I'm--

RIEPE: Well, I don't know that it's been really grandly successful--

TODD STULL: Well, I'm very familiar with it and I, I know Joel quite well.

RIEPE: You know Joel Bessmer?

TODD STULL: Quite well.

RIEPE: Good man.

TODD STULL: And so-- yes. And so you are-- I'm glad you brought that up, Senator. I appreciate that.

RIEPE: Well, I'm glad we had Joel around to be a perfect person to be the model.

TODD STULL: Yes, well said.

RIEPE: But anyway, thank you for your concern. We do have to take care of everyone, including our physicians.

TODD STULL: It's easier to take care of patients if you take care of yourself first.

RIEPE: Well and sometimes I think-- excuse me, Mr. Chairman-- we think they may be superhuman and so that-- other-- like other people, they don't have problems.

TODD STULL: Yeah,

RIEPE: We all do. OK. Thank you.

M. CAVANAUGH: Thank you.

TODD STULL: Thank you.

RIEPE: Thank you.

M. CAVANAUGH: Any other questions? Thank you for your testimony. We'll take the next proponent. Good afternoon.

DANIEL ROSENQUIST: Good afternoon, Vice Chair Cavanaugh and members of the Health and Human Services 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 in Columbus and the current president of the Nebraska Medical Association. I'm

here to testify in support of LB286 on behalf of the NMA. The NMA would like to thank Dr.-- or Senator Walz-- sorry-- for introducing LB286 and for recognizing the need to address physician wellness in Nebraska. As a practicing physician in Columbus, I can tell you the concerns about burnout, career fatigue and wellness are very real. Physicians work long hours. The demands continue to increase. Family obligations, responsibilities to patients, administrative burdens, all of these things take a toll in addition to dealing with the matters of death, disease and chronic conditions. What Senator Walz and Dr. Stull stated in their testimony is true. Physicians are reluctant to ask for help when they are, they're struggling. I had a conversation with one of my rural colleagues earlier this week. They told me that they actually counsel six people from the metro area because they are afraid to seek the medical help that they need in their own community. That is just the impact that this type of thing has and this is where the need for all of this protection. They are concerned about the potential repercussions of being treated. LB286 is a step toward reducing the stigma and the worry from physicians asking for help. I think this is just a small thing. Just adding the physician wellness program to some protections that already exist in statute for other programs, but it could have a positive impact as Nebraska does its best to retain and recruit a skilled and healthy physician workforce. Thank you for your time and I'm happy to answer questions.

M. CAVANAUGH: Thank you. Dr. Rosenquist. Senator Riepe.

RIEPE: Thank you. I assume that this comes before any reporting to the national databank.

DANIEL ROSENQUIST: Because there-- yes, because there's not an action by the state or in a court of law. So, yes, it does.

RIEPE: So it's trying to help the physician before it puts a black mark, if you will, on his or her record.

DANIEL ROSENQUIST: It's actually helping a physician say, you know, I think I may have some problems, I'm struggling here and can I find some help? Is there anybody else who's experiencing the same type of feelings that I have?

RIEPE: Can partners assuming-- I think the most dangerous one is solo practice, at least historically have said that. Can partners-- I suppose they can intervene and recommend and-- but the person has to

want to come. My question would be though, are spouses or significant others allowed to participate in the program?

DANIEL ROSENQUIST: At this time, we can only-- we only have this set up for physicians. We would like-- and what we're here to ask for is the protection from discovery for physicians.

RIEPE: Oh, OK.

DANIEL ROSENQUIST: We'd like to exempt-- as a program, we would certainly like to involve those people because that's the-- that's probably the most support-- supportive individual for that physician.

RIEPE: Yeah. OK. Thank you.

M. CAVANAUGH: Thank you, Senator Riepe. Any other questions? I would like to just note, do you still have an active practice?

DANIEL ROSENQUIST: Yes, I still practice three days a week.

M. CAVANAUGH: Wow because you are, you are very active for this committee, which I appreciate. And just wanted to note that it doesn't go unnoticed that you keep showing up for your medical community and I hope that your membership is noticing as well.

DANIEL ROSENQUIST: There are probably six physicians in Columbus who would like to hear you say that because they're feeling the same way.

M. CAVANAUGH: Well, thank you so much for, for--

DANIEL ROSENQUIST: Thank you.

M. CAVANAUGH: --showing up and testifying.

DANIEL ROSENQUIST: Thank you.

M. CAVANAUGH: And we will take the next proponent testifier if there is one. OK. And is there anybody in opposition? Is there anyone in the neutral capacity? Seeing none, Senator Walz, you're welcome to close. And as you close, we have two proponent letters for LB286.

WALZ: Can you see me?

M. CAVANAUGH: I can, sort of.

WALZ: I'm just going to make it very quick. I just want to thank the testifiers for coming today and educating us on the physician wellness program as well as the very, very important role confidentiality plays in physicians being able to access care and the protection that it provides for physicians so thank you very much.

M. CAVANAUGH: Thank you, Senator Walz. Are there any questions from the committee? Seeing none, that will close the hearing on LB286 and we will open the hearing on LB326. We are just switching the chair out and we will welcome Senator Raybould for LB326. Welcome, Senator.

RAYBOULD: Good afternoon, colleagues. Whoops. I got the extra low seat, is that--

M. CAVANAUGH: No, we just switched it actually.

RAYBOULD: What?

M. CAVANAUGH: This is higher.

RAYBOULD: I can barely see Senator Riepe.

RIEPE: Lucky you.

DAY: I know, right?

RAYBOULD: My, my notes say good morning, but it's actually good afternoon, colleagues, and certainly Vice Chair Cavanaugh and members of the Health and Human Services Committee. My name is Jane Raybould and Jane is J-a-n-e and Raybould is R-a-y-b-o-u-l-d. I represent Legislative District 28 and appear before you today to introduce LB326. LB326 would change the continuous eligibility for children and youth under 18 years of age in the Medicaid system from the current six months to 12 months, ensuring no disruption in healthcare services. Currently, federal Medicaid law allows states to adopt a 12-month continuous eligibility for children and youth age 18 and under from very low-income households. Thirty-three states-- let me say that again-- 33 states have implemented this option, including the surrounding states of Iowa, Kansas, Colorado and Wyoming. Nebraska does not and Nebraska requires a review of income eligibility of parents every six months. This does not require a state plan amendment or a Medicaid waiver, but rather the state has to check a box on a form submitted to the Centers for Medicare and Medicaid Services. Just check a box. Twelve-month continuous eligibility for low-income children and youth to continue to access-- to continue to have access

to healthcare throughout the school year and summer months is a proven strategy. It protects against lapse in services because parents fall through the cracks. They do not get notices because of a move. They don't get the forms submitted in time or have a fluctuation in income through the year. Continuity of care improves health outcomes, keeps kids out of the emergency rooms and other costly hospital care. Without coverage, families forgo preventative visits or filling prescriptions. Children and youth without gaps in coverage are 25 percent less likely to have a preventable hospitalization. I would like to take a moment to address the fiscal note for LB326, which places a very large price tag on implementing continuous eligibility. LB326 is intended to fill the gap-- not the whole year-- the gap between now and January 1, 2024, when all states will be required to adopt 12 months of continuous eligibility for children. The fiscal note includes additional costs after January of 2024, when continuous eligibility for children will be required in all states. The department's analysis claims that adopting LB326 will increase the total spending by $57 million for the remainder of the fiscal year. Given the experiences in states that have enacted continuous eligibility, this estimate seems wildly inflated and fails to account for any administrative savings or the savings you would see for children who don't have to be rushed to the emergency room. I can't think of a more important investment for us to make than a proven strategy like LB326 that protects children and youth, particularly as we have seen such a crisis in mental health needs. And with a bipartisan vote, so does the U.S. Congress. Last fall, they included 12-month continuous eligibility for children in the Medicaid system of all states by 2024 in their omnibus budget legislation passed this past December. I believe it is important that we implement this common-sense move now and invest in these children and youth who will be the future of our state. Thank you for your time and I will be more than happy to answer any questions.

M. CAVANAUGH: Thank you, Senator Raybould. Do we have any questions from the committee? Senator Riepe.

RIEPE: Thank you, Ms. Chairwoman.

M. CAVANAUGH: He's over here.

RAYBOULD: I can see you. If I really--

RIEPE: You can see me. Maybe my white hair, you can see that. My question would be may I ask who asked you to bring this legislation?

RAYBOULD: I'm, I'm trying to remember the organization because we've worked on so many legislative bills. I don't know if it was the hospitalization or First Five, being an advocate for young children, but it's, it's one that I wholeheartedly support.

RIEPE: OK. You said some magical words when you said continuity of care. That's always good. Thank you.

RAYBOULD: You're welcome.

WALZ: Do we have any other questions from the committee? I, I have some questions.

RIEPE: Hey, you can see me now.

RAYBOULD: Yes.

M. CAVANAUGH: So the fiscal note, did you have any conversations with the department about the fiscal note? I know they get them to us probably this morning, but.

