STINNER: Please sit. Please take your seats, settle in. Thank you. Good morning and welcome to a joint hearing with the Appropriations Committee and Health and Human Services. My name is John Stinner, I'm Chairman of the Appropriations Committee. I represent the 48th District which is all of Scotts Bluff County. To my right is my esteemed colleague who is Chair of the Health and Human Services Committee, Sara Howard. We'll start today's proceedings with self-introductions starting at my left, Senator Dorn.

DORN: Senator Myron Dorn from District 30, which is Gage County and the southeast fourth of Lancaster.

CLEMENTS: Rob Clements from Elmwood: Cass County, part of Sarpy and Otoe County, District 2.

ERDMAN: Steve Erdman, District 47: 10 counties in the Panhandle.

MURMAN: Dave Murman from Glenvil, District 38: 7 counties, south central Nebraska.

BOLZ: Senator Kate Bolz, District 29.

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

HOWARD: Senator Sara Howard, I represent District 9 in midtown Omaha.

WILLIAMS: Matt Williams from Gothenburg, representing Legislative District 36: Dawson County, Custer County, and the north portion of

Buffalo Counties.

CAVANAUGH: Machaela Cavanaugh, District 6: west central Omaha.

B. HANSEN: Senator Ben Hansen, District 16: Washington, Burt, and Cuming Counties.

McDONNELL: Mike McDonnell, LD5: south Omaha.

STINNER: We also have our clerk today is Brittany Bohlmeyer. On the cabinets both to your left and right are green sign-in sheets for testifiers. If you plan to testify today, please fill one out and hand it to the page when you come up. Actually, we don't have a page today so you'll have to hand it to Brittany. If you, if you have any handouts, please keep those until you come up to testify and then hand them to Brittany. We need 16 copies. If you don't have enough copies, please raise your hand and we will try to have somebody take care of that copying for you. We will begin today's, today's testimony on each interim study with an opening statement by the introducer. Following the opening statement we will first hear from invited testimony. Actually, we will only hear invited testimony, excuse me. We will finish with the closing statement by the introducer if you wish to give one. We ask that you begin your testimony by giving your first and last name and spelling them for the record. We will be using a five-minute light system. When you begin your testimony the light will be green, the yellow light is your one-minute warning, when the red

light comes, comes on we ask that you wrap up your final thoughts. As a matter of committee policy I would like to remind everyone that the use of cell phones and other electronic devices are not allowed during the public hearing. At this time I would ask for all of you to silence your cell phones and make sure that they're on vibrate. With that, we will begin today's hearing with Senator Morfeld, LR170.

MORFELD: Thank you, Chairman Senator. Good morning members of the Appropriations and Health and Human Services Committees. My name is Adam Morfeld, for the record, A-d-a-m M-o-r-f-e-l-d, representing "fighting" 46th Legislative District here today to introduce LR170, an interim study that focuses on Medicaid expansion implementation process as proposed by the Department of Health and Human Services. Last November, as many of you are aware, Nebraskans overwhelmingly voted to support expanding Medicaid to 90,000 of our fellow citizens. Voters believed that it was important to provide health care access to our hardworking friends and neighbors who cannot afford insurance. Voters wanted to support people like Emily, who couldn't be here in person to testify today because she's currently under a student teaching job in Omaha. Emily just turned 26 last month and lost health care coverage she received from her parents' coverage. She thought that Medicaid expansion would be there to help her access affordable insurance while she pursues her dream of being a teacher. But Medicaid expansion won't be there for people like Emily until October 2020 at least. On April 1 of this year the Department of Health and Human

Services said that it would take them 23 months to implement Medicaid expansion, a time line that came as a surprise because we know that other states have successfully implemented their programs much more quickly. The delay in Nebraska's program is due to complex and unnecessary Section 1115 waiver that DHHS has decided to pursue to create a two-tiered benefits scheme with benefits cuts and work requirements. This waiver represents an intentional bureaucratic nightmare for both providers and enrollees. I introduce LR170 to study what DHHS is proposing, its impact on Nebraska's overall implementation of expansion, and its effects on those who have been waiting for over six years to have the opportunity to have quality affordable health care. You will hear testimony from groups across the state that have worked on this issue and have been monitoring DHHS's progress. You will also hear from Kevin De Liban with Legal Aid of Arkansas who will speak to the negative impact that a similar 1115 waiver proposal has had on Arkansas. Who you will not hear from, as I'm aware of, today is DHHS. I hope that changes within the time that the people here testify today and that they come down and actually testify on potentially one of the biggest health issues in the state in the last 20 years. My understanding is that an invitation was sent from the committee and they declined that invitation. I want to make clear that at the start, that this 1115 waiver is not what voters intended. An 1115 waiver is not required to expand Medicaid in Nebraska. It is an option that DHHS is pursuing that intentionally

slows down the implementation of the program, makes it overly burdensome and complex for those who just want to see a doctor. And importantly for many of us who have a lot of other competing priorities in our district, it will unnecessarily cost the state tens of millions of dollars and the delays endangering the lives of nearly 100,000 Nebraskans who would otherwise be receiving critical access to care and health insurance. It is something that we as a Legislature need question, oversee, and push back on to ensure that the will of the voters who elected us and elected for Medicaid expansion is truly met. Thank you.

STINNER: Thank you. Questions? Seeing none, thank you.

KEVIN De LIBAN: Good morning, members of the committee.

STINNER: Good morning.

KEVIN De LIBAN: My name is Kevin De Liban, that's K-e-v-i-n D-e L-i-b-a-n. I work for Legal Aid of Arkansas. And for those of you don't know, Legal Aid organizations everywhere are nonprofit entities that provide free legal services to low-income folks. So my clients are the people who benefited from Medicaid expansion. My clients are CNAs, they're maintenance workers, they're farmhands in rice fields and soybean farms, they are convenience store clerks, they're factory workers. The best jobs that my clients can imagine getting is a $12 an hour job at a rice mill in rural Arkansas. So these are all people who

traditionally had never had access to health insurance even through their employers. So I saw firsthand the benefits of Medicaid expansion to our clients. Prior to 2014 when Medicaid was expanded in Arkansas, one of the first southern states to do so, people couldn't get access to anything beyond routine primary care, and that was only if there was a federally qualified community health center nearby. Otherwise anything specialty you couldn't get. Behavioral health treatment, physical therapy, cancer treatments, anything else was totally off limits just by pure reason of finances to our client community. Once Medicaid expansion happened in 2014 you could see the benefits immediately. And you saw the way that Medicaid contributes to people's ability to work and engage actively in the community. One of my clients for example was a woman who was a home health aide who worked. Now she had a bad shoulder. How can you lift people, how can you help others with activities of daily living when you can't lift and sustain other people's weights? After she got access to Medicaid and was able to see a doctor she got physical therapy and other treatment that helped her manage her shoulder pain so that she could continue to work and be productive. I have countless stories of similar clients who were needing health in order to be able to continue school, improve their situation in life, or just maintain stability to care for their families. Now that shows us that you've got to be healthy in order to be able to work and to participate in your community. And it also shows us that people are doing the best that they can with what

they've got. Now the statistics are that 57 percent of the people on Medicaid expansion in Arkansas already work, another 23 percent have some sort of disability, and 12 percent are caretakers. There's also a proportion that's beyond that that has, that are in students in other, other regular activities. So everybody is already doing the best they can with what they've got. Then Arkansas introduced these so-called work requirements. Now they don't make sense, there's no problem to solve here because, again, over 95 percent of the people would have met an exemption or would have met the engagement, the work requirement itself. But they're also wildly illegal. And, as some of you may know, that we sued to stop the work requirements and that is, that was a successful lawsuit and is pending before the D.C. Circuit Court of Appeals. Despite the fact that the state was warned that they would be devastating to our client communities and despite the fact that the state was warned that they were wildly illegal the state chose to go forward and endanger the stability and progress of the low-income folks that we serve. And as a result 18,000 people lost coverage in only five months, in only five months. And that was with the state putting up what they would consider significant guardrails. They automatically exempted a significant, basically three quarters of the people who would be subject to the work requirements, they just automatically took them out of the pool based on data that they had available. Of the people left, the people who had to affirmatively go forward and do something, every month 80 to 90 percent of those people

