[LB513 AGENCY 25]

The Committee on Appropriations met at 1:30 p.m. on Monday, March 13, 2017, in Room 1524 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on the budget for Agency 25 and LB513. Senators present: John Stinner, Chairperson; Kate Bolz, Vice Chairperson; Rob Clements; Robert Hilkemann; John Kuehn; Mike McDonnell; Tony Vargas; Dan Watermeier; and Anna Wishart. Senators absent: None.

SENATOR STINNER: (Recorder malfunction)...Appropriations Committee hearing. My name is John Stinner and I'm from Gering and represent the 48th District. I serve as Chairman of this committee. And I'd like to start off by having members do self-introductions, starting with Senator Clements.

SENATOR CLEMENTS: I'm Rob Clements from Elmwood, District 2.

SENATOR McDONNELL: Mike McDonnell, LD5, south Omaha.

SENATOR HILKEMANN: Robert Hilkemann, District 4, west Omaha.

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

SENATOR BOLZ: Senator Kate Bolz. I represent District 29 in south-central Lincoln.

SENATOR VARGAS: Senator Tony Vargas, representing District 7 in downtown and south Omaha.

SENATOR STINNER: I believe Senator Kuehn and Senator Watermeier are in a meeting. They'll be joining us shortly. And Senator Wishart is missing in action. I also want to introduce our committee clerk, Jennifer Svehla. She is to my far left. And I'm flanked by my two favorite fiscal analysts, Liz Hruska and Sandy Sostad. At each entrance you'll find green testifier sheets. If you are planning on testifying today, please fill out a green sign-in sheet and hand it to the committee clerk when you come up to testify. If you will not be testifying at the microphone but want to go

on record as having a position on a bill being heard today, there is white sign-in sheets at each entrance, where you will leave your name and other pertinent information. These sign-in sheets will become exhibits in the permanent record at the end of today's hearing. To better facilitate today's proceedings, I ask that you abide by the following procedures. Please silence or turn off your cell phone. Move to the reserve chairs when you are ready to testify. Order of testimony will be introducer, proponents, opponents, neutral, and closing. When we hear testimony regarding agencies, we will first hear from the representative of the agency. We will then hear testimony from anybody who wishes to speak on the agency's budget request. When you come up to testify spell your first name and last name for the record before you testify. Be concise. And it is my request to limit your testimony. I'm going to try five minutes but we may have to pull it back to three just to get everybody through. Written materials may be distributed to committee members as exhibits only while testimony is being offered. Hand them to the page for distribution to the committee and staff when you come up to testify. We need 12 copies. If you have written testimony but do not have 12 copies, please raise your hand now so the page can make copies for you. With that, we will begin today's hearing with Agency 25, Department of Health and Human Services. Good afternoon. [AGENCY 25]

(AGENCY BUDGET HEARING)

COURTNEY PHILLIPS: (Exhibit 1) Good afternoon, Chairman Stinner, members of the Appropriations Committee. For the record, I'm Courtney Phillips, C-o-u-r-t-n-e-y, Phillips, P-h-i-l-l-i-p-s, and I serve as the chief executive officer for the Department of Health and Human Services. I am joined today by several division directors: Calder Lynch with the Division of Medicaid and Long-Term Care; Dr. Tom Williams, director of Public Health and Chief Medical Officer; and John Hilgert, director of the Division of Veterans' Homes. The other directors--Director Dawson, Miller, and Weinberg--will come before you tomorrow and testify. The team at the Department of Health and Human Services is guided by our mission of helping people live better lives. This, together with our values and core competencies, is the foundation for the culture that is transforming DHHS. Through new process improvement techniques, hard work, and dedication to succeed, we're seeing significant advances in providing Nebraskans with responsive, high-quality, and efficient services they deserve. Last year we developed our first ever business plan outlining 25 agency priority initiatives that include strategic actions and

measurable outcomes. You will hear more about these from each division director. We have been working with Governor Ricketts since early last summer as he sought input on budget priorities in light of the current shortfall in tax revenues. We understand our programs and services have a direct and meaningful impact on Nebraskans and we value the opportunity to be directly involved in the process. The department conducted a review of services and programs and identified both strategic increases necessary to meet critical services as well as strategic reductions in response to the budget gap that we believe will have the least impact to direct client care, service capacity, and recipient services. Decisions regarding reductions are never easy but are necessary for the state to meet its financial responsibilities. The Department of Health and Human Services' fiscal year 2017 original base appropriations was $3.696 billion total funds, which of $1.63 billion are state General Funds. The Governor's biennium budget recommendations consist of strategic reductions and necessary increases that result in a total base appropriation of $3.598 billion for fiscal year 2018, of which $1.6 billion are state General Funds. The total fund net decrease is 2.66 percent, and the General Fund net decrease is 1.93 percent. The total fund base appropriation for fiscal year '19 is $3.6 billion, of which $1.625 billion are state General Funds. Therefore, the total fund net decrease for fiscal year '19 from the '17 base is 1.51 percent and the General Fund net decrease is .6 percent. The Governor's budget recommendations identified by DHHS as modifications include $61.6 million in strategic General Fund reductions and $100.5 million total funds in fiscal year '18 and $61.8 million of General Fund reductions in '19. These recommendations achieve savings in administrative areas through efficiencies, shifts in General Fund spending to other funding sources, and alignment of our budget to historic and forecast expenditures. Also included are savings through rate reductions, program modifications, and eliminations. As part of the iterative process this past summer, the agency, together with the Governor, identified the Governor's recommendations: General Fund increases of $30.1 million in fiscal year '18 and $52 million in fiscal year '19. The increases include the need to implement federal regulations, the opportunity to maximize federal funding, and to address growth in program utilization, capacity, or costs. These recommendations reflect the realities of the current economic situation and enable us to implement operational efficiencies throughout the department and to redirect resources where necessary. Our commitment remains to deliver on our mission of helping people live better lives. The recommendations build on the Governor's priorities of creating a more-effective, a more-efficient, and a more customer-focused state government. In light of the most recent Economic

Forecasting report, the Department of Health and Human Services supports and is fully prepared to implement in full the lower of the two, whether it's the Governor's budget recommendations or the committee's recommendations as contained in the preliminary report. I want to thank you, your staff, particularly Sandy and Liz, as well as all members of the team, the Department of DHHS that have contributed to put this together. The directors will follow regarding the work of their divisions. And now I'm happy to answer any specific questions you may have. [AGENCY 25]

SENATOR STINNER: Thank you. Questions? Senator Bolz. [AGENCY 25]

SENATOR BOLZ: Good afternoon. [AGENCY 25]

COURTNEY PHILLIPS: Good afternoon. [AGENCY 25]

SENATOR BOLZ: I want to take a step back and ask kind of a big-picture question, not about any specific rates for any specific service or provider but a question about, as CEO, what are the principles or factors that we should be taking into consideration as we set rates for different providers of different services. Just sort of give me your philosophy about how we fairly set rates. [AGENCY 25]

COURTNEY PHILLIPS: And so what we've looked at across the department as we started the budget process overall in terms of looking at where we spend our dollars, where we had over/underutilization of those dollars, looking at where we had, in terms of access and those types of things. And so as we look at rates across the department, not just within Medicaid but the other divisions as well, looking at equity across the department, looking at where we pay in across in terms of other states and their rates, what does it look like in terms of private sector versus state government. And so those are all things that we look at as we put forward some of the rate recommendations that you saw in the Governor's submission. [AGENCY 25]

SENATOR BOLZ: So just so I've caught that, equity across states was one of the first things you said and the other...? [AGENCY 25]

COURTNEY PHILLIPS: What we did was we look at other state rates as well, particularly as it relates to the Medicaid rates. [AGENCY 25]

SENATOR BOLZ: I'm sorry. I just couldn't quite keep up with your list. You said equity across other states... [AGENCY 25]

COURTNEY PHILLIPS: So things that we look at is in terms of what rates do we have across multiple areas in the department. So, for instance, if we have rates that are in the Medicaid program, if we have rates that are in the behavioral health programs, children and family services, sometimes we have providers that are providing services across multiple spectrums, particularly on the DD side, Medicaid side, those sorts of things. So that's one thing that we look at. we also look at where do we fare across other states, primarily states that are surrounding us, as well. [AGENCY 25]

SENATOR BOLZ: Uh-huh. So... [AGENCY 25]

COURTNEY PHILLIPS: And then at particularly access, what does it look like, and also historically what have our rates looked like across from multiple years in our state. [AGENCY 25]

SENATOR BOLZ: Okay. That's helpful. And then a related question is, do you have any thoughts or ideas about how we think about setting fair rates moving forward? And I'll ask it this way. You know that my greatest familiarity is with the developmental disability system and their processes in place to rebase those rates. [AGENCY 25]

COURTNEY PHILLIPS: Uh-huh. [AGENCY 25]

SENATOR BOLZ: So is that something we should be doing across service provider systems? Do you have any plans to do those in other systems? Is that even something we should be thinking about? I think we struggle as Appropriations Committee members sometimes in figuring out what the right choices are with provider rates across a fairly complex system. [AGENCY 25]

COURTNEY PHILLIPS: Yes, I do think, you know, that's one of the things that we have to look at is making sure our rates are based off of sound information and data that's collected, particularly as we move forward in the Medicaid realm in looking at rates that are actuarially based and set. You see we're doing the same thing on the developmental disability side and we're working with our federal partners in terms of that in looking at our rate methodology that is based on sound information. Behavioral health has actually taken on some of their rates and really looking at digging in on how the rate was developed and what's an appropriate rate. So that is something that we're looking at across the department. [AGENCY 25]

SENATOR BOLZ: Okay. That's helpful. Thank you. [AGENCY 25]

SENATOR STINNER: Additional questions? I have a couple... [AGENCY 25]

COURTNEY PHILLIPS: Okay. [AGENCY 25]

SENATOR STINNER: ...that I've just kind of circled and these are modifications that were suggested in your report. This eliminate medical needy group, tell me what that's about and how you came about that cut. [AGENCY 25]

COURTNEY PHILLIPS: So is that the...in the Medicaid, you're looking at some of the original Medicaid? [AGENCY 25]

SENATOR STINNER: I believe it is. [AGENCY 25]

COURTNEY PHILLIPS: Yeah. So one of the things we did as we went through the overall budget and started putting forward some of the reductions on the table when putting together our budget, we looked at what was some of the elements that we would reduce that would have the lesser impact in terms of the population that we serve overall. [AGENCY 25]

SENATOR STINNER: So the needy...what is the medically needy group? [AGENCY 25]

COURTNEY PHILLIPS: Are you talking about the Medicaid medically needy or the state disability? [AGENCY 25]

SENATOR STINNER: This is aid. [AGENCY 25]

COURTNEY PHILLIPS: Aid. [AGENCY 25]

SENATOR STINNER: Under aid, not operations. [AGENCY 25]

COURTNEY PHILLIPS: Well, I'll get you the information in terms of the percent category of what the eligibility criteria is for that particular group, Senator. [AGENCY 25]

SENATOR STINNER: Okay. I was going to ask you about these eliminated programs: eliminate optional parent/caretaker relatives was a $44 million. I mean we're eliminating programs, right? And you considered those low...these were aid to programs that came through apparently Medicaid? [AGENCY 25]

COURTNEY PHILLIPS: So these were some that we put on the original...our original... [AGENCY 25]

SENATOR STINNER: And if it's more appropriate that I ask Calder, (inaudible). [AGENCY 25]

COURTNEY PHILLIPS: Yeah, and you can go into detail with Calder. But as we developed our overall budget in terms of meeting that particular threshold, and so we did a particular ranking in terms of priority listing, and those didn't move forward in that recommendation. [AGENCY 25]

SENATOR STINNER: Okay. Okay, I'll wait till I can ask Calder. Any additional questions? Senator Wishart. [AGENCY 25]

SENATOR WISHART: Well, thank you so much for being here today, Director. I wanted to talk a little bit to the budget unit consolidation portion of the recommendations, and you've outlined it to us in the testimony, in the handout that you gave us. You had talked about potentially one of

the differences that we did not in our budget recommend, a merger of Medicaid and the CHIP program. And I can't recall, and I'll have to look it up, how much you had projected in savings. I was just wondering, with that merger, how did you come up to the projected savings dollars? What was the process for coming up with that number? [AGENCY 25]

COURTNEY PHILLIPS: Are you referring to the merging of the two programs? [AGENCY 25]

SENATOR WISHART: Yes. [AGENCY 25]

COURTNEY PHILLIPS: We didn't have a savings for that particular merger. [AGENCY 25]

SENATOR WISHART: I...oh, okay. So what was the... [AGENCY 25]

COURTNEY PHILLIPS: It was combining our reporting capabilities in terms of the two programs within Medicaid. [AGENCY 25]

SENATOR WISHART: Oh, okay. Okay. Thank you. [AGENCY 25]

SENATOR STINNER: Additional questions? Seeing none, thank you. [AGENCY 25]

COURTNEY PHILLIPS: Okay. And I'll still be here. [AGENCY 25]

SENATOR STINNER: Okay. [AGENCY 25]

COURTNEY PHILLIPS: So next we'll move to Director Hilgert with the Veterans' Homes. [AGENCY 25]

SENATOR STINNER: We...I'll reserve the option to have you come back up... [AGENCY 25]

COURTNEY PHILLIPS: Okay. [AGENCY 25]

SENATOR STINNER: ...at some point and maybe explain some other things if you need to. [AGENCY 25]

COURTNEY PHILLIPS: Absolutely. Thank you. [AGENCY 25]

JOHN HILGERT: (Exhibit 1) Good afternoon, Senator Stinner, members of the Appropriations Committee. For the record, my name is John Hilgert, J-o-h-n H-i-l-g-e-r-t. I'm the director of the Department of Health and Human Services' Division of Veterans' Homes, as well as the agency director of the Nebraska Department of Veterans' Affairs. The Division of Veterans' Homes includes the four state veterans' homes in Grand Island, Norfolk, Scottsbluff, and Bellevue which provide assisted living and skilled nursing care to 471 of our nation's heroes and spouses. The construction of the Central Nebraska Veterans Home is well underway. The projected opening is the fall of 2018. We are drawing down funds from the United States Department of Veterans Affairs' State Veterans Home Construction Program to the tune of nearly $20 million. We continue to try innovative ways to address our staffing needs. We have set up our own training opportunities in each of the four communities in which we're located. Each approach is slightly different but each shares the common goal of educating a motivated work force to take care of America's heroes. The Governor's budget recommendation includes General Fund reductions of approximately $2.7 million of General Funds for the Division of Veterans' Homes by shifting funding to federal and cash resources for staffing, training, transportation contracts, and savings realized from the new pharmacy software and medication dispensing machines. We will be accessing the funds identified in the Kearney proposal for staffing, transportation costs. The department has conducted a thorough review of the programs and services, identified both strategic increases necessary to meet our needs and strategic reductions in response to the budget gap that we believe will have the least impact on direct client care, service capacity, and recipient services. The budget proposed by Governor Ricketts reflects the realities of the current economic situation and enables us to implement operational efficiencies through the department and to redirect resources where necessary. It is intended to continue strategic and priority services in our commitment to our mission to help folks live better lives. The recommendations build on the Governor's priorities of creating a more efficient, effective, and customer-focused state government. And the Division of Veterans' Homes supports and is fully prepared to implement the Governor's budget recommendations. I would like to thank you and your staff for your work

on behalf of the department. I will now address any...I will address our requests that are included in your preliminary recommendation unless you have further additional questions for me. Regarding the merger, LB340 has been introduced on behalf of Governor Ricketts and transfers the Department of Health and Human Services Division of Veterans' Homes to the Department of Veterans' Affairs. This merger would bring together, under one roof, if you will, the state services provided specifically to Nebraska veterans and it will provide consistency and contribute to a more efficient, effective, and customer-focused state government. Just for the record, our department supports LB340 and urges our support...your support for that recommendation and would observe that if it was passed, LB340 would be able to take advantage of $1.6 million in savings, as identified in the department's fiscal note. Any questions or...? [AGENCY 25]

SENATOR STINNER: Questions? Senator Bolz. [AGENCY 25]

SENATOR BOLZ: LB340 wasn't referred to Appropriations. I can't recall. Was it referred to HHS or was it referred to Government? [AGENCY 25]

JOHN HILGERT: It's referred to the Government, Military and Veterans Affairs Committee, but it does realize a $1.6 million in General Fund savings so I thought I would bring it up. [AGENCY 25]

SENATOR BOLZ: Sure. And that was my question. I haven't had a chance to review that fiscal note. Could you walk this committee through that fiscal note, please? [AGENCY 25]

JOHN HILGERT: The fiscal note, basically what it does is it takes the Division of Veterans' Homes that currently exists, which are operational folks that work in the four facilities, and transfers those over to the Nebraska Department of Veterans' Affairs. It also takes about 37 operational folks that are located within...that are open positions that are located within Lincoln and also many of the operational folks within our facilities: human resources, IT, support services, and some other financial services. Those are the 37 administrative positions that aren't in the division that will transfer over. When those positions transfer over, if LB340 is passed, along with the staff that provide the operational capability of the division, that 37 is currently

paid for with all General Funds. When they're transferred over we plan to pay for the 37 with our current fund mix which will allow an increase in utilization of cash and federal funds and reduce the amount of funds that we use for General Funds. So...and that number is $1.6 million. So it would save $1.6 million of General Funds. It's a simple bill. That's essentially what it does. [AGENCY 25]

SENATOR BOLZ: I appreciate that. And I'll review the fiscal note in... [AGENCY 25]

JOHN HILGERT: Thank you. [AGENCY 25]

SENATOR BOLZ: ...some additional detail. It would be helpful, if it's not explicitly included in the fiscal note, just to see the list of those 37 positions so that we can have a better understanding of how the two agencies will come together. [AGENCY 25]

JOHN HILGERT: Okay. I'll look into that, make sure that the...we get you that list, certainly. [AGENCY 25]

SENATOR STINNER: Thank you. Additional questions? Seeing none, thank you. [AGENCY 25]

JOHN HILGERT: Thank you. Oh, by your leave, Senator,... [AGENCY 25]

SENATOR STINNER: Yes. [AGENCY 25]

JOHN HILGERT: ...I did omit one part of my testimony and I beg your indulgence. There was a committee recommendation and as our director, Courtney Phillips, said, we are willing to take the lower of the two. We had in our modification proposed a 1.6 reduction and we are able to sustain that and would request that 1.6 be taken. [AGENCY 25]

SENATOR STINNER: Okay. [AGENCY 25]

JOHN HILGERT: Thank you for your indulgence. [AGENCY 25]

SENATOR STINNER: Thank you very much. [AGENCY 25]

JOHN HILGERT: Thank you. [AGENCY 25]

SENATOR STINNER: Good afternoon. [AGENCY 25]

CALDER LYNCH: (Exhibit 1) Good afternoon, Chairman Stinner, members of the Appropriations Committee. My name is Calder Lynch, C-a-l-d-e-r L-y-n-c-h, and I'm the director of the Division of Medicaid and Long-Term Care in the Department of Health and Human Services. I want to begin my testimony by thanking Chairman Stinner, the members of the committee and your staff for the collaborative conversations that have brought us to this point. Obviously, we collectively have many difficult decisions to make on behalf of Nebraska's taxpayers and the people we serve, and I appreciate the dialogue that has occurred. As the state's Medicaid director, I have responsibility for a significant share of our state's finite resources, and this is a responsibility that I and my team take very seriously. I would like to begin my testimony by highlighting some of the efforts that we've been working on to modernize our programs to enable more effective management and cost control within the Medicaid program. Over the past 20 years, the method of delivery for Medicaid in the state has moved gradually from fee-for-service to capitated managed care. Last year we awarded contracts to three qualified managed care organizations, or MCOs, to administer Heritage Health, a program which integrates physical health, behavioral health, and pharmacy services for nearly all Nebraska Medicaid enrollees. The program began operations on January 1 of this year. Having one health plan responsible for a more complete range of services encourages investment in more cost-effective services to better address the healthcare needs of the whole person. Heritage Health is already delivering value to Nebraska, as reflected in the low overall forecasted growth in utilization and the additional $6.1 million in General Funds in savings that are in the budget, proposed budget, related to reducing costly and avoidable care through better coordination in the coming fiscal year. Shifting services into a more manged environment means better cost control and greater budget predictability. With the implementation of Heritage Health, the Medicaid-eligible population remaining in the unmanaged fee-for-service delivery system will constitute less than 2 percent of the overall population. Later this year we'll take another step toward that goal by implementing a managed dental services program. And finally, last week we released our draft plan for the redesign of

long-term supports and services in Nebraska, which includes the proposed eventual shift toward a managed long-term supports and services system, often referred to as MLTSS. MLTSS services account for...or, sorry, LTSS services account for $818.2 million in annual spending in fiscal year 2016. While the folks who receive those services make up less than a quarter of our enrollees, they consume nearly 66 percent of our total spending. As our population continues to age, it is imperative that we create a complete and well-coordinated delivery system for long-term care that is sustainable and helps people live as independently as possible for as long as possible. Over the next few weeks we'll be traveling the state and meeting with consumers, advocates, and providers to hear their feedback on this plan before it's finalized this summer. Finally, I'll note that significant work is underway to modernize the systems that support our programs to better leverage technology and data to drive better decisions and program outcomes. This includes both the replacement of our eligibility enrollment system and the modular replacement of our Medicaid Management Information System, or MMIS. This has resulted in a focused effort of procuring a data management and analytics platform that will improve data quality, enhance fraud detection capabilities, and increase access to timely data, while enhancing capabilities to ensure quality, medically necessary, and cost-effective services are being provided to our clients. Together, Nebraska's model for a modular and services-based approach is expected to cost as much as 50 percent less than a traditional MMIS replacement solution. Governor Ricketts proposed a responsible budget for the Medicaid program. The MLTC current fiscal year appropriation is $2.29 billion of which $881 million is compromised (sic--comprised) of state General Funds. The Governor's budget recommendation totals nearly $2.2 billion for fiscal year '18, of which $866 million are General Funds. This represents just over half of the total General Fund request for DHHS. The total fund net decrease is negative 4.75 percent, however, that's largely driven by a proposed elimination of excess federal funds of $100 million. The recommended budget declines in terms of General Funds at 1.65 percent decrease. In fiscal year 2019 there is a modest proposed increase of 1.74 percent over the recommended FY '18 budget. This is significant and highlights the efforts we have taken to constrain spending when you compare this to the national picture. According to the Kaiser Family Foundation's annual Medicaid budget survey, the median Medicaid spending growth rate was 3.9 percent in nonexpansion states in fiscal year 2016 and is projected to be 4 percent in fiscal year 2017. Like Nebraska, enrollment growth among nonexpansion states has also been relatively flat, with median national enrollment growth pegged at 1.6 percent in FY '16 and forecasted to be 1.2

percent in FY 17. In Nebraska, we experienced a year-over-year enrollment decline of negative 1.1 percent in FY '16. That has ticked up in recent months, where we have seen an increase of 1.7 percent in enrollment through January of the current fiscal year. The largest driver of growth in the budget is related to the anticipated growth and enrollment costs that totals nearly $17.2 million in fiscal year '18 and nearly $35 million in fiscal year '19 across the Medicaid aid budgets in General Funds. This modest forecasted growth is based on an analysis of historic trends as well as forecasted program changes. The expected increase in costs is offset by a number of budget modifications recommended by the Governor across the Medicaid budget, which totals $35 million General Funds. The Medicaid budget recommendation, as proposed by the Governor, also included the consolidation of several budget units to ease administrative burdens on management of the program. I support the Governor's budget recommendation as the prudent course forward given the current revenue forecast. These recommendations reflect the realities of the current economic situation and enable us to better operationalize efficiencies and to redirect resources where necessary. Our commitment remains to deliver on our mission of helping people live better lives. The recommendations build on the Governor's priorities of creating a more effective, more efficient, and customer-focused state government. In light of the most recent Economic Forecasting report, DHHS supports and is fully prepared to implement the Governor's budget recommendations. I want to thank the committee for retaining many of the Governor's recommendations, including the merger of two administrative budgets and inclusion of funding for forecasted utilization increases and federally mandated projects. The committee also retained many important budget modifications necessary to hit our spending targets. With that said, I want to highlight some specific differences between the Governor's budget recommendations and the committee's preliminary recommendation that we believe warrant further review. The Governor's budget recommended an average provider rate reduction of 3 percent. This amounts to $24.2 million in General Fund savings. The committee's recommendation significantly constrains the magnitude of these reductions and even includes rate increases for some providers resulting in $13.6 million in additional costs in FY '18 and $15.4 million in FY '19 over the Governor's recommended budget. I would also note that the committee recommended rate increases for providers of developmental disability waivers services while holding rates steady for aged and disabled waiver providers. As these services can be similar and often provided by the same individuals, we would strongly encourage parity with regard to the approach of these rates. While reducing reimbursement rates is a difficult decision,