RAYBOULD: Yes, I did. And as a matter of fact, I met with Director/Commissioner Kevin Bagley. And I think when they initially did the fiscal note, they were looking at the-- not only fiscal year '24 from January 1 to December, they were also looking at the gap. And I don't know if you have a copy of the fiscal note, but the fiscal note, just pertaining to that gap, which would be for this year, from October 1 through December 31, 2023, the gap really is only $16 million. But you have to-- that's total $16 million of which nine and-- almost $10 million of that is federal funds. So-- and if you want to look at the total outcome, you have to also consider the funding that CHIP provides as well. So in totality, if you really want to look at it, you can look at it. The general funds would be a total of $7.5 million. Not the $57 million, but $7.5 million. And I think it's a common confusion. They think that they have to fund the continuous eligibility from where that gap ends, but it's really only from that period of October until January 24 when they're obligated to fund it no matter what.

M. CAVANAUGH: And just for historical context, we have actually been doing continuous 12-month funding for the last three years.

RAYBOULD: That is correct. Because of the pandemic, that was one of the requirements to safeguard families in trying to get through the public health crisis.

M. CAVANAUGH: And in doing this six-month eligibility, that is a choice that the state is making. We are not required to do the six-month eligibility.

RAYBOULD: Yes, we're one of the few states that does a six-month eligibility. For the most part, it's routine and customary for all the states to do that 12 month.

M. CAVANAUGH: And so-- and beginning in January 2024, we are required to do a 12-month eligibility.

RAYBOULD: That's correct.

M. CAVANAUGH: OK.

RAYBOULD: And I think what they're seeing is that family members, if they relocate, trying to come up with the records. Some families struggle if they have to show any increase in their income. They have to try to figure out how to get a pay stub since most people do direct deposit. And so it creates a tremendous amount of hardship for that parent to try to regather all the documents to be able to, to make their case so that their child continues to get the care and treatment that they need.

M. CAVANAUGH: And the $7.5 million-- oh, sorry.

RIEPE: No, no, no.

M. CAVANAUGH: The $7.5 million, is it your understanding that that is coverage for all children that would qualify for that six-month period or is that for children that might not qualify? So if we don't-- if we, if we did the 12 months without doing the renewal and there could be a portion that no longer qualify during that six months, is this $7.5 million to cover those that would otherwise not qualify?

RAYBOULD: Well, that $7.5 million includes the 6.8 from our General Funds--

M. CAVANAUGH: Right.

RAYBOULD: --for Medicaid and then $736,000 from CHIP.

M. CAVANAUGH: I guess what I'm asking is-- and you don't have to actually answer this.

RAYBOULD: Yeah,

M. CAVANAUGH: This is just maybe more a question to put into the ether for others-- perhaps can answer. That $7.5 million, is that covering all of the children for that six-month period--

RAYBOULD: It is my--

M. CAVANAUGH: --whether they qualify or don't qualify?

RAYBOULD: It's my understanding the answer is yes.

M. CAVANAUGH: OK. So we have some math problems with our fiscal note, but I'm going to turn to Senator Riepe.

RIEPE: Well, thank you, Senator. I'm very proud of Senator Cavanaugh. She's become a fiscal hawk.

M. CAVANAUGH: I am a fiscal hawk.

RIEPE: My question as kind of a follow-up to that is the $7.5 million, that's what I would call the first payment, but then subsequently to maintain that, there's every fiscal-- there's-- so over 20 years, it's $7.5 million times X. So it's kind of a-- and my only concern there is, is we have money at this time. I'm not sure what all money in three years or five years or whatever.

RAYBOULD: Well, I think--

RIEPE: So you take on added entitlements, added responsibilities and we have to make sure-- I've lived through, as a state, a period of time where we had-- we were told never bring a bill to the floor if it had a fiscal note. That's how poor we were. So-- and you were there too. It was bleeding.

RAYBOULD: Well, I think one thing we need to keep in mind, that there are federal matching funds. So for-- even through the end of this year, 2023, from our General Funds, it's $7.5 million. But the federal funds are about $11.5 million, so.

RIEPE: To get that 11.5, we're going to have to come up with our 7.5.

RAYBOULD: That's, that is correct and-- but starting January 1, 2024, we are obligated-- federally mandated, all states, to provide that continuous coverage eligibility.

RIEPE: OK. I don't want to-- that's a whole nother debate, but thank you very much--

RAYBOULD: You're welcome.

RIEPE: --my fiscal hawk friend.

M. CAVANAUGH: Thank you. I'm glad you picked up on that. I, I-- are there any other questions from the committee? Seeing none, are you going to stay to close?

RAYBOULD: I think I can.

M. CAVANAUGH: Are you, are you aware-- I don't see in the room-- if the department is going to be coming to testify? OK. Well, we will then follow up--

RAYBOULD: OK.

M. CAVANAUGH: --with the department with some of these questions. Our first proponent for LB326. Welcome.

AMY BEHNKE: I feel special that I get the big chair. I was getting invested in what was happening. Good afternoon, Vice Chairwoman Cavanaugh and members of the committee. My name is Amy Behnke, A-m-y B-e-h-n-k-e, and I'm the CEO at Health Center Association of Nebraska. I'm here today on behalf of Nebraska's seven federally qualified health centers, who collectively serve over 113,000 patients statewide. HCAN stands in strong support of LB326, which would have Nebraska Medicaid provide 12 months continuous eligibility for children. Twelve-month continuous eligibility is a proven method to increase enrollment in Medicaid, ensure continuity of coverage, limit administrative burden, and eliminate red tape. And I also, with the handouts, do have a letter of support from the Nebraska Child Health and Education Alliance as well. Throughout the year, children churning on and off the Nebraska Medicaid program is a common occurrence. More often than not, this churn is due to administrative burden. Losing insurance coverage due to red tape happens far too often for children living in poverty and disproportionately impacts children of color. Although coverage for Medicaid is intended to last for 12 months, additional income reviews can be requested by the state at any time during this coverage. In 2019, pre COVID-19, about 12,400 children were disenrolled from the Medicaid program due to periodic income checks. However, according to data submitted to the department-- by the department to CMS, 72 percent of those children who were

disenrolled by the state were disenrolled because they did not properly fill out requested paperwork, not because they did not qualify. Paperwork should not cause children to lose their insurance coverage. At one of our centers, OneWorld Community Health Centers in Omaha, over one-third of their patients are children. Their parents are hardworking individuals, often working multiple jobs to support their families. Among low-income workers, seasonal or monthly variations in income are very common and can cause interruptions in insurance status. These people are not hitting the lottery. They have minor variations in their income that trigger a cumbersome income verification process. Providing income verification is also not easy for many low-income families, especially those that have low literacy or limited access to technology. A common barrier is getting proof of income if you have direct deposit. Many employers no longer give employees pay stubs and they need to figure out a way to create an email account and then register and negotiate an electronic payroll system. They need to find access to a printer. Another challenge occurs for people who change jobs. If the state still has your previous job information in the system, you need to work to get your former pay stub employee coverage. You'd have to go back to your previous employer and ask them for a letter verifying that you no longer work there. That can be hard to do, especially if you quit or were fired. In the end, many families get stuck in the process and children lose their insurance coverage. Because no one lost coverage during COVID-19 public health emergency, we were able to witness the impact continuous coverage has on our patients. Nationally, the uninsured rate for children dropped, reversing a multiyear trend of the number of uninsured children actually going up. At OneWorld in Omaha, we saw the uninsured rate for children drop from nearly 30 percent prepandemic to 24 percent, the lowest it has ever been at that health center. Continuity of Medicaid coverage is essential to continuity of healthcare. Children with gaps in coverage are more likely to skip well-child visits. They are unable to afford medications or access to specialty and behavioral healthcare. Children with gaps in coverage are nearly 25 percent more likely to have preventable hospitalizations. As Senator Raybould mentioned, beginning January 1, 2024, all states will be required to provide 12 months of continuous eligibility for children enrolled in Medicaid and CHIP. LB326 merely bridging that gap until then. Adopting 12-month continuous eligibility now will help more low-income Nebraska children keep their Medicaid coverage in order to stay healthy. I'd like to thank Senator Raybould for introducing this bill and thank the

committee for your time and encourage your support on-- of LB326. I'm happy to answer any questions.

M. CAVANAUGH: Thank you for your testimony. Are there any questions from the committee? No. Wow. Are we sure?

RIEPE: Lost my voice.

M. CAVANAUGH: Oh, OK. I do, I do have some questions.

AMY BEHNKE: OK.

M. CAVANAUGH: So as you heard discussing the fiscal note, my favorite topic--

RIEPE: As it should be.

M. CAVANAUGH: --there, there appears to be an assumption that all of the children currently covered on Medicaid and CHIP would not qualify for that final six months. Does that seem accurate to you?

AMY BEHNKE: So the experience in other states is that they see about a 2 percent increase in their enrollment and in their costs when they adopt continuous eligibility. So looking at the numbers, not being a mathematician, but kind of doing back-of-the-envelope math, this seems high, especially for, for three months for the end of the year.

M. CAVANAUGH: OK. Thank you.

AMY BEHNKE: You're welcome.

M. CAVANAUGH: Any other questions? Seeing none, thank you for your testimony.

AMY BEHNKE: Thank you.