were unable to report and ultimately 75 percent of them got terminated from coverage. So when you hear the term 18,000, know that that's a low-end estimate. That could have been much higher, and it also excluded the people who were going to be terminated from coverage prior to our lawsuit victory. Now in addition to the devastating effect of beneficiaries who many of whom were actually working or disabled, it causes immense harm to providers and to the state agency. You cannot imagine, or perhaps by the absence of the state agency you can imagine, how administratively unfeasible work requirements would be right? That the structure needed to enable people to report something that they're already doing on a monthly or quarterly basis is ridiculous. You can imagine how much the line workers have to do, how much more paperwork they have the process, how much confusion there is if somebody marks one month the wrong way, which happened consistently. We had to help clients. We spent hours on the phone, I myself spent hours on the phone regularly. One of my colleagues spent four hours on the phone with the state agency trying to clear up what was a routine error. This is not unusual, and people should not need lawyers to be able to go see the doctor. And that was one of the fundamental lessons that we had from Arkansas. Now if people are concerned with promoting economic advancement and opportunities there are really viable proven alternatives. You folks can invest in voluntary meaningful job training, child care assistance, state earned income tax credits. So if the concern is economic advancement there

are proven policies that work. Work requirements do nothing but endanger the stability and progress of low-income folks and give people another way to trip up and fall back. Now I've offered you guys some statistics that I haven't gone over here that talk about, you know, lack of rural hospital closures. Arkansas was unique. All the other states mentioned there didn't expand Medicaid. That is not a coincidence. You have statistics showing that people have actual better health outcomes or the ability to have better health outcomes. And you have the uninsured rate dropping significantly. There are many other statistics I can go over here. But I think that is my time for opening statement and I would love to entertain any questions that people have.

STINNER: Have any questions? Senator Williams.

WILLIAMS: Thank you, Chairman Stinner. And thank you for being with us today. I want to be sure I understood your testimony as it relates to the lawsuit that you filed against Arkansas. First of all, can you compare the waiver requirement or what was applied for in Arkansas to the 1115 waiver that's being applied for in Nebraska and see how those compare? And then what is the current status of the lawsuit?

KEVIN De LIBAN: And Senator, I can't go into details and opine over the legality of Arkansas-- of the details of Arkansas, or I'm sorry, the details of Nebraska's waiver. What I can tell you something about is Section 1115 and why any work requirement would likely be illegal.

And that said, 1115 is a very narrow waiver authority. It allows for the federal government to approve experimental projects in very limited situations, and work requirements are not found anywhere in the Medicaid statute that would allow this narrow 1115 authority to be used to create what is essentially a fundamental sweeping change to the Medicaid system. So I think any proposal for work requirements that you, that any state could offer would face the same legal scrutiny and would be likely illegal.

WILLIAMS: And so what's the current status of that?

KEVIN De LIBAN: That's pending. So we prevailed. The federal government and the state governments appealed to the D.C. Circuit Court of Appeals. The oral arguments on that case is set for next month, October 11. And then it could be a few months before the court offers its opinion.

WILLIAMS: Thank you.

KEVIN De LIBAN: You're welcome.

STINNER: Additional questions? Senator Cavanaugh.

CAVANAUGH: Yes, thank you, Chairman. Thank you for being here. And are you familiar with Indiana's implementation of the 1115 waiver?

KEVIN De LIBAN: I'm familiar with it in broad strokes.

CAVANAUGH: So over the summer we heard some information from them and

they are to date, I believe, the only state that has successfully implemented the 1115 waiver using the work requirement avenue. But they don't allow, or it, it's self-reported, I guess, is how they've gone about it. And so I'm just curious if you have thoughts on the legality of that.

KEVIN De LIBAN: Yeah. So for, and Indiana has delayed the consequences of work requirement noncompliance, right? You're not going to see people being kicked off or suffer adverse consequences I think for a year. But nonetheless it goes back to the same Section 1115 authority, right? It has to be an experimental project that advances the objectives of the Medicaid Act. What the objectives of the Medicaid Act are to cover people, to provide health insurance to people. And giving, or implementing some sort of policy like work requirements that takes away health insurance from people doesn't meet that criteria. So I think the question of particulars of any state's way to implement the work requirements doesn't change the fundamental fact that work requirements are not permissible at all under the Medicaid Act.

STINNER: Additional questions? Senator Wishart.

WISHART: Well, thank you for being here today. I'm interested have you tracked the fiscal cost in terms of administrative overhead between states that have implemented these kind of work requirements and those

that have not?

KEVIN De LIBAN: So Kentucky took a different approach than Arkansas. Arkansas didn't hire any additional workers. They did have to contract with vendors to run call centers and operate Web sites and other things. But they did a much less robust bureaucratic blow up, I guess, than Kentucky did. Kentucky was going to be several hundred million, I believe. Arkansas did not actually provide estimates of the administrative cost. And this was another aspect of Arkansas' implementation. They didn't track any data. They didn't have projections for how many people were going to lose coverage. They didn't track how administrative costly it was going to be. It was just this commitment to apparently taking away people's care under the false guise of offering some sort of economic process-- promise, which of course was illusory. So I think there are those different approaches that came out, and I don't think any state could administratively implement work requirements in any workable way, right? You're asking people to jump through more hoops and to build those hoops you have to take mounds of paperwork, mounds of computer system logging, mounds of notices that are sent to beneficiaries, information delays. You have to set up this hugely intricate and complex network to do something that is fundamentally unnecessary.

STINNER: Additional questions? Seeing none, thank you.

KEVIN De LIBAN: I thank you all very kindly.

MOLLY McCLEERY: Good morning, Senator Stinner, members of the Appropriations Committee and the Health and Human Services Committee. My name is Molly McCleery and I'm the director of the health care access program at Nebraska Appleseed. We are a nonprofit legal advocacy organization that fights for justice and opportunity for all Nebraskans. One of our core priorities is working to ensure that all Nebraskans have access to quality affordable health care. Along with my testimony today I also have three letters from folks that are in the coverage gap that we're unable to be--

STINNER: Molly, if you could spell your name.

MOLLY McCLEERY: Oh, yeah.

STINNER: That would be wonderful.

MOLLY McCLEERY: Yes. First name, M-o-l-l-y, last name, M-c-C-l-e-e-r-y. So there are three letters from folks in the coverage gap that are unable to be here for various reasons. I would really point you to the letter from Erin Wehrbein from Plattsmouth. She describes her family's situation as a family of four who are a fourth generation Nebraska farm family and who are uninsured and in the coverage gap. The timely and effective implementation of Medicaid expansion in Nebraska has the potential to significantly improve the health and financial well-being of 90,000 Nebraskans who currently

have no access to health insurance. However, Nebraska Appleseed has a number of concerns about the impact of the proposed Section 1115 waiver to establish the Heritage Health adult plan. To reiterate Senator Morfeld's point in his opening, a Section 1115 waiver is not necessary to implement Medicaid expansion in Nebraska. The statutory language passed by voters through Initiative 427 which is codified in our Nebraska state code at 68-992 does not require a Section 1115 waiver. It does not require or even include a two-tiered benefit system, work requirements, or wellness requirements. It certainly does not contemplate changes to existing Medicaid policies such as eliminating early periodic screening diagnosis and treatment coverage for a 19 and 20-year-olds, reducing the period for retroactive eligibility, or changing recertification policies. Rather, the Heritage Health adult plan is an option that the state is pursuing. And, as the first two speakers have noted, it's one that is administratively complex, unnecessarily confusing, and burdensome for enrollees and providers. The number of questions that we have received from folks in the coverage gap or folks currently on Medicaid about how this will work is significant. Lots of questions of how will I report the activities that I'm doing? How will this work with me having to talk to my employer to get paperwork? What happens if I don't do it correctly? What happens if I don't have the Internet? All sorts of questions. We're concerned that this unnecessary waiver will create numerous barriers to care and will reduce the health and