Medicaid has maintained a commitment to working with provider groups to develop an implementation strategy that preserves access to services and sustainability for providers. Nebraska has been very fortunate to offer Medicaid provider rate increases in 10 of the last 11 fiscal years. As we have reviewed our rates in comparison to other states in which comparable data is available, we believe our rates will allow us to maintain access to services with the recommended 3 percent average reduction. In addition, the committee did not include in its preliminary recommendation a proposed reduction in the annual dental benefit cap for adults from $1,000 to $500. Dental benefits for adults is an optional benefit under federal regulations. The reduction in the annual dental cap will allow us to retain the benefit while saving over $1 million annually in General Funds. Adults accessing dental benefits represent less than one-tenth of 1 percent of the total Medicaid population, and of the adults who use the Medicaid dental benefit, only a quarter of them utilize more than $500 in services annually. The Governor's budget recommendation also included savings from the implementation of a fiscal agent for home care services. This effort would employ a fiscal intermediary to manage claims payments for home and community-based services resulting in opportunities for cost savings. A fiscal agent for home care could reduce aid costs by detecting and avoiding, potentially, fraud, waste, and abuse. Recognizing that time is necessary to procure and award a contract and conduct the necessary systems changes to the implementation, the Governor's recommendation only included a half year of savings in FY '18. The committee preliminary recommendation took a full year of savings. This will not be practical and we urge the committee to adopt the Governor's recommended approach and restore $820,000 in General Funds to the budget for fiscal year '18 only. The department supports the $1.6 million reduction in FY '19. The committee did not include a recommendation to merge the Medicaid aid budgets, which are currently divided between the Children's Health Insurance Program, or CHIP, and regular Medicaid. I understand that this has generated some questions and concerns, which I hope to allay today. Medicaid and CHIP are both entitlement aid programs that operate using the same delivery system, benefit package, and regulations. By combining these programs we are increasing the flexibility for matching state aid as needed when enrollment or utilization shifts occur. CMS, legislative, and agency reporting requirements will continue to be met as CHIP activity will continue to be tracked in a separate budget program. This in no way impacts the services provided under either program or enables us to somehow not meet our obligations to either CHIP or Medicaid. It also does not generate any savings. This merger will also better prepare us for future federal changes

in the structure of these aid programs, which are likely to look different than they do today. We also note that the committee did not include a $76,000 General Fund reduction recommended by the Governor related to rural health clinic payments. I would only note that this modification was the result of discovering that our payment practices were not in line with our regulations which specify that RHCs are reimbursed the lesser of the Medicare rate or bill charges. Our systems have already been corrected and these savings are being achieved. The department supports the reduction as recommended by the Governor. Thank you for your consideration of these items and I'm happy to answer any questions you may have. [AGENCY 25]

SENATOR STINNER: Thank you. Questions? Senator Bolz. [AGENCY 25]

SENATOR BOLZ: Good afternoon, Director Lynch. So Heritage Health green-lighted January 1, correct? [AGENCY 25]

CALDER LYNCH: That's correct. [AGENCY 25]

SENATOR BOLZ: So while there's projected savings of $13 million into the future, we've only got two months' worth of data in the bank. So how's it going so far in terms of creating those savings? [AGENCY 25]

CALDER LYNCH: Thank you, Senator. I would say that, you know, it is very early into the program and so the data that we're using to develop rates we're still using off of fiscal years '15 and '16. So none of the actual experience from the first two months will be utilized in terms of rate setting for some time because it takes a while for that to normalize out. We're currently in the process of finalizing our rate adjustments for the next rating period, which begins on July 1, and the preliminary analysis by our actuaries is that there will be actually about a 1 percent decrease in the capitation rates through the plans based on utilization in FY '16 that was lower than FY '15. So in general, when you think of managed care including both the previous program and Heritage Health, I believe it is achieving its goals of helping us constrain spending growth and we expect to continue to see that as we deploy new tools, like the advanced analytics that our actuary is working with us on determining the rates of potentially preventable episodes of care and looking at targeting some further reductions in those with the plans by looking at hospital

readmissions and other unnecessary episodes of care that result from maybe poor coordination. So there's a couple of different elements at play there. In general, in terms of operations, I think the implementation has gone well. We know that for some providers we have certainly increased the administrative complexities, specifically with regard to our behavioral health providers, going from having just Magellan to having three plans to work with. And we're working with them on, you know, a daily to weekly basis to address issues that are arising. We know there are some providers out there who are struggling a little bit with some of the new claims processes, so we're working with them to make sure that that's being addressed timely, the plans are providing cash advances when necessary to ensure cash flow. But overall, I think when we look across the board at how quickly we started being able to pay claims, how quickly we were able to get folks enrolled and get into care management, I think we've seen some really positive success. [AGENCY 25]

SENATOR BOLZ: It's good to hear that we're optimistic. So what I'm hearing you say and I realize this is very oversimplified given the sophistication that's in managed care, but the combination of utilization and the capitation, keeping capitation down, leads to your actuaries to do an analysis that leads you to these dollars. [AGENCY 25]

CALDER LYNCH: Uh-huh. [AGENCY 25]

SENATOR BOLZ: I appreciate that, though this committee, that's all prospective. [AGENCY 25]

CALDER LYNCH: Right. [AGENCY 25]

SENATOR BOLZ: And it's prospective for you as well. And so any information that the actuary has given you that you think might be of assistance to this committee in getting a comfort level with those numbers would be helpful for you to provide. [AGENCY 25]

CALDER LYNCH: Absolutely. Senator, we're hoping to try to update our forecast for the next fiscal year as we finalize the rates, so as we get that information finalized we'd be happy to share it. [AGENCY 25]

SENATOR BOLZ: That would be helpful. My next question is I am more familiar with the developmental disability waiver... [AGENCY 25]

CALDER LYNCH: Uh-huh. [AGENCY 25]

SENATOR BOLZ: ...than I am with the aged and disabled waiver, but my understanding is that they are pretty different, even though they may have some of the same services, that specifically services related to employment are pretty different. And so can you just help me understand your recommendation that we treat those two the same,... [AGENCY 25]

CALDER LYNCH: Uh-huh. [AGENCY 25]

SENATOR BOLZ: ...when my understanding is that there are some substantive differences? [AGENCY 25]

CALDER LYNCH: Thank you. There are some substantive differences between the two waivers, specifically when you consider some of the services that are covered, like in the AD waiver, provides for assisted-living services. But there are also many providers that do provide services across both waivers and those are predominantly the folks that are providing in-home assistance. Like the community-based and chore type of services, I think there's some similarities. And there are providers that enrolled across both programs. And so whenever we've approached the home and community-based waivers, in general, we've tried to do that or at least recently we've we're tried to do that in parity. We're trying to do that in administrative ways as well by bringing alignment between some of our quality oversight programs. And one of the recommendations that came out of the redesign report was to further streamline and better align the administrative management of those waivers. [AGENCY 25]

SENATOR BOLZ: Okay. My last question is just your recommendation related to the dental cap. [AGENCY 25]

CALDER LYNCH: Uh-huh. [AGENCY 25]

SENATOR BOLZ: Are there ever any exceptions to the dental cap? Can you allow an exception through regulation or statute? [AGENCY 25]

CALDER LYNCH: Yes. Thank you, Senator Bolz. We actually do, in some cases, provide for exceptions today when it's reviewed by our dental consultants. And we recognize that even with this policy there would need to be...continue to be exceptions, like, for example, when dentures you know are being provided. And so we fully recognize that and will work with both our staff and the dental benefit manager, once it implements, to have a process in place for that. [AGENCY 25]

SENATOR STINNER: Senator Wishart. [AGENCY 25]

SENATOR WISHART: Well, thank you so much for being here today. I wanted to speak as well to the dental benefit cap. One of my concerns with capping it at $500 is, while it's considered an optional benefit, there is a lot of preventative care that is important to our teeth and that actually affects some more serious chronic illnesses. And so one of my questions would be, when you're looking at the decisions that you're making, like for example with this cap, are you looking at the potential future costs that may be associated with not providing the preventative care up-front? [AGENCY 25]

CALDER LYNCH: Thank you, Senator. I think that's a great question. We're very lucky in Nebraska to have an adult dental benefit. Many states do not at all. [AGENCY 25]

SENATOR WISHART: Yes. [AGENCY 25]

CALDER LYNCH: And so we, as we looked at the recommendations and trying to reach our budget targets, felt that this would allow us to help get to that savings amount while still preserving the benefit and being able to still provide some of those preventative services. And as I noted, most of the folks accessing the benefit don't exceed that cap currently so it was a way for us to be able to preserve that and preserve access to those services without full elimination of the programs. That's how we viewed it. [AGENCY 25]

SENATOR WISHART: Okay. And then just expanding that question further, I'm a new senator and really trying to immerse myself in healthcare policy in the state, and so one of my question is just how much are we spending in terms of these dollars on prevention? What is the percentage of our Medicaid dollars that you would consider as going towards preventative care? [AGENCY 25]

CALDER LYNCH: Thank you, Senator. I have not run that analysis in that way. [AGENCY 25]

SENATOR WISHART: Okay. [AGENCY 25]

CALDER LYNCH: That is certainly something we can do. We'd have to sit down and kind of work with our clinical teams to sort of define what falls into that category of prevention. So I can do that and get back to you with some analysis there. [AGENCY 25]

SENATOR WISHART: Yeah. Thank you. [AGENCY 25]

CALDER LYNCH: Absolutely. [AGENCY 25]

SENATOR WISHART: That would be great. [AGENCY 25]

SENATOR STINNER: I have a couple questions. One of them that I think relates to what Senator Bolz was asking about, the managed care aspect of this,... [AGENCY 25]

CALDER LYNCH: Uh-huh. [AGENCY 25]

SENATOR STINNER: ...I, when I'm in the field, I try to get...when I'm in my off time I try to get back to the providers out there and they continue to complain or have a problem with the managed care people saying this is the template for this type of treatment. If you vary from that, you're just not going to get reimbursed. There's no flexibility. Timing of repayment was an issue. I think we've got that straightened out, possibly straightened out. As we bring more of these managed care folks in, where's the oversight? How do we ensure that people get the appropriate amount, because sometimes it's a mental health issue, sometimes it's a combination of several

things that need to happen to that person? So what...do you foresee oversight in this? Where's it coming from? And where's the qualitative side going to be located? [AGENCY 25]

CALDER LYNCH: Thank you, Chairman Stinner. That's a very good question and one that we could probably speak on for quite some time. I think that, you know, right now...first of all, I would say that Nebraska is lucky in that it has, more so than other states that have brought on large-scale program changes recently, quite an extensive history of managing managed care programs with, you know, our first contracts being signed in the mid-nineties, so about 20 years of experience in running a managed care program, which has allowed us to build up some capacity knowledge in our team that's been helpful as we've managed this transition. We still have a ways to go. We're working on reorganizing internally and creating teams to manage these contracts and not just have one person but actually have a team of individuals led by an administrative level individual to manage each of these contracts, make sure they're meeting our targets. I think our new contracts with the plans are much stronger. They have clear expectations with regard to their performance, timeliness of payments, quality outcomes, the things that we're measuring and tracking. I think we're being more transparent about that process. We've recently formed several different advisory groups that have been meeting on an ongoing basis leading up and then "postimplementation" looking specifically at things like our quality metrics that we're measuring them by, the administrative processes that the plans are using. Our administrative simplification committee is planning to tackle projects this year looking at exactly what you said, how to create more consistency between the plans. I can tell you we started some of that work before going live, specifically on the behavioral health side. We worked with the plans and with our providers to develop a common set of behavioral health service definitions that all the plans have agreed to use. And I think that's opened up some new access in that it allows some new provider types to expand the number of services than what they had previously been able to provide. But there's still some differences that we need to work through with regard to, for example, how long the plans are authorizing for community behavioral health services or residential services. So we're working with them right now to create a uniform set of time frames that if you're going to authorize, you know, 14 days or 90 days or depending on the service and try to create some uniformity between the plans. So as we're kind of working through those things, we're identifying and working with providers to prioritize what we want to tackle and create some consistency around. We're also...I will note that we're working to...with our external

quality review organization which is a third-party contractor that helps us sort of audit the plans' quality programs and make sure they're meeting all of the federal and state expectations. And we're also working to come into compliance with the final managed care regulation from the federal level, which will require that we begin doing public report carding of the health plans and their performance across a variety of different metrics, both operational and qualitywise. And since implementation, we've been publishing monthly reports on our Web site on things like operational metrics, their call center performance, their claims processing, claims processing time lines. And so we're making that...some of that information available for the first time as well. [AGENCY 25]

SENATOR STINNER: Well, that all sounds good. Do you have a board of appeals that these providers can go to, to say this is what I provided, this is the reason I do, I did this? And you know where does that board of appeals reside? [AGENCY 25]

CALDER LYNCH: Uh-hum. So each of the plans, first and foremost, as a first line has to have both a member and a provider grievance and appeal process in place, and that has to be reviewed and monitored by the state. And as part of that contract management team approach I described, there's anticipated to be one individual for each plan. That's kind of sole focus is managing that grievance and appeal and making sure that they're providing proper oversight of the plans, grievances, and appeals. Members can always appeal decisions up to the state fair hearing process. And so if a member, you know, for whatever reason, is denied a service, regarding the quality or duration of the service or timeliness of accessing a service and they file that appeal and they're unhappy with the health plan's decision, they can appeal that to the state for a hearing and the state is the final decision maker in those regards. Generally, the provider disputes are managed at the plan level, but we maintain an open line of communication with the providers through our Medicaid Assistance Advisory Committee, through those other different groups and meeting regularly with the various associations to get feedback. I can tell you that, you know, we've had a lot of conversations in just the last week or so working with many of the behavioral health folks, working through some of the issues, you know, recognizing that this is the biggest change for them and trying to manage and work with the plans to get some of those issues resolved. So we maintain those lines of communication directly with the state whenever they're not getting resolution with the plans. [AGENCY 25]

SENATOR STINNER: And I understand, I'm still trying to reconcile your numbers because I'm showing them off the Governor's recommendation by about $74 million right now, which $24 (million) I think resides in HHS, which would leave me $50 million. [AGENCY 25]

CALDER LYNCH: Uh-huh. [AGENCY 25]

SENATOR STINNER: So it's got to be something that we've done either in the provider rates or forgot to look at something and I'm trying to get somebody to provide me that information right now. But here's the deal on provider rates. [AGENCY 25]

CALDER LYNCH: Uh-huh. [AGENCY 25]

SENATOR STINNER: As I said, I spend a whole lot of time with nursing homes, with mental health providers, behavioral health providers, and all of them show what private pay is versus Medicaid. I talk to the nursing homes. They're losing $60-$80 a day by taking on Medicaid. In fact, I have one in Mitchell that right now is scratching their head, wondering how they're going to stay in business. And then you've turned around, as HHS, have investigated and said we can enforce a 3 percent reduction. How does that happen? Where do you come up with these numbers that said providers can take these types of hits? That's where we've drawn the line as a committee and said, uh-uh, we're not going to balance the budget over this deficit on the backs of providers who are independently providing access to healthcare. And cut them rates? I would say that there's a lot of them that haven't had increases over a long period of time. And obviously, formulas are in the way. You and I have had that discussion on nursing homes. We've put $8 million into it. Somehow those dollars didn't quite get out because of complexity. So that's the rub we have right now and that's where I have to reconcile as a committee person, as Chairman, to say let's be fair to the providers. Let's make sure we have access. Because, guess what, if they quit providing services, like dental has done out west, the only place that they can go right now is my federally qualified healthcare clinic to get service. That's the only place. And I actually went back and I spent time going through a month's worth of statements with them and it seemed like everybody that walked in had a high problem. I mean it was an over a $1,000 charge. So putting them back to $500 cost them, I think, $5,000-$6,000 a month, which is a big deal to them. So all of that has kind of weighed into the committee's kind of bowing their neck right

now saying, we're not going to allow the providers to take the big hit of this thing. Until you can provide me information that says we're fair to providers, that we are fair and equitable across the board, I don't see our committee backing up too far on it. [AGENCY 25]

CALDER LYNCH: Uh-huh. [AGENCY 25]

SENATOR STINNER: But that's where I'm putting it back on your shoulders to say...show us where we're wrong. That's what I'm asking today. And that might be a little over the top. [AGENCY 25]

CALDER LYNCH: No, no, I appreciate that, Senator. And I think it's absolutely the conversation that we need to be having. I mean these are obviously very difficult decisions to be made and we don't take them lightly and don't, you know, relish the opportunity to come and recommend rate reductions. You know, we're trying to put forward what we can as the most responsible plan to hit those budget targets that we've got to hit together. And I agree that I think that it does need to be a targeted approach. And what we've said from the beginning is that we want to sit down and work with the providers to figure out the best path forward. We don't have all the answers internally. We need to have that dialogue to hear from them. We've gotten some feedback about some ideas of how to approach this that could help us get to those savings numbers but may be a more palatable approach from the provider perspective, because at the end of the day we're both here to make sure that our members are getting access to the services that they need, and that's our collective mission and goal. And so we've been polling some of that information. I know we've started sharing some of that with the committee and we're going to continue to do that. I just recently on the hospital side shared some analysis with the association to get some feedback from them about how our rates compare to other states and, you know, make sure that we're looking at things correctly. And so as we vet some of those types of analysis, unfortunately, there's not a data set out there of comparable rate information across all states that's easy to plug into, but our team has been trying to pull in as much as they can access to do some of that analysis. There are some areas we look fairly favorable. Nebraska is one of a handful of states that elected to continue paying primary care at Medicare after the enhanced funding for that expired at the end of 2015, and we've continued to do that. And so our professional services, as a comparison to other states and as a percentage of Medicare, looks favorable. Our dental services

don't look as favorable when we compare that to other states. So I do think it varies and so we do need to look at, as we develop the implementation strategy for whatever the committee and the Governor together, you know, is finally appropriated, to put something together that works and that makes sense and that is going to preserve access. And that's been our commitment from the beginning. [AGENCY 25]

SENATOR STINNER: Well, this is important to the committee and so as fast as we can get that information... [AGENCY 25]

CALDER LYNCH: Absolutely. [AGENCY 25]

SENATOR STINNER: And this is what these hearings are about is to try to figure out the best way forward, the fairest and most equitable way forward. And right now I don't think you have a consensus in this committee that providers need to be cut. And so that's a lot about what we're looking at today and a lot about what these next two days are going to be about, is to take a look at the differences that we have versus maybe where the Governor's budget is at, try to reconcile the difference. I know about the numbers. I know what numbers I have to hit. But I'm absolutely adamant about making sure that we measure the outcomes of those cuts to the best we can. So anyhow, that's my speech for the day. I'm sorry. [AGENCY 25]

CALDER LYNCH: Thank you. [AGENCY 25]

SENATOR STINNER: Any other additional questions? Senator Bolz. [AGENCY 25]

SENATOR BOLZ: Thank you, Chairman. Appreciate those comments. And I have a couple of follow-ups. To get to a couple of specific rates, one of the things that CEO Phillips referenced as a factor when you're considering what appropriate rates are is the two things are history...the four things were quality, equity across states, equity across departments, access, and history. And so to start with nursing facilities, I have some information from the Nebraska Health Care Association that says that we are...we have the sixth lowest funding among the states that they have reported, which isn't a comprehensive list. And I know that historically during my time on the committee we have never adjusted nursing facility rates more than 3 percent. And so I guess

I'm just wondering how well you think we're doing in terms of providing fair rates to nursing facilities so that we can sustain access to care. [AGENCY 25]

CALDER LYNCH: Thank you, Senator. You're absolutely right in that it's something we've been having a lot of conversation with the association about. Certainly they brought forward some information and data that is helpful in working through these issues. And as what we've communicated and what we've been very open to as part as we move forward is to take a look at the methodology that's in place, that's in regulations, to see if it's continuing to serve us well. You know, we've seen declines in utilization and that's not necessarily a bad thing as we serve more folks in the community and we're able to provide more community-based options. But so when we look at total dollars that are going, you know, even with the rebasing that's occurring in the way the current methodology works is those dollars are honestly catching up in terms of total spending increases. And individual facilities are feeling different impacts from that, depending upon what their mix of members looks like. There's a couple of different factors at play, so there's utilization, there's the mix of individuals, we're seeing the folks that are residing in nursing facilities being at a higher acuity than ever before, as we're serving the folks that weren't at the high acuity in the community. So as our...and there's a new methodology that's coming out from the federal perspective that changes the resource utilization groups that kind of define those levels of acuity and set reimbursement, so that's going to impact facilities differently. And we also recognize that we've got a range of...our nursing facilities serve folks from a range from maybe a few percent of their total patient days are Medicaid to maybe 90 percent are Medicaid. And so the changes that happen in our rates can have disproportionate impacts on individual facilities, and currently our rate methodology doesn't take those differences into account. So as we move forward with the long-term care redesign project, I think that this has to be part of that conversation of looking at the rate methodology, of course within the context of our overall budget picture. [AGENCY 25]