M. CAVANAUGH: Do we have any other proponents for LB326? Welcome.

KELSEY ARENDS: Thank you. Good afternoon, Vice Chair Cavanaugh and members of the Health and Human Services Committee. My name is Kelsey Arends. That's K-e-l-s-e-y A-r-e-n-d-s and I'm the healthcare access program staff attorney at Nebraska Appleseed testifying in support of LB326 today on behalf of Nebraska Appleseed. We are a nonprofit legal advocacy organization that fights for justice and opportunity for all Nebraskans and one of our core priorities is working to ensure that all Nebraskans have access to quality, affordable healthcare. Nebraska

Appleseed supports LB326 because continuous eligibility promotes children's health, while decreasing healthcare system costs, unnecessary coverage losses and administrative costs. Frequent changes in Medicaid eligibility, known as churn, interfere with the continuity of care for enrollees, which results in high healthcare costs and increases administrative burdens for providers, managed care organizations and state agencies. Ensuring consistent coverage for kids who have Medicaid is particularly important right now, as you've heard from previous testifiers, as state Medicaid agencies are preparing to resume normal operations and unwind from COVID-19-related protections. Since March 2020, federal law has generally required states to keep most people with Medicaid enrolled in coverage regardless of changes like changes in income during the federal COVID-19 public health emergency. Recent federal legislation has set an end date to the COVID-related continuous coverage requirements. States can start processing fresh renewals for all Medicaid enrollees this spring. Terminations may start as soon as April 1, 2023, and are likely to continue for a full year in Nebraska. The federal government has provided guidance to states encouraging implementation of strategies to help eligible, eligible individuals maintain their coverage, prevent churn and mitigate procedural denials, including recommending a state plan amendment or other action to implement continuous eligibility for children, as proposed under LB326. Procedural disenrollments occur when the state agency does not have enough information to process an enrollee's renewal, meaning that for a lack of information, as opposed to actually not meeting the eligibility criteria, the person is terminated from coverage. Historically, many individuals who lose coverage for procedural reasons remain eligible for Medicaid but become uninsured. The risk for children is particularly high. A recent study by federal HHS projected that more than 72 percent of children who are predicted to lose Medicaid coverage during this unwind period will be terminated even though they are still eligible. Healthcare disparities based on race and ethnicity are expected to be exacerbated during this process as well. The same study predict-- projected that Latino enrollees will be more than three and a half times as likely as white enrollees to be terminated, despite remaining eligible for their Medicaid coverage. Additionally, as you've heard, new federal legislation requires states to implement continuous eligibility for kids as of January 1, 2024. Implementing continuous eligibility as soon as possible, even multiple months before the federal implementation date, will provide for additional stability and coverage throughout the unwind of the COVID-related continuous eligibility protections for Nebraska kids.

Separate from the COVID-related unwind concerns, as you've heard, continuous eligibility helps children maintain consistent care, which in turn helps them succeed in school and keeps the state's communities healthy. When children have consistent healthcare access, they are able to regularly access preventive services like vaccines, well-child visits and other age-appropriate care. Keeping children covered also helps providers develop relationships with children to better manage their care and monitor their development. On the other hand, there's evidence that changes in coverage are associated with increased emergency room visits and result in higher healthcare costs. Guaranteeing continuous eligibility for low-income children also helps combat unnecessary coverage losses and gaps in coverage. There's ample evidence that paperwork, periodic checks and inadequate notices can cause eligible individuals to improperly lose coverage. The rates of churn are lower in states that have already implemented 12-month continuous eligibility at 2.9 percent, compared to 5.3 percent in states without continuous eligibility policies. This bill would reduce unnecessary loss of coverage and would be less burdensome for families. Because this bill encourages continuing-- continuity of care, better health outcomes for children and provides for administrative efficiencies, Nebraska Appleseed supports this bill.

M. CAVANAUGH: Thank you for your testimony. Are there any questions?

RIEPE: Excuse me.

M. CAVANAUGH: Yes, Senator Riepe.

RIEPE: How does the CHIP program for-- and I should know this, I suppose, but how does the CHIP program contribute or distract-- detract from this?

KELSEY ARENDS: So CHIP, both Medicaid and CHIP, both programs will be required to implement continuous coverage under the new federal legislation and I believe under this bill as well. So the difference between Medicaid and CHIP practically for kids who get to enroll is that the CHIP income limit is a little bit higher and the federal match rate for CHIP is also higher. So more federal funds come in to pay for the CHIP program.

RIEPE: OK. Thank you.

KELSEY ARENDS: Yeah.

RIEPE: Thank you.

M. CAVANAUGH: I have some questions. So, first of all, I'm continually asking about the fiscal note. Have you had a chance to see the fiscal note?

KELSEY ARENDS: I've seen it.

M. CAVANAUGH: OK.

KELSEY ARENDS: I'm not sure I have any new information for you.

M. CAVANAUGH: OK.

KELSEY ARENDS: But you can ask. I'll tell you if I don't know.

M. CAVANAUGH: Well, I'm just trying-- it is very unclear to me. And, and since I don't have the information in front of me as to what this program costs for six months regularly, it's unclear if the $7,500 in the fiscal note for the remainder of 2023 is for all children or if it's just for the children that they-- the department is assuming would no longer be eligible. And I don't know if you have a sense of that.

KELSEY ARENDS: I don't have an answer for you.

M. CAVANAUGH: OK

KELSEY ARENDS: I think we, we'd be very interested in that as well.

M. CAVANAUGH: I'll just keep asking it and then maybe the department will show up and answer the question. That's kind of what I'm hoping, but I'll just, I'll just keep on asking. Thank you so much. Are there any further questions?

KELSEY ARENDS: If I could, I would just note, as other testifiers have said, but just to say again, the, the costs will be just required very quickly after this would possibly be implemented. So the costs are going to be what they're going to be, but they'll be required as of January whether this bill passes or not.

M. CAVANAUGH: Oh, and I did want to note you, you mentioned administrative costs. And I just wanted to note for the record that I don't see a breakout of how much more it would cost administratively in the fiscal note. So perhaps an oversight by the department to include those costs, but thank you so much.

KELSEY ARENDS: Yes and, and just to-- if it's OK--

M. CAVANAUGH: Yes.

KELSEY ARENDS: --to follow up on that--

M. CAVANAUGH: Go ahead.

KELSEY ARENDS: --yeah-- we do know that states have seen administrative cost savings based on implementing continuous eligibility because of we know state agencies spend time diligently reviewing eligibility. And so the-- that time, if you don't have to do that every six months, saves a lot in administrative costs as well.

M. CAVANAUGH: Maybe we will see that in an amended fiscal note. Thank you.

KELSEY ARENDS: Thank you.

M. CAVANAUGH: Do we have any other proponents for LB326? All right, welcome. Oh, my.

GARRET SWANSON: I promise it's not a prop.

M. CAVANAUGH: Not a prop.

RIEPE: It's candy.

M. CAVANAUGH: It's candy. If you want to hang it to our page, she can distribute when she's able to. Welcome.

GARRET SWANSON: Thank you. I'll wait a second to have her pass that out.

M. CAVANAUGH: No, go ahead.

GARRET SWANSON: OK.

M. CAVANAUGH: Yeah.

GARRET SWANSON: Members of the Health and Human Services Committee, my name is Garret Swanson. That's spelled G-a-r-r-e-t S-w-a-n-s-o-n and I'm here on behalf of the Holland Children's Movement in support of LB326. Last year, our sister organization, the Holland Children's Institute, conducted 55 pages of research to develop policy options for the Legislature to consider in relation to Medicaid and public

schools. After months of development, we boiled down our research to three suggestions for the Legislature to, Legislature to consider. LB326 is our second suggestion, which you can find an in-depth analysis on on page 32. Senators, children are particularly sensitive to change in their formative years, frequently citing changing eligibility status cycles children on and off of coverage, a phenomenon known as churn. In many cases, the churning children are disenrolled despite becoming eligible again soon after disenrollment. Unstable, changing levels of program and service availability due to lack of continuous eligibility hinders continuity of coverage and negatively impacts a child's ability to thrive. In 2003, Washington state replaced its 12-month continuous eligibility with a six-month continuous eligibility like we have here in Nebraska. The results were so profound-- or excuse me-- this resulted in more than 30,000 children losing coverage in the following two years. This consequence was so profound that in January of 2005, Washington reversed that decision, reverting to its 12-month continuous eligibility period, resulting in 30,000 children gaining or having coverage restored by the end of the year. Nationally, with historic and chronically low early and periodic screening diagnostic and treatment performance, changing children's health coverage further complicates the ability to coordinate with providers and deliver required care. For disenrolled families, Nebraska does make transitional medical, medical assistance available to qualifying families who no longer meet Medicaid and.or CHIP eligibility requirements for a period of six months. TMA may be used for both adults and children. TMA is an attempt at addressing unintended policy consequences, commonly known as the cliff effect. The cliff effect return-- refers to a sudden, often-unexpected revocation of income-linked benefits such as Medicaid or CHIP. Often a modest increase in a family's annual income can and does see some or all eligibility and associated benefits. Because of this, heads of household frequently decline incremental opportunities for professional advancement. It has a small increase-- leads to a loss of benefits that far surpasses the increased wage. As a result, instead of a ladder out of, it can become an anchor into poverty, trapping benefit-- beneficiaries in a cycle of systemic poverty in which there is no way to bridge the gap between advancement and household stability. While continuous eligibility can ostensibly increase state costs, the cost burden is primarily related to keeping children covered. Continuous eligibility is one of the most effective strategies a state can take to ensure eligible but uninsured children are, are enrolled. When implementing 12-month continuous eligibility, we should expect a decrease in health costs over time by ensuring

better continuity of preventative and intervention care for children and a reduction in churn. And reducing administrative costs of processing frequent eligibility determination enrollment/disenrollment as children and families cycle on and off of Medicaid and CHIP. Extending the term of continuous eligibility paired with existing TMA program would allow Nebraska to better address the cliff effect for Medicaid and CHIP coverage. In a national study, nearly half of U.S. children who were disenrolled from Medicaid re-enrolled within one year, with higher-risk demographics having sorted Medicaid-- shorter Medicaid enrollment gaps, but more likely to have instances of Medicaid enrollment. Continuous eligibility alleviates this churn and insures cover-- consistent coverage for children during years of important physical, physiological and socio-emotional development. The Holland Children's Movement strongly urges this bill to be voted out of committee. And just as an aside, our third policy recommendation is actually Senator Day's LB85 and we, we thank you very much for that.