financial benefits that to both enrollees and our state as a whole. The two-tiered benefit system where enrollees can shift between the tiers will be challenging for enrollees and providers to manage and will reduce access to critical services like dental and vision care. Dental and vision care are significant in ensuring that people can work and can support their families and get ahead. We also have serious concerns about the work requirements included in the proposal. As Mr. De Liban mentioned, work requirements are contrary to the purpose of the Medicaid program and legally suspect. The purpose of Medicaid is to provide medical insurance to folks who cannot afford it. Reducing services to those who do not fulfill a work requirement is, conflicts with that purpose. The majority of Nebraskans in the coverage gap are already working except in low-wage jobs that do not provide insurance. About 70 percent are employed and the remainder are folks who, like students, stay-at-home spouses, folks who may have a disability but not a formal disability termination. Due to potentially challenging reporting requirements we are concerned about individuals erroneously losing benefits but still meeting those requirements but being unable to complete the paperwork just demonstrate that they are completing them. Evidence suggests that work requirements don't actually promote employment and don't address barriers to employment like transportation, child care, or other challenges that folks may face. Medicaid itself is a program that supports work by providing the coverage workers in low-wage jobs' need to stay healthy to support

themselves and their families. If our state wants to invest in work force programs other programs exist where that investment would be more appropriate and where the health of individuals would not be leveraged as a means of meeting those employment goals. With that, I would be happy to take any questions.

STINNER: Questions? Senator Howard.

HOWARD: Thank you. Thank you for visiting with us today. Can you tell us a little bit about the lawsuit that Nebraska Appleseed filed and give us an update on that?

MOLLY McCLEERY: Sure. So we filed a few weeks ago an original action in the Supreme Court to challenge the time line for implementation. Our client's position is that under 68-992 there is a provision that requires the state to maximize federal financial participation to pay for Medicaid expansion, so to maximize the federal dollars that we're bringing back. Because 93-- we as a state could receive 93 percent for Medicaid expansion this year and that number drops to 90 percent next year, we are losing that 3 percent if we are not doing that this year. So it's an ongoing obligation that the state has to draw down the most amount of federal funding. The Supreme Court of Nebraska declined to take original jurisdiction of that case. It did not pass on the merits of the case. They have the ability to say we don't want to take it, go to the district court. So yesterday we filed, refiled the same action

in the district court.

STINNER: Senator Cavanaugh.

CAVANAUGH: You might not know the answer to this but do you have an estimate of what the, that 3 percent, how much money that is?

MOLLY McCLEERY: I do. I don't have it on me. It is in the petition in the filings though.

CAVANAUGH: I'm just curious. Would be nice to hear how much money we are losing. Thank you.

STINNER: Senator Hansen.

B. HANSEN: Thanks for being here. Maybe in your professional opinion or in Appleseed's opinion, what kind of requirements should the state implement, if any, that might ensure that the taxpayers' money is being used wisely. And that people who do get Medicaid are using it appropriately? I'm not saying they don't but, like, in your opinion is there any requirements, whether in the 1115 waiver or not that maybe the state could implement besides work requirements in your opinion?

MOLLY McCLEERY: So that's a good question. I think they're-- part of what an eleven 1115 waiver is designed to do, and we've heard a little bit about this already, is to test some sort of hypothesis or to do a demonstration. The things that states are testing including what is included in our waiver are things that have been tested before and

have received bad results. So we know from states that have tried work requirements from our own outcomes in ADC or TANF and other work programs that kind of that punitive nature doesn't lead to actually promoting employment. So I think that there are states that are doing innovative things through waivers such as trying to address some of the barriers that people have to health. Whether that's access to appropriate housing, issues in communities that kind of create challenges for people accessing care in a way that is preventive and saves the taxpayers dollars in the long run. So I think that we can ensure that there is a greater focus on preventive care, on wellness, and ensure that kind of we're using our, our dollars most effectively on the front end.

B. HANSEN: So like, for instance, I think part of the 1115 waiver is that the recipient of the Medicaid is required to have a yearly visit to once a year or they cannot miss-- as a provider myself this is one thing I think is, I think is a smart thing to put in there is that they cannot miss more than three appointments in a year. You think those are reasonable requirements or do you think those are too burdensome?

MOLLY McCLEERY: I think that, you know, having, and I think this is something that our managed care system currently does which is making sure that each enrollee has a primary care provider that's designated to them and trying to create sort of a medical home is really

important. I think where we start to get questions from folks that we work with that are trying to kind of make their way through the program is requirements like loop-- dropping to a different level of insurance for missing an appointment can be really challenging to overcome when, for example, you're relying on Medicaid transportation to get to an appointment and they get you there late. Or if you have transportation or health care issues or things like that that there isn't anything to help you sort of overcome that. So I think that there are ways to, to get to some of the issues that you're talking about of ensuring that people are getting preventive care of doing those wellness things. But when we're creating a system where there aren't the supports there to do that and then reducing insurance to get there, I think that's where we have some concerns.

B. HANSEN: Thank you.

STINNER: Additional questions? Senator Howard.

HOWARD: Thank you, Senator Stinner. May I ask for a point of clarification? So when we're considering managed care and the wellness work that a managed care company does, if you, so for instance if you missed three appointments and you're in managed care, you're not going to lose your coverage?

MOLLY McCLEERY: No, I was speaking to the part that's in the concept paper around missing appointments and being dropped from prime

coverage to basic coverage. What we've heard from a lot of folks is that a lot of times it's not their fault that they're late for an appointment if they're relying on public transportation or Medicaid transportation. And so that was the example I was using was that they may be trying to comply with that requirement but then end up missing the appointment or being late and then end up losing benefits as a result. But in our current system that's not what we're doing.

HOWARD: And then I'm not actually sure if the committees are sort of aware of the challenges within our Medicaid transportation system, if you want to touch on that for a moment as well.

MOLLY McCLEERY: Sure. Yeah, so and I think this is sort of a kind of ongoing issue, especially in some of our more rural areas where there are fewer opportunities and fewer providers. But one, this is an issue that we hear from folks about a lot is that we have nonemergency transportation as a state to, to get people to appointments. That is not always the most reliable, depending on where you are and sort of what company is subcontracting to operate it. What we've heard is sometimes folks will end up being late or that they are one of three people in the car and they're the last one to be dropped off and so then they end up missing their appointment. There's also been concerns about like sending the wrong vehicle. So if someone needed a wheelchair and then the transportation gets there and it's not equipped to get that person there, that that's an issue as well so.

HOWARD: Thank you.

MOLLY McCLEERY: Yeah.

STINNER: Additional questions? Seeing none, thank you.

MOLLY McCLEERY: Thank you.

TIFFANY FRIESEN MILONE: Good morning.

STINNER: Morning.

TIFFANY FRIESEN MILONE: Chairperson Howard, Chairperson Stinner, and members of the Health and Human Services and Appropriations Committees, my name is Tiffany Friesen Milone, T-i-f-f-a-n-y F-r-i-e-s-e-n M-i-l-o-n-e, I am policy director at the OpenSky Policy Institute. I'm here today to speak to the potential fiscal impact of the department, Department of Health and Human Services proposed 1115 waiver. We're concerned, excuse me, we're concerned the state will spend significantly more money implementing expansion with the proposed waiver than it would spend by simply allowing the expansion population to enroll in the state's traditional Medicaid program. This would effectively shift dollars away from health care for families toward added bureaucracy and contracts with private vendors. The Department of Health and Human Services has estimated it will spend more than three times as much as in administrative costs to implement expansion with the waiver than would be needed without it. In a 2017