SENATOR BOLZ: I appreciate that. I think specifically related to nursing facilities and those four factors referenced by CEO Phillips I worry about access,... [AGENCY 25]

CALDER LYNCH: Uh-huh. [AGENCY 25]

SENATOR BOLZ: ...because you're right, those rates have disproportionate impacts depending on the facility, particularly those facilities that have high Medicaid rates. And I know I'm not telling you anything you don't already know. But that's one of the reasons I think I feel so adamantly that we need to be fair in terms of Medicaid providers, particularly when we look at those that have the greatest fund mix of Medicaid. I want to ask you another question specifically about hospital rates. And you and I have had a written exchange about this issue and I'm afraid I still don't have clarity. [AGENCY 25]

CALDER LYNCH: Uh-huh. [AGENCY 25]

SENATOR BOLZ: So I'm just going to ask you a couple... [AGENCY 25]

CALDER LYNCH: Sure. [AGENCY 25]

SENATOR BOLZ: ...of questions today in this hearing. I guess, just to maybe ask it bluntly, I'm still unclear as to why we're hearing from the Hospital Association that they weren't paid the rates that we appropriated them to be paid during our last budget cycle and, yet, there were $7 million in unspent Medicaid funds returned to us through the deficit budget. I guess I just...I don't understand why the dollars that we appropriated to the hospitals weren't paid out to them and why they weren't paid out to them even when there were unspent Medicaid funds. If you could share on the mike some thoughts about that, I'd appreciate it. [AGENCY 25]

CALDER LYNCH: Absolutely. Thank you, Senator. Just...and I know we've had a lot of conversation about this issue but just so we're all working with the same set of facts, I think, you know, what occurred was obviously multiple years of effort to move to a new reimbursement methodology for our prospective payment system hospitals, which are our community-based hospitals, and excluding our critical access hospitals from the AP-DRG to the APR-DRG, which takes into better account some of the diagnoses that are common around Medicaid patients and is just...was an evolution of our reimbursement strategy as AP-DRG was no longer going to be supported by the company that produces the groupers for those rates. And in doing so, when that was first approached, and this was prior to me, back in 2014, the agreement at that time was that it would be in a budget-neutral way. So as they rebased the base rate, and the way DRG works is

there's a base rate and it's multiplied against a multiplier depending upon the patient's acuity level based on their diagnosis. And so that base rate matters a great deal because then it spills out into all the rates in terms of impact up or down. And so setting that base rate, you know, depending on what that new mix looks like when you model it against our existing patient mix, you know, there's modeling that has to be done to figure out what's the budget-neutral approach to that. And when we did that, it was based off a version of APR-DRG that was available at the time. I think it was version 34. And then by the time it was actually implemented, version 35 had come out. And in the regulations that we had promulgated in working closely with the Hospital Association, those regulations said that we would use whatever the most current weights were, you know, based on that was available in the most current version. So we actually implemented based on version 35 and those weights were different. And so the way that they actually impacted the mix of patients in Nebraska Medicaid resulted in an overall decrease in spending of about 6 percent across those hospitals. So it's not to say that, you know, there was a cut in the base rate. It's just that that base rate applied against those weights, against our patients, resulted in a 6 percent average decrease across those provider types. This was recognized kind of as this was implemented. Hospitals, you know, looking at it, I think it was maybe UNMC that first recognized the sort of the change in reimbursement and that was brought to our attention, brought to my attention after I got here. I know we worked with our consultants to do some modeling to kind of confirm the impact of that and we had been planning on implementing. Last summer, because of some technical issues of getting that loaded appropriately and in time and getting the proper regs in place, it wasn't. It was delayed to January. And then between then and January obviously the state's budget picture changed and with some of the revenue forecasts. So we made the decision to hold off on implementing that until we got clarity about where our budget was going to be in the forecast going forward. And the communication we've had with the Hospital Association have been very positive. We've had very good dialogue around this issue with their board and with many of their members. And the commitment has been is that the budget is finalized. As we get a clear forecast in the next year and continue to work forward that, you know, we'll work to rebase those rates as the budget allows but at this point didn't feel we were comfortable doing that. [AGENCY 25]

SENATOR BOLZ: So that's a lot of information to absorb, so just give me a second here. I guess what I...revisit for me, you said that the budget picture changed and then you waited to

implement those rates. That's where maybe there's some misunderstanding or misalignment. Would have implementing the change, would that have resulted in a cost increase in this session or would it have just gotten somewhere between what the dollars you had in the bank and where you were spending out at that point in time? [AGENCY 25]

CALDER LYNCH: So thank you, Senator. So up to that point, we were forecasting based on our current spend level, which since 2014 had been based on the revised rates, the lower rates. So to correct the issue would have increased our spend above our forecast. And it's about... [AGENCY 25]

SENATOR BOLZ: Sorry. [AGENCY 25]

CALDER LYNCH: Sorry. [AGENCY 25]

SENATOR BOLZ: I don't mean to be impolite but above your forecast or above the amount of dollars that we had appropriated to you? [AGENCY 25]

CALDER LYNCH: Well, we're not appropriated at a service level so there's not like an appropriation for hospital payments. So we look at it in totality. And so there was obviously a number of moving pieces with regard to the total forecasts against the total appropriation. And depending upon...but we weren't at that point looking at a revised appropriation level. We just knew we didn't know how much the revenue forecast was going to change for the fiscal year. And so our directive was really to hold the line as much as possible in terms of spending until that picture was clearer,... [AGENCY 25]

SENATOR BOLZ: Uh-huh. [AGENCY 25]

CALDER LYNCH: ...and so looking at all opportunities. So at that point, knowing that to make this change would have increased our spending over what it would have otherwise have been, and that's what kind of led to the decision to hold off on implementing that. [AGENCY 25]

SENATOR BOLZ: Okay. I don't want to monopolize the committee's time. And I can appreciate that there was cautiousness about moving forward, given the fiscal climate. But the flip side of that coin is that this committee makes policy decisions and we make appropriations decisions and there's always tension when what we've appropriated, given a set of facts and circumstances, isn't put into practice. And that becomes a tension between branches of governments and that tension is just as important I think as fiscal tension. So I know we'll continue to discuss this issue. [AGENCY 25]

CALDER LYNCH: Absolutely. [AGENCY 25]

SENATOR STINNER: Thank you. Additional questions? Senator Vargas. [AGENCY 25]

SENATOR VARGAS: Actually, this is just a follow-up to that because it sounds like the way that you've walked through at least this time line is that there's been...there was a formula change and there was a holding pattern, but then you had a question. There was a statement you made around as a result of the changing climate, we made decisions differently to withhold or to not move forward. But at that time, when we realized that there's something that we can do to rebase, to address this gap, did we have...did you have the funds to be able to address it? [AGENCY 25]

CALDER LYNCH: I would say that in Medicaid we're never certain of that answer because of the fact that our spending is driven by enrollment and utilization. So at any moment I could see, because of changing...the changing economy, you know, an influx of enrollment based on, you know, more folks qualifying for the program. We could have a terrible flu season and see our costs increase. So without having, you know, when we're constantly updating our forecast and we're constantly trying to improve our forecasting abilities, but I can tell you it's been a challenge for us because of some of the limitations we have in the systems that we're extracting data out of to understand exactly where we stand at any point in a given fiscal year. So it wasn't clear to me at that point if we had the funds based on our current spending and what the appropriation was. And so that was the decision to take a more careful, cautious route. [AGENCY 25]

SENATOR VARGAS: And then, you know, as somebody new on the committee, was there a conversation with the previous Appropriations Chair/Committee when this was...became a concern, potentially not having the funds to be able to address this...these payments not happening, to address based off the formula? Was that a conversation that happened with the previous committee/committee Chair. [AGENCY 25]

CALDER LYNCH: Not that I'm aware of. [AGENCY 25]

SENATOR VARGAS: Okay. Is there a reason why not? [AGENCY 25]

CALDER LYNCH: You know, I don't...it's certainly not something we were trying to hide. You know, I think we were trying to understand what the impact was as they brought this issue forward and what the best path forward was. You know again, we're not appropriated at a service level so we're always having to make decisions that impact, you know, expenditures in one area or another. We may see movement based on forecasts and utilization changes. For example, as I mentioned earlier, there's a new methodology out now for resource utilization groups for nursing facilities that adds quite a few new what we call RUGs to...and that can change the total level of reimbursement if we implemented that new system. And so we could do that and it could be budget neutral or not budget neutral, depending upon what the actual mix is and what adjustments we make. So there's a lot of different pieces that are moving. And we work with providers and we work with the committee to try to figure out how to best do that. But, you know, it wasn't something that we were looking at from an appropriations perspective. [AGENCY 25]

SENATOR VARGAS: Yeah. I appreciate that. And I ask because I've been trying to bring together these two perspectives, one from this perspective if we have formula that was changed and we're looking at the climate but we're also trying to figure out how to right this wrong and make sure people are paid out, providers are paid out but also from providers that are expecting a certain amount of funds coming to them based on the services they provided. And then also we're making cuts to Medicaid, that's been proposed, $7 million. But so I'm trying to make sense of all that and when we will right this wrong and if there's ever going to be what information we need to then move forward. It sounds like you're saying it's more when we have a better climate.

But I'm just trying to get a better sense of what we would need, what's the tipping point here. [AGENCY 25]

CALDER LYNCH: Uh-huh. [AGENCY 25]

SENATOR VARGAS: Because I know from our committee we're hearing a lot from...at least I'm personally hearing a lot from hospitals and providers regarding this issue. [AGENCY 25]

CALDER LYNCH: And, Senator, and I want to start by saying that I think we have an excellent relationship with the Hospital Association and they have been very, very good about working together on this issue and have brought good information forward. And we've recently shared with them some analysis that I want to get some feedback on before we share it more broadly and maybe incorporate some additional layers to it around, you know, how does our reimbursement for prospective payment system hospitals compare to other states, because some of the preliminary analysis we're seeing is that we look quite favorable. Now there are factors that aren't taken into consideration and that's what we need to have some of that dialogue about. But, you know, so not disputing what occurred, you know, in terms of the rebasing, coming under what we anticipated, but I think also it's a responsibility for us to collectively to look at, as we're going to put dollars back into the system, whether it's in fixing this or in restoring other rates or whatnot, what is the most high-need area. And at this point, I can't tell you it's hospitals, it's this. I mean we need to do some further analysis there. [AGENCY 25]

SENATOR VARGAS: No, that's helpful and I appreciate you're trying to, I think in some ways, do some comparability. [AGENCY 25]

CALDER LYNCH: Uh-huh. [AGENCY 25]

SENATOR VARGAS: But then there's also fixing and rebasing,... [AGENCY 25]

CALDER LYNCH: Right. [AGENCY 25]

SENATOR VARGAS: ...seems like a precursor to that at times. (Inaudible). [AGENCY 25]

CALDER LYNCH: And we're rebasing back to what existed in the past, and I can't say that was really based on anything scientific, you know, with that regard and that. There's just been 2 percent, 2.5 percent, 2.25 percent each, you know, each year, depending when the Legislature appropriated increase to that. So compared to many other states, we've had rate increases during years that other states maybe didn't. So in some cases that may be why some of our rates look more favorable. But then again, there could be other factors based on our patient mix that aren't being taken into account in that analysis. [AGENCY 25]

SENATOR VARGAS: Thank you very much. [AGENCY 25]

CALDER LYNCH: Thank you. [AGENCY 25]

SENATOR STINNER: Senator Wishart. [AGENCY 25]

SENATOR WISHART: Well, thank you again. So I believe in our deficit budget we lapsed millions of dollars in Medicaid. Did you ever consider that we would sort of use some of those dollars to right this error? [AGENCY 25]

CALDER LYNCH: Senator, I think you know it's not my decision alone in terms of, you know, what dollars are appropriate or unappropriated, if you will, from our budget. I think that's being made collectively by both this body and through working with the Governor and his Budget Office. And we try to provide the best information we can to help make those difficult decisions. But I think even if there were dollars available this fiscal year, you know, doing that rebasing would only deepen the gap for the next fiscal year that we have to close. So I think we have to look at things over a multiyear basis to try to figure out, you know, what the picture looks like and what the best path forward is. So we were looking I think both at this year and in the coming year, which we knew would have even bigger challenges. [AGENCY 25]

SENATOR WISHART: Yeah. Okay. [AGENCY 25]

SENATOR STINNER: I've been scurrying about here trying to reconcile numbers. Your number of $24 million and my number of $74 (million). And actually, it's about $70 million in provider

rate differences that we have, depending on category. So they might be different categories. [AGENCY 25]

CALDER LYNCH: And it could be my...the numbers I cite in my testimony, Senator, were General Funds and providers are probably more concerned about total funds, rightfully so, because those are the dollars that get the state and federal mix that go to them. So that may be the source of some of the discrepancy. [AGENCY 25]

SENATOR STINNER: I do have a question there. It's come up in conversation and I haven't seen anything come across my desk, but there is a Nebraska Family Collaborative contract apparently that is $10 million over what our thinking was. So is that a $10 million bust that I have in the budget again? [AGENCY 25]

CALDER LYNCH: You should save that question for Director Weinberg when he comes up. [AGENCY 25]

SENATOR STINNER: Ah. [AGENCY 25]

CALDER LYNCH: That would be under his purview. [AGENCY 25]

SENATOR STINNER: Okay. Now do you want to comment on the audit report? We had a special review session, really kind of targeted to your back room, to say, you know, we've listed all the fines that we potentially could have, all the clawbacks that we have had. We came up with a number and we talked about internal controls, a whole bunch of things. And then we get an audit report that really kind of says we really have a lot of work to do. And so that doesn't give me a great deal of comfort. But do you want to talk about that audit report? Do you want to... [AGENCY 25]

CALDER LYNCH: Uh-huh. [AGENCY 25]

SENATOR STINNER: ...kind of tell me what the items were, what you've done about it, management's response type of thing? [AGENCY 25]

CALDER LYNCH: Absolutely. And I can speak from Medicaid's perspective and other directors may be able to speak from theirs or Courtney may want to speak from the department's perspective overall. But from, you know, obviously, a lot of dollars flow through Medicaid and we're...you know, we are scrutinized at both the state level, rightfully so, from the APA, as well as our federal partners at HHS, the Office of Inspector General. So there's a lot of looking at, you know, dollars that are flowing through: how they're being reported, how they're being claimed. And a lot of that is important and there's been a lot of progress I think in improving the way some of those processes work. Working with our internal audit team, working with our finance division to increase the speed at which we're doing some of those reconciliations. We look at how we're making sure that we're reporting accurately and timely. And then individual program perspective, as we tighten up the management and administration of how dollars are going out the door, moving things away from the fee-for-service delivery model where we were processing claims in that antiquated MMIS, which was difficult to fix and reprogram on a timely basis to make sure we were compliant with the most current standards; as well as building up capacity within our division; bringing on a deputy that's over finance and program integrity specifically, which was a new role for us; building up a finance team to be able to manage and oversee kind of a lot of these types of transactions and issues; and making sure that our staffing levels are where they need to be in that regard, to make sure that we're not having those types of findings. Many times what we see is that whenever we get a finding, whether it's from the state or the federal level, we...that's identified and we begin working with them to figure out what the scope of that is, to respond to that, and then to put corrective action in place. And by the time that process is completed, you know, they're already sampling data from that new fiscal year. So you usually get to see that one more time before it gets closed out. And we're really trying to put processes in place to speed that process up, that as soon as something is identified we're working to put corrective action in place, we're making sure there's somebody accountable to it, we're reviewing that regularly at our leadership team meetings to make sure that those are being addressed. Some of them are years old; some of them are more recent. A lot of them are related to old contracts that are no longer in place. And so, you know, and sometimes they're related to specific providers that may not be in business, so it's difficult to recover those dollars against those dollars. So it really varies depending upon what you're looking at. But we are very much committed to reducing the number of those findings and particularly those number of repeat findings that we're getting. [AGENCY 25]

SENATOR STINNER: Okay. And we did allocate, for the record, another auditor position, so we're kind of committed. You know, a $32 million fine, you can pay for a lot of back room... [AGENCY 25]

CALDER LYNCH: Absolutely. [AGENCY 25]

SENATOR STINNER: ...quality control checks, reprogramming, those types of things. So is there additional questions? Senator Clements. [AGENCY 25]

SENATOR CLEMENTS: Thank you, Director Lynch. You talked about the provider rates in comparison with other states and a 3 percent reduction. Are you saying that our rates would be comparable after reducing them 3 percent? [AGENCY 25]

CALDER LYNCH: Thank you, Senator. I think that we would still be above some states at 3 percent and it would vary based on provider and service and it would also vary based on which states we were comparing ourselves against. Medicaid provider rates vary a great deal in many cases from state to state, and there are differences in state programs depending on what they cover, what populations they cover that drive some of those differences. Also, just the overall percent of the population enrolled in Medicaid can influence the pressure that the program faces in terms of reimbursement. So sometimes it's difficult to find apples-to-apples comparisons, so we try to look widely as much as we can and find the data that's available to us. So I think it varies somewhat depending on provider and which states we're looking at. [AGENCY 25]

SENATOR CLEMENTS: Thank you. [AGENCY 25]

CALDER LYNCH: Thank you. [AGENCY 25]

SENATOR STINNER: I would hope regionalization has something to do with it too. [AGENCY 25]

CALDER LYNCH: Yes, Senator, we try to pull in our neighboring states as much as we can, as much as (inaudible). [AGENCY 25]

SENATOR STINNER: I'm talking about regional inside the state of Nebraska,... [AGENCY 25]

CALDER LYNCH: Oh. [AGENCY 25]

SENATOR STINNER: ...because delivering service in western Nebraska is a little different than Lincoln and Omaha. [AGENCY 25]

CALDER LYNCH: Oh, that's a great point, Senator. So under federal regulations, the fee-for-service program is not allowed to vary rates, you know, regionally, but our managed care plans can, depending on how access issues are facing. And so that's one area which we work with them to try and improve accesses. There may be cases where they need to provide enhancements in rates based on regional access issues or things like that. So that's something we're working on. [AGENCY 25]

SENATOR STINNER: Thank you. [AGENCY 25]

CALDER LYNCH: Thank you. [AGENCY 25]

SENATOR STINNER: Senator Wishart. [AGENCY 25]

SENATOR WISHART: Well, just that made me think of a question, what Senator Stinner said about access to care in rural areas. I know I've been hearing a lot about telehealth and advancements and Nebraska actually being a pioneer in terms of telehealth services. But one of the concerns I've heard from like home healthcare providers is being reimbursed for some of the telehealth services that they provide. Can you talk a little bit about how we are moving forward to incorporate those services in our reimbursement process? [AGENCY 25]

CALDER LYNCH: Thank you, Senator Wishart. We just promulgated regulations that were effective January 1 of this year that broaden the scope at this we can reimburse. For telehealth, it would include both reimbursement for the originating site as well as for the delivery site, and it would also allow for reimbursement both of real-time telehealth as well asynchronous telehealth where it could be stored and then sent and reviewed later. And we're working with our plans to

materialize and sort of operationalize that. I think we'll probably put a greater emphasis, once we get through the operational, you know, kind of go-live period, to get updates on where they are with getting contracts in place with providers to be able to provide some of that, but is now in place in our regulations as of January 1. [AGENCY 25]

SENATOR WISHART: Thank you. [AGENCY 25]

CALDER LYNCH: Thank you. [AGENCY 25]

SENATOR STINNER: Thank you. Additional questions? Seeing none, thank you. [AGENCY 25]

CALDER LYNCH: Thank you. [AGENCY 25]

SENATOR STINNER: Good afternoon. [AGENCY 25]

TOM WILLIAMS: (Exhibit 1) Good afternoon. Good afternoon, Senator Stinner and members of the Appropriations Committee. For the record, I am Tom Williams, T-o-m W-i-l-l-i-a-m-s, director and Chief Medical Officer of the DHHS Division of Public Health. The Division of Public Health includes areas of community and environmental health, including health promotion, life span health activities, environmental health services, and community and rural health planning. We also focus on health licensure and health data. This work includes facility, professional, and occupational licensure; epidemiology and health data collection; investigations; public health preparedness and emergency response; and vital records. Our work furthers the department's mission of helping people live better lives. As Courtney said earlier, the DHHS team has focused on priority initiatives and process improvements, underscoring the Governor's priorities of a more efficient, effective, and government (sic--customer) focused state government, and the Division of Public Health is benefiting. Process improvement activities and projects in the division have taken hold. Our first, in nursing licensing, simplified applications and streamlined screening, resulting in faster turnaround times. The first time application completion rate was 28 percent before, now it's 98 percent; and turnaround time for applications went from 96 days to 36. Other licensing improvements projects are underway in mental health,

substance use, social work, emergency medical services, childcare, nursing and assisted-living facilities, and physician and pharmacy licensing. We are seeing real benefits from these improvements. Another initiative is the enhanced prescription drug monitoring program, or PDMP, we launched together with the Nebraska Health Information Initiative, aka NeHII. We've received over $3.5 million in federal funding to help advance drug overdose prevention, and we're working with partners to establish opioid prescribing guidelines to increase provider and patient education, and create awareness about expanded access to treatment. These efforts are ongoing and several areas within the department are partnering with the Attorney General on the Dose of Reality public awareness campaign to prevent prescription painkiller abuse in Nebraska. The budget proposed by Governor Ricketts reflects the realities of the current economic situation and enables us to implement operational efficiencies throughout the department and to redirect resources where necessary. The Division of Public Health will continue strategic and priority services in our commitments to our mission of helping people live better lives. The recommendations build on the Governor's priorities of creating a more effective, more efficient, and customer focused state government. In light of the most recent Economic Forecasting report, the Division of Public Health supports and is fully prepared to implement the Governor's budget recommendations. I will highlight the specific differences between the Governor's recommended budget and the committee's preliminary recommendation. First is merge the Public Health Administration Program 179 budget into the Program 262 budget. The committee has included the merger of two administrative programs within the Division of Public Health, Programs 179 and 262, consistent with the Governor's recommendation. Maintaining these two as separate programs is simply not necessary. There appears, however, to be a discrepancy in the committee recommendation summary that was shared with the department. The committee preliminary recommendation summary shared with the department shows appropriation amounts remaining in Program 179. Merging Program 179 into 262 should result in zero appropriations recommended for Program 179. Second is reduce pass through to local health departments. The Governor's recommendations include a reduction of pass through funds to the 18 local health departments in Nebraska that receive General Funds, for a total of $189,824 in fiscal year 2018 and $189,824 in fiscal year 2019. This will reduce each department's allocation by $10,545. We continue to support the local health departments with over $5 million in cash funds and $1.7 million in General Funds. Local health departments also have the ability to apply for grant funding from other sources. The Division of Public Health will continue to work with the local

health departments to maximize use of federal funding they receive to monitor local health issues, provide guidance to their populations, and collaborate with healthcare providers and local government. I urge the committee to reduce the local health department aid as recommended by the Governor. Thank you for your consideration of these items and I'm happy to answer any questions you may have. [AGENCY 25]