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

GARRET SWANSON: Thank you.

M. CAVANAUGH: Do we have any other proponents for LB326? Seeing none, do we have any opponents for LB326? Seeing none, do we have anyone in the neutral for LB326? No? No neutral? OK. Seeing none, Senator Raybould, you are welcome to close and as you do, I will say that we have 14 proponent letters for LB326. Thank you. Senator Raybould.

RAYBOULD: That's terrific. Thank you very much. And so I heard some questions that we all agree that the estimate or the fiscal note provided by HHS is a little out of whack. And I know Ms. Behnke, in her testimony, said that really the, the states that have already adopted the 12-month eligibility have experienced an average of 2.2 percent increase in the cost. And that's really in reference to that gap where those kids may have fallen off so that's how you have to calculate it. You shouldn't be calculating it for the entire year. And then so if you look at that 2.2 percent, really it should come out to about $5.5 million in, in General Funds for the gap instead of what HHS had come up with the, with $7.5 million. And it could be even more because I'm just kind of calculating as I go, so.

M. CAVANAUGH: Thank you. Are there any questions from the committee? I would just note that we have, in the past, seen departments come in

with a revised fiscal note. So perhaps that's something that we can expect from DHHS on this particular one, but.

RAYBOULD: Well-- and, and I think so. After, after having conversations with Director Bagley, he said, I get what you're seeing, I get what you're saying. And I think we, we can come back with a revised fiscal note that more accurately reflects the gap. And I think it's a common mistake for other states that have done it. They just give you that big, big whole year, this is how-- it looks pretty scary, but it's only that gap.

M. CAVANAUGH: Thank you so much. And that--

RAYBOULD: Thank you all very much.

M. CAVANAUGH: --closes our hearing on LB326 and we will open our hearing on LB468. Welcome, Senator DeBoer.

DeBOER: Hello, Vice Chair/second Vice Chair/Senator Cavanaugh.

RIEPE: Second Vice--

M. CAVANAUGH: Second-- third Vice Chair.

DeBOER: My name is Wendy DeBoer. Thank you to the Health and Human Services Committee. My name is Wendy DeBoer, W-e-n-d-y D-e-B-o-e-r. I represent the 10th Legislative District in northwest Omaha. I'm here to introduce LB468. Last year, as a part of LB752, the HHS Committee priority bill, we passed a bill that I had added onto it, the creation of the Alzheimer's Disease and other Dementia Advisory, Advisory Council. Due to staffing concerns at HHS, the council, although it is-- was appointed by Governor Ricketts, has been as yet unable to meet, which is why I introduced LB468 to address those staffing concerns. Having a specific person inside of DHHS to work on Alzheimer's and other related dimensions-- dementias is vitally important. I was pleased to see, as part of the Governor's budget, the inclusion of a staff member in DHHS to do this work. And following a conversation with the department, I do, I do believe that this staff person will meet most of the needs of the council and Nebraska. There are a few areas that we talked to the department about that we would still want to have covered as well and they believe that they can. So as such, I'm requesting the committee to hold the bill and should we need to further support them next year with more efforts for dealing with Alzheimer's and other related dementias, we have this bill as a starting point. And in the meantime, I would ask you to hold it. I'm

happy to answer any questions you may have. I will waive closing because we're a little shorthanded in Judiciary and I gotta get back over to the--

M. CAVANAUGH: Thank you, Senator DeBoer. Do we have any questions from the committee? Senator Riepe.

RIEPE: Thank you, Senator. My question would be this is, do you know who in-- because it's a function that's going on with Alzheimer's and dementia, is there someone designated that you're aware of within DHHS who's now performing that function?

DeBOER: There isn't yet, but the Governor's budget had the provisions to add someone to do that work.

RIEPE: What I struggle to think that someone is not paying attention because it is a significant issue.

DeBOER: It is a significant issue and I--

RIEPE: So somebody in there has to be doing it.

DeBOER: So there is a department on aging, but they don't-- you know, they're all issues regarding aging. So it's just something that we haven't had. We're adding it in now. I'm so glad the Governor was-- you know, recognizes the importance of this issue and was able to prioritize that. And we do have this council, which we have asked to update the state plan, which is, I don't know, ten years old or something. And that new council will be meeting so they will be focusing on that. So while we do not yet have all the resources in place, we're close. We're going to get them together.

RIEPE: Does the fiscal note match up with the Governor's budget piece?

DeBOER: You know, I'm not 100 percent sure exactly how they match up, but I think that whatever is in the Governor's budget is obviously what we're going to do right now. And if we need additional resources, then I may be coming back to this committee next year.

RIEPE: That assumes as well that we do adopt the Governor's budget.

DeBOER: Yes. I'm sorry.

RIEPE: Because we'll come up with our own.

DeBOER: I, I am so sorry. I misspoke--

RIEPE: No, no--

DeBOER: --assuming we adopt the Governor's budget.

RIEPE: My other piece on the fiscal note is it says that 815-- $81,500 in fiscal '23-24. I think that's a low number. My experience is you get a director, you get an associate director or a deputy director, you get a support person, you get-- you're talking more like a quarter of $1 million for every director position. I don't care whether it's in state government or in the private industry, it all pyramids.

DeBOER: Senator Riepe, I'm glad you brought that up. One of the things that were we to pursue this bill now, we had an amendment that would change that from director-level position to just a point person. So that would have changed from our original request in the green copy to, to just a point person within the department. And that probably would match more with the fiscal note that you're referencing.

RIEPE: Maybe bring them in at an AA salary.

DeBOER: Hopefully not.

M. CAVANAUGH: Thank you, Senator Riepe.

RIEPE: Thank you.

M. CAVANAUGH: Are there any other questions from the committee? I-- just following up with what Senator Riepe said, if we do not adopt the Governor's budget, as Senator Reid has indicated as an option available to us--

RIEPE: Of course.

M. CAVANAUGH: --then perhaps you'll come back to us about moving this bill forward this year.

DeBOER: Absolutely.

M. CAVANAUGH: OK. Well, thank you, Senator DeBoer, and we will take our first proponent testifier.

DeBOER: All right. Thank you.

M. CAVANAUGH: Welcome.

NICK FAUSTMAN: Good afternoon. I'm Nick Faustman, N-i-c-k F-a-u-s-t-m-a-n. I'm the director of public policy and advocacy at the Alzheimer's Association- Nebraska Chapter. The Alzheimer's Association is the leading voluntary health organization in Alzheimer's care, support and research. Our vision is a world without Alzheimer's and all other dementia and we support LB468. There are currently 35,000 Nebraskans over the age of 65 living with the-- a diagnosis of Alzheimer's and that number is expected to increase by nearly 15 percent in 2025. And so it's easy to see that the coordination of state programs for people with dementia is absolutely critical. Currently, there are staff at DHHS designated to the other chronic diseases: asthma, arthritis and cancer, just to name a few. But there is no designated staff for Alzheimer's or dementia. The lack of coordination hinders the ability of our state to evaluate the effectiveness of policy efforts that serve this population. It will also hinder the implementation of future policy solutions. That is why we are advocating for the creation of a position at the Department of Health and Human Services to serve as the point for all things dementia. The position need not be a directors-level staff and whether the position is called a specialist, a program manager or a division coordinator means little in the grand scheme of things. Numerous state governments have established dementia services position under a variety of names and through a variety of implementation methods, including statutory changes, inclusion in their state budget and even repurposing an existing vacant position. Senator DeBoer did speak of the Alzheimer's Disease and Other Dementia Advisory Council, which, according to the law that went into effect last summer, was to have met by the end of 2022. However, council members have yet to hear of the first meeting or first steps so we were elated to see the Governor's-- Governor Pillen's budget proposal included funding for a designated person at DHHS in the Public Health Division to coordinate for the adverse-- the ad-- advisory council, sorry. And we'd like to thank him for recognizing the need to prioritize the state's response to the growing Alzheimer's population in Nebraska. And so in conclusion, between LB468 and the Governor's budget proposal, it is our hope that the position will not only coordinate the council, but also be able to take on new dementia-related projects such as applying for grants, federal grants, and assist with implementation of any future policy designed to help Nebraskans impacted by Alzheimer's, things that simply put, have yet not been able to occur yet.

M. CAVANAUGH: Thank you. Any questions? Senator Riepe.

RIEPE: Recently there have been reported some research study that says that medical marijuana is an advantage for Alzheimer's patients on the agitation side. I just wanted some assurance that this is not a gateway to legalized marijuana.