fiscal note DHS projected it would need around $1.8 million in administrative costs in FY '20 to implement expansion without the waiver. The agency now says it will need about $6 million in FY '20 to implement its expansion with the waiver, an increase of $4.2 million. More than half of the increased amount due to the waiver will go to additional staff. The agency has already begun hiring 108 new staff at a predicted cost of $3.9 million in FY '20. That's more than twice the staff at triple the cost than was earlier projected for a straight expansion. Generally the costs incurred by a state in covering eligible individuals are matched by the federal government at 90 percent rate, while the costs incurred in administering Medicaid are matched at 50 percent. As a result, the more the state shifts its spending to administration the less it receives from the federal government. Nebraska wouldn't be the only state seeing an increased administrative costs associated with this kind of waiver. Both Kentucky and Tennessee have seen or projected increased costs of about $35 million as a result of work requirements. Kentucky saw its administration costs jump 40 percent the year it started implementing its work requirements. And a fiscal note to a recently signed work requirements law in Tennessee projected $34 million a year in recurring administration costs. Looking beyond future costs, we also have concerns about the amount of federal funding the state is forgoing right now in order to pursue the waiver. Last fall DHHS estimated that a voter-approved expansion would bring about $25.5

million a month in federal matching funds for FY '20. Therefore, had the state implemented a voter-approved expansion on April 1, the day the state plan amendment was filed, Nebraska would have received $460 million in federal matching funds by October 1, 2020, the date DHHS plans to implement the waiver. These funds would strengthen rural hospitals, many of which are operating on the margins, and flow through local economies. According to the University of Nebraska at Kearney, increased medical spending, Medicaid spending through a straight expansion would create 11,000 jobs and generate $1.3 billion annually in new economic activity in the state. By delaying implementation the state is therefore also forgoing about $2 billion in economic activity. These projections mirror actual data from Louisiana's expansion and its impact on economic activity there. A state commission study found that expansion had created and supported over 19,000 jobs and generated state and local tax receipts over $175 million. Expanding Medicaid has therefore brought $50 million more revenue to the state of Louisiana than what it spent on implementation. Considering the experience of other states we conclude that this waiver will only end up costing the state money in lost federal funding and additional bureaucracy. We would encourage you to consider abandoning the waiver and moving forward with a straight expansion. I'm happy to answer any questions.

STINNER: Additional questions? Senator Cavanaugh.

CAVANAUGH: Thank you, Chairman. Thank you for being here. So just I really want to clarify, because these are some pretty big numbers. $460 million in federal matching funds that we have forgone this year or for the next year?

TIFFANY FRIESEN MILONE: Yes.

CAVANAUGH: OK. And, and $1.3 billion in economic activity. So obviously that economic activity isn't necessarily revenue for the state but that would be, there would be a percentage of that that is income tax revenue that we're missing out on from those 11,000 jobs?

TIFFANY FRIESEN MILONE: Yeah, it would be, I mean, when you have new, I mean, not new money but when you have the funds that go to providers then the providers do better, they hire more people. And so, yeah, you've got more people able to pay income taxes.

CAVANAUGH: So we're, so we are as a state missing out on the revenue from the income taxes from those jobs that would have been created?

TIFFANY FRIESEN MILONE: Yes.

CAVANAUGH: Thank you.

STINNER: Senator Bolz.

BOLZ: Thank you. I wanted to give you an opportunity to dive a little deeper into your comments around the fiscal impact of the administrative burden. And you reference a comparison between the 2017

fiscal note that said it would be about $1.8 million in administrative costs but now the agency would need about $6 million. Can you just speak to that with a little bit more depth and tell us a little bit more how the agency is justifying those additional costs or where we see those expenditures going?

TIFFANY FRIESEN MILONE: Yeah. I mean, there haven't been very detailed kind of projections released. So it's pretty much broken out into administrative costs and staff, and a lot of it is going to be staff because you're going to need more people to process paperwork. You're going to have more appeals, so you will probably need more administrative law judges. Because as people get dropped down you're going to have more appeals. And then you'll also have, it's going to be quite a bit of upfront expense, at least with other states, just in notifying people. I mean, that's an expensive process. And in Minnesota-- Minnesota when they, they did a fiscal analysis of work requirements there, and they went really in the weeds with it and like broke it down into how many additional minutes of work the work requirements would cause. And they concluded they need, they would mean like, I think, 300 more people. And we had about 125,000 people in the expansion population. So it's, you know, it's a few more people. But at the same time, when you're looking at increasing something-- like I think it was 55 minutes to process compliance paperwork. And so they did like a full Lean Six Sigma timing people

kind of thing. Yeah.

BOLZ: That's, that's really helpful detail. And I think it's useful to think through a little bit. We know that there will be administrative costs related to technology updates and, you know, the contract workers to make sure that we're meeting compliance standards and those kinds of things. But what I'm hearing you say is that part of OpenSky's position is that there are significant new expenditures related to the staffing and oversight of work requirements. And I think there is a conversation--

TIFFANY FRIESEN MILONE: Yeah, and they also will not be matched at the same rate. So like staff, personnel and staff generally are matched at 50 percent, where benefits would be matched at 90. So some of the upfront IT costs can be matched at the higher rate, but any ongoing administrative costs won't be matched at the 90. There are certain ones that will be matched at 75, but it's really limited.

BOLZ: Thank you.

STINNER: Additional questions? Senator Vargas.

VARGAS: Thank you very much for coming. It's really interesting to see the 40 percent a year implementation work requirements. The administrative costs, when we're talking about any programs or changes we do, we have to try to find a frame of reference. That was concerning to me. But to make sure I have a full picture, what's

this-- do we have any data from Kentucky showing that, OK, if it is 40 percent administrative costs jump, were there any savings that they found? Efficiencies? Any, any data?

TIFFANY FRIESEN MILONE: Yeah. So where they projected seeing the savings was by having people kicked entirely out of the system. And so the governor, in January of 2018, like publicly said that they were going to end up spending more money to give people worse coverage.

VARGAS: So the data that we have is that fewer people will be enrolled and that's going to save the state money?

TIFFANY FRIESEN MILONE: Yeah, for Kentucky. But they ended up, but they haven't ever implemented work requirements because of the lawsuits. So they've spent $35 million and have not seen any savings because they haven't implemented.

VARGAS: Thank you.

STINNER: Additional questions? Senator Wishart.

WISHART: So their hypothesis is if they kick people off of Medicaid they will save money. But what have-- don't we have statistics on the fact that if somebody doesn't get regular health care it costs more money?

TIFFANY FRIESEN MILONE: Yeah. I mean, there is-- yeah, there is data showing that preventive care is the most cost-effective way of kind of

helping people. Because if you, if you're kicking them out of Medicaid entirely then you're going to increase your emergency room costs which are, that's a problem for hospitals, it's a problem for the state, it's a problem for people who are going to the emergency room instead of having gone to the dentist, you know, five years earlier where they could have caught something that blew up. So from a fiscal standpoint you would want to encourage preventive care early on.

STINNER: Senator Howard.

HOWARD: Thank you, Senator Stinner. Thank you for visiting with us today. And you may not be the right person to ask this question to, but one of my major concerns with the Department overall is their inability to hire people. Because they're not paying enough compared to other, other groups they're having a really hard time staffing up for certain projects. And so when I think about sort of the long-term challenges of Medicaid expansion and Medicaid expansion in a sort of a more challenging context, do you know about some of the work force challenges that the department is experiencing and whether or not they will need actually more money in order to pay people more in order to get them to work for us?

TIFFANY FRIESEN MILONE: I do not.

HOWARD: Yeah, it's kind of, it's kind of a bigger question but we're seeing it in every facet of the department in terms of hiring

challenges. And just when you're talking about that they need 180 staff, I'm not sure where they're going to come from right now.

TIFFANY FRIESEN MILONE: And it's--

HOWARD: Even with a straight expansion.

TIFFANY FRIESEN MILONE: I mean, it is also scheduled to increase. They, I think they project between six and eight new staff every year for the next decade.

HOWARD: Thank you.

STINNER: Senator Murman.

MURMAN: Thank you for testifying today. Did you do any research as to the benefits to the health care system of encouraging beneficiaries to make appointments and not go to the emergency room?

TIFFANY FRIESEN MILONE: I, yeah, I-- well, so I went a little in the weeds with that question because it's a complicated one. I did look at, I mean, like the cost difference between providing dental care versus the emergency room. I mean, it's, I mean, it's just a stark difference. I don't know that you could quantify economically, you know, the requirement to have people regularly see the doctor, you know, in terms of the overall fiscal impact.