SENATOR STINNER: Any questions? Senator Bolz. [AGENCY 25]

SENATOR BOLZ: I've got a few. And welcome to the Appropriations Committee. [AGENCY 25]

TOM WILLIAMS: Thank you. [AGENCY 25]

SENATOR BOLZ: The first question I have is in reference to the funds for the local health departments. The $5 million in cash funds that you're referring to, are you referring to Health Care Cash Funds? [AGENCY 25]

TOM WILLIAMS: I was referring to general cash funds, I believe. Yes. [AGENCY 25]

SENATOR BOLZ: What is the source of those cash funds then? [AGENCY 25]

TOM WILLIAMS: They're cash funds of Nebraska, are they not, Ryan? I'm sorry? Health Care. Okay, I'm sorry. [AGENCY 25]

SENATOR BOLZ: It is. It is the Health Care Cash Fund. [AGENCY 25]

TOM WILLIAMS: It is the Health Care, I'm sorry. [AGENCY 25]

SENATOR BOLZ: Okay. I guess one of my concerns there is that, you know, while we continue to fund local health department services through Health Care Cash Funds, what the Investment Council tells us is that we're overspending the Health Care Cash Funds by $6 million and so the sustainability of that fund is in question. And so saying that the local health departments should

rely on cash funds, I just...I think there maybe is an opportunity for further discussion there. [AGENCY 25]

TOM WILLIAMS: I see. [AGENCY 25]

SENATOR BOLZ: And the grant funding from other sources that you reference, what other sources? Is there a new federal fund or is there something out there that hasn't been out there in the past that leads you to reference that? [AGENCY 25]

TOM WILLIAMS: The ones that I'm aware of are the VetSET and Health Literacy Funds are at least two examples. [AGENCY 25]

SENATOR BOLZ: Uh-huh. And are those funds that have been previously available or are those newly available under new (inaudible)? [AGENCY 25]

TOM WILLIAMS: I believe they've been previously available but not completely used by all departments. That's my understanding. [AGENCY 25]

SENATOR BOLZ: Okay. And then I have a question related to Program 514. [AGENCY 25]

TOM WILLIAMS: Okay. [AGENCY 25]

SENATOR BOLZ: So it's my understanding that the public health departments' request was that you be allowed flexibility within Program 514 to manage all the different programs that are within Program 514 and those needs. [AGENCY 25]

TOM WILLIAMS: Uh-huh. [AGENCY 25]

SENATOR BOLZ: I guess one of the things that I'm trying to understand better is whether or not the demand for those programs is consistent year over year. I think I'd be more comfortable decreasing the funding and giving you flexibility if we knew that those requests were pretty steady. [AGENCY 25]

TOM WILLIAMS: Right. [AGENCY 25]

SENATOR BOLZ: But if they increase and decrease, depending on the economy and demand and a variety of other things, then it makes me a little bit more hesitant. And so I just wondered if you could speak to whether or not you consistently, year over year, see the same requests for the same programs or if there's some variability in those programs. [AGENCY 25]

TOM WILLIAMS: Well, what I can say is that in general almost all of those reductions represent alignment to historic spend or anticipated spend. [AGENCY 25]

SENATOR BOLZ: Uh-huh. [AGENCY 25]

TOM WILLIAMS: As to whether they vary enormously from year to year, I'm not aware of that at this time, but I'd be happy to find out for you. [AGENCY 25]

SENATOR BOLZ: I guess it would be helpful to know, with a little bit more specificity, what the difference between historic spend and variability year-to-year spend is. I mean if it's based on ten years' worth of historic data and that's averaged, that may or may not be able to be reflective of a gradually increasing demand over time or something that varies quite a bit from year to year. [AGENCY 25]

TOM WILLIAMS: Uh-huh. [AGENCY 25]

SENATOR BOLZ: So just some more detail on the historical expenditures in Program 514 so that we can either justify the request of... [AGENCY 25]

TOM WILLIAMS: Understand. [AGENCY 25]

SENATOR BOLZ: ...additional flexibility or maybe adjust those numbers, as appropriate. Thank you. [AGENCY 25]

TOM WILLIAMS: You're welcome. [AGENCY 25]

SENATOR STINNER: Additional questions? Senator Hilkemann. [AGENCY 25]

SENATOR HILKEMANN: Thank you, Dr. Williams, for being here today. Can you just...you mentioned the NeHII program and the overdose program. Can you just elaborate a little bit how this is rolling out? [AGENCY 25]

TOM WILLIAMS: Well, it's rolling out very well. I think there's really...I think of it as having two aspects to it. One is opioid prevention and there's a task force working that that is reviewing guidelines to develop communications to healthcare providers and patients on how to manage opioid issues. They've been meeting regularly. They hope to wrap up their work by this fall. Dr. Massey (phonetic) I believe is in charge of that. And they've adopted CDC guidelines, worked through and massaged actually by the state of Oregon, which the CDC recommended among other states, and they have adopted and are now looking at "Nebraska-izing" those recommendations to be most helpful. The Dose of Reality Campaign, as launched by the Attorney General and Governor Ricketts, you might remember that there was a public announcement about that, and the Broadcasters Association has provided an enormous amount of air time to help with that. And so we're going to be seeing I think some very forceful, both auditory and video, pieces that are going to be educating the public and hopefully apprising the public of the serious risks of opioid overdose. Nebraska is not as seriously affected as other states, but the concern, of course, is that it will come here. And so what we're doing is trying to get ahead of the curve on that. The PDMP is related to that. That's the Prescription Drug Monitoring Program and that is a group that's also been meeting through NeHII for some time and this year we, for the first time now, have mandatory reporting of controlled medications starting in January of this year into the PDMP. People are being trained and that is providing ways for prescribers and dispenser to enter data and acquire data about the patients they're seeing to ascertain what their opioid use is. And next year in 2018 the PDMP will also be putting all prescription drugs into the database. And so if you're a prescriber you can go in there and see what your patient is taking and it's useful for the patient as well. [AGENCY 25]

SENATOR HILKEMANN: And you feel that the NeHII program, the changes that they're making to the monitoring program, are adequate to provide that prescription monitoring? [AGENCY 25]

TOM WILLIAMS: I do. I think Nebraska is generally considered to be a leader in the medical applications of PDMP and it's...and the NeHII. They've spoken nationally on that topic and it's quite a program. [AGENCY 25]

SENATOR HILKEMANN: Okay. Thank you. [AGENCY 25]

SENATOR STINNER: Additional questions? Senator Wishart. [AGENCY 25]

SENATOR WISHART: Thank you so much for being here today. I have become more familiar with the citizen advocacy programs that are housed within your...I think Program 514 Health Aid. [AGENCY 25]

TOM WILLIAMS: Okay. [AGENCY 25]

SENATOR WISHART: And there it's just a wonderful organization but it's very small. And so I'm concerned that a 10 percent cut to their funding would significantly hurt their program. Can you talk a little bit about how you are going to...you know, where you're going to look at making 10 percent cuts and whether you're going to hold harmless some of the programs within the Health Aid Program 514? [AGENCY 25]

TOM WILLIAMS: Can you give me a little bit more information on which program specifically you're referring to, Senator? [AGENCY 25]

SENATOR WISHART: It's called citizen advocacy under Disability Rights Nebraska. [AGENCY 25]

TOM WILLIAMS: Under Disability Rights Nebraska. Okay. [AGENCY 25]

SENATOR WISHART: Yeah. [AGENCY 25]

TOM WILLIAMS: Disability, that is projected to be a $48,000 reduction and only it is a program...that program is federally funded by a number of grants, as I think you know. And so

it's largely federally funded. There are state funds that go to it but we believe that they have federal funds that they can access that will cover that for them. [AGENCY 25]

SENATOR WISHART: Okay. Okay. Thank you. [AGENCY 25]

SENATOR STINNER: Additional questions? We'll be looking forward to the historical analysis of this program. [AGENCY 25]

TOM WILLIAMS: Okay. [AGENCY 25]

SENATOR STINNER: I think Senator Bolz requested that so... [AGENCY 25]

TOM WILLIAMS: Yes, okay. Thank you. [AGENCY 25]

SENATOR STINNER: ...I always like to look at things over a long period of time. [AGENCY 25]

TOM WILLIAMS: It's a good idea, I agree. [AGENCY 25]

SENATOR STINNER: Thank you. [AGENCY 25]

TOM WILLIAMS: Thank you, sir. [AGENCY 25]

SENATOR STINNER: Any additional proponents? Take your seat up here, please. There's assigned seating. [AGENCY 25]

JUDY HALSTEAD: Good afternoon. [AGENCY 25]

SENATOR STINNER: Good afternoon. [AGENCY 25]

JUDY HALSTEAD: (Exhibit 2) Good afternoon, Chairman Stinner and members of the Appropriations Committee. It's a joy to be with you this afternoon and have an opportunity to

speak to you. My name is Judy Halstead, that's J-u-d-y H-a-l-s-t-e-a-d. I'm the health director for the Lincoln-Lancaster County Health Department and I'm testifying today on behalf of Friends of Public Health, which is an organization representing the local health departments in the state of Nebraska. On behalf of the local health directors, we wish to express our appreciation to the committee for keeping the funding we receive from the state budget intact. This funding is critical for our departments in carrying out their statutory responsibilities. I know we have new members on the committee and so I want to just give a little bit of information relative to local health departments. Local health departments are not part of the Nebraska Department of Health and Human Services. Local boards of health oversee local health departments. The services that are required to be provided by local health departments are found in state statute and local health departments are required to provide annual reports on their program services and account for how their funds are spent. Prior to 2001, only 22 of the 93 counties in Nebraska had local health departments to provide services to their county. Local health departments in Nebraska were established as district departments as a result of LB692 in 2001 and funded through the Health Care Cash Fund created from the national tobacco settlement dollars. Since that time, we've become a statewide system that does cover all 93 counties. Local health departments have mobilized our communities to address needs identified by them and formed partnerships and coalitions to help them address the unique community problems. Whether it's high rates of cancer, diabetes, or heart disease; low birthweights; lack of adequate dental, medical, or childcare; injury prevention; seat belt usage; underage tobacco and alcohol use; addressing drug abuse in the community or violence prevention, public health has a valuable presence in local Nebraska. Through the state General Funds we're discussing today, and that is Program 502, local health departments contribute to statewide surveillance activities, including national recalls such as eggs, ground beef, peanut butter, and alfalfa sprouts, just to name a few. Local health departments have been responsible for disease investigation in their districts when there have been disease outbreaks or local disasters. We gather case information on infectious disease, such as mumps, measles, and pertussis, we follow up with these cases reported to us by the state and by local laboratories, as well as local hospitals, physician clinics, nursing homes, day cares, and schools. A recent example is the national recall of a soy nut product. The national recall of I.M. Healthy, and this is the true name of the product, is a brand of soy nut butter that resembles peanut butter that was issued last week. Suppliers notified grocery stores, bulk food distributors, and general public via the media. However, as we know, not everyone watches, listens to, or

reads the media. Getting the word out of a possible E. coli contamination in this product is critical. This product happened to be sold as everything from single snack servings to large tubs sold to school districts, childcares, and nursing homes. The Lincoln-Lancaster County Health Department notified schools and childcares of the recall. We urged them to check their supply to see if they had potentially contaminated product. The next day we were notified by two childcares that they had purchased and served the product to children below age five on Monday, March 6. These childcare centers had many low-income families whose children were potentially exposed to a contaminated product. The Lincoln-Lancaster County Health Department wrote a letter to the parents of the children of these centers explaining what to look for in their child for signs of E. coli and gave instructions on contacting their healthcare provider right away if the child developed any possible symptoms. Childcare staff also instructed the parents, if their child developed symptoms, to take the letter that we wrote to take to their doctor so the doctor could look for possible signs of E. coli. We notified Lincoln physicians and healthcare providers that we were aware that two large childcare centers had served the potentially contaminated food to the young children and encouraged them to screen young children presenting with diarrhea more closely than they may otherwise feel the need to do. If children exposed to E. coli become ill, the more quickly they're diagnosed correctly, the less likely they will be to develop life-threatening kidney failure and other complications from E. coli. By getting the word out to providers, physicians, and parents, we reduce the likelihood of the spread and the severity of disease. This is the job of local public health. Many hours were spent by our childcare health consultant, our food safety staff, our communicable disease staff, and our physician liaisons to assure that the right message was provided to the right people at the right time. This work is critical to preventing the spread of disease and deaths in Nebraska. The work of this team of local public health providers may save the state Medicaid program hundreds of thousands of Medicaid dollars if we prevented one Medicaid-eligible child from getting sick from E. coli. That's what this General Fund appropriation does for Nebraska and we're grateful for your continued support. I'm happy to answer any questions you might have. [AGENCY 25]

SENATOR STINNER: Questions? Senator Wishart. [AGENCY 25]

SENATOR WISHART: Well, Judy, thank you so much for being here and thank you for your service over the years to Lincoln and Lancaster County. The next director has big, big shoes to fill. So thank you. [AGENCY 25]

JUDY HALSTEAD: Thank you, Senator. [AGENCY 25]

SENATOR WISHART: I wanted to ask you, just because you have been serving in the healthcare field for a long time, just your thoughts about provider rates, what you've experienced at the local level. [AGENCY 25]

JUDY HALSTEAD: Specifically related to Medicaid provider rates? [AGENCY 25]

SENATOR WISHART: Yes. [AGENCY 25]

JUDY HALSTEAD: It has been a challenge. As you know, particularly in the Lincoln area, we've seen not only a growing population of our jurisdiction but also a growing population of refugees, immigrants, and asylees who are legally in our country. Because these individuals present to us, many of them have never experienced what we would consider Western medicine before. They've never seen a doctor. They've never seen a dentist. They don't even understand that that is the need for them. But in addition, we have tens of thousands of working individuals who have always been lifelong residents of the state of Nebraska who are having a harder and harder time accessing care, particularly in relationship to our provider rates related to preventive care, so immunizations and dental as was discussed earlier. Senator Stinner was right. We are having fewer and fewer, in particular dentists, who are willing to take Medicaid. We currently have eight dentists that are employed with us under contract. We have two pediatric dentists and six general dentists. We did 12,000 patient visits last year. Sixty percent of them were Medicaid-eligible and forty percent were uninsured, so they had no other capacity to pay. We do provide a sliding fee scale. We do ask patients to pay what they can. But looking at a reduction of our cost...at our cost reimbursement from Medicaid impacts us dramatically, and what that falls to is local tax dollars having to pick up that cost. We have seen virtually a doubling in our dental program, primarily because businesses are not providing dental insurance as a benefit for their employees. And as you are aware, many of you who access dental care, the cost is very

expensive, and particularly our low-income individuals can't provide payment or what they can provide is $5 or $10. So a reduction of 3 percent, as was proposed originally for our dental program, is somewhere in the neighborhood of about a $20,000 reduction for us because we are one of the largest Medicaid dental providers in our jurisdiction, in Lincoln. In addition, we are looking at that cap that was mentioned as well. We provide...we bill Medicaid for immunization services for children and adults we provide. We bill for refugee services. We bill for additional healthcare services. But that reduction is significant to us if we see another provider cut. [AGENCY 25]

SENATOR WISHART: Thank you. [AGENCY 25]

SENATOR STINNER: Additional questions? Senator Bolz. [AGENCY 25]

SENATOR BOLZ: Not to put too fine of a point on it, but what I'm hearing you say is that if rates for dental services were reduced, it would have a negative impact on access. [AGENCY 25]

JUDY HALSTEAD: Absolutely and will continue to have a negative impact on access because our dentists don't have to take Medicaid. There is no written rule anywhere that says dentists have to take Medicaid. And they're not, in greater and greater numbers. We actually sought some additional grant funding to pay dentists, private dentists in Lincoln, to take patients for what they would be reimbursed for Medicaid to help us with the high demand of uninsured individuals. They're willing to take grant funds from us to provide service to those patients but they don't want to bill Medicaid because of the costs associated to their practice to bill Medicaid to get those payments denied, to have to provide language interpretation and have to pay out more money for language interpretation than what they receive in payment for the service. [AGENCY 25]

SENATOR STINNER: Additional questions? Have you looked at the cuts that are proposed in...on this, on these programs? [AGENCY 25]

JUDY HALSTEAD: Yes, I have. [AGENCY 25]

SENATOR STINNER: How many of those are going to fall on the county as unfunded mandates? [AGENCY 25]

JUDY HALSTEAD: Senator, without a plan from HHS on which of those programs they will actually use other funding for, which we have not received, I can't answer that. But I would be happy, once the department makes that information available, to let you know that. [AGENCY 25]

SENATOR STINNER: I would like to know the unfunded mandates. Thank you. [AGENCY 25]

JUDY HALSTEAD: Uh-huh. [AGENCY 25]

SENATOR STINNER: Additional questions? Seeing none, thank you. [AGENCY 25]

JUDY HALSTEAD: Thank you. [AGENCY 25]

SENATOR STINNER: Good afternoon. [AGENCY 25]

RYAN BEETHE: (Exhibit 3) Good afternoon. Chairman Stinner and members of the Appropriations Committee, my name is Ryan Beethe, R-y-a-n B-e-e-t-h-e. I'm the director at Maxim Healthcare in Omaha. Today I'm representing the 72 Home Care Association members that make...agencies that make up the Nebraska Home Care Association and the thousands of patients and families that we serve across the state. I first want to say thank you for taking time out of the past six weeks to meet with representatives of our association. I know we had a lot of one-on-one meetings to kind of talk to you about the services we provide and the patients that are impacted. As you have learned, we have a very limited revenue stream outside of Medicaid, making a strong Medicaid reimbursement fee schedule vital for us to continue to provide current and future patients with the cares they are receiving. With that being said, I want to say thank you for the preliminary recommendation of a 1 percent rate increase for home care. As you know, home care saves the state money over facility-based care for patients who are eligible. This 1 percent rate increase will allow us to get the patients home with their families and create a cost savings to the state at the same time, which is a win-win. On behalf of the Nebraska Home

Care Association and all the patients and families, we appreciate you being committed to keeping the families and patients together in their homes. Any questions? [AGENCY 25]

SENATOR STINNER: Any questions? Are you just a Nebraska-based provider? [AGENCY 25]

RYAN BEETHE: We do Iowa as well, Iowa Medicaid. [AGENCY 25]

SENATOR STINNER: And how do our reimbursement rates look compared to Iowa? [AGENCY 25]

RYAN BEETHE: Iowa has a very unique Medicaid reimbursement structure that follows the Medicare episodic payments, so the only reimbursement we have...we're actually not a traditional Iowa Medicaid provider. We're only contracted with the managed care plans. And those rates, some are a lot lower than Nebraska Medicaid and a few are actually higher. There's a big range in Iowa. [AGENCY 25]

SENATOR STINNER: So depending on the service that you provide, you get reimbursed at a different rate. [AGENCY 25]

RYAN BEETHE: It actually depends on the managed care plan that the patient is on, same services. [AGENCY 25]

SENATOR STINNER: I see. [AGENCY 25]

RYAN BEETHE: It's a lot different than Nebraska. [AGENCY 25]

SENATOR STINNER: Okay. Is it better or is it worse? [AGENCY 25]

RYAN BEETHE: I think Nebraska is better. [AGENCY 25]

SENATOR STINNER: Okay. Just thought I'd ask. (Laughter) [AGENCY 25]

SENATOR HILKEMANN: Right answer. [AGENCY 25]

SENATOR STINNER: Any additional... (Laughter) [AGENCY 25]

RYAN BEETHE: Thank you. [AGENCY 25]

SENATOR HILKEMANN: Thank you. [AGENCY 25]

SENATOR STINNER: Good afternoon. [AGENCY 25]

KATHY WARD: (Exhibit 4) Good afternoon, Chairman Stinner and members of the Appropriations Committee. My name is Kathy Ward, that's K-a-t-h-y W-a-r-d. I'm here as a volunteer for the American Cancer Society Cancer Action Network. And I also happen to be the former administrator of that Department of Health and Human Services office that included Every Woman Matters and the Nebraska Colon Cancer Program, and they are both funded through Program 514 in the DHHS budget. I retired from DHHS in 2013, but these programs for low-income Nebraskans are always going to be near and dear to my heart. I've seen their growth from the first grant for breast and cervical cancer in 1991. In 2000, the program began offering cardiovascular health services. And in 2005, the Nebraska Colon Cancer Program began, also known as Stay in the Game. I helped with a recent project with Every Woman Matters and compiled responses from clients who were asked for letters of support for a grant that was submitted. There were over 300 letters that came in and the most persistent theme was that these programs provided preventive care to people who otherwise had absolutely no access. Client after client said that this was their only opportunity to see a doctor or to receive preventive care, and several said, without these programs they would likely have died. In the years since Every Woman Matters began, Nebraska's mammography screening rate has risen from 43 percent of women over the age of 40 to currently 70 percent, and the death rate from breast cancer has dropped in Nebraska by 20 percent. Every Woman Matters has provided over 200,000 medical office visits, 130,000 mammograms, and 146,000 Pap smears. It's detected and treated 1,193 breast cancers and over 80 cervical cancers. Colon cancer screening has an attribute that's even better, though, than breast cancer screening and that is if you find and remove precancerous polyp, you can prevent colon cancer from ever occurring. Can you imagine what a gift that is to

prevent somebody from every having to hear the words "you have cancer"? Colon cancer is a problem in Nebraska. We have an incidence rate that's higher than the U.S. average. We have a screening rate that ranks 37th in the country. Governor Ricketts has named colon cancer screening as a priority. So today I'm asking that the committee consider increasing funding for the Nebraska Colon Cancer Screening Program in Program 514 by $400,000, which would replace, partly, dollars lost because of a federal grant that was not renewed two years ago. That $400,000 will double current funding. And in addition, I ask that you consider directing $20,000 of that new funding to be used for outreach and education so Nebraskans can know the program is even there and to increase efficient follow-up. Since the Nebraska Colon Cancer Program began, it's served both men and women and it's detected and treated 10 colorectal cancers, 532 high-grade polyps, and 978 polyps suspicious for cancer. And a high-grade polyp is almost certain to develop into a cancer if it's not removed, and a large percentage of the polyps suspicious for cancer will become cancerous if they're not removed. The costs for treating colon cancer are rising even faster than the national healthcare costs. One study a few years back showed the cost of treating colon cancer range from $31,000 for cancer at a local stage, $68,000 for regional stage, to $126,000 for cancer at a distant stage. If you take those 532 high-grade polyps that the program detected and removed times the $68,000 cost for treatment, we can estimate a savings of more than $36 million. And many of those cancers that, fortunately, now are never going to occur would have been treated with public dollars or uncompensated care. My second ask is that the $85,000 cut in both the Governor's budget and your preliminary budget for Every Woman Matters in Program 514 be restored. Again, I ask that you include language allowing the department to use funds for outreach and education. The only way that clients that can access a program is if they know it's there. And as an example, data from the latest breast cancer state plan showed a mortality rate for African-American women in Nebraska 40 percent higher than for white women. The Metro African-American Breast Cancer Task Force was created and trained 100 women to be screening advocates. And because of this outreach, enrollment of African-American women in Every Woman Matters has increased by 30 percent. So I'm going to close with a quote from one of those letters of support that I mentioned earlier. There was a client named Pamela who said, when I first found out I had breast cancer, I called Joey. She's a staff member at Every Woman Matters. She told me, don't worry, everything will be okay. I couldn't afford the follow-up mammogram my doctor wanted. You all made that possible. As of this date, I'm cancer free. So I want to say that you all made that possible with your

funding and your support of these programs over the years, and I ask you to consider these increases for those two programs. You can save lives, save state dollars, and help more Nebraskans have stories like that with happy endings. And I thank you and I'd be happy to answer any questions. [AGENCY 25]