NICK FAUSTMAN: Oh, absolutely not. I don't even think our organization has a position on medical marijuana. So that's news to me, Senator. I hadn't heard that.

RIEPE: OK. I'm being a little bit--

NICK FAUSTMAN: Okay.

M. CAVANAUGH: Are there any other questions? Well, I'm disappointed by that answer, but I guess I'll--

NICK FAUSTMAN: Yeah.

RIEPE: Oh.

NICK FAUSTMAN: I'm sorry you didn't like it.

RIEPE: This is not a confessional.

M. CAVANAUGH: OK.

NICK FAUSTMAN: Senator Riepe, if I may, you did ask a couple of questions earlier. I did want to circle back on those. If you could remind me what they were that you had asked Senator DeBoer earlier?

M. CAVANAUGH: About the levels of the--

RIEPE: Well, mine was my primary sense was-- and I think you answered that. You said this person-- you know what? I didn't-- I took concern over the fiscal note. I thought it was particularly low.

NICK FAUSTMAN: Yes, yes. The fiscal note on the bill is comparable. However, the, the amount earmarked within-- on LB814, the Governor's bill, was 100 and thousand-- $100,000 even.

RIEPE: Is that what his was?

NICK FAUSTMAN: Um-hum and it's to go to Public Health for the position.

RIEPE: So by the time you back out benefits, you're back down to 75. And I still continue--

NICK FAUSTMAN: Yeah, yeah and, and--

RIEPE: I'd argue with the government that you can't do it for 75 and not have an FTE in there.

NICK FAUSTMAN: Yeah and I, and I think--

RIEPE: This won't end up at one. It will end up with at least two.

NICK FAUSTMAN: Yeah. And I don't think that the Governor's proposal meant for this position to be directors level. To be honest, I'm not sure where the directors-level language came from in LB468. We never intended for it to be directors level.

RIEPE: OK. Thank you.

M. CAVANAUGH: Any other questions? Seeing none, thank you for your testimony.

NICK FAUSTMAN: Thank you.

M. CAVANAUGH: We'll take the next proponent of LB468. Welcome.

JUNE RYAN: Thank you. Good afternoon. My name is June Ryan, J-u-n-e R-y-a-n, and I'm here today testifying in support of LB468 on behalf of AARP Nebraska. AARP supports this legislation, a bill that will create the position of a state dementia director in the Department of Health and Human Services. As Nick stated, we do talk to each other. According to the Alzheimer's Association, we know that currently 35,000 Nebraskans over the age of 65 are living with Alzheimer's disease. Under the current trajectory, more than 13.8 million additional baby boomers are expected to develop dementia by 2050. A 2015 AARP policy survey revealed that virtually all of our members recognize that dementia is a serious problem and that 85 percent know someone who has or had dementia. While members want to know about their mental functioning and healthcare providers are the first line in the defense for individuals who notice a decline in cognitive health, few healthcare providers are really discussing dementia with their patients or assessing mental functioning during their made-- their annual Medicare wellness visit. Nearly half of our members mistakenly believe that dementia is a mental ill-- a mental illness and 41 percent think that dementia is a normal process of aging. The

human, society-- societal and financial costs of dementia are all very high, including healthcare costs, impacts on individuals, their family and friends and on the workforce. Currently, it's estimated that the average per person Medicare spending for people 65 and older with dementia is three times higher than that for seniors without dementia. Medicaid payments are 19 times higher and research projects that the cost of caring for those with Alzheimer's will make up 24.2 percent of Medicare spending by 2040. Dementia not only impacts the patient, but also their families and friends. In 2015, the direct annual cost of caring for those with dementia was estimated to be 20-- $226 billion, with expectations that it will reach over $1.1 trillion by 2050. People caring for family or friends with dementia had $9.4 billion in additional healthcare costs of their own due to the physical and emotional toil-- toll of caregiving. And I just want to stop here for a minute and say that I personally am among the many Nebraskans who served as a caregiver for a spouse with dementia. I would have appreciated knowing that Nebraska had a plan for educating and supporting families such as mine, but I was left to find my own support system and appropriate services for my husband, who had dementia that lasted for about six years before his death. It's the policy of AARP that policy men-- member-- policymakers should expand and bring to scale demonstrations that are cost effective, person centered and proven to improve the quality of life for, for individuals all across the stages of the diseases that cause dementia. One of the goals of this program would be to delay the progression of dementia and increase independence through person-centered care while lowering overall healthcare costs. Dementia centers for excellence, which educate, conduct research and expedite the adoption of cost-effective best practices, should be established and replicated. With the passage of LB752, as was mentioned in the 2022 legislation-- Legislature, Nebraska created the Alzheimer's Disease and Other Dementia Advisory Council. The purpose of this council is to examine the needs of individuals with Alzheimer's and other dementia, the service-- the services available and the ability of healthcare providers to meet the current and future needs of those with Alzheimer's and other dementia. LB468 will provide this advisory council the support and the initiative to work to examine the needs and create a working plan for Nebraska moving forward in addressing and creating solutions for Nebraskans and their caregivers in addressing dementia and Alzheimer's in our state.

M. CAVANAUGH: I'm sorry--

JUNE RYAN: Thank you to Senator DeBoer--

M. CAVANAUGH: Oh, there we go, sorry.

JUNE RYAN: I'm done. Thank you to Senator DeBoer for introducing this important legislation and I'm--

M. CAVANAUGH: Thank you.

JUNE RYAN: --available to answer questions.

M. CAVANAUGH: Are there any questions? I just have a comment, first of all. So thank you for your testimony and also, I am sorry for your loss. I know that oftentimes when we have someone with dementia and Alzheimer's, we lose them twice. So thank you for taking time to share your story with us.

JUNE RYAN: Thank you.

M. CAVANAUGH: Do we have any other proponents? Welcome.

KIERSTIN REED: Thank you. Good afternoon. My name is Kierstin Reid. That's K-i-e-r-s-t-i-n R-e-e-d and I am here to testify in support of LB468. I serve as the president and CEO of LeadingAge Nebraska. We are a statewide advocacy organization that supports long-term care providers across the state. In addition to my role as the CEO at LeadingAge, I recently was also appointed to the Alzheimer's Disease and Other Dementias Advisory Council. I am also a family member of a person with dementia. My father was diagnosed with dementia nearly ten years ago so my appointment to the advisory council was both personal and professional. While this advisory council has been a recent development, there has been little movement in the advisory council. The bill for the development of that council was approved in the last legislative session, as you had heard, and to date, we have not had our first meeting. I've called the Governor's office. I've emailed. I've asked questions in regard to the council, but I haven't received any answers. This could just be my lack of patience, but it could also be the need for more time to get this council underway. Unfortunately, my family does not have more time for Nebraska to understand that dementia needs to become a priority. Neither do the thousands of other family members caring for the 33,000 Nebraskans that are living with Alzheimer's and dementia disease in our state. I'd like to provide a little bit of history on where dementia services have come in Nebraska. So as we talked about earlier, in 2014, there was a bill that was passed that organized a task force on aging. That is known as the Aging Nebraskans Task Force. Then in 2015, another bill was

introduced, which then set in motion the implementation for those recommendations that were in that task force the previous year. And it provided the governance for the task force to then develop the state plan on dementia and Alzheimer's disease. So then that was done and they did develop a state plan in 2015. The Nebraska state plan for Alzheimer's disease and other dementia-related conditions that's posted on the state of Nebraska's website is dated June of 2016. The plan developed three main goals, multiple recommendations and those were outlined to assure that residents that were living with dementia and their families had the information they needed to manage their lives, that they were provided the support to maintain their health and well-being and that they lived in safe-- that they were safe in the communities they lived in. To date, there have been no other updates on this plan. The goals and the recommendations that are outlined in that plan are relative, they are actionable and they are necessary to ensure that Nebraskans that are living with dementia are able to live the good life. The problem is that most of the actions that are in there have never made it off the line of scrimmage. I believe that that's because we're missing that dedicated person to carry this ball. I believe that with dedicated resources, these actions are a reality and that Nebraska could actually become a leader in dementia care and research. There are millions of dollars in grants and funding from the federal government and other private organizations that are already in existence. Nebraska is unable to leverage any of those because they lack the person to carry that ball to make that a reality. So to close, I'm here to support this bill, LB468, to provide better resources and opportunities to those living with dementia and their families. We can do better and we need to do better. The, the research in dementia is expanding and we need to be ready to meet that goal. So I'll be happy to answer any questions that you have. Thanks for having me.

M. CAVANAUGH: Thank you for your testimony.

KIERSTIN REED: Yeah.

M. CAVANAUGH: Are there any questions? Seeing none, thank you so much for being here today.

KIERSTIN REED: Thank you.

M. CAVANAUGH: Do we have any other proponents for LB468? Seeing none, do we have any opponents for LB468? Anyone in the neutral? OK and since Senator DeBoer has waived closing, we have four proponent

letters for LB468 and this will close the hearing on LB468 and we will open our hearing on LB530-- or sorry, LB353 and you're welcome to open, Senator Raybould.