STINNER: Additional questions? I just want to make a comment that the Appropriations Committee spent a lot of time sifting through the

administrative cost piece of this. I can assure you that the $6 million there is a lot of one-time costs in there that will go away in terms of implementation. The other thing I think OpenSky has assumed that everybody would show up, 90,000 and the 4, $460 million would be something that we've lost the opportunity. There is a ramp-up period to get 90,000 people on to cover it. So we're using this-- be careful how you use the numbers, that's all I'm suggesting. With that, any additional questions? Seeing none, thank you.

TIFFANY FRIESEN MILONE: Thank you.

CLAUDIA DAVIS: Hello. My name is Claudia Davis, C-l-a-u-d-i-a D-a-v-i-s. What else? Is that it? OK. I am a retired LM-- LIMHP, excuse me, which means licensed independent mental health practitioner. And I worked in two specific counties where Wahoo and David City are for about 15 years. When I come up here I'm thinking that many people here do and many people do not know about rural communities. In our rural community, our rural communities out there, there isn't a lot of mental health, there aren't many mental health programs. Many counties do not have mental health programs that are private nonprofit or even private, and so many people do not get health care for mental health. And economically, many of them are not able to get to mental health appointments. Many of them do not have cars, transportation is difficult in rural areas. And if they do have a serious mental health problem and come in for a crisis, most

counties do not even have the ability to house a person in crisis and they are often tried to-- we try to take them to Lancaster County, which has not always worked out well either, because the beds are difficult to get into. So we have people that are maybe suicidal or very, very angry and possibly homicidal. And it's very difficult to get them services in these areas. Those of us who have lived close to the bone at some point in our life know that when you don't have enough money you not only don't get over-the-counter medicines or go places that you want to go or even be able to provide some of the healthy foods that you need but you also do not sometimes, especially if you're not on Medicaid, you don't get your emotional and mental health medications either. That's really, really important because many of them are not inexpensive. Some of the really older ones are, they're pretty inexpensive. But the newer ones are not. And some of the newer ones really help people, especially people with bipolar disorder and depression, as well as the chronic medical illnesses like schizophrenia and-- I lost the train of thought on that one. But like schizophrenia and schizoaffective disorder. Medicaid expansion would allow people that work in rural areas that are farm workers but also many farmers, like someone else has pointed out or already, get some help so that they can get into appointments or you can have child care. Many offices do not allow children to come in with their parents. And when they're small, it's very difficult to do therapy with someone with a 2-year-old in the office. But it happens. It's

better than nothing at all, but it would be nice if there was a way that they could have some, some help with child care during sessions. OK. I think that I'm finished with this. I have never done this before. I appreciate you listening to me. But I really felt that someone has to speak up for the rural mental health needs in our, in our, in our state and counties. And I do think that severely important is getting this finished up and implemented because people do not just sit in buildings and wait. They need it now. And when you don't have your medications and you don't have services, it's not like a year is nothing. It's really important. Is there any questions?

STINNER: Thank you. Questions?

CLAUDIA DAVIS: Don't know that I can answer them all.

STINNER: Questions? Seeing none, thank you.

CLAUDIA DAVIS: Thank you.

MARY SPURGEON: Good morning. My name is Mary Spurgeon, M-a-r-y S-p-u-r-g-e-o-n. Today I am testifying on behalf of Omaha Together One Community or OTOC. OTOC is a coalition of more than 25 congregations and other community organizations that work together for the common good. OTOC wants the actions of government to create structures that enable all people to achieve a good life. Our members strive to implement the ethic of care for your neighbor as yourself. We want to see that ethic also acted out in our government institutions. The

proposed waiver for expanding Medicaid ignores this ethic and the common good of the citizens of the state in the following ways. One, it fails to expand Medicaid expeditiously and in the least costly manner. Thereby it sentence, sentences to death approximately 500 people per year who urgently need care, while shifting the costs of late an ineffective emergency room care to Nebraskans who currently pay for health insurance. Two, OTOC leaders with medical administration experience are unanimous in their conclusion that the waiver provision that recipients reapply for benefits every six months is impossible to manage. This plan is designed to fail in a spectacular mess and fail with financial costs and embarrassment for the state, and/or the unknowing private contractor that will be expected to administer the waiver. Three, this waiver proposal reduces benefits for current Medicaid recipients which is not what the voters or the Unicameral approved. It also places Nebraska hospitals at increased financial risk for continued high rates of unreimbursed care. Four, this benefits package that requires people to engage in certain activities including work requirements is a violation of Section 2 (4) of the law. It is logical to assume that it will take another layer of government or government contractors to keep track of that data. It is safe to assume that Nebraska taxpayers will pay that bill. Five, postponing implementation through this waiver ensures that the state of Nebraska will not receive $460 million in federal matching funds for this year. Also a violation of Section 2 (3) of a

law. Nebraska is losing this money while the Unicameral's Revenue Committee struggles to find a way to get income for statewide needs to relieve pressure on local property taxes. In sum, this waiver is wasting lives, time, and money by planning to implement a complicated, inefficient plan that is completely optional and was never authorized by Nebraska voters. By so doing, Nebraska is loudly proclaiming to low-income working people ages 19 through 64, living the American dream on less than $17,000 a year: Take your energy, your dreams, your innate talents and skills and initiative to another state. You are not wanted here. Nebraska should be swiftly and efficiently implementing Medicaid expansion as instructed by the voters. Instead, at the Governor's direction, it is hurting individual Nebraskans by deferring care. Again, for the seventh time, the financial well-being of the state is threatened by preventing the return of Nebraskans' federal tax dollars to the state. By these actions the Governor is failing to carry out his constitutional duties. Instead, he demonstrates disdain for Nebraska voters, the rule of law, and the Unicameral. Enough is enough. Implement Initiative 427 as passed by the voters.

STINNER: Thank you. Questions? Questions? Seeing none, thank you.

MARY SPURGEON: Thank you.

JORDAN RASMUSSEN: Good morning, Chairman Stin-- Stinner and Chairwoman Howard, members of the committee. My name is Jordan Rasmussen, J-o-r-d-a-n R-a-s-m-u-s-s-e-n. I serve on the policy team with the

Center for Rural Affairs. Under the proposed 1115 waiver 90,000 Nebraskans who will be eligible for care under expansion and an estimated 25,000 additional residents currently enrolled in Medicaid stand to lose access to vision, dental, and over-the-counter drug benefits. These ancillary benefits are crucial to improving and achieving overall health outcomes. Nebraskans certainly did not vote for these barriers and delays to be placed into this coverage. Dental health is essential to overall health, affecting not only physical but mental and emotional well-being, oral health is critical and complex issues that span beyond just straight teeth and a white smile. Dental condition like gum disease have been identified as an indicator for a number of chronic diseases like cardiovascular disease, stroke, diabetes, and Alzheimer's. The Nebraska Department of Health and Human Services health assessment found that those mortality rates for some of those diseases like heart disease and stroke were greatest in our state's rural communities. The report also noted that for in our urban counties their residents are 12 percent less likely to go see a dentist than in our urban areas. Without adequate rural hygiene, awareness of dental health issues, or regular visits to a dentist individuals may disregard these warning signs and allow underlying conditions to advance into more costly chronic conditions. Data from the Bureau of Labor Statistics consumer expenditure surveys found that Americans spent $36.8 billion on dental services in 2016. That equates to about $700 per person. Of these personal dental expenses incurred,

44 percent were paid out of pocket, 43 percent by private dental insurance, and just over 8 percent were paid by public coverage such as Medicaid. In Nebraska this cost undoubtedly inhibits residents from visiting their dentist. The American Dental Association found that 54 percent of Nebraskans who had not visited their dentist in the past 12 months did not go because they could not afford the cost associated with care. Unsurprisingly this percentage is significantly higher for low-income households, 74 percent of which said costs prevented them from seeking care. For high-income households that percentage shrinks to just 1 percent. When Nebraskans cannot access the dental care they need through planned visits to the dentist's office, they go to our emergency rooms. The state provided some pretty amazing statistics that between 2003 and 2015 the number of nontraumatic dental visits to emergency rooms nearly doubled from 4,800 to about 8,200 with a price tag of $10 million in costs for emergency rooms. Of these emergency room dental visits more than 2,800 occurred, or were made by rural residents. Creating these additional barriers to dental care for coverage for current and expansion Medicaid clients through the proposed 1115 waiver will only exacerbate this utilization of emergency services for dental care. Overall, Nebraskans in the state's rural counties have much to gain with the expansion of Medicaid. The number of uninsured in our rural counties matters not only because of the number of rural Nebraskans who are left uninsured, but also for those in their communities who are left to shoulder high insurance

premiums and radiating effects of uncompensated care on our health systems. While expansion does not offer the solution to all of the challenges of rural health care delivery, the expedient and unencumbered implementation of Medicaid expansion will make a difference for thousands of rural residents and the communities they call home. It's time to move forward with the will of the voters and implement Medicaid expansion without barriers. Thank you, and I would welcome your questions.