SENATOR STINNER: Questions? Seeing none, thank you. [AGENCY 25]

KATHY WARD: Thank you. [AGENCY 25]

GERRY FINNEGAN: (Exhibits 5 and 6) Chairman Stinner, members of the committee, my name is Gerry Finnegan and I'm a businessman here in Lincoln. And I'm speaking on behalf of the Citizen Advocacy Programs around the state, urging the committee to maintain the current level of pass-through funding through Disability Rights Nebraska. And if there are questions at the end, I also have Dr. Evans here who can answer questions with respect to the Disability Rights Nebraska and of this. What Citizen Advocacy Program does is it makes the life of intellectually and developmentally disabled people better. A secondary benefit is that savings are realized. What is the need? Okay. Here are what the numbers look like. About 2.25 percent of the population is born with an IQ below 70. Add to that those with Down's syndrome, those on the autism spectrum, those with congenital impairment, those with impairment due to traumatic brain injury in their youth, and the number rises to about 4 percent of the population. That applies here in Lincoln, Lancaster County, and across the state. You can do the numbers actually for your own district. Lincoln, Lancaster County, that would be about 10,000 to 12,000 individuals that would qualify as intellectually impaired, developmentally disabled. The good news is that the luckiest 80 percent of that group have family that care for them or extended family. They get help in dealing with the complexities of life. However, the bottom 10 percent of that group struggles and the bottom 1 percent are truly desperate in some situations just trying to negotiate the system. Let me relate my personal experience with a couple of brief stories about two men for whom I have advocated. The first is Pat's story. I became acquainted with Lincoln Citizen Advocacy in 1993 when the Lincoln coordinator introduced me to Pat and his advocate Vera. Now Vera was recently widowed. Vera and her late husband had advocated for Pat for over 20 years, since he had left the Beatrice Home. But a problem had arisen with Social Security, his benefit, and Social Security was actually looking for reimbursement. She was trying to get some

financial guidance. She felt this was beyond her abilities because there was a benefit that was going to be cut from Patrick. As I learned of Pat's fully story, I decided that a little bit of effort on my part might be helpful and I agreed to become Pat's representative payee. After a succession of phone calls within a month dealing with Social Security Administration, they relented, agreeing that Pat owed them no money and, in fact, Pat had been underfunded in previous years to the tune of $4,000. Problem was that we had six weeks to spend that extra $4,000 that Pat was going to be getting. In the subsequent 18 months, I got to know Pat pretty well and had grown to appreciate the vital role that Vera played in his life. Then Vera became very ill and died, leaving me as the logical person to become Pat's advocate. That is when I became a Citizen Advocate and I was pleased to be able to fill that role. Pat was born in 1922, a full generation older than me, and at the age of four he had been abandoned into the "Beatrice Home for the Feeble-minded"--that's what it was called back in those days--where he spent the next 43 years of his life with no family contact whatsoever. In fact, the only human contact he had was from those people who were paid to be in his life. Pat was an inordinately decent human being. He was never able to learn to read or write, but he memorized every church hymn, every Bible verse he had ever heard. His manners were impeccable, and the only people he ever disliked were people that he actually observed being unkind to others. Pat died on Valentine's Day in the year 2009. Two months earlier we had gone Christmas shopping and I had a memorable conversation with Pat in the slow traffic on the way back home. I had asked him if his parents had ever come to see him after they had left him at the Beatrice Home. Pat sighed, there was a brief pause, and he replied to me with four words: No, they never did. It was an 86-year-old man who was speaking, but the voice was that of a 4-year-old boy who could not understand why Mom and Dad had never come back for him. They had never come to get him. It was also in 2009 when I was introduced to Mike. Now Mike is a little bit of a different story. Mike needed a payee. He was born in 1959, one of eight children, raised in and out of foster care system and never had a stable family life at all. At the time, his day-by-day dealings with life were in complete disarray. At high-stress times, hospital care became his safety valve. He'd call 911 when the stress got really strong, and that was four or five time a year. Additionally, he would seek admittance to emergency room every few months. On occasion, he would threaten to harm himself because it would get the attention and he knew that such a threat required admission for observation. I'm sure you're all aware from the comments you've made here today that you fully understand how costly these behaviors are. Today his life is stable. Okay? He lives with an extended family

home. He works in a daily program. He eats healthier, his hygiene is better, he goes to Friendship Club every Wednesday night. His expensive misbehavior is gone because his life is orderly and it is dependable. Now we... [AGENCY 25]

SENATOR STINNER: Gerry, if you could wrap it up. [AGENCY 25]

GERRY FINNEGAN: Yes, I will. [AGENCY 25]

SENATOR STINNER: The light has been on. [AGENCY 25]

GERRY FINNEGAN: Because we're all familiar with false economies and cost shifting can temporarily give the appearance of savings while simply deferring expensive consequences to someone else's watch. That's what we do sometimes in the Legislature here, and I would hope that you would take into consideration those who are going to be sitting in your seats two, four, six years from now and don't do that to them, and don't do that to the taxpayers of Nebraska. You can read the next few paragraphs of my testimony, but at this point I would be happy to field any questions you might have about the Citizen Advocacy Program. [AGENCY 25]

SENATOR STINNER: I do have to check with the clerk. Did he spell his name? I... [AGENCY 25]

GERRY FINNEGAN: I am sorry. It is Gerry with a G, G-e-r-r-y F-i-n-n-e-g-a-n. [AGENCY 25]

SENATOR STINNER: So we have it accurate in the testimony. Thank you. Additional questions? Senator Hilkemann. [AGENCY 25]

SENATOR HILKEMANN: Just a comment. Thank you... [AGENCY 25]

SENATOR WISHART: Yes. [AGENCY 25]

SENATOR HILKEMANN: ...for stepping up and being an advocate. I had an aunt, also left at the Beatrice Home and that same story could almost have been told for her. So thank you. You made a difference. [AGENCY 25]

GERRY FINNEGAN: Well, I appreciate that and I think it's good to know you'll see in the testimony that advocates are architects, professional athletes, production line laborers, doctors, wives, businessmen like me. They come from all walks of life. Thank you all very much for your service to the state of Nebraska. [AGENCY 25]

SENATOR STINNER: Thank you. Any additional questions? Seeing none, thank you very much. [AGENCY 25]

GERRY FINNEGAN: Thank you. [AGENCY 25]

SENATOR STINNER: Good afternoon. [AGENCY 25]

JON DAY: (Exhibit 7) Good afternoon, Chairman Stinner and the members of the Appropriations Committee. My name is Jon Day, J-o-n D-a-y. I'm a representative of NABHO, which is the Nebraska Association of Behavioral Health Organizations, and the executive director of Blue Valley Behavioral Health, a private, nonprofit behavioral health organization that covers 16 primarily rural counties in southeast Nebraska. Blue Valley treats about 5,000 adults every year as well as youth who are dealing with a variety of mental health and substance abuse issues. The people we treat on a daily basis cover a wide spectrum of ages, incomes, social and economic status, and varying degrees of mental health and substance abuse issues. In other words, these people are our friends and families, coworkers, and people we all care about. I'm here today to talk about the Appropriations Committee preliminary budget and how your intentional efforts are allowing funding to be returned to Medicaid and erasing the 3 percent reduction that previously existed. This returned funding will not only allow continued accessibility and availability to behavioral health services statewide, but it would also allow individuals and families in both rural and urban communities to gain greater stability in their daily lives. When discussing this funding that would have been reduced from Medicaid, it's important to reveal all the numbers that were involved with this biennium budget impacting

behavioral health services. When the initial budget was presented this past January, a 3 percent reduction was not the actual percentage decrease behavioral health providers were dealing with. Instead, it was 5.25 percent. Each year behavioral health providers depend on an annual rate increase in Medicaid reimbursement, which is typically around the 2.25 range. Providers statewide depend on this minimal increase to attempt to balance out the increased costs that automatically occur each year. These increased costs come from employee salaries, increasing health insurance benefits, and other basic operational expenses. The 2.25 rate increase never comes close to neutralizing all these annual rate increases, which results in the continuing gradual erosion of available behavioral health treatment. Knowing this fact helps explain the extensive wave of alarm that was created when the state budget was initially presented. Behavioral health providers knew they weren't dealing with just a loss of the annual 2.25 (percent) of Medicaid rate increase but also dealing with an additional 3 percent Medicaid decrease on top of it, equaling that 5.25 total funding reduction. A 5.25 decrease in funding would have impacted every behavioral health provider organization throughout Nebraska in terms of decreasing their staff, their offices, and other access points. Subsequently, it would affect thousands of adults and youth needing mental health and substance abuse treatment in Nebraska. As director of Nebraska's largest rural behavioral health provider, in addition to providing services here in Lincoln, it's become evident that people are not truly fully aware of the impact that any funding decrease would create. A reduction in behavioral health services throughout Nebraska results in adults and youth not receiving help for depression, anxiety, trauma, family conflict, substance, and other related issues that can disrupt a person's life. In addition, it impacts the lives and entities that people are intertwined with, such as their employment, their schools, and the stabilization of the family environment. But let's not stop there. A funding decrease of this size, 3 percent or larger, would have impacted a large number of agencies and other entities that refer and depend on behavioral health services. These include healthcare providers, attorneys, law enforcement, probation, schools, HHS, local businesses, and other organizations in both the rural and urban communities would have fewer resources and other behavioral health providers to depend on. This would result in physicians or hospitals throughout Nebraska not being able to refer people for treatment, county district courts or correctional system not having local providers available or having their referrals placed on a wait list, or even schools statewide experiencing a higher dropout rate due to students with mental health or substance abuse problems not having access to the available local treatment. As you

can see, limiting or reducing access to behavioral health treatment has consequences that reach far beyond just the individual or provider. We again thank the Appropriations Committee in eliminating the Medicaid 3 percent funding decrease and taking a proactive step in preventing a larger loss impacting behavioral health treatment. We will also ask for the full support from the Nebraska State Legislature. Thank you for prioritizing the value and funding of behavioral health services, as well as understanding and reaching in the far impact of these services and to everyone who are in need of them. Available for any questions. [AGENCY 25]

SENATOR STINNER: Thank you. Questions? Senator Wishart. [AGENCY 25]

SENATOR WISHART: Well, thank you so much for being here today. Can you speak a little bit, in your testimony you talk about how providers statewide depend on a minimal increase to attempt to balance the increased costs that automatically occur each year. Can you talk, what are those increased costs? [AGENCY 25]

JON DAY: Sure. As a provider I can talk to them personally as well as through other organizations we come in contact with. Every year...we're not any different than any other business. Every year goes by and so one of the primary...one of the biggest expenses we experience is in health insurance increases. I think we all here have experienced that to certain degrees and we also read about that in the paper. But every year our health insurance increases so that that benefit we provide to our staff, that will be an added increase to us. We also have salary increases, when they occur, as well as rent. We have other utilities. Just your daily operational expenses always increase every year. We try to minimize that. We always look to be efficient as possible, but those expenses, such as salaries and health insurance benefits, those are things you really can't do much with other than try to deal with them as best as you can. [AGENCY 25]

SENATOR STINNER: Senator Bolz. [AGENCY 25]

SENATOR BOLZ: Thanks for coming this afternoon. You heard the previous testimony of CEO Phillips and her criteria that she addressed in terms of rates were equity across states, equity across departments, access, and history. And you touched on a couple of those issues,... [AGENCY 25]

JON DAY: Uh-huh. [AGENCY 25]

SENATOR BOLZ: ...concerns that if we reduce rates we'll have a negative impact on access. And you, of course, referenced the historical trend of being able to provide 2.25. Do you have any further comments on those issues or any issues related to equity or comparison to other Medicaid services? [AGENCY 25]

JON DAY: Sure. I'm not...I mean I have some familiarity what occurs in different states. To be honest with you, I'm not that concerned about what other states are paying. I'm worried about what we're doing here in Nebraska, because I'd rather be a leader than a follower. The services we're very concerned with are just your...can range from outpatient services to more services like inpatient. We, as a provider, as well as any behavioral health provider throughout Nebraska, do depend on that annual rate increase. Can range sometimes, it might be a 2 percent increase, sometimes it's a 2.25. I think one year it was a 3 percent and that was because the previous year had lagged behind. And we as an organization depend on that. In fact, when we're putting our budget together now, we would prefer to be able to add in that 2.25 percent increase. Instead, we're having to look at where are we going to cut costs? Where can we become even more efficient and where can we...or where do we have to maybe close an office? So those are the type of things we don't want to do because primarily if we remove services, especially in the rural communities, people are going to have to drive miles, people are going to have to take more time off of work to go get services. So imagine yourself, if you're in a smaller community and you're having concerns with depression or your wife is having depression or concern with your son or your daughter, rather than just going down five, ten minutes down the street to see your local behavioral health provider, you may have to drive an hour. And so that means time off of work both ways. [AGENCY 25]

SENATOR BOLZ: Sure. [AGENCY 25]

JON DAY: And then what usually ends up happening in those type of situations, either treatment is either prevented, which delays it, or they'll discontinue it prematurely just because of the added expense. So the added annual increase that we would get would definitely help with our

increased costs and keep services as they are and we continue to work with them every year. [AGENCY 25]

SENATOR BOLZ: True. Well, I appreciate your concerns about access and, you know, just maybe for the record because you've shared with us some charts that illustrate a concern that came...that perked my attention as it relates to equity across departments, because your charts illustrate that Medicaid fee-for-service and Medicaid managed care have some rate differentials. And so, you know, being able to keep up with the behavioral health rates overall can help address some of those disparities between even programs and services within the Medicaid Division. [AGENCY 25]

JON DAY: Exactly. And we have some concerns regarding the implementation of Heritage Health. There's nothing wrong with managed care companies. I mean that's their business, is to save money. And so when I talk with other providers as well as our own staff they say, you know, when they're looking to save money, that's their job, you know? Our job is just to make sure we are able to provide the preferred services we need to. And so the roll out of Heritage Health has been fairly problematic for many providers throughout Nebraska. And we worked first-hand with each of the providers, with each of the Heritage Health plans, and we have a good working relationship with them. But talk is great, you know? Action and resolution is better. And so we're still having some problems with that throughout the state. And so I'd like to tell you that 100 percent what we just have billed out from January 1 will be reimbursed, but I know there's a possibility that some of it won't be just because when you're dealing with hundreds of claims each month, each week, it's hard to keep track of all of that. And we're doing as best as we can. In fact, we're one of the leaders in dealing with these Heritage Health providers. But at the same time, when you have three different providers and three different authorizations and three different processes, something is going to get lost between the cracks here and that's just kind a dose of reality there. And so we're trying to do everything we can to prevent that from happening. [AGENCY 25]

SENATOR STINNER: So help me with the chart. Exhibit 1 you were showing that the red line at the bottom is actually the line for Medicaid fee-for-service. And it shows that on September 1,

2013, we switched to the full-risk managed care. Did that mean that you moved...that you got to double your rates? [AGENCY 25]

JON DAY: (Laugh) Yes, that happened. No, I'm just kidding, of course. (Laugh) [AGENCY 25]

SENATOR STINNER: Well, you went from 12 to 24. I just wanted to ask that. [AGENCY 25]

JON DAY: Right. No. The chart I think was going to be more related to my next presenter or one of the other presenters that's going to be here. But when Magellan took over as the full managed care company, there was not a rate increase other than just what generally applied. [AGENCY 25]

SENATOR STINNER: Does this also reflect maybe the disparity between what Nebraska pays and what Magellan pays over their national... [AGENCY 25]

JON DAY: Right, there's a national trend that shows there's a difference in that in terms of what Nebraska Medicaid receives and pays and compared to other states. Again, with this chart, our other testifier, we'll be able to hear more to that, but. [AGENCY 25]

SENATOR STINNER: So would my conclusion be that we're actually at half the rate of the national average paid by Magellan? [AGENCY 25]

JON DAY: Magellan is no longer around. It would be hard to...I would not be able to say that is for all services but maybe for some services. I think that took into consideration all the different services that are provided on an outpatient and inpatient basis. [AGENCY 25]

SENATOR STINNER: Okay. And it does show that it, even with the Magellan rate, even though they're not around, that you're substantially below whatever index inflation that you're using. [AGENCY 25]

JON DAY: Right, and that does happen. You have inflation. You have the cost of prices index that goes on as well. [AGENCY 25]

SENATOR STINNER: So if I follow this out, somewhere along the line you fall into bankruptcy, I suppose. [AGENCY 25]

JON DAY: Well, that's what we're trying to avoid. [AGENCY 25]

SENATOR STINNER: Okay. [AGENCY 25]

JON DAY: (Laugh) What I think that chart really demonstrates as well is that there continues to be an increasing cost but the reimbursement is not keeping up with it. And so over a period of time what ends up happening is what I mentioned in my testimony, is that there's going to be a gradual erosion of behavioral health services. And usually it's not done quickly and abruptly. It's done slowly over a period of time. So what's being done now can be drastically different five years from now. May not be much different from next year, but five years out there will be a big change in services being available. [AGENCY 25]

SENATOR STINNER: What it does is probably as far as finding work force to go into this field becomes harder and harder to find. [AGENCY 25]

JON DAY: Oh, it does, definitely so, especially in the rural communities. You have a smaller pool to work with. And so one of the things we try to do as a provider, we really...we have a very low turnover rate and that's very intentionally done because there's a lot of things that go on where providers can work in other locations in larger urban areas. So we work very diligently trying to filter out some of these changes as best we can and make them more efficient. And that's what's been kind of a problem with this Heritage Health process is because as an organization we're pretty efficient with things. I guess I'd probably liken it to your roof being ripped off in a tornado. Then all of a sudden all the elements start coming in. And so you end up having to do a lot more for the same pay. And so you end up having to hire more staff, end up having to juggle more things just to be able to keep on track of the funding and what's going on with that. And so, again, we're very...we're working with Heritage Health as well as with Medicaid. At the same time, we need to have greater traction in terms of our reimbursement through Heritage Health. [AGENCY 25]

SENATOR STINNER: Trends in...as far as number of clients that you have or number of patients that you have,... [AGENCY 25]

JON DAY: Uh-huh. [AGENCY 25]

SENATOR STINNER: ...what's that trend look like? Is it going up fast or is it pretty stable? [AGENCY 25]

JON DAY: It increases. It increases. I testified here a few months ago regarding the Division of Behavioral Health and compared to three years ago I think we're seeing about 600 to 700 more people than we did. Some of that is just because we have good traction in the communities and we provide a good service to a lot of different people. We expanded through telehealth. So Senator Kolterman and we've worked with that. But we've been doing telehealth for the last four or five years. In fact, we're kind of the pioneers in doing mental health services in Nebraska. And so we've been able to expand services without having really additional funding, you know? So each year when we get that Medicaid rate increase, it helps us keep...year we get that money, we're able to invest it and use it for every penny we can and then we grow with that. And so by seeing the hundreds more people as we have three years ago is a testimony to what we're doing with our funding. So when that 2 percent is gone or that 3 percent was going to be gone--and fortunately it's back in--we're not going to go backwards. We want to go forward and we want to be able to create a big difference in Nebraska. We really want to be a leader in behavioral health treatment here in Nebraska. [AGENCY 25]

SENATOR STINNER: Okay. Any additional questions? Senator Clements. [AGENCY 25]

SENATOR CLEMENTS: Thank you, Mr. Day. You show that you've treated nearly 5,000 people and I was wondering what percentage of those would be Medicaid patients. [AGENCY 25]

JON DAY: About a third. [AGENCY 25]

SENATOR CLEMENTS: One third? [AGENCY 25]

JON DAY: Uh-huh. About a third of our funding comes from Medicaid and Medicare. The other third comes from Division of Behavioral Health funding, and the other third comes from private insurance. [AGENCY 25]

SENATOR CLEMENTS: Thank you. [AGENCY 25]

JON DAY: Uh-huh. [AGENCY 25]

SENATOR STINNER: Additional questions? Seeing none, thank you. [AGENCY 25]

JON DAY: Thank you. [AGENCY 25]

SENATOR STINNER: Afternoon. [AGENCY 25]