RAYBOULD: It's so good to be back. Well, good afternoon, Vice Chair Cavanaugh and members of the Health and Human Services Committee. My name is Jane Raybould. Jane is J-a-n-e and Raybould, R-a-y-b-o-u-l-d. I represent Legislative District 28 and appear before you today to introduce LB353. LB353 aims to provide grants of up to $250,000 to nursing or skilled nursing facilities to enable the acceptance of complex acute transitional patients to those facilities. To accomplish this, this bill asks for a one-time, one-time appropriation of $25 million. Ultimately, the goal of LB353 is to support our hospitals and our nursing home providers across the state and to also aid in the safe transition and necessary care for patients. There are currently 182 people waiting in the hospital to be discharged to a nursing home or long-term care provider. However, many of our long-term care providers lack the equipment and infrastructure to be able to receive complex patients from our hospital systems. These one-time funds would assist the long-term care providers to make these needed improvements. This, in turn, would assist with hospital capacity to allow them to be able to continue to support more acute patient needs. A facility interested in making improvements with this grant and funding would develop a memorandum of understanding with at least one hospital to accept complex acute transition patients into the facility. Obviously, their needs would need to match up between what they are able to do at the facility to improve capacity and the person that is seeking a placement. But this could open the door to new possibilities. The bill requests that the Department of Health and Human Services manage the grants based on the agreements between the long-term care facility and at least one hospital. Hopefully, you'll hear testimony today from individuals representing long-term care facilities in our hospitals. They will be able to share more about how, as a legislator, prioritizing these one-time funds will be a huge investment in our nursing homes, the people they are caring for in our state now and in the future. And I want to say thank you so much for your time. And I know you have all heard and seen about the nursing home closing and shortages and workforce staffing issues. I know firsthand when my, my father was at Madonna in long-term care, I just remember they needed so many more pieces of equipment, lift equipment that would help those in long-term care, that would help the, the nursing team or the CNAs get their jobs done more efficiently and effectively. And I know I can-- in my mind, I can see exactly where one facility might take that

$250,000 grant and probably build a new bathroom/restroom facility that would have a whirlpool that would help these people perhaps in rehab or just make them feel more comfortable and to create a bathroom to be able to accommodate a lift. I know that that was high demand. All the patients in long-term care loved that facility, but they only had one. They could easily take care of more, more patients and increase their comfort level if they could even build two, two more restrooms. So for me, I guess this is personal. And of course I would be happy to answer any questions.

M. CAVANAUGH: Thank you, Senator Raybould. Are there any questions? Yes, Senator Riepe.

RIEPE: Thank you, Chairwoman. My question, is this $25 million in the Governor's budget or is it in possibly the legislators' budget?

RAYBOULD: I think it's in General Funds and I'm looking at the fiscal note that HHS prepared and it-- I know that they had estimated three FTEs to do this. I don't, I, I don't think that's quite necessary and-- to be able to, to manage a grant. I think it is anticipated that there probably-- you know, there's quite a number of facilities out there and I don't think we would have that number of requests come in for the $250,000. You know, that $25 million, maybe only 50 percent of the 200 nursing homes would make that request for the funding. And I don't think that would necessarily require three full-time employees to be able to do that.

RIEPE: Is-- in the-- I mean, $25 million is not an insignificant amount. I don't know whether that's a line item, line item in the Governor's budget or, or Senator Clements is going to, through Appropriations, put it in the Legislature's budget to sort of compare with the Governor's spot and see where we end up.

RAYBOULD: I, I don't know the answer to that question--

RIEPE: OK.

RAYBOULD: --but I would be very happy to, to find out.

RIEPE: That's a-- we'll find out probably soon enough as it goes along. The other question that I have is do you or the people supporting you in this have a preference for-- and this is an either/or, as I see it-- is grants for $250,000 or Medicaid rate increases with the idea that you don't get both?

RAYBOULD: Well, I think-- to be honest, all are necessary and I don't know if-- I have another bill coming back in front of you for increasing the reimbursable rates to allow those nursing homes, particularly in the rural areas, to be viable and stay in business. So that's certainly a very-- a big priority that is-- that we need to take a serious look at funding.

RIEPE: So it's on top of this $25 million?

RAYBOULD: I would easily say it's going to be on top of that $25 million and of course--

RIEPE: That could be a challenge.

RAYBOULD: --and of course, there needs to be an adjustment in the wages too that will go in the reimbursable rate so that these nursing homes can stay viable. I look on it as economic reinvestment in these rural communities. If we want our rural areas to continue to thrive and be successful, this is something that is needed because we see more and more nursing homes close and primarily in those rural communities. And oftentimes those nursing homes are the largest employer in that community. And it's well known that the hospitals feed into the, the nursing home or assisted living facilities for these transitional patients, but it also works the other way around. The nursing homes also feed into those community hospitals. And so, you know, there's a great deal of synergy and codependency on each other and both facilities are some of the largest employers in those rural communities. And so I look on it as economic reinvestment. You may look on it as a big expenditure and a big line item, but I don't-- I think if we don't start looking at the reimbursable rates, along with supporting grants that help our nursing home facilities take on patients, the cost will continue to rise because these patients are staying longer and longer periods of time in a hospital. And if you can imagine the hospital build there, that starts to add up rather quickly. So they are tremendous cost if we don't start supporting these initiatives.

RIEPE: Well, I've given some thought to Medicaid reimbursement in nursing homes and I think if we can move people into and through nursing homes, we can alleviate the burden that the hospitals experience of unpaid services to many patients, many patients they can't place. My formula would say the more Medicaid you take, the higher your, your percentage of increase would be. And if you don't-- say if you don't-- if you take 10 percent, I consider that charity and

that's maybe a 2 percent rate increase. If you take 50 percent in Medicaid of your payor, then you might get a 10 percent rate increase

RAYBOULD: I think--

RIEPE: So it kind of gets down to a means test in a reverse manner for the providers in the nursing homes.

RAYBOULD: And I think the percentages that you're talking about are still insufficient to allow those nurse-- rural nursing home facilities to stay viable.

RIEPE: So you're proposing a cost plus for them?

RAYBOULD: I-- we know that the reimbursable rates are not even coming close to the actual daily costs to run a nursing home facility. And I think you probably know the numbers better than I do because of your experience as a hospital administrator. But we know right now that the reimbursable rates are not sufficient, even with an additional 10 percent increase-- I think that's what you mentioned-- to be able to help them stay viable. And I'm not a nursing home administrator. I've just seen some of the numbers. And like I said, it's-- to me, it's economic reinvestment in our rural communities.

RIEPE: OK. Thank you.

RAYBOULD: You bet.

M. CAVANAUGH: Are there any other questions? I did want to note we had a hearing this morning for Senator Brewer on LB451, which was also a granting program. And I notice that the same individual at HHS prepared both of your fiscal notes and we might want to do some reconciling on their FTEs. So I just wanted to note that for the record and we will take our first proponent. Thank you, Senator Raybould.

RAYBOULD: Thank you very much.

M. CAVANAUGH: Welcome.

MARGARET WOEPPEL: Thank you. Thank you very much, members of the Health and Human Services Committee. My name is Margaret Woeppel, M-a-r-g-a-r-e-t W-o-e-p-p-e-l, and I am the vice president of workforce quality and data at the Nebraska Hospital Association. I am testifying in support of LB353. After hearing numerous anecdotal

stories about the difficulty transferring patients out of the hospital and into a post-acute setting, the Nebraska Hospital Association began collecting monthly data from their hospitals in the fall of 2022. According to the monthly data, there has been consistently approximately 230 patients waiting longer than seven days post-discharge for placement. The majority of these 230 patient delays are attributed to delays getting admitted to a skilled nursing or a long-term care facility. Of note, in January of this year, 2023, 18 of those 230 total patients have been waiting at the wrong level of care in a hospital for over six months to be placed in a post-acute setting. In the summer of 2022, the Nebraska Hospital Association launched a transitions of care council to monitor and provide solutions for this issue. Members of this council include hospitals and post-acute professional association representatives. During these meetings, we learned that one significant barrier to post-acute placement is Nebraska's aging post-acute facilities. These facilities are simply not equipped with the necessary infrastructure to take on certain complex patients. For example, a bariatric patient requires patient lifts, as we've kind of talked about already, wide doors to accommodate extra-large wheelchairs, weight-supported chairs and toilets, among other things. Many of our Nebraska facilities do not have the existing infrastructure nor the capital funding to accommodate the needs of a bariatric patient. Other complex patient capital needs include items such as IV pumps, ventilators and wound care devices. The Nebraska Hospital Association supports a grant specific to projects that increase post-acute facilities' capabilities to support complex patient types. Hospitals and post-acute settings working together to ensure the most appropriate setting for patients is good for all Nebraskans. Thank you very much and I will take any questions.

M. CAVANAUGH: Thank you for your testimony. Senator Riepe.

RIEPE: I guess my first question-- I think I heard you, correct me if I'm wrong-- you talked about some access issues, if you will.

MARGARET WOEPPEL: Yes.

RIEPE: That would seem to me a gross violation of the ADA that-- you know, the American Disabilities Act. And I don't know how they would comply with codes to be able to even qualify to be in a nursing home if they can't accommodate ADA patients. The other question that I would have is you talked about the problem of placement of patients.

My question is that-- can you break that down just a little bit for this? Is, is that primarily getting people back home in--

MARGARET WOEPPEL: Good questions.

RIEPE: --rural Nebraska as opposed to urban Nebraska?

MARGARET WOEPPEL: Home, meaning to post-acute--

RIEPE: Well, to--

MARGARET WOEPPEL: --nursing home or long-term care?