STINNER: Thank you. Questions? Senator Hansen.

B. HANSEN: Thanks for being here.

JORDAN RASMUSSEN: Yes, thank you.

B. HANSEN: So, again, maybe in your opinion, since we're talking about dental care primarily with Medicaid expansion, what percentage would you say-- say we expanded Medicaid without any kind of requirements at all. What, what percentage of ER visits would you see in your opinion decline with Medicaid expansion?

JORDAN RASMUSSEN: I cannot make an estimate on that. I'm sorry.

B. HANSEN: OK. And I want to pose this question the same way that I posed it to somebody earlier. What kind of requirements do you think the state should implement, if any, that ensure or make sure that, just like we do with any kind of government program, that we want to

make sure that we're getting the best bang for buck, make sure we're getting a good return, and make sure we're helping people in the right kind of manner, and the most kind of people that we can due to our limited budget? Are there any requirements that you see the state should implement to help make sure we're spending taxpayer money wisely?

JORDAN RASMUSSEN: I would agree. I think that there are opportunities for us to invest in some of these wellness programs and initial preventative care. We could save cost in that, in that fashion upfront as opposed to putting up barriers. So investing in those caseworkers and folks that are there to help people navigate the system and the health care system as well, because it's complex. For somebody that doesn't have access to internet or isn't savvy enough to be able to navigate those systems, they need somebody by, by their side. And so being able to help, help them through that process, I think that would be valuable long-term.

B. HANSEN: OK. And this is kind of the same answers that I heard before, it's not so much a requirement for as making sure we spend more money to help people get to Medicaid to help, you know. And so I see, I see where that's coming from, to, to help people navigate the system, make sure they get to their appointments on time. Do you see any requirements or any kind of sense of responsibility we should put on a patient to make sure that they are either keeping their

appointments, making sure they're using Medicaid efficiently?

JORDAN RASMUSSEN: I think pairing those together what would be beneficial. Probably not to the extent that's proposed in the waiver but, yes, being there to be by their side to help them navigate those systems.

B. HANSEN: Thank you.

STINNER: Additional questions? Senator Bolz.

BOLZ: Since this question has come up a couple of times I just, I thought maybe we could talk about it for a second. There are existing Medicaid regulations about access to care, about making sure that the services that we are purchasing with Medicaid dollars are the correct services. An example that comes to mind is certain behavioral health services can only be provided by a trained clinician, for example. In addition to that, we have the three managed care providers. Which not only are designed to sort of promote that preventative care and make sure that we're using dollars wisely, help people navigate the system, but also are looking for those strategies like how do we make sure that diabetics get the lower cost level of care rather than emergency level of care. And the fact that we have three means that there's innovation among those three managed care providers, which means we're also looking for new ways to create those cost efficiencies. And so to shake this into the form of the question, it seems to me that there's

already a pretty good infrastructure there by people who have a lot of expertise about controlling costs and getting the best bang for our buck. Can you help me think through all of those strategies as it compares to just the strategy to say: Do it or you'll lose access? Is there any data or information that compares which is better or which is more effective?

JORDAN RASMUSSEN: I don't have any data off the top of my head that would point to that but that would, I mean, from a logical perspective, yes, that does make sense. Those that are working at the ground level, working in those spaces with those clients, understanding the complexities of, of being a low-income person and the challenges that you face, whether that's transportation or access to child care. Yes, that makes sense. And so, yes, incentivizing those opportunities and drawing upon that expertise obviously makes the most sense logically. Yes.

BOLZ: And just briefly, one quick example, I was that the Medicaid Assistance Advisory Committee meeting and one of the managed care providers did present specifically on how they are improving the both the quality of care and the health outcomes for diabetics and controlling costs by making sure that they have some of those navigators just like you are suggesting. So I think we already have some of the proof in the pudding from some of those managed care providers who are already showing us how it can be done.

JORDAN RASMUSSEN: That's great.

BOLZ: Thank you.

STINNER: Additional questions? Seeing none, thank you.

ASHLEY FREVERT: Good morning.

STINNER: Morning.

ASHLEY FREVERT: Members of the committee, my name is Ashley Frevert, that's A-s-h-l-e-y F-r-e-v-e-r-t, and I work for Community Action of Nebraska as the executive director. We are the statewide association for Nebraska's nine community action agencies. Community Action is the largest anti-poverty movement in the nation with over 1,000 agencies serving 99 percent of counties. All of Nebraska's 93 counties are served by our agencies, and in any given year we serve between 83,000 and 86,000 low-income Nebraskans. You're going to see coming around to you on the second page our most recent data, which is always the previous fiscal year, a little more about those numbers. We are longstanding and established in communities with just over 55 years of proven success in addressing the causes and conditions of poverty in Nebraska. We see its many faces and are there helping individuals, families, and communities to weather the storm both figuratively and literally. Our agencies employ over 1,200 staff across our great state. What we see every day is the resiliency, pride, the determination of Nebraskans. It's our job to make sure the basic human

needs of those we serve are addressed. If we're doing our part the people, those individuals, families, and communities, are able to thrive. They become independent, productive, and contributing neighbors. Community Action was and remains supportive of Medicaid expansion in Nebraska. This is consistent in all states who are attempting to or who have implemented Medicaid expansion. As I've said, we're in 99 percent of all counties across the nation. We saw great success through our Affordable Care Act Navigator program which was implemented through a federal Navigator grant from 2013 to 2018. Our navigators assisted Nebraskans through zero-cost education and enrollment in health insurance plans through the health care exchange. We also provided and still do provide guidance and education on Nebraska Medicaid for anyone wanting to apply for eligibility. What is concerning to Community Action is the idea that including work requirements, benefit limitations, significant policy changes, and an additional fiscal impact is more important than the health and well-being of Nebraskans. And we are talking about all Nebraskans, the entire community. Initiative 427 was a victory, a success. It was a win for the people we serve and it was to be implemented in the time we had hoped. To be honest, stretching implementation out for far longer than necessary isn't the Nebraska our residents have come to know and trust. To those of you on this committee, having Medicaid expansion implemented in Nebraska will positively impact your communities because it will positively impact Community Action which

is in 93 counties. The more people we help, the greater the well-being of Nebraska. And we have the outcomes to prove it. If we have healthier individuals and families, we have healthier communities. We encourage support for LR170, that the HHS Committee be designated to conduct an interim study to carry out its purposes and that the community-- committee shall include with a report to the Legislative Council or Legislature. It's good Nebraska common sense. Thank you, and I'm happy to answer any questions for you.

STINNER: Additional questions? Questions? Seeing none, thank you. Senator.