KATHY NORDBY: (Exhibit 8) Good afternoon. Thank you, Chairman Stinner and members of the Appropriations Committee. I'm Kathy Nordby, K-a-t-h-y, Nordby is N-o-r-d-b-y, and I'm the CEO is Midtown Health Center in Norfolk. I'm here today representing the Health Center Association of Nebraska and our seven federally qualified health centers. Our health centers are nonprofit, community-based organizations that provide high-quality medical, dental, behavioral health, pharmacy, and support services to persons of all ages. Nebraska's health centers served over 76,000 patients annually. Seventy percent of our patients are minorities, ethnic and racial minorities. Ninety-three percent are at or below 200 percent of poverty. Poverty is established, at 200 percent, as $49,200 for a family of four for an annual income. Our health centers are a safety net for providers to provide care regardless of insurance. Half of our patients are uninsured. These patients pay a nominal fee using sliding fee scale services based on their income and household size. Our patients are truly the working poor in your communities. I'm here today to thank the committee for your recommendations to restore the proposed cuts to Medicaid provider rates and the adult dental care dental caps. I urge you to hold fast to these commitments and recommendations as you continue the difficult process of setting the state's budget. Midtown Health Center has clinic locations in Norfolk and Madison and will soon be adding a mobile dental unit to take high-quality oral healthcare to nursing homes and other underserved rural communities in our area. These places often, especially the residents of nursing homes, find oral

healthcare access challenging at best and sometimes impossible. Last year we served nearly 6,000 unduplicated patients for 22,000 different types of patient encounters. Nebraska's health centers, as a state, we serve the second highest number of uninsured patients in the country, which means we have to augment the cost of care of those patients with other resources. This means that our patients who do have access to health insurance, whether it's private insurance, Medicaid, or the marketplace, are extremely important to our financial stability. While health centers receive an encounter payment for physical and behavioral health services, we do traditional fee-for-service for certain services, which includes our dental care. You will hear shortly from Dr. Brian Penly, the dental director at OneWorld Community Health Center in Omaha, and he'll talk more directly to the role of oral healthcare and the importance of maintaining the cap for those services. For me, I'm speaking about rural communities and particularly access to care and rural care can be difficult, even if an individual has Medicaid. I think you were talking about whether our rates are high enough and I would say if our rates were competitive we wouldn't be struggling to find providers to take Medicaid. So it's a supply-demand thing to me, although I haven't studied what I was paying or reimbursements. The network of providers in rural areas includes dentists and all types of providers are aging and retiring and creates a shortage in rural Nebraska. Because reimbursement rates under Medicaid tend to be lower, finding a provider who accepts Medicaid or hasn't placed a cap on accepting new Medicaid, can create a challenge for those that are on Medicaid. Preventing further cuts to Medicaid provider rates prevents further strain on access to care. Studies have repeatedly shown that disadvantaged individuals who have access to care at health centers have fewer visits and fewer hospitalizations and are more likely to receive preventative care, preventative screenings than any of the non-health-center patients. Among uninsured health center patients, we have fewer outpatient and emergency room visits compared to non-health-center patients. Moreover, research has demonstrated that people who receive care in a health center system have a 24 percent savings toward the system as a whole. In Nebraska, that conversion where we save money for the whole system converts to $97 million a year. We really respect and understand the choices that you face in the budget challenges. In fact, the health centers were awarded additional funding last year from this very committee, who worked hard to recognize the work that we do. That funding is not included in any budget proposals this year, and it magnifies the importance of holding true to the Medicaid reimbursement rates and not changing the cap on dental services. We appreciate what you've done and we hope that you will continue to protect

the most vulnerable citizens in Nebraska. With that, I'd be happy to take any questions that you may have. [AGENCY 25]

SENATOR STINNER: Questions? Seeing none, thank you. [AGENCY 25]

JESSIE HOVER: Hi. [AGENCY 25]

SENATOR STINNER: Good afternoon. [AGENCY 25]

JESSIE HOVER: (Exhibits 9 and 10) My name is Jessie Hover, J-e-s-s-i-e H-o-v-e-r. I'm representing the Ponca Tribe of Nebraska. I'm their tribal health planner and I'm here today to give testimony in regards to the Native American Public Health Program. This was established in 1998 to address serious health problems for Native Americans. It's a flat funding of $500,000 for the four Nebraska tribes. The Ponca Tribe receives $100,000 out of that appropriation. In 1998, when it was established, we still all these years later still get just the $100,000. When we look at that in according to buying power, that amount of money pretty much now equates to $67,122, about. So as our population is growing, the funds that we're getting are not growing. When we look at other entities like FQHCs, they get increased funding. In 2004 and 2005, it was $437,500, which now it looks like it's $3,000,825 in 2016. So while they have consistently received more funding, this has not helped Native Americans serve the population. As a tribal health facility, we have dual responsibilities. We have...we provide medical, pharmacy, dental, behavioral health services. We also have public health. We have the responsibility to the Native Americans in our service areas. The Ponca Tribe is kind of different from the other tribes because we have 15 service delivery areas; 11 of those are in Nebraska. So with this money we're serving all of these counties and the Native Americans that live in our counties, whether they're Ponca or whatever. So, you know, it's not a lot of money to go around for the people that we serve. You know, when we look at our population, half of them are uninsured, so we're basically picking up the cost. And tribal clinics fall under the definition of an FQHC center in the Social Security Act, but we're not actually...we're not supported by the federal program, the 330 or the Public Law 104-299, like the seven health centers are in Nebraska. As a tribally operated facility, we're kind of different than the IHS-operated facilities. The tribe has a lot more control over what's going on. But we also still fall under some IHS guidelines. So the public health services

that we provide are funded some by IHS but we're responsible for making up the rest of that, and this grant actually supports our services that we provide. Just like tribal health departments, well, like local health departments, we have the responsibility to meet accreditation standards and function as a health department, which is kind of hard when we're also seen as an FQHC. But we do partner with local health departments, universities, and systems for service, research, and professional development. With continued funding or not decreasing this for going forward to save costs in Nebraska...sorry, I'm nervous. (Laugh) So we have IHS funding but we're underfunded, so we need this to meet what we're providing to our clients. Tribal clinics, we get 100 percent reimbursement from Medicaid, so that would save dollars to Nebraska. Very few Native Americans use the FQHC services. If you look at HRSA, in 2014 only 597 Native Americans in Nebraska used these seven services. They come to places like ours that provide more culturally appropriate care. So what I'm asking is that you make this fund minimally exempt from the cuts and that you provide tribal...prevent tribal shares from being reduced by adding nontribal awardees, and also to take into consideration the amount that we've received that hasn't been increased and look at increasing the appropriations for tribal departments to compensate for inflation in matching FQHC appropriations. This will improve public health, primary care. We can increase federal support and third-party income to tribal agencies and reduce health disparities. That's it. Any questions? [AGENCY 25]

SENATOR STINNER: Thank you. Questions? Seeing none, thank you. [AGENCY 25]

JESSIE HOVER: Thank you. [AGENCY 25]

SENATOR BOLZ: Good afternoon. [AGENCY 25]

BRIAN PENLY: All right. We lost our Chairman. [AGENCY 25]

SENATOR BOLZ: Go right ahead. [AGENCY 25]

BRIAN PENLY: (Exhibit 11) Oh, very good. Okay. Chairman Stinner, who's now absent, and members of the Appropriations Committee, my name is Dr. Brian Penly, B-r-i-a-n P-e-n-l-y. I'm the dental director for OneWorld Community Health Centers in Omaha, Nebraska. I'm here

today representing the Health Center Association of Nebraska and our seven federally qualified healthcare centers in the state of Nebraska to share with you the important role that dental coverage plays in the overall needs of our neediest citizens. I urge the committee to maintain the preliminary recommendations to restore the proposed Medicaid provider rate cuts and the reduction in the adult dental Medicaid maximum. As the dental director at OneWorld, I ensure that our patients have access to high quality, culturally appropriate healthcare, regardless of insurance status or the ability to pay. In 2016, OneWorld saw over 24,000 individual patient encounters in the dental clinic across four clinic locations and two pediatric mobile clinics that are deployed to area schools. More than 30 percent of our dental patients are Medicaid recipients. And those who do not have health insurance contribute to the cost of their care based on a sliding fee scale. The link between oral health and overall health has been well established. Individuals with chronic conditions, such as diabetes, are more likely to suffer oral health issues. Oral health problems have been linked to cardiovascular disease. As recent as last month, February 2017, research from the University of South Carolina School of Medicine has shown that stroke risk increases up to 2.2 times the baseline risk when gum disease, or periodontitis, is present. We have seen claim of oral cancer that have risen 61 percent since 2011. A simple search through Medline shows that we have 967 research articles associated simply with oral health and cardiovascular risk. So oral health is often the conduit through which other medical problems manifest. Lack of access to routine preventive dental care is a major driver of dental-related hospital visits. In addition to preventive screenings, our patients are in dire need of pain-relieving and life-enhancing treatments, such as fillings, crowns, root canals, dentures, and emergency dental services. One of our clinic locations has a one day per week walk-in clinic dedicated just to emergency patients. Often, it is very difficult for us to meet the demand of this, so we as an organization have made a decision to create a full-time, five-day-a-week, walk-in clinic specifically to service adult emergency patients. We see on a weekly basis individuals who are less than 24 hours away from the emergency room due to the severity of their conditions. Twice in the past month I, myself, have personally performed emergency incise and drain procedures on patients, late on a Friday afternoon, knowing that if I didn't their next step would likely be a multiday visit to a hospital to treat cellulitis with possible life-threatening implications. Due to the access provided by ourselves and other Medicaid dental providers, the state is able to avoid costly ER and extended hospital stays. For many of our adult patients, they present with oral health needs that far outpace the $1,000 cap currently in place, let alone a $500

cap that's been proposed. FQHC dental patients, especially adult patients, often have previously limited exposure to dental care, which amplifies their need for more frequent treatment. Lack of access to oral healthcare not only impacts their overall health but is a quality of life issue impacting speech, nutrition, and their ability to get and hold a job. Across the state the dental clinics of Nebraska-based health centers are at capacity, with some clinics reporting appointments set out as far as three to six months. Reductions in Medicaid provider rates would place further strain on access to oral health issues. With oral health provider rate reimbursements already falling far below the actual cost of care, further reductions could lead to an increased number of providers refusing to accept Medicaid patients. I also serve as a board member on the Nebraska Academy of General Dentistry. I'm not representing them today, but conversations with our Medicaid serving constituents has basically shown a reduced interest in becoming Medicaid providers. I can say with great certainty that further reductions would overall reduce the access to care for the vulnerable Medicaid populations. While our health centers serve all that come through our doors, our capacity is limited. Without appropriate reimbursements in place, we cannot meet the demand for services. As safety net providers in Nebraska, our health centers are the only source of healthcare for uninsured and underinsured, especially with respect to oral health. Preserving access to that care provides a critical role in the success and well-being of Nebraska families. I urge the committee to hold fast to the recommendation to restore the cuts to Medicaid provider rates and to the dental benefits. Thank you for your time. I'd be happy to answer any questions. [AGENCY 25]

SENATOR BOLZ: I do have one question. [AGENCY 25]

BRIAN PENLY: Yes. [AGENCY 25]

SENATOR BOLZ: You've heard me ask other committee members, based on the criteria of...other testifiers, based on the criteria that CEO Phillips addressed to us--equality, equity across states, fairness across the Medicaid Division, access, and historical rates--how are we doing in terms of dental services rates? [AGENCY 25]

BRIAN PENLY: My own, okay, so my own history has been I was a private practice dentist up until about a year and a half ago when I made the move to become OneWorld's dental director. I

did serve in Council Bluffs and was a participant in the Iowa Medicaid program, so that's really going to be my only across state bounds sort of, I guess ability to speak to that overall. I would say that we're falling somewhat short of what other states are providing. Although I do recognize that we are also one of the only states that has adult Medicaid benefits, so I appreciate that. And I don't want to think the Medicaid people...or that I'm being ungrateful by any means. I know that with the reimbursement rates that we currently get versus a full fee-for-service practice, we're probably getting about 34 cents on the $1 in terms of what our...what we would normally charge somebody that would just be coming and paying cash. Against normal PPO insurances, we're probably getting about a 20 to 35 percent rate reduction over that as well. A further 3 percent decrease would take us down to about 31 cents on the $1 in terms of our reimbursements. Average annual overhead for a dental practice, and I'm not even talking an FQHC but a private practice, those are usually around 60 to 70 percent overhead. And what ends up happening is that the costs can't even be covered, so you have less and less of those providers that are going to want to take care of it. As an FQHC provider, I'm concerned about that mainly because we don't have the capacity for every single Medicaid patient to come to our clinics. We need the private practice providers out there being able to support the Medicaid population as well. [AGENCY 25]

SENATOR BOLZ: Thank you. Thank you. [AGENCY 25]

BRIAN PENLY: All right. [AGENCY 25]

KRIS STAPP: (Exhibit 12) Well, shorten this up a little bit since Senator Stinner needed a break. But thank you for letting me visit with you, Appropriations Committee members. My name is Kris Stapp, K-r-i-s S-t-a-p-p. I am representing the Visiting Nurse Association which is celebrating our 120th year of serving Omaha and surrounding communities in the provision of community health services, including services to vulnerable mothers and children. VNA, in partnership with OneWorld Community Health Center, provides the evidence-based early childhood home visitation model Healthy Families America in Douglas County which is funded under LB327, Program 514, as a part of the Health and Human Services budget. These funds also provide three additional Healthy Families America providers, including Lincoln-Lancaster County Health Department, Northeast Nebraska Community Action Partnership, and Public

Health Solutions, which have provided written testimony or educational materials. I'm here today to respectfully request the preservation of funding for the critical services provided through evidence-based early childhood home visitation. Currently in our third year of funding, VNA began enrolling families in June 2014, and since that time 131 families, including 360 mothers, fathers, and children, were provided 2,558 home visits to ensure the best start in life for their young children. In 2016, 72 percent of these families has household incomes of less than $25,000 with 41 percent bringing in less than $15,000 annually. Families seen through this program often struggle with extremely complex issues, including poverty and lack of resources, such as adequate food and stable housing, mental health issues, domestic violence, substance abuse, physical health issues, physical and cognitive disabilities, and more. We believe it is critical to engage families early in home visitation so they may receive the benefit of a preventive approach, proven through rigorous research to result in positive outcomes critical to healthy families and strong communities. We know evidence-based home visitation programs make a significant impact on struggling and vulnerable families while also saving time and money for the justice and human services system. In May 2012, The Pew Center on the States reported in the case for home visiting that the highest quality home visiting programs produce positive outcomes which yield savings of up to $5.70 per taxpayer dollar spent in reduced mental health and criminal justice costs, decreased dependence on welfare, and increased participant employment. Mothers in home visiting programs are more likely to deliver healthy babies and less likely to become involved in the criminal justice system, and their children are less likely to suffer from abuse and neglect. Additionally in your handouts you'll find Healthy Families America specific impact sheets that I hope you'll take a look at. In closing, I'd like to share a success story of a participant in VNA's HFA program. When Mary entered our program, she was 21 weeks pregnant, stressed, suffering from depression, and unsure how to address her older children's behavioral issues. On her second home visit Mary confided to her home visitor that her husband had assaulted her when drinking earlier that week, resulting in hospitalization. Mary's home visitor immediately referred her to the Women's Center for Advancement for domestic violence services, which would help her develop a plan for keeping her and her children safe. They would also help her determine a course of action for the future of her relationship. When Mary reached a decision to pursue divorce, the support of the WCA and her home visitor allowed her to safely begin the move toward independence. At that time, Mary was also referred to legal aid services to assist with the legal process. Unfortunately, Mary's husband and the father

of her children refused to provide financial support, causing them to struggle to meet even basic needs. Mary's home visitor connected her with community resources, including essential pregnancy services, food pantries, utility assistance, and suitable day care so Mary could attend school and become self-supporting. Now, two years old, Mary's youngest is happy, loves his day care, and is developmentally on target. Mary has completed her LPN training and working part-time as she continues her education to be an RN. Now divorced, Mary works to keep communication open with her ex-husband so her children can continue to build a relationship with him. She finds great joy in the ability to provide for her family and is excited about her future and the future of her children. We wish to thank you for your time and again respectfully ask for the preservation of funding for these critical services. We know you have many difficult decisions to make but appreciate the value you place in supporting our most vulnerable children in the state of Nebraska. [AGENCY 25]

SENATOR BOLZ: Thank you. Any questions for Ms. Stapp? Okay. Thank you very much. [AGENCY 25]

KRIS STAPP: Thank you. [AGENCY 25]

SENATOR BOLZ: Further proponents for Agency 25, HHS Operations, Veterans' Home, Medicaid and Long-Term Care, and Public Health. [AGENCY 25]

CAROL ERNST: (Exhibit 13) Good afternoon, members of the Appropriations Committee. My name is Carol Ernst, C-a-r-o-l E-r-n-s-t, and I am the cochair for the board of directors for Nebraska Health Care Association. And I'm also the executive director for Eastmont Towers, a retirement community here in Lincoln. On behalf of the Nebraska Health Care Association, please accept this letter into the record in support of the proposed Medicaid nursing facility and assisted-living rates included in the Appropriations Committee 2017-2019 biennium budget. Nebraska Health Care is the largest statewide association, representing nonprofit and proprietary nursing facility and assisted-living providers. Our 430-plus nursing and assisted-living facility members employ over 2,800 who care for the most vulnerable Nebraskans every day--those who are elderly, ill, frail, disabled, or at the end of their lives. On behalf of our members, we thank the members of the Appropriations Committee and express our appreciation for the alternative

solution to our state's budgetary challenges which you have developed, which includes a 1 percent rate increase for nursing facility care and eliminates the rate decrease for assisting-living services. Medicaid is the main payer for nursing facility services, with 53 percent of our residents reliant on this reimbursement to cover their care. This percentage is lower than the national average of 62 percent, mainly because Nebraskans' tendency to prepare for their future through savings or long-term care insurance is higher and better than other states nationally. Each year individuals paying for their care, usually with self-pay or private resources, increasingly supplement the Medicaid payment for those receiving the same care. Currently, the Medicaid rate is $25 per day per person, less than the average cost of providing the care. And I think many of you know that there are providers where it's much larger than that. Facilities in this state, there are many facilities in this state who could not withstand a future rate decrease. Senator Stinner, you were absolutely on target. Because I work with many of my colleagues across the state, there are some who are struggling mightily, many of them are rural providers who have high Medicaid utilization rates. They simply cannot withstand that decrease. Although the 1 percent increase in nursing facility rates and the lack of decrease in assisting-living rates will not cover Medicaid underfunding, we understand that you are doing the best that you can to address this budget deficit, at the same time care for the most vulnerable of our citizens. We support your efforts. We encourage you to hold the line on provider rates in the face of what's likely to be increasing demands to divert funds for other purposes. The elderly and the disabled need our help to ensure that they can continue to receive vital and necessary medical care and health services in their own communities. They are counting on you. We are counting on you. Nebraska Health Care Association appreciates your leadership in the legislative services and to your services of all Nebraskans. Thank you. Does anybody have any questions for me? [AGENCY 25]

SENATOR STINNER: Questions? Senator Bolz. [AGENCY 25]

SENATOR BOLZ: I'll ask you the same question I have asked many of the other testifiers. Given CEO Phillips criteria of equity across states, fairness across the division, access to services, and history of funding, how are we doing in terms of nursing facility rates? [AGENCY 25]

CAROL ERNST: Well, and my answer is probably much like others. Nursing facility rates for Medicaid vary markedly from state to state, some better, some worse. But I think we know that we've continued to lose in terms of what our rates, of our costs, for providing services are compared to what the rates that we have received in the past are. So it's difficult to compare apples to apples, but what we do know is that providers are increasingly unable to provide this access, which means they simply can't take as many Medicaid residents or for some providers they need to get out of the...to get out of that product line. For me, as a provider, we have independent living, assisting-living, skilled nursing, and hospice here in Lincoln, so we have multiple product lines. Many of the nursing homes do not have that, that luxury. So if they have a 70 percent Medicaid utilization rate, it's almost impossible to make up for that through private pay. I hope I answered your question. [AGENCY 25]

SENATOR BOLZ: (Laugh) Well, I guess I might put it a little bit more bluntly than you put it. It sounds like because of historic underfunding of nursing provider rates, we're beginning to have an impact on access, particularly in rural communities. [AGENCY 25]

CAROL ERNST: Absolutely, without a doubt. [AGENCY 25]

SENATOR STINNER: Any additional questions? Seeing none, thank you. [AGENCY 25]

CAROL ERNST: Thank you. [AGENCY 25]

JULIE KAMINSKI: (Exhibits 14 and 15) My name is Julie Kaminski, J-u-l-i-e K-a-m-i-n-s-k-i. And in the interest of time and the number of people behind me and somewhat duplication, I'm not going to read my testimony. Basically, we oppose the 3 percent cuts. We support the 1 percent biennium increase that was in your preliminary budget. I am normally not an alarmist; I'm an optimist. I am ringing the alarm bell that if these 3 percent cuts go through, we will have nursing homes across the state close their doors. In Omaha, one of our providers who's running 90 percent Medicaid estimates $300,000 loss a year. They will close their doors. Rushville, Nebraska, an assisted living that's running about 60 percent Medicaid to 80 percent estimates about a $50,000 loss that will close their doors. This is across our state. Our members, as nonprofits, consider it their calling to serve the Medicaid population, their right, their honor,

their duty. They can't continue if these cuts go through. My second sheet talks about the underfunding of long-term services and supports. It spells out quantitative data, what the gap is at the nursing home level, what it is at the assisting living and the adult day. We're seeing fewer homes taking nursing home...or taking Medicaid patients. I would encourage any of you to try to find an assisting-living bed for a Medicaid individual or memory care. You can't do it right now. It's just the access is already increasingly difficult. If these cuts go through it will be even more so. And at a time when our aging population is growing, we need proactive, creative, innovative solutions, not cuts to provider rates. And I'm happy to answer any questions. [AGENCY 25]

SENATOR STINNER: Questions? Seeing none, thank you. Afternoon. [AGENCY 25]

SCOTT JANSEN: Good afternoon, Senator Stinner, members of the Appropriations Committee. My name is Scott Jansen, S-c-o-t-t J-a-n-s-e-n. I'm speaking on behalf of the Nebraska Medical Association. They've asked me to speak on their behalf. I'm also the practice administrator for Complete Children's Health. We are a large pediatrics practice here in Lincoln. I want to share just a little bit of information on what I am facing if the Governor's budget, especially the 3 percent reduction in provider reimbursement, goes down. We currently have 23,880 active patients; 6,276 of those patients are Medicaid patients. That population is approximately 26.2 percent of the patients that we serve currently and we're proud of that. We're proud to provide services to that segment of our population and wish we would do more. However, currently that 26 percent of the population represents a little over 14 percent of our revenue. In addition to that, we have seen over the last five years a pretty significant increase in cost of providing interpretation services, a cost that we absorb unreimbursed, because our preference is to have a live interpreter as opposed to a phone interpreter. Eighty percent of the interpreter clients or eighty percent of those patients who require those services are also Medicaid patients. We've seen an increase from $70,000 a year five years ago to this year we expect to spend over $120,000 for those services as well. So as a small business, we're faced with a decision, too, and that is what do we do when we start to see a reduction in our revenues? We're faced with the same choices that you are faced with and that is, do we look to eliminate jobs and reduce costs and expenses, or do we look to potentially change the model of services that we provide? Right now for me to see a commercial paying patient, I get about three times what I receive in reimbursement currently for a Medicaid patient. So if the decision that I am facing and the

question that has been asked is, would a change like this result in the need to limit access or would access be limited to Medicaid population? I most certainly fear that it would. I would hate to see that happen but I fear that it would. It would reduce access to my services. What it, however, won't reduce access to, and I think this is a question that doesn't get asked enough is, where will these folks go for services? They will go to the most expensive avenue that is available to them and that's the emergency room. So instead of actually saving dollars on services by making a reduction in the providers, my fear is that the costs will actually increase ultimately as a result of where these folks will have to go to receive services. I would hate to see that happen. So I would again encourage you not to pass on the Governor's requirement for a reduction in provider reimbursement. I'm happy to answer any questions. [AGENCY 25]

SENATOR STINNER: Questions? Seeing none, thank you. [AGENCY 25]

SCOTT JANSEN: Thank you. [AGENCY 25]

SENATOR STINNER: Afternoon. [AGENCY 25]