RIEPE: Say if they live in, you know, picking Hastings and they happen to be at Bryan or St. E's here in Lincoln. Is that a bigger problem for them to find a nursing home in Hastings or maybe even a smaller community than it is say in a more larger market like Omaha?

MARGARET WOEPPEL: Absolutely.

RIEPE: Now, there's also the affordability. Finding a bed is one thing, but finding an affordable bed is a totally different story.

MARGARET WOEPPEL: Yeah

RIEPE: You can find one if you've got a lot of money.

MARGARET WOEPPEL: Yes. Well, your first question, I am not an ADA expert, but I am a nurse and I do work with quality in hospitals.

RIEPE: Nurses know everything.

MARGARET WOEPPEL: And so what we're talking about, ADA, is, is the ability to get in and out of rooms, but then the limitations come in those extra-large bariatric patients. And so older facilities were not built in the manner of which Nebraskans and, and the whole United States are growing in weight. We're seeing heavier patients and these nursing homes were built in the time in which patients just weren't necessarily that, that heavy. So they can accommodate, you know, wheelchairs and a, a, a patient time-- type of the older, older generation, but not necessarily the ability to keep up with how we're changing. We're sicker, we're heavier and, and that's throughout, throughout the United States. We have done some analysis, to your second question, and, and there are some differences. It is a little bit difficult, more difficult to get placement in certain populations

and that is because there, there is a gap of nursing homes. So we have a monthly throughput survey and in certain districts, there are just no nursing homes or post-acute placement in multiple counties, especially out west. So, so the lack of nursing homes and-- in the western part of the state is really creating a significant issue on beds in general, let alone beds for medically complex patients. Some of the facilities in the Lincoln and Omaha area are newer. They've been built more recently so they, they do have some of the infrastructure. For example, a lift, you know, we not only have to, to take the lift, but what about the actual ceiling and the supports? Can they support a 600-pound patient? In the older facilities, we're finding that, that they're not. And that's where this grant would serve us in, in just updating those and so we can get more rooms. You know, they don't have to have every room able to take a medically complex patient, but maybe one or two. Does that answer your question?

RIEPE: Yes, thank you.

MARGARET WOEPPEL: OK. Thank you.

M. CAVANAUGH: Thank you. Any other questions? Senator Ballard.

BALLARD: Thank you, Senato Cavanaugh. What's the-- of the top of your head, what would be the demand for this, for this grant? There's a possible 100, 100 grants that could be administered. Is there-- would this, would the grant be obsolete in a year, two years, ten years?

MARGARET WOEPPEL: That's a great question. I think I'm going to defer to those behind me who are in the nursing home business. I do know that the majority-- so every month we've collected data, there's been 230 approximately patients waiting for discharge. And the majority, 80 percent or more of them, have been waiting for post-acute placement in a long-term care or, or skilled nursing. So there, there would be a great need on the hospital side. We see that. As for how willing and how many post-acute placements are willing to say, hey, yeah, we would like to go into partnership with a facility to take on a bariatric patient or complex wound care, I don't know, but I bet those behind me can--

BALLARD: Thank you.

MARGARET WOEPPEL: --answer.

M. CAVANAUGH: Are there any other questions? Seeing none, thank you for your testimony.

MARGARET WOEPPEL: Thank you very much.

M. CAVANAUGH: We will take the next proponent for LB353. Welcome back.

KIERSTIN REED: Thank you for having me again. All right. Good afternoon, Senator Cavanaugh and the committee. Again, my name is Kierstin Reed, K-i-e-r-s-t-i-n R-e-e-d, and I still serve as the president and CEO of LeadingAge Nebraska. LeadingAge is a statewide advocacy organization for providers of long-term care services, including nursing homes, and I am here today to testify in support of LB353. This bill is being brought forward to establish tangible outcomes to address the backlog of patients that remain at the hospital because they are unable to find placement at a long-term care provider due to those complex medical conditions. So according to our colleagues that you already heard from at the Nebraska Hospital Association, when I pulled this data, there were 227 patients that were awaiting discharge and 182 of those were seeking nursing home or long-term care placement. These delays are for a multitude of reasons, but one of those is their complex care needs put them in a situation that a nursing home is simply just not being paid enough to support their complex care needs and to support the infrastructure that needs to be put in place to get there. So some of these needs would include one-on-one supervision, bariatric care, psychiatric care, dialysis, transportation barriers and currently even COVID quarantine has been an issue. So this bill would provide grant funds for long-term care facilities to be able to make modifications, infrastructure improvements to their facility and to be able to provide for the needs of long-term care patients. When a person is supported through a nursing home, it becomes the responsibility of the nursing home to address all of their needs for care, treatment, anything that they need ongoing. This can mean equipment, staffing, supervision, even the cost of medication and much more. So the risk and the expense of supporting someone with a complex medical condition far outweighs the payment that the nursing home receives for their daily care. Our nursing homes are just simply not in a position to purchase new equipment to support someone or modify their location or train additional personnel on the complex needs of some of these referrals. So I'd like to give a couple examples of how this could be used. One type of patient that Margaret was speaking about is someone that has a bariatric condition and that means that they are significantly overweight. This condition requires a nursing home to have oversized bed, wheelchair, a scale, a lift. All of those things have to be able to handle that increased weight. Doorways might need to be widened for, for these patients as well. With these grant funds, a nursing

home could invest in the equipment or the modifications that they need to make to one or two rooms within their program to be able to support someone with these conditions. Another area that we haven't really talked about is psychiatric needs. So patients with psychiatric diagnosis are sometimes difficult to to discharge and there simply are not enough geriatric psychiatric services in our state. And the majority of our nursing homes in our state are not secure facilities so using these funds, they could provide additional security, supervision, specialized training to be able to meet the needs of those with significant psychiatric and sometimes behavioral issues. This would allow for more robust psychiatric services. Bottom line is our nursing homes do have beds available and they are able to take on more patients, but they need assistance in being able to meet the needs of those patients. A lot of that is coming from the upfront cost of the complex medical conditions. So I look forward to seeing this move forward. I'm happy to answer any questions that you have. Thank you.

HANSEN: Hi.

KIERSTIN REED: Hi.

HANSEN: Thank you for your testimony. Are there any questions from the committee?

RIEPE: I would have--

HANSEN: Yes, Senator Riepe.

RIEPE: Senator, thank you. This might be a comment. It seems to me that one of the strengths in your argument might be the-- which is very common in nursing homes-- the workplace injuries--

KIERSTIN REED: Yes.

RIEPE: --to backs because of lifting and, you know, and so a worker will get off balance and they're out for weeks on end

KIERSTIN REED: Absolutely.

RIEPE: Maybe that'll come to the Business and Labor Committee.

KIERSTIN REED: Well, that's a good idea. That would have been nice. And yes, that, that's a huge issue.

RIEPE: It is.

KIERSTIN REED: I mean, the more injuries that they have among their workforce, the higher their work comp rates get, which also means that that's just more money that they--

RIEPE: They just lost an FTE.

KIERSTIN REED: Yes and they've got employees that are out. Geriatric psychiatric issues are, are one of the main reasons. There's folks that are sitting in the hospital for long periods of time because they're-- they may not need secure facility, but we've all-- you're all in Health and Human Services. You've all heard that they don't look good on paper referral. This is, this is what we, we deal with. You know, when someone doesn't, doesn't look like someone that you can easily support with what you're being paid, your likelihood to take that person in is, is pretty low. And you had a question earlier that I think I have an answer to.

BALLARD: Great, yes.

KIERSTIN REED: I'm--

BALLARD: --if I may, Mr. Chairman.

HANSEN: Yes, explain, Senator Ballard.

BALLARD: The same question. I will ask a question. What, what would be the demand for this grant?

KIERSTIN REED: Great question. So we-- when we were talking about the framework for this, you know, we started out at $100,000 per grant. You can't really get a lot done with $100,000 so we moved it up to 200, 250, really felt like a good place to be. You can make the modifications that we need to make with $250,000. You can purchase the piece of equipment that probably cost $250,000 to buy some of this equipment. Demand, we set it up so that, like you said, 100, which is roughly half of the nursing facilities that would be able to access this on that budget, we're envisioning this being one-time use and it is specifically to address this hospital capacity that we're dealing with right now. My suggestion would be to make it one year, 18 months, 24 months, somewhere around there, so that we can get it out, get it used. And then if there's unused money, then that can go back. That would be my, my idea for it. Now, how many of those 100 would take up-- take us up on this? Staffing is a huge issue and we've, we've

talked about the finances for Medicaid and some of those services. So I do think that that's, that's a concern. They have to be able to staff the bed along with taking that person in. But I do think that there would be-- I've-- we've talked to our membership and there's, there's several that have said, yes, we will absolutely put in something for this.

BALLARD: OK. Thank you.

HANSEN: Yes, Senator Riepe.

RIEPE: One follow up. Thank you, Mr. Chairman. How many nursing homes are now owned by and funded by county boards?

KIERSTIN REED: Well, that is a wonderful question.

RIEPE: Well, thank you.

KIERSTIN REED: I don't know how many are funded through county boards specifically. We can definitely look into that. LeadingAge actually, for many years up until last year, we only accepted nonprofits. So we do serve a lot of those as our members that are county/city operated. The hospitals own some of them. We have a variety, but 99 percent of our membership at LeadingAge is all nonprofit organizations and they support 80 percent of-- 80 percent of their patients that they support are Medicaid.