MORFELD: Thank you, Chairman. Members of the committees, a few different things. First, I-- we tried very hard to get some folks to be able to come down here and talk that would otherwise have Medicaid expansion. But quite frankly, and the ironic thing is, is that all of them had to work and couldn't come down here. And so I think, one, that's a demonstration that these are working Nebraskans. These are folks just trying to get ahead and they're folks like Emily, who I just want to read a very, very brief letter here, who stated: I wish I could be at the hearing in person but I'm a student teacher this semester and not able to take off work. Here's my story. I graduated from UNO in 2016 and worked for a couple of years as a legal unit specialist at an underwriting firm. I knew it wasn't my lifelong calling, so I went back to school so I could become an elementary

school teacher. Something that we need a lot of, from what I hear on the Education Committee. I'm currently teach, student teaching third-graders at Reeder Elementary School in Millard. Once back in school full-time I worked in my uncle's accounting firm to help pay the rent and eventually moved back home with my parents to save money. Unfortunately it never occurred to me that this decision to attend school full-time at age 25 would put me in a perilous position regarding my health insurance this year. You see, I turned 26 last month, so I couldn't stay on my parents' health insurance. I work full-time as a teacher but I'm still technically a student, not an employee of the school district. Medicaid expansion passed almost a year ago, so I was shocked when I was an eligible for affordable health insurance. I made $9,000 in 2018 working as a full-time student, so the irony is I made too little money to be eligible for a subsidy on the health insurance exchange. After working with a friend of the family who is a health insurance broker, I ended up with a catastrophic insurance. I pay $70 a month and have a $10,000 deductible. Keep in mind that I'm a working full-time student not getting paid really. In fact, I have to pay tuition for the student teaching. Another student teacher, my coworker Brent, made over, made over the $12,000 threshold last year so he is getting great insurance on the exchange at an affordable cost. Thank goodness I'm healthy. If anything happens, I get in an accident or fall severely ill, I will go bankrupt. I'm merely making mends eat-- ends meet. I certainly don't

have $10,000 laying around should something go wrong, and I would say that statistically most Nebraskans don't. Medicaid expansion was passed to help people like me. I don't understand why it was implemented. I'm told that there's about 90,000 other people like me in the same situation. You have the power to help us. Please, I'm asking for your help. Sincerely, Emily, Emily Novacek. There's a few things I want to address here. First, based on the HHS numbers we had a loss of $149 million this year alone by not expanding Medicaid the way that the voters intended, including we have other losses that are hard to account. But the UNK study that was done two years ago found that productivity among workers and also the availability of work force increases as the access to health care increases, which I don't think is rocket science. But there's actual numbers to prove that and I would encourage you to read the UNK study that goes into that in depth. In addition, I think that some questions were asked about ER visits. On your handout that I believe the gentleman from Arkansas sent around, before work requirements were implemented after Medicaid expansion was implemented, ER visits went down 60 percent. And so there is numbers, there's real facts that show that utilization of health care becomes more efficient, ER visits do go down, and that we see healthier outcomes. In addition, I think that that's why we have managed care companies that are supposed to be managing the health care outcomes, monitoring them, navigating people successfully so that number one, they get the best care; but number two, they get the most

efficient care for their dollars and the state dollars. I think what we really need is more appropriate oversight from DHHS of managed care companies rather than making it more difficult for everyday Nebraskans to receive this type of care. And I also want to say I know that several of us have been involved with ballot initiatives in the past or are currently involved with ballot initiatives, and I think that this really sets a dangerous precedent that the third house of our government, the people, as intended when we passed a Unicameral Legislature, having a third house or a second house I should say, third branch of government maybe. But the second house, the people, have the right to the initiative petition process. And Senator Erdman I know that you're involved in a property tax ballot initiative. Just imagine if you passed that, you go through all that hard work, Nebraskans pass it and then suddenly the Department of Revenue is like, well, we've got a-- there's this two-year delay that we have to do. Sorry, can't do anything about it. I know the language is really clear, just like our language was, but we're going to have to wait two to four years of study or tweak or it's not 100 percent clear, so just hold on for a while. This diminishes the power that the people have of the initiative petition process, it diminishes the respect that Nebraskans have that government is going to carry out the will of the people, and more importantly it impacts people's lives. There are people that do not have access to health care in our communities all across the state that are suffering unnecessarily, unable to work, and

dying prematurely. And I can't emphasize that enough. These aren't just numbers, they're not just statistics. It's not just federal dollars, it's people's lives. And this is despicable. And the fact that the Department of Health and Human Services isn't here today and the fact that they continue to bungle this, either on purpose or because of incompetence, is completely unacceptable. And it's not something that should be taken lightly and it's not something that should just be passed over and gone, oh well, that's too bad. So with that, I'm happy to answer any questions.

STINNER: Senator Wishart.

WISHART: Well, thank you so much, Senator Morfeld, for being here today and bringing this in front of us. So what are, what can we do for those of us who are concerned about this waiver, what can we do as senators to try to reverse this? I mean, what kind of powers do we have as a legislative body to be able to address this issue?

MORFELD: It's a good question. You know, quite frankly the reason why we went to the ballot was because we realized that the supermajority of the Legislature was not willing to pass it in the first place. And so then we go to the ballot, we pass it, it's only a few paragraphs. It's pretty clear, much like some of the other ballot initiatives that are currently on the ballot. And the administration refuses to implement it. And so I don't know how to answer your question very well other than saying go to the courts, the court system. Because

when you have a Legislature that's unwilling to act, when you have to actually pass it. And even if they did, the Department of Health and Human Services might be doing the same thing right now, quite frankly. And then you have an administration that is willfully violating the law, not implementing the law as passed by the people, it's tough to know what to do other than for all of us to demand that the administration, whether we agree with the policy or not, we can have reasonable policy differences on whether Medicaid expansion is a good thing, whether the Affordable Care Act is a good thing. But I think we can all agree that when the people pass a law on the ballot that we should all be demanding that the Department of Health and Human Services or any other state agency that is directed by that law and the people should be implementing it and not playing games with it. We all took an oath here to uphold the Constitution and the laws of this state. The Governor took that same oath. It's not being carried out. And anybody that tells me with a straight face that it is being carried out is lying. It's not being carried out. So, Senator Wishart, I don't have a good answer for you, but I think that what we can do is continue to provide pressure on the administration to carry out the law. We could introduce a bill saying Medicaid expansion must be implemented without a waiver by X amount of date. But, quite frankly, I don't know if the administration would follow that either.

WISHART: OK. So just to clarify, say there are enough senators compelled, even if they didn't agree with expansion in the beginning,

compelled enough by a concern that, that we are growing administrative overhead as a state in a time when it's, when we have fiscal challenges. And we've been convinced that the benefits of, of having a work requirement don't pay out in terms of the amount of money it costs to do that. Say we have enough senators that agree with that, what, what could we do as a legislative body? We could, we could introduce legislation?

MORFELD: We certainly could introduce legislation saying that any waivers have to be approved explicitly by the Legislature being, before being submitted to the department, that the Department of Health and Human Services on the national level. And so that's one option, we don't currently have that legislation in place.

WISHART: OK.

MORFELD: So, yeah, I mean, that is one option. There's many different options. But the issue is, is that the reason why we went to the ballot in the first place was because we didn't have the 33 votes to implement it. Now looking back on it, even if we had the 33 votes to implement it, it looks as though the administration wouldn't have actually implemented it anyway without a waiver. And so it's disingenuous and it has real consequences on real people's lives.

STINNER: Senator Cavanaugh.

CAVANAUGH: Thank you, Chairman. Thank you, Senator Morfeld, for

bringing this resolution today. This is an important conversation. It's not the first conversation these two committees had together about this particular implementation obstacle. I share your, your frustration and concern over the fact that the department is not here today to answer any questions. It is clearly laid out in this LR170 that we are here to learn more not just from the people but also from the department. And in reading over Director Van Patton's letter I just wanted to call attention to the bottom of the first page in the second sentence. It says the waiver allows us to create a product with greater value for beneficiaries, and I don't know what that means. And so I more want to just state that on the record for you and for the committee that it would be really nice to hear from the department what they mean by creating greater value for the beneficiaries. Because what we've heard today is that this actually creates greater barriers and obstacles and limits access to care. And I just don't know how one would qualify these greater values. And I'm also concerned about how we are supposed to in good faith work with the department to come to a resolution on this implementation if the department doesn't show up to talk to us. So I just wanted to share that frustration, and I'm disappointed that we couldn't get a better conversation today from the department. But thank you for bringing this.

MORFELD: Yeah, and I don't think-- I share your sentiments and your concerns and I would be interested to talk to some of these

beneficiaries that lose some of their benefits and ask them how that created better value for them.

STINNER: Additional questions? Seeing none, thank you.

MORFELD: Thank you for the committee's time.

STINNER: We do have letters for, that will be submitted to the record from the League of Women Voters in Nebraska, Nebraska Association of Behavioral Health Organizations, AARP Nebraska, Health Center Association of Nebraska, American Cancer Action Network, DHHS, Reverend Jessica Palys, and Sandra Rasser-Herbek. We did by-- we did ask the DHHS to come in and testify today. They did send a letter. I am going to read the letter into the record because I think it's significant. Dear Chairperson Howard, Chairperson Stinner, and members of the Health and Human Services and Appropriations Committee, I ask that this letter be included in the record for LR170. Due to prior commitment in Omaha with health care providers, academic institutions, and our Nebraska Health Information Initiative I am unable to appear at the September 20th hearing. The Department of Health and Human Services Division of Medicaid and long-term care met the deadline in the Initiative 427 by submitting three state plan amendments to the federal government on April 1, 2019. Work to implement Medicaid expansion is currently underway and on schedule. Implementing expansion is a significant project between systems builds, staffing, and discussion with federal government. Launching an expanded Medicaid

program that is right for Nebraska takes time to do well. The application for Section 1115 demonstration waiver is the next step. The waiver allows us to create a product with greater value for beneficiaries and providers who care for them. From an audit perspective it will allow us to create a program that prioritizes accurate Medicaid eligibility determinations in compliance with recent, recent federal requirements that we are accurately anticipating. We are going to meet with Nebraskans at a public hearing in the following dates: Tuesday, October 29 in Scottsbluff; Wednesday, October 30 at Kearney; Thursday, November, Norfolk; Tuesday, November 12, Omaha. Medicaid long-term care maintains a Web page specifically related to Medicaid expansion and we also share updates on the social media. DHHS submits a monthly report to the Legislature which is publicly available. We encourage all Nebraskans to follow our progress on this, on Medicaid expansion Web page. We recognize that some interest groups have different perspective on Medicaid expansion and have exercised their constitutional right to seek review by the courts. That said, we remain focused on the established work plan and project time lines with a set go live on October 1, 2020. For your convenience, the current project time line with all 10 project work tracks is attached. Thank you for the opportunity to provide this information. I look forward to continuing your work with you to fulfill our mission and help people live better lives. Sincerely, Matthew Van Patton. With that, that concludes our hearing on LR170. We

will now open our hearing with Senator Cavanaugh's LR116.

CAVANAUGH: Well, I'll try to not take that mass exodus personally.

STINNER: Thank you.

CAVANAUGH: Good morning, Chairman Stinner, Chairwoman Howard, and the Appropriations and HHS Committees. My name is Machaela Cavanaugh, M-a-c-h-a-e-l-a C-a-v-a-n-a-u-g-h, and I represent District 6, west central Omaha. I'm here to introduce LR116, an interim study to examine the long-term sustainability of the Health Care Cash Fund. I introduced LR116 to create an opportunity for both Appropriations and HHS to learn more about the history and use of the fund. I hope that this joint hearing will offer the two committees the opportunity to green-- gain a greater understanding of the purpose of the fund and help inform and strengthen our policies moving forward. Created by LB692 in 2001, the Health Care Cash Fund is made up of money from the Tobacco Settlement Funds, the Medicaid Intergovernmental Transfer Fund and the investment income from that principle, and was created to ensure that essential public health programs could be funded long-term. Some examples of these programs include Children's Health Insurance Program, behavioral health, and starting next year the Brain Injury Trust. First up this morning we will hear from Liz Hruska from the Fiscal Office who will give an overview and update on the Health Care Cash Fund. Next, Michael Walden-Newman from the Nebraska Investment Council will give an update on the investment of the fund.

And then you will hear from several organizations that currently receive the funds distributed-- disbursed from the Health Care Cash Fund. Thank you for your time this morning and I'm happy to answer any questions.

STINNER: Thank you. Questions? Seeing none, thank you.

LIZ HRUSKA: Good morning, Senator Stinner, Senator Howard, and members of the Appropriations and Health and Human Services Committee. My name is Liz Hruska, it's L-i-z, last name is H-r-u-s-k-a, I'm with the Legislative Fiscal Office. I will provide a very brief overview of the Health Care Cash Fund and the related funds that are deposited into the Health Care Cash Fund. I know quite a few of you are very familiar with the Health Care Cash Fund already. I'll begin by describing the sources of funding for the Health Care Cash, Cash Fund. The main sources the Nebraska Tobacco Settlement Trust Fund. In 1968, Nebraska, along with 40 other states and territories entered into a settlement agreement with tobacco manufacturers. The basis of the settlement was reimbursement to the states for additional Medicaid costs to the states incurred treating smoking-related illnesses and diseases. The terms and conditions of the settlement are contained in the Master Settlement Agreement. This agreement contains a schedule of payments the participating manufacturers are required to make to each of the states annually in perpetuity. So there is no termination of these payments. Payments are adjusted based on an annual inflation and

volume adjustment. Those payments are then deposited into the Nebraska Tobacco Settlement Fund. The revenue varies from year to year, it generally has trended between $36 and $39 million. The state must meet certain conditions of compliance contained in the Master Settlement Agreement. The Attorney General's Office is responsible for ensuring compliance and the Department of Revenue assists with this active, activity. Once the state receives the funds there are no restrictions on the use of the fund, o the use of the funds. So Nebraska is unique in how we have used it for health, health-related activities. Other states have used it to build roads or buildings or just supplement their general funds. All states are required to enforce the provisions of the settlement relating to the nonparticipating manufacturers. Those that aren't part of the settlement agreement. Failure to comply with this provision can result in the loss of up to an entire year's worth of payments if the state has been determined to not meet enforcement requirements. So our enforcement provisions are very necessary in the continuation of obtaining the revenue. The other source of funding for the Health Care Cash Fund has been the Medicaid Intergovernmental Transfer Trust Fund. The Medicaid Intergovernmental Trust Fund was a loophole that was allowed by the Medicaid law. Nebraska was the second state to access fund, additional funds to this loophole. And basically it, it allowed states to overpay publicly supported nursing facilities, and the overpayments then were returned to the state. The General Fund was made whole and the federal portion

of the overpayment has been deposited into the Medicaid Intergovernmental Trust Fund. As more states began to access this loophole the federal government shut it down, phased it out, and as of 2005 there is no additional revenue other than, there's been no additional revenue other than investment income into the Medicaid Intergovernmental Trust Fund. The Legislature actually directed that this fund be depleted since it really didn't have a source of revenue other than investments, and most of the money was transferred out in fiscal, at the end of FY '19. And there are still some residual revenue that showed up this year and that should be transferred out in the current year. As of June 30, '19, the balance in the combination of the two funds was $15.7 million and this is a net increase of close to $37.9 million from, from the year before. And this is primarily due to very good investment returns this past year. I also want to note that although the tobacco settlement inter-- intergovernmental funds are called trust funds, in the statute they are not trust funds. Trust funds are assets held in trust and their use is governed by the condition of the trust. We don't have either of that, we don't have that controlling these two funds. The fund, funds are directly controlled by, by the Legislature so any 25 votes can direct that funding. There was a new source of funding in 2015, and that was a $1,250,000 from the cigarette tax. There were, there was a revenue stream going into another project that that ended and Senator Nordquist at the time directed the use of the cigarette tax to various

projects. And the Health Care Cash Fund was one of ben-- beneficiaries of that. Now to the Health Care Cash Fund. As Senator Cavanaugh mentioned, in 2001 the Legislature passed LB692 which provided the policy framework for the use of the Health Care Cash