RICHARD AZIZKHAN: (Exhibit 16) Good afternoon. Good afternoon, Chairman Stinner and members of the Appropriations Committee. My name is Dr. Richard Azizkhan, R-i-c-h-a-r-d A-z-i-z-k-h-a-n. I'm the president and CEO of Children's Hospital and Medical Center and I'm here speaking on behalf of Children's Hospital and our patients, as well as the Nebraska Hospital Association. I'm also here to provide some background and context on why the proposed reductions in Medicaid payments in the preliminary budget are of such strong concern to our hospital, our employees, and most importantly our patients and families who we're entrusted to serve. Your job this session is certainly not easy, and hopefully I can provide some clarity of the impact these cuts would have on our growing Medicaid population. As the only full-service pediatric specialty healthcare facility in Nebraska, we are tasked with taking care of children with very complicated, chronic, and unusual diseases, in addition to providing primary care for children. Children's Hospitals around the country provide care for a disproportionate share, about 70 percent, of the children that have complex and chronic diseases, most of whom have Medicaid, and this is due to the financial impact of their healthcare needs on their family. Our institution is no different and serves as the safety net hospital for all children in our state and

region. These are children with complex anomalies, like congenital heart disease, childhood cancer, extreme prematurity, and children that require major surgical needs, and also those who require complex subspecialty pediatric expertise for the unique needs of these families. The volume of our services is growing at a significant rate, about 6 percent per year, and this demand is because of population growth but also because of expanded new programs and services. Families are traveling long distances to receive care that they cannot receive in their local or regional hospitals. We're currently exceeding our physical capacity and our patient census often exceeds 95 percent. In fact, in January of this year we had to divert 27 children for critical care services because we did not have the physical capacity to care for them. Many of these children had to leave our state. They went to Denver or to Kansas City or other Children's Hospitals in six states surrounding our region. Despite the volumes we saw in January and February this year, Children's Hospital experienced a financial loss, in large part due to our growing percentage of Medicaid patients and their high levels of acuity. Just to give you some background, in 2015 Children's Medicaid mix was 43.5 percent, resulting in over $30 million of uncompensated costs in the Medicaid program and charity care. This number grew to 45.1 percent in 2016. Each quarter, the percentage continues to grow and the last two months we have seen our Medicaid mix rise to 50 percent. For every percentage of Medicaid, this results in a $2.4 million decrease in our margin. The proposed 3 percent Medicaid cut will greatly impact our ability to grow and expand to meet the needs of nearly 2 million children that live within a 250-mile radius of our Children's Hospital. We're the only Children's Hospital in that radius. If we continue to operate at a 50 percent Medicaid mix, the 3 percent cut to all inpatient, outpatient, and provider services would be an $8.1 million cut annually. This cut is truly concerning and is going to disproportionately impact the Children's Hospital. In addition to the proposed 3 percent cut, the state's largest 27 hospitals, including Children's, have sustained a 6 percent reduction to all inpatient services through the state Medicaid reimbursement model. Nebraska DHHS has acknowledged that since July 2014 these hospitals have not been paid accurately due to the rebasing issue. The financial impact to Children's alone has been $9.5 million to date. I know you'll be hearing from other hospital testifiers on the bill today and Children's is very supportive of that proposal. In conclusion, Children's and other safety-net hospitals cannot sustain a 9 percent reduction, Medicaid cuts and to Medicaid reimbursement in this biennium, and still be able to provide accessible, innovative, and quality healthcare. Coupled with the uncertainty of Medicaid funding at the federal level, we are genuinely concerned that access to healthcare for

our children will be diminished. And as you know, the children are our future. We know that the state is facing a very difficult budget decision this year and we want to be a partner in helping address the temporary shortfall by growing high-demand nursing and physician jobs and making healthcare finance and the delivery system less expensive for all. However, we would encourage you to look at all the proposed cuts that hospitals like Children's are facing and our ability to continue down the path as you make your final budget recommendations. I want to thank the committee for the opportunity this afternoon to discuss this important matter. As you make these difficult decisions in the coming weeks, I hope you will consider Children's Hospital and myself as a resource to you. Thank you. [AGENCY 25]

SENATOR STINNER: Thank you. Senator Wishart. [AGENCY 25]

SENATOR WISHART: Well, thank you so much for being here today. I had the privilege of touring the Children's Hospital this summer and it is an exceptional institute. So thank you for the work you do leading the hospital. Can you talk a little bit, when I did tour I was introduced to some of the plans for expansion. Can you talk a little bit about those plans, the dollars that it's going to cost and why you're expanding at this time? [AGENCY 25]

RICHARD AZIZKHAN: So we have a major unmet need in the region. Our patient volumes continue to grow at 6 percent a year, as I mentioned, and our surgical volumes have grown 20 percent in the past 18 months. We're also realizing that we have certain gaps in our services that we're trying to fill, so, for example, we have only one pediatric neurosurgeon in the entire state. That neurosurgeon is involved in treating brain tumors in children, which, by the way, we have the second highest prevalence of brain tumors of any state in the country. And rheumatology, there's only one rheumatologist in our region. So these individuals, these providers are over saturated with patients. And so we are aggressively recruiting individuals to help fill those gaps and grow those programs and create interdisciplinary subspecialty programs that address the needs of these children with very complicated problems. We are also...we have a lease for our NICU beds in Methodist and that lease expires in 2021. So the combination of our need to expand because of the critical aspects of providing services, and the fact that we need to actually build our NICU on our site because the lease is running out, we're adding basically a 500,000 square foot facility that will be almost all ICU beds and expanded operating rooms. This is a

$450 million commitment and we are largely paying for this out of our operations and our reserve funds. We are borrowing $100 million. We just had a bond that was appropriated. And so we are entrusted to care for these children. There's no other facility in the region. I'm a pediatric surgeon by training and when I practiced for 40 years and I was in Cincinnati Children's Hospital, we had many children coming from Nebraska for the services that we offered there because the Children's Hospital here did not have those services. I am planning to close those gaps so that our kids, our community can be served better and those children and families don't have to travel. [AGENCY 25]

SENATOR STINNER: Additional questions? Senator Bolz. [AGENCY 25]

SENATOR BOLZ: You're here today representing the Nebraska Hospital Association as well as Children's. Is that correct? [AGENCY 25]

RICHARD AZIZKHAN: Yes. [AGENCY 25]

SENATOR BOLZ: So from the perspective of the Nebraska Hospital Association, I'll ask you the same question that I've asked other types of providers which is, according to CEO Phillips, the criteria we should be using to assess the fairness of rates is equity across states, fairness across the division of...the Department of Health and Human Services, access to services, and historical information. So in terms of our budget proposal, the Governor's budget proposal, and rates overall, how are we doing on those criteria? [AGENCY 25]

RICHARD AZIZKHAN: It depends who we get compared to and whether they're expansion states or not. I would say overall we're in the bottom quartile compared to the states that I've practiced in. And I spent 17 years in Cincinnati so the state of Ohio appropriations were significantly better than what we are experiencing here. And that really is challenging in being able to recruit the right kind of individuals who support the professional practices. Our physicians are largely employed so they're salaried, but we have to be nationally competitive. We set our physician salaries somewhere between the 25th and 50th percentile because it's difficult to match some of the reimbursement that we see in other large urban areas and academic health centers. [AGENCY 25]

SENATOR BOLZ: And the other criteria, fairness across the Department of Health and Human Services, access, and history? [AGENCY 25]

RICHARD AZIZKHAN: Well, it's hard for me to really address that. I've been in this region only 18 months so I'm still learning a lot about our community. It's a wonderful state and a wonderful community, but I'm not sure that we're equitable across the entire system as we should be. [AGENCY 25]

SENATOR BOLZ: Thank you. [AGENCY 25]

SENATOR STINNER: Additional questions? [AGENCY 25]

SENATOR HILKEMANN: Yeah, Dr. Azizkhan, thanks for coming and I'm looking forward to the wonderful addition that you're going to be putting on at Children's Hospital. Isn't part of the reason (inaudible) that is so dependent upon Medicaid is like aren't the preemie babies and so forth like that, that you take care of, don't they kind of like automatically qualify for Medicaid even if their parents have insurance or their parents' insurance is very inadequate to take care of them? Is that...isn't that part of the situation? [AGENCY 25]

RICHARD AZIZKHAN: Well, I think that there's a component of that. But 80 percent of the babies that are in our NICU have Medicaid and the primary reason for it is that they have very complicated problems. They're extremely premature and often have a coexisting comorbidity, as congenital heart disease or a surgical problem. We're the only level for a NICU, the highest level that's possible, in the entire state. So these babies have an average length of stay of 30 days, so they tend to be very ill and we try to back transfer them to other, closer to their homes, when they are stable. But this is a very, very sick group of babies. And so because of that, the family's financial situation usually make them qualified for Medicaid. [AGENCY 25]

SENATOR HILKEMANN: Okay, it's not necessarily that the baby automatically qualifies for Medicaid because of the diagnosis. [AGENCY 25]

RICHARD AZIZKHAN: That's correct. [AGENCY 25]

SENATOR HILKEMANN: Okay. Thank you. [AGENCY 25]

SENATOR STINNER: Senator McDonnell. [AGENCY 25]

SENATOR McDONNELL: Doctor, thank you for being here today. With your budget, how much...what percent of your budget comes from the private, just private donations? [AGENCY 25]

RICHARD AZIZKHAN: For operations, almost nothing. We use our philanthropic support to invest in the programs and in the capital for the building, the, you know, expansions or those sorts of things. But our...you know, we've run a very lean shop for a long period of time and we try to make...our philanthropy doesn't support our operations. [AGENCY 25]

SENATOR McDONNELL: You were also talking about 70 percent of the babies, Medicaid. [AGENCY 25]

RICHARD AZIZKHAN: Uh-huh. [AGENCY 25]

SENATOR McDONNELL: How do you deal with that? If they're not meeting right now the cost, with Medicaid is not going to cover the cost, are you able to handle that? [AGENCY 25]

RICHARD AZIZKHAN: So we make it up on the commercial side and...but 54 percent of our patient days are Medicaid for the hospital and about 50 percent of our patients currently. So it's...what concerns me is Director Lynch says, well, the enrollments are flat. But why are we seeing such a huge increase in patients who have Medicaid or are eligible for Medicaid? Part of it is we're seeing other states that have normally taken care of some of our Nebraska patients, especially from the western part of the state. Those, Denver is not accepting some of the Nebraska Medicaid patients so they're coming our way. We're seeing an influx in certain communities of immigrants that don't have the resources and have become eligible for Medicaid. So we're seeing a lot, I think there's a lot of factors. And as we expand our programs that serve children with complex and chronic diseases, those children, many of the families are just not able to support them with their commercial insurance products. [AGENCY 25]

SENATOR McDONNELL: Thank you. [AGENCY 25]

SENATOR STINNER: Senator Hilkemann. [AGENCY 25]

SENATOR HILKEMANN: Following up on that, what percentage of the care do you provide that you will never receive reimbursement for, that they have no insurance at all? [AGENCY 25]

RICHARD AZIZKHAN: It's about 1.5 percent of our patients have no insurance mechanism at all. [AGENCY 25]

SENATOR HILKEMANN: One and a half percent. [AGENCY 25]

RICHARD AZIZKHAN: Uh-huh. [AGENCY 25]

SENATOR HILKEMANN: Okay. I would have thought it might have...I would have expected it to even be higher than that, but. [AGENCY 25]

RICHARD AZIZKHAN: Well, most children get covered by CHIP or Medicaid, so, you know, we're very fortunate in this country to have these... [AGENCY 25]

SENATOR HILKEMANN: Okay. [AGENCY 25]

RICHARD AZIZKHAN: ...mechanisms to support children. So it is very different than the adult population where you may not have, you know, a young person may not have, you know, adequate insurance or they're at the poverty line and they still don't have access. [AGENCY 25]

SENATOR HILKEMANN: Okay. So that's kind of where I was coming at when you get some of these micro preemies and so forth like that, that they do...just just simply...that's how...their families are immediately put into the Medicaid. Is that how that works? [AGENCY 25]

RICHARD AZIZKHAN: Well, if they reach a certain financial metric then they become eligible. [AGENCY 25]

SENATOR HILKEMANN: Okay. [AGENCY 25]

SENATOR STINNER: Senator Vargas. [AGENCY 25]

SENATOR VARGAS: Thank you very much for being here. I also had the opportunity to visit and it's a great facility. I just wanted to expand on some part of your testimony. I think you were elaborating or you're highlighting this aspect of the impact it's going to have on you specific to this, you know, the increases that we're seeing and the number of the mix, Medicaid mix. And you say that it's concerning because it's going to disproportionately impact Children's Hospital. Can you elaborate on how this will...how it's disproportionately going to impact Children's Hospital relative to other institutions? [AGENCY 25]

RICHARD AZIZKHAN: Well, if you compare Children's Hospital to other large hospital systems, the percentage of Medicaid patients is so much higher than other community hospitals. And there, you know, when you reach in the 50 percent range, that's pretty significant for an acute care facility. Children's Hospitals nationally are 53 percent Medicaid and so this is pretty consistent across the free-standing Children's Hospitals, of which there are only 32 in the United States. So we have a privilege of being one of those 32 Children's Hospitals, but we're all in the same boat in terms of we're safety-net institutions. We never turn a child away or a family away that needs care. And so...and we also provide highly specialized care, so this is expensive care today. And so our reimbursement to cover the cost is less than 70 cents on the dollar. [AGENCY 25]

SENATOR VARGAS: Thank you. [AGENCY 25]

SENATOR STINNER: Senator Wishart. [AGENCY 25]

SENATOR WISHART: So you called your institute a safety net in the sense that you do not turn away care. Do you see, as with continued cuts, that you will no longer be able to serve that purpose? [AGENCY 25]

RICHARD AZIZKHAN: We'll never turn away a child that needs acute care, but we may restrict certain kinds of programs that are more elective and those children may have to be served in other ways. [AGENCY 25]

SENATOR WISHART: And then just to add on to that, because this is something that I've been thinking a lot about as we're looking at our appropriations, we spend so much time and effort and money in finding cures for diseases in this country. We try to innovate cures. And it's startling to me that we spend so much of that effort and then people...a lot of people in this country don't have access to that. [AGENCY 25]

RICHARD AZIZKHAN: Uh-huh. [AGENCY 25]

SENATOR WISHART: I've been waiting to ask somebody about this but...and I think you'd be the right person. Just from your perspective in the work you do, can you talk a little bit to that? [AGENCY 25]

RICHARD AZIZKHAN: Yeah, when...I'm an academic surgeon and so I've spent my entire career in academic environments, and so I understand the importance of research and innovation because it's really the currency of the future. It also helps us drive the educational process so our work force is replenished appropriately with highly skilled individuals. At the same time, we have disparities in healthcare. We have disparities in access. We have disparities in outcomes. In the same community, even though we're providing excellent care across the board, we still have outcome disparities between the African-American population that lives in north Omaha versus people who live in west Omaha, and there are lots of reasons for it. It's a very complicated set of issues. One of our roles as a Children's Hospital, as in my role as the CEO, is to drive the healthcare equation upstream so that we prevent these major issues going forward. And so as a Children's Hospital, we are continuously looking for ways to partner with community enterprises, community agencies, other healthcare systems, the schools to be able to drive down the consequences of unmet needs way upstream. So for me, conception or before conception is where we have to even intervene. And so I'm working very closely with all the healthcare enterprises, all the CEOs as well as the YMCA and Building Healthy Futures in how do we create a system that will improve the health status of children? So if we can prevent something,

which I think we could prevent probably 40 to 50 percent of the diseases that we are currently treating, by going upstream, that will save huge amounts in the long run. [AGENCY 25]

SENATOR WISHART: Well, thank you for the work you do. [AGENCY 25]

SENATOR STINNER: You indicated in your presentation that a 3 percent cut would be $8.1 million. How much of that is state money? [AGENCY 25]

RICHARD AZIZKHAN: Well, it's the Medicaid component. [AGENCY 25]

SENATOR STINNER: Okay. And the $9.5 (million) then, how much of that is state money? [AGENCY 25]

RICHARD AZIZKHAN: That's the result of the cut that has already occurred, the 6 percent that's already occurred. [AGENCY 25]

SENATOR STINNER: Okay. [AGENCY 25]

RICHARD AZIZKHAN: And that's over the last two years. [AGENCY 25]

SENATOR STINNER: Okay. Then I'll have to look and see which part is the state and which is feds, so. [AGENCY 25]

RICHARD AZIZKHAN: Yeah. [AGENCY 25]

SENATOR STINNER: Additional questions? Seeing none, thank you. [AGENCY 25]

RICHARD AZIZKHAN: Thank you so much. [AGENCY 25]

MARK INTERMILL: (Exhibit 17) Good afternoon, Senator Stinner,... [AGENCY 25]

SENATOR STINNER: Good afternoon. [AGENCY 25]

MARK INTERMILL: ...members of the Appropriations Committee. My name is Mark Intermill, it's M-a-r-k I-n-t-e-r-m-i-l-l, and I'm here today on behalf of AARP Nebraska. First of all, I want to thank the committee for restoring the cuts in the dental benefits and also some of the provider rate cuts. I'm here today to discuss the Medicaid and Long-Term Care budget, and specifically the last half of that phrase. The Long-Term Care portion of Medicaid and Long-Term Care refers to a handful of state-funded programs that provide important services, particularly to older persons. And the two that I wanted to address are known as Programs 559 and 571, the Care Management Services Act and the Community Aging Services Act, and to request an increase in funding for those programs. You can see in my statement that I'm not going to read, in the interest of time, and normally I hadn't planned to be here today to ask for additional funds until I began to look more closely at the, first of all, the Department of Administrative Services' annual budgetary report, also the Governor's request, and began to identify that there may be some room in the budget to make a request of this nature. As I see in the budget, there are three factors that lead me to conclude that the Program 348, and what I'm proposing is that we offset the increased funding in the two Aging Services Programs with a reduction in the Medicaid budget. The three primary factors that lead me to conclude that Program 348 is larger than it needs to be are that it's built on a larger base than may be necessary; that the Federal Medical Assistance Percentage assumptions may be lower than they need to be; and finally that the utilization growth, the assumption for utilization growth may be lower than it needs to be. In terms of the base, in looking at the Department of Administrative Services' report, that we budgeted $854 million for Medicaid in FY '16 and spent $771 (million), a difference of $83 million less spent than had been budgeted. That budgeted amount was the basis for the appropriations for FY '17, which seems to be moving on to FY '18. In terms of the Federal Medical Assistance Percentage, we are in the process, we...FY '16 was the lowest FMAP that we've every had and probably ever will have. Typically, we're in the 58 to 61 percent. We were just above 51 percent in FY '16. This is based on personal income information, federal compared to state personal income information. It appears that we are headed back to 55 percent by FY '20, just based on information that has already occurred. So every percentage point in FMAP is worth about $20 million or an increase in FMAP relieves $20 million of state funding. And then utilization growth, we looked at the assumptions of the Governor's budget, looked, it translates to about a 2.2 percent growth in utilization. Over the past three years, we have not grown at all. In fact, if you look at the CMS numbers, we're down a little bit from the third quarter of FY '13. So we see that we have...we

believe that we have some room in the Medicaid budget, both for this small increase in funding for Community Aging Services but also for some of the restoration of rate cuts that you've been hearing about this afternoon. We would encourage you to take a close look at this. This is...these are very important programs that serve people who have tremendous needs and we would encourage that you take a look at both the Aging Services additional funding and restoring some of the cuts in Medicaid. And with that, I will end. [AGENCY 25]

SENATOR STINNER: Thank you. Any questions? Senator Hilkemann. [AGENCY 25]

SENATOR HILKEMANN: To sum it up, what you're saying is that we traditionally overbudget and that's...so we're causing some needless cuts that we shouldn't have to be having. Is that what you're saying? [AGENCY 25]

MARK INTERMILL: Yeah. And I think there was some lapse of some of the over...the money that wasn't spent last year, but we still moved some of it into the next year. And in my statement I make the point that typically this is not a problem because we're not in the type of fiscal situation that we're in this year. Every dollar that we budget but don't spend is...it just doesn't seem to make sense to me to go that direction. We need to be a little bit more careful and budget a little more tightly than we may have done in the past. But basically, what you said is right. [AGENCY 25]

SENATOR HILKEMANN: What you're saying is we're not as deliberative as we should be? [AGENCY 25]

MARK INTERMILL: I think just to look a little bit more closely at the assumptions and the trends. You know, we've been in a trend line of lower Federal Medical Assistance Percentage, but now we bottomed out and we're going back up. And the assumptions that were based, at least in the Governor's budget, were based on kind of that 51.86. I think by the end of this biennium, this next biennium, we'll be getting close to 55 percent based on the personal income information from Nebraska and the United States. [AGENCY 25]

SENATOR HILKEMANN: So you see an influx of more federal dollars coming in to help us on Medicaid. [AGENCY 25]

MARK INTERMILL: Predicting the future of Medicaid is dicey right now. (Laugh) But if the Medicaid program stays as it is currently constituted, yes. And I think our personal income in Nebraska was, for the last three quarters, has been equal to the United States' personal income. That circumstance leads to a 55 percent FMAP. It's the...if they're equal, that's what the Federal Medical Assistance Percentage would be. So that's what I see as an opportunity for...that there could be some additional funding available for some of these services. [AGENCY 25]

SENATOR HILKEMANN: Thank you. [AGENCY 25]

SENATOR STINNER: Any other questions? Seeing none, thank you. Oh, Senator Bolz. [AGENCY 25]

SENATOR BOLZ: One of the things that I struggle with in the Medicaid program and the Medicaid appropriation is how to appropriate based on utilization that we can't fully predict,... [AGENCY 25]

MARK INTERMILL: Uh-huh. [AGENCY 25]

SENATOR BOLZ: ...and how to appropriate based on utilization that we can't fully predict and assure that there is a cushion in case of a contingency. And I just wondered, based on your history and expertise, if you have any input regarding what those appropriate levels might be. [AGENCY 25]

MARK INTERMILL: Yeah. And I worked in HHS back when there was no cushion, so that's a very painful situation to be in so I think it's very important to build in a cushion. But I think in terms of utilization, when we first started looking at the Medicaid expansion information, which is where we have the best information about utilization state by state, we saw that Nebraska actually went down a little bit and then stabilized at that lower level. We just didn't, you know, at first I thought, you know, maybe it was some sort of a fluke, but it's continued month after month

for four years now. And so it indicates to me that we're in a pattern and it basically mirrors our state's population growth. We're growing at about maybe six-tenths of a percent a year rather than the 2.2 percent that we're looking at Medicaid utilization growing at. So I think there is...I've come to the conclusion that we can look at that lower rate or sort of that six-tenths of a percent rate as a basis for making some assumptions about the future growth of Medicaid. [AGENCY 25]