RIEPE: That's a tough number.

KIERSTIN REED: Yes.

HANSEN: Any other questions?

RIEPE: Thank you. Thank you.

HANSEN: Seeing none, thank you for testifying.

KIERSTIN REED: Thank you.

HANSEN: Is there anybody else who wishes to testify in support? Welcome.

LOIS JORDAN: Thank you. Good afternoon and thank you to Senator Raybould for introducing this bill. It's, it's encouraging to hear your understanding of what we experience every day in long-term care so I appreciate you. Thank you. Well, good afternoon, Chairman Hansen

and members of the Health and Human Services Committee. My name is Lois Jordan, L-o-i-s J-o-r-d-a-n, and I'm the president and CEO for Midwest Geriatrics, which operates Florence Home Healthcare Center, Royale Oaks Assisted Living, House of Hope Assisted Living and Memory Care in Omaha. We are members of LeadingAge Nebraska and I serve as the president on the LeadingAge board of directors. Thank you for the opportunity to testify on LB353. Florence Home Healthcare Center is a nonprofit, mission-driven organization that provides skilled nursing and long-term care services for 95 to 100 seniors in Nebraska. More than 80 percent of the individuals we serve are eligible for Medicaid. LB353 aims to provide grants to nursing and skilled nursing facilities to facilitate the acceptance of complex acute transitional patients to those facilities. As Ms. Reed mentioned in her testimony, Nebraska hospitals experience significant delays in transitioning patients to the next level of care when their acute care needs have been met and they're ready for discharge. Nursing homes such as ours, Florence Home, need those referrals and admissions to stay in business and yet we must decline to admit some of these individuals when the cost of their care will far exceed our reimbursement or there is no payor or payment source to cover the cost of their care. As a result, individuals remain in the hospital longer than is medically necessary or they may transition to their home before they're 100 percent ready, resulting in a higher risk of readmission to the hospital when attempts to live independently are not successful. If approved, this bill would assist nursing homes such as ours to make modifications to our nursing homes so that we could accept those individuals that we currently decline due to structural limitations, staffing needs, no payor or insufficient reimbursement for that level of care needed. For example, individuals may be prescribed medications or treatments that far exceed our daily reimbursement rate. Additional funds to supplement our daily reimbursement rate would allow us to cover the cost of such medications or treatments. Funding could be used to support structural changes, as was mentioned, for bariatric care, such as widening doorways or purchasing those specialized bariatric beds, wheelchairs and lifts. And we are ADA compliant. However, as Margaret had mentioned, ADA compliance, we're, we're doing that daily. But for the individual who requires a lift that can go beyond a max of 500 pounds would need to be a specialized lift. If they're in a wheelchair and we need to transport them somewhere, their weight plus the wheelchair weight would exceed the weight that our lift on our van could accommodate. And so those issues are kind of at the end of-- or outside of the spectrum of what we've been able to care for. We may be able to serve more individuals with psychiatric and behavioral needs

if nursing homes are reimbursed at a level that would compensate for one-on-one caregiver support. To accommodate individuals who are COVID positive, nursing homes must dedicate a specific area of their building to isolate that individual from the general population. Creating that separate and distinct area of the nursing home is very costly. In addition, you must have dedicated staff for that isolation area and to ensure greater infection control and less risk of spreading this virus. All of these modifications require funds we do not have. Funding from this bill would ensure citizens of Nebraska can safely transition to the next most appropriate level of care following a hospital stay. Please accept my testimony in support of LB353. Thank you.

HANSEN: Thank you for testifying. Are there any questions from the committee? Senator Riepe.

RIEPE: I have one. You mentioned about the wheelchair or the van lifts.

LOIS JORDAN: Sure.

RIEPE: So I'm seeking clarification here. Would the money be flexible to be-- doesn't have to necessarily be used on the facility to make and put another bathing area or another widening doors. You could use it on a lift or program?

LOIS JORDAN: That's my understanding.

RIEPE: Is that your understanding?

LOIS JORDAN: Yes.

RIEPE: So that gives you quite a bit of flexibility as well.

LOIS JORDAN: Sure.

RIEPE: OK. Thank you.

LOIS JORDAN: And if we have to transport them back to their doctor's office for a visit and accommodate them in our vehicle, we'd need the lift that could--

RIEPE: OK.

LOIS JORDAN: --could do that.

RIEPE: Now, do you have-- I assume you have a physician contractor, medical director that comes to the--

LOIS JORDAN: We do if they would switch providers to that, but they have a choice of providers. So if they wanted to stay with their physician that they were with in the hospital or prior to their hospital, their primary care physician has been with them, they can stay with that physician and they may not come to our facility. They may want them to come to the building, to their clinic.

RIEPE: But my opinion is, if they choose to stay with their private physician, God love them for it, it's their obligation to get there and get home. Again, I don't think they should be able to pass that burden on to you as the provider and run up your costs, but that's my personal--

LOIS JORDAN: I wish it could be that way--

RIEPE: [INAUDIBLE] administrator--

LOIS JORDAN: --but, you know, we're obligated to get them to the position of their choice.

RIEPE: You're obligated because you want to be.

LOIS JORDAN: No, because we're dictated to.

RIEPE: Pardon?

LOIS JORDAN: We're dictated to. We have to. We can't force them to change to a different physician.

RIEPE: Only because they're Medicaid?

LOIS JORDAN: No, because CMS tells us we can't force them to change a physician.

RIEPE: Federal government. OK. Thank you.

LOIS JORDAN: All right, thank you.

HANSEN: Any other questions from the committee? You good, Senator Ballard?

BALLARD: I'm good.

HANSEN: All right. OK, thank you for your testimony. Is there anybody else wishing to testify in support of LB353? Is there anybody wishing to testify in opposition to LB353? Is there anybody wishing to testify in a neutral capacity? Seeing none, we'll welcome Senator Raybould up to close. I was so glad I made it back. I had so--

RAYBOULD: Oh, I am--

HANSEN: --many questions for you.

RAYBOULD: I am thrilled to see you, Senator Hansen. So I think at the beginning of my testimony, we established that there-- right now, this snapshot in time, we have 182 patients that need to be transferred out of the hospitals and into additional facilities. And Senator Ballard, you had a great question. So how, how could we leverage this funding? So I think we, we know that there's a little more than 200 nursing homes. If 100 of those nursing homes took us up on this grant program-- and hopefully they modify their facilities and say they could add two more beds, that would be 200 beds that would take care of the 182 that are currently waiting in the hospital and racking up costs. And I know that the question-- I think, Senator Riepe, you had asked about the vans. But this funding can go to those vehicles that will help transport those individuals, particularly the bariatric patients that need a larger vehicle. But-- and I know you had a question about ADA. I, I just know that when you have the electric lifts, they're a little bit bigger. They can fill-- fit inside an ADA-compliant door, but they're still big and if you have a larger patient. And since I'm in the grocery business and we have forklifts, can you imagine, you know, for a larger patient, you will need to have some type of mass that will be able to balance that weight and load to be able to transport in or transfer that person safely? You had a great question about the Governor's budget. Is it in the Governor's budget? And my answer was, I don't know and I still don't know. But I wanted to say that we have that capability. We have General Funds that we could put it in. We have what could be one of the most historic surplus of, of funding to go towards the seniors or the most vulnerable patients that are our obligation to take care of. So there's multiple avenues besides the Governor's budget. We as legislators have the funding authority as well, how we spend our dollars and I can't think of a better way, like I've said before, about economic reinvestment in, in our healthcare, as well as taking care of those in our community.

RIEPE: OK, thank you.

RAYBOULD: You're welcome.

HANSEN: Thank you. Are there any other questions from the committee? I have one.

RAYBOULD: Yes, sir.

HANSEN: Is there any other funds you've looked at to pay for this besides General Fund, Cash Funds or any other kind of-- I'm just kind of curious.

RAYBOULD: I have not. Is there other funds I could look at?

HANSEN: There's a whole bunch of--

RAYBOULD: Like--

HANSEN: But of course, if you touch them, you're going to have 80 people coming after you.

RAYBOULD: OK.

HANSEN: But I don't know.

RAYBOULD: I just thought because we have a tremendous surplus, but if there's other funds, I would be more than happy to go after them.

RIEPE: Isn't there healthcare funds?

HANSEN: There's a Health Care Cash Fund, but when you touch that--

M. CAVANAUGH: Hey, woah.

HANSEN: --if you touch that-- Senator Howard, I think personally [INAUDIBLE]--

RIEPE: Everything is up for grabs.

RAYBOULD: So that's a no probably, but if there are other funds that--

HANSEN: If that's how bold you want to be. I don't know.

RAYBOULD: I would be-- I would love to chat with you about other funds and their availability. Since I'm new to this, I'm not sure what other funds I could tap into, but I'm all ears.

HANSEN: I think that takes some-- I, I was just kind of curious if you'd look at anything, so. OK--

RAYBOULD: OK.

HANSEN: --seeing no other questions, thank you very much.

RAYBOULD: Thank you all very much.

HANSEN: All right. And for the record, there were four letters in support, one in opposition and two neutral to LB353. So with that, that will close our hearing on LB353 and our hearing for this afternoon.