SENATOR BOLZ: So it's not necessarily an argument that we should adjust our...the way that we think about building in a cushion. It's an analysis that our utilization has been stable and we could find some additional budget room using that assumption. [AGENCY 25]

MARK INTERMILL: Yeah. The cushion is important. I would agree with that. But how much of a cushion? Do we need $80 million, does that...when we have needs that need to be met? [AGENCY 25]

SENATOR BOLZ: Thank you. [AGENCY 25]

SENATOR STINNER: Senator Hilkemann. [AGENCY 25]

SENATOR HILKEMANN: Following up on that, is there a percentage that you found in your work with Medicaid that would help us in that? [AGENCY 25]

MARK INTERMILL: In terms of how much... [AGENCY 25]

SENATOR HILKEMANN: The cushion. [AGENCY 25]

MARK INTERMILL: No, I went back and looked at some of this year's and there was a...before we used the reappropriations process there was a...there would be an obligation of funds that were funds that were obligated but not expended. And those were reported in the DAS budgetary reports. I looked at those and the average for the...and it tended to be...I think there were four years I looked at. The average was about 2.5 percent of the budget was what was obligated but

not spent. And so that kind of gives me an indication of what a cushion might look like. [AGENCY 25]

SENATOR HILKEMANN: Two and a half percent. [AGENCY 25]

MARK INTERMILL: Yeah. [AGENCY 25]

SENATOR HILKEMANN: Okay. Thank you. [AGENCY 25]

SENATOR STINNER: Any additional questions? Seeing none, thank you. [AGENCY 25]

MARK INTERMILL: Thank you. [AGENCY 25]

JOHN CAVANAUGH: Good afternoon, Chairman... [AGENCY 25]

SENATOR STINNER: Afternoon. [AGENCY 25]

JOHN CAVANAUGH: ...and members of the committee. My name is John Cavanaugh, J-o-h-n C-a-v-a-n-a-u-g-h. I'm at 3425 South 94th Avenue. I'm here today representing the Holland Children's Movement and the Nebraska Children's Health and Education Alliance, a group of healthcare providers and education advocates. I want to address the question presented by the Child Care Subsidy, which is your Program 347 of Public Assistance. And this issue probably arises partly because of that labeling, where we're labeling Child Care Subsidy as part of Public Assistance as opposed to education, which has been primarily exempted from the cuts. LB335 was introduced at the behest of the Governor to freeze the biennial increase that occurs in this program as a result of a federally mandated market survey that is required to be taken to assess the cost of childcare providing every two years and then adjusting the compensation for the providers. This program serves the poorest of the working poor. Most of the people on this program are earning less than $25,000 a year and they cannot work without access to subsidized childcare. The flip side of that has been that we know that the providers are providing the lowest quality childcare in the state. This Legislature has taken leadership in changing that two years ago mandating...beginning to mandate quality standards. So now what we're confronted with is

the mandate of improving quality for these providers serving the highest-risk children that we have. This program currently serves more than 30,000 children a year, 9,000 of whom are birth to three year...or six months to three years old. They're the most vulnerable, both at home and in the childcare service. We know that the children of these working poor parents are the children who predominantly come to kindergarten with huge deficits in their development and their readiness to pursue K-12 education. They continue to be the children who don't read at the 3rd grade level and we know the story all the way through. So this is the most vulnerable of our vulnerable populations. It is what the Legislature has been struggling over the last ten years to raise the quality for these children so that we can change that dynamic, that we can have them come to kindergarten ready and prepared to learn, and that they can have a successful transition. So if this is labeled as an education program, we probably wouldn't be freezing it. LB335 presents some particular problems in that it simply eliminates the requirement to compensate over the next two years based upon the survey. If you cannot, we would like to see you restore the program and keep these funds flowing because we are continuing to demand improvements in quality and that only comes by giving these providers, who live hand-to-mouth and shoestring economic operation, the ability to pay more; that 90 percent of the compensation here goes to employee compensation. And the rate of that compensation has generally been the lowest in the state in terms of minimum wage. The higher it goes, the more qualified people you can get providing the childcare. And that's what we want to see happen. If you cannot restore the full funding, we would like to suggest that you adopt what the Legislature...what the Appropriations Committee did in 2011 in a similar circumstance, which is to establish a firm floor that it wouldn't fall below 50 percent and freeze it at the current compensation rate so that they're not taking a cut, which is the avowed intention of LB335, but what...it does not establish a floor and it doesn't freeze at the current compensation rate for providers. So this is an extremely important issue for this very vulnerable population, and we urge you to take up, to do what you can to save this funding. Thank you. [AGENCY 25]

SENATOR STINNER: Thank you. Questions? Thank you very much. Good afternoon. [AGENCY 25]

MOLLY McCLEERY: (Exhibit 18) Afternoon. Chairman Stinner, members of the committee, my name is Molly McCleery, M-o-l-l-y M-c-C-l-e-e-r-y, and I'm a staff attorney in the Health

Care Access Program at Nebraska Appleseed. We are a nonprofit legal advocacy organization that fights for justice and opportunity for all Nebraskans. I'll keep it short as you have a full slate of folks here to comment on this, but I do want to echo what some other proponents have mentioned in terms of maintaining provider rates and then also the current $1,000 cap for dental services. We would share the concerns that have been brought up around how reductions in rates and reductions in that cap would lead to reduced access for Medicaid clients. We would also share some of the hesitation around combining the Medicaid and CHIP programs, Programs 344 and 348, as we see that keeping those two programs separate would go a long way to ensuring needed transparency in two crucial programs. Additionally, I think this goes to some questions, Senator Bolz, that you brought up and, Chairman Stinner, to Director Lynch. We understand the committee's inclusion of the $6...around $6 million projected savings through the transition to Heritage Health and a more robust managed care system. Think moving forward we would encourage the committee to make sure that those decisions about savings are data driven. When I say that, what I'm getting at is that in the past couple decades since managed care became a trend among states, it's been very difficult to find data that shows that managed care actually saves the money that it is represented to save. And when it does save money, it's hard to break down whether that cost savings is as a result of efficiencies and better coordination or if it is a result of providers not getting paid, increased barriers for clients, or increased service denials. So just having an understanding of where those savings comes from I think is crucial in terms of projecting some of those savings out. So we would encourage work with the Health and Human Services Committee. That is where those contracts most squarely sit in terms of oversight. Lastly, as a couple of other testifiers have mentioned today, there is great uncertainty as to what is happening with our Medicaid financing system at the federal level. Last week House members introduced the American Health Care Act, which in addition to repealing and replacing the Affordable Care Act would dramatically change the financing structure from our current state-federal partnership in Medicaid to a per capita cap system. We've talked a lot today about the difficult decisions that this committee has to make in this current budget climate, and I don't envy the position that you're in. It's a lot of very difficult decisions. But our concern is that moving forward those decisions will get even more difficult under a per capita cap system. I mentioned some figures in my testimony around sort of out-year projections of what a cap system would look like and over the first ten years it would be about a $116 billion reduction for federal Medicaid aid to states, and then in the out years it would be about $20 billion annually. I

will note that the CBO score of this bill came out while I was sitting in the back of the room (laugh), so these are the best numbers I could get you as of this morning but there are probably better numbers this afternoon. The reason for the sort of initial cut and then an out-years cut is that the rate that is presented in this bill is based on 2016 utilization and financing, which, as some other testifiers have mentioned, that was our lowest FMAP year ever, and we also were low in enrollment that year as well. So we're starting off at a low rate plus it's using the Consumer Price Index medical, which doesn't actually track Medicaid cost growth. So we're sort of starting out in a hole and then the hole is going to get deeper. So just wanted to reflect that because of these potential changes and sort of the conversations that are happening, we would urge the committee to keep those things in mind as they're making some of these decisions. With that, I'd be happy to take any questions. [AGENCY 25]

SENATOR STINNER: Questions? Seeing none, thank you. [AGENCY 25]

MOLLY McCLEERY: Thanks. [AGENCY 25]

MARK KRESL: (Exhibit 19) Good afternoon,... [AGENCY 25]

SENATOR STINNER: Afternoon. [AGENCY 25]

MARK KRESL: ...Chairman Stinner and the committee. Thank you for having me. My name is Mark Kresl, M-a-r-k K-r-e-s-l. I'm with Midwest Geriatrics in Omaha. We're a senior...we operate four senior homes: a skilled nursing home, two assisted livings, and a memory care unit. We are a nonprofit. I'm here today to speak to you about the Governor's proposed 3 percent Medicaid cut and how it would affect us. Chairman Stinner has kind of captured a lot of what I was going to talk about earlier today when he spoke to the dramatic impact that it can have. I'm going to just personalize it a little bit to our specific businesses. In our four residences, we care for about 150 Medicaid residents on any given day. Our mission for 111 years now, since 1906, has been to serve the underserved in the Omaha area. At Florence Home, our skilled nursing home, nearly 85 percent of the residents in our care are paid by Medicaid. On any given day, that's about 75 Medicaid residents. Our current average Medicaid reimbursement is $166 a day. Our actual cost of care is $190 a day, and those numbers line up with a few people that I've heard

speak earlier today, about a $24 shortfall in every day of every Medicaid resident. It doesn't take a mathematician to see that those numbers don't add up. With this reimbursement gap and the rising costs of government compliance, we find ourselves challenged like never before to sustain our mission. Two thousand sixteen was our most financially challenging year in our 111-year history. Two thousand seventeen has seen CMS regulations added that are estimated to cost us $56,000 this year alone, $55,000 in every subsequent year. A 3 percent cut in Medicaid reimbursement would add another $150,000 to the losses at Florence Home alone. Our four residences combined, this cut would negative impact us by $225,000. Our mission of service to the underserved would not be able to sustain taking that kind of a financial hit. It always begs the question, and I've had a lot of people in my office, including Director Lynch, talking about it and if we are to go away, if not us, who? Who is going to care for these people? Where will they go? I heard a saying that I heard years ago that I've always liked. It's a nation's greatness is measured by how it treats its weakest members. So I wonder how we will be measured and what history will say about us. As the baby boomers retire in record numbers, the call for missions such as ours will only increase. It's estimated that one in three people retiring in the next 20 years will retire with no savings. And I understand budgets. We live with them too. And I understand that a deficit in our state must be addressed. But I also know that there is discretion as to which programs will be addressed and you are able to give weight to each line item and the value that it represents and the citizenry that it represents. So I ask you to just keep these people in mind. These are our poor seniors. And if we are not here to care for them then I just ask, who will be? That's all I've got and I would welcome any questions. [AGENCY 25]

SENATOR STINNER: Thank you. Any questions? Senator Hilkemann. [AGENCY 25]

SENATOR HILKEMANN: Just one quick question: Midwest Geriatrics, you said you're a not-for-profit organization? [AGENCY 25]

MARK KRESL: A nonprofit, yes, 501(c)(3). [AGENCY 25]

SENATOR HILKEMANN: And is this just...tell me who's like on your board. [AGENCY 25]

MARK KRESL: Oh, we've got a lot of board members. We've got Bob Bloechle from Hawkins Construction; Nancy McCarthy, she's a retired nurse, her husband is with McCarthy Capital. We've got...gee, going off of memory here. [AGENCY 25]

SENATOR HILKEMANN: But there's no underlying hospital or any (inaudible)... [AGENCY 25]

MARK KRESL: No, no, no. We are stand-alone. [AGENCY 25]

SENATOR HILKEMANN: Florence at one...that Florence facility at one time was owned by one of the hospitals, wasn't it? [AGENCY 25]

MARK KRESL: Not to my recollection, but I don't go back that far. But I know going back to the '60s at the very least, because I have done some work on that, that we are a stand-alone, no underwriting big brother. [AGENCY 25]

SENATOR HILKEMANN: Thank you. [AGENCY 25]

SENATOR STINNER: Seeing nobody else with questions, thank you very much. [AGENCY 25]

MARK KRESL: Thank you. [AGENCY 25]

SENATOR STINNER: Good afternoon. [AGENCY 25]

TRACY ROBLEDO-CLARK: ((Exhibit 20) Good afternoon, Senators. My name is Tracy Robledo-Clark, it's T-r-a-c-y R-o-b-l-e-d-o C-l-a-r-k. I am here on behalf of Immanuel and we are also members of LeadingAge Nebraska and the Nebraska Health Care Association. We want to voice our opposition to the proposed 3 percent reduction in Medicaid rates, but we are in support of the 1 percent increase. We were going to say the same thing that everybody else has said. Basically, Senator Stinner I felt said it best earlier when he said this burden is not that of the providers, so the care for the aging population truly is the responsibility of the state. Most providers that do this do so because it's part of their mission. Aging services are currently going

through a highly regulated change. With that, as the previous speaker said, comes greater expense, greater expense at a time when you're proposing Medicaid cuts. With those cuts you're going to...you have a quality-of-care issue come into play. Immanuel currently has two communities operating at a financial loss due to the current Medicaid reimbursement rate. We have an assisted living that accepts waiver. For 68 apartments we currently project a loss of $305,000 in revenue this year. A 3 percent cut would mean an additional $62,000 loss this year. this is not including the average increase of 2.5 to 4.5 percent for operations. We have a long-term care community in Omaha. They operate at 90 percent or more for Medicaid. The average Medicaid rate is $203 a day. A 3 percent cut would be a loss of $6.09 a day, roughly eliminating 4.5 positions; a 2 percent cut would be a $4.06 per day reduction, eliminating 3 positions; a 1 percent cut would eliminate 2 positions. Immanuel, like many other aging services, will be negatively impacted by a 3 percent reduction. This will affect the quality of care, employment, individuals served, and the sustainability of serving the aging population. While we respectfully acknowledge the current financial situation in the state of Nebraska, please remember aging service providers have chosen to serve individuals who are on Medicaid. The number of aging service providers will decrease with any proposed reduction in the Medicaid reimbursement rate. A decrease in providers will create a shift in the current partnership with the state. The responsibility to care for the aging Nebraskans will be that of the state without providers to provide this service. Your thoughtful consideration to the severe implications/impacts of cuts in the provider rates is appreciated. If you have any questions, be glad to answer. [AGENCY 25]

SENATOR STINNER: Questions? Seeing none, thank you. [AGENCY 25]

TRACY ROBLEDO-CLARK: You're welcome. [AGENCY 25]

MICHAEL ICKOWSKI: (Exhibit 21) Chairman Stinner, I want to apologize. I've only been on the job four months at Regional West and I feel like I should have spoken to you before this, but I intend to speak to you sometime in the near future. I have two pages of documented narrative that I read about 300 times, but I'm not going to read it. I'd rather have a conversation with you and the conversation kind of takes in what was said already but also my own thoughts, being a newcomer to Nebraska. I come from Buffalo, New York, so it's a little similar weather today but usually I get a little bit more snow. But what I'd like to talk about is we talked about across the

state is the Medicaid rate fair compared within the state, to other states. And I guess I would just ask you to entertain the idea, is Medicaid paying its fair share of costs for the service provided? If any one of you have...obviously, you all have used hospital facilities and the type of service that's provided doesn't distinguish who the payer is. So someone comes in and they have pneumonia or they need a tracheotomy or it's a newborn, it costs relatively the same amount, yet the payers, Medicaid typically pays well short of what that cost is to provide that service. And I think that's important because what's been said earlier is, and I know I'm here...I want to repeat up-front and I'll say it at the end, I'm against the 3 percent cut because to me Medicaid is a shortfall to what it should be paying now, to a large degree. But not only that, is everybody has to do budgets. We do budgets and we prepare assuming that if you go back to the 6.03 percent cut. Budgets were made at hospitals all across Nebraska assuming that we were getting that amount. Now I want to go back to that I'm a newcomer. I'm so new that when I drove over from Iowa into Omaha, I thought I was near Scottsbluff. (Laughter) I was not. In fact, as I continued driving probably about another eight hours I realized there's a lot of land and not so much a lot of people but there's a lot...there's pockets of people. And around Scottsbluff and Gering, they're used to having a level II trauma center and that's what we have in Regional West. What does that mean, is that hospitals themselves are usually high cost. Well, a level II trauma center, especially in Scottsbluff and Gering, to provide that level of service costs a lot and not just the typical cost. Let me explain that for a second. Being that we're on the far end that I told you is a little bit of a drive, we can't get a lot of physician specialists. We get those specialists because they're good docs but they're fly-by-nighters. We're paying them a premium cost to fly into Scottsbluff, work a couple weeks, they fly out. They might come back and they might work routinely over time. But we've got a lot of docs coming in and out that aren't necessarily the employed, live in Gering, live in Scottsbluff doctors. That costs us like 2 to 2.5 percent more for a doctor. Now think of an orthopedic doctor or a neurosurgeon. We're paying a premium on top of a high, well-paid position. Now that's the top tier position. Nurses, because we're a level II trauma center, I would argue their day is a little bit harder than possibly a critical access hospital. They're both needed RN positions. But what is happening is that critical access hospitals get a large percent of their cost reimbursed, 98 percent, and you can give raises to the RNs because it's built into the 98 percent. Well, in our case, we're losing nurses. We're 30 nurses short of what we need to be. And we lose the nurse that goes to a critical access hospital partly for two reasons. One is maybe an easier work day, not necessarily, but they're getting paid more. So we can't compete with that

because our margins are so slim that I can't give you the 3 percent. I just need that 3 percent to get by. Now go down to a lower level position, the typical purchasing clerk or a business office clerk. We're competing, believe it or not, with Walmart. Walmart was paying a higher rate than what we were paying because we couldn't afford to give the increases that they needed in order to keep them. So we have a larger turnover that we're fighting all the time. I mentioned to you the docs, the nurses, and the clerk positions. That's difficult and we're dealing with that every day and that's my main thing that I want to get across to you, is it's very difficult. We need to be a level II trauma center and we can't take a 3 percent hit and not have it hurt us, because it will hurt us. And I forgot to spell my name because you're not going to get it right. (Laughter) The first name is Michael, and let me spell the last name. It's I-c-k-o-w-s-k-i, 100 percent Polish. Any questions I can answer for you? [AGENCY 25]

SENATOR STINNER: Welcome to Nebraska. Tell me the percentage of Medicaid patients. [AGENCY 25]

MICHAEL ICKOWSKI: Fee-for-service Medicaid is 10 percent with another 15 percent that would be part of the managed care plan as they come through UnitedHealthcare and Blue Cross. [AGENCY 25]

SENATOR STINNER: So about 25 percent... [AGENCY 25]

MICHAEL ICKOWSKI: Twenty-five. [AGENCY 25]

SENATOR STINNER: ...of your revenue is made up of Medicaid. [AGENCY 25]

MICHAEL ICKOWSKI: Yes. [AGENCY 25]

SENATOR STINNER: Any additional questions? Thank you for driving in. I know how far it is. (Laughter) [AGENCY 25]

MICHAEL ICKOWSKI: Yes, I'm sure you do. Thank you. [AGENCY 25]

SENATOR STINNER: And I wouldn't even have limited your time. You could have kept talking. (Laughter) [AGENCY 25]

KIM ROBAK: Senator Stinner, members of the committee, my name is Kim Robak, K-i-m R-o-b-a-k. I'm here today on behalf of the Nebraska Dental Association in opposition to the 3 percent provider rate cut in the Medicaid program and encouraging you to keep the $1,000 cap on adult dental Medicaid services. My firm has had the wonderful fortune of being able to represent the Nebraska Dental Association for over 20 years, and in that time dental Medicaid has been on the table numerous times. And what we've discovered over the year is that Medicaid a lot like a balloon and when you push in one place to cut, something else gives someplace out, the balloon expands. And so what happens is if you cut someplace, you're going to pick up the cost someplace else. You heard dental Medicaid being mentioned by numerous services throughout the afternoon and what you're hearing is that we're having trouble finding providers to give Medicaid services. Let me tell you why that is. First of all, Medicaid pays on average 40 cents on the dollar. In 2003, that was 60 cents. It's dropped in 2013 to 43 percent, and today at 40 percent. You ask what the rates are in surrounding states. As of 2013, according to the American Dental Association, all of the surrounding states, with the exception of, I believe, Iowa, have higher rates than we do: Kansas, Colorado, Wyoming, and South Dakota. The payments are often late. We just had a complaint at the Nebraska Dental Association that clean claims are over three months late. And they are told that they have up to 12 months to pay. So even though you provide the services at a 40 percent cost, the payments aren't made timely. In addition, dentists have been subject to, in recent years, to some onerous RAC audits, for people who provided dental cleanings one day early ended up having to pay back the entire cost of the services. You may remember that bill. It came before you in 2015 because we enacted legislation to stop that practice. During that bill, many dental Medicaid providers came forward and said they want to provide services, we just make it harder and harder for them to do so. On top of this, as you are all aware, dental Medicaid population can be a difficult population. They're lacking resources, education, often transportation, have an inability to take off work, and many of them are no-shows. But these providers want to take Medicaid patients as long as we help them do so. But unfortunately, I hear over and over from dentists that it's harder and harder to do so and now we're talking about another 3 percent cut and another cap on adult dental services. I remember when the $1,000 cap was put on and the difficulty that that caused, so now we want to cut in half

again. What we're finding out is that when you cut Medicaid services, you lose Medicaid providers. And when you lose Medicaid providers, they don't come back. And what happens then is that these patients then go to the emergency rooms, as we have heard today, and in fact hospitals in greater Nebraska have actually hired dentists in their emergency room because they don't have the dental providers to provide the services. So the Nebraska Dental Association asks you to help them continue to be able to provide dental services to the population of Nebraska. And in that regard, we want to thank you for LB18 which advanced today from Select File on to Final Reading. This is a bill that we've been working on for over ten years with the dental assistants and dental hygienists. It will allow us to expand the scope of care for dental assistants and hygienists so we can provide lower-cost services to Medicaid patients and continue to provide those services. We want to help and we are offering those services to Nebraska Medicaid, to HHS, to also figure out ways that we can provide lower cost services but continue to provide them. So I'd be happy to answer any questions. [AGENCY 25]

SENATOR STINNER: Questions? Seeing none, thank you. Now I would ask for proponents, but I'm thinking that we had opponents and proponents all at one time. (Laughter) I'm not sure how that all works but...any additional proponents? How about any opponents? Seeing none, anybody in the neutral capacity? Seeing none, that concludes our hearings on Agency 25 that included Operations, Veterans' Homes, Mediciad and Long-Term Care, and Public Health Divisions. We will now open... [AGENCY 25]

SENATOR HILKEMANN: You've got some letters. [AGENCY 25]

SENATOR STINNER: (Exhibits 22-26) Oh, we have letters. Excuse me. I'll open 25 back up. We have letters of support from National Association of Social Workers. We have letters of opposition from Claudia Lindley, Anne Ireland, Paula Peterson, Nebraska Speech-Language-Hearing Association, and Megan from Public Health on (Program) 514. So that concludes our hearings on Agency 25, Health and Human Services, and we will now open with LB512. Senator Hilkemann. LB513. [AGENCY 25 LB513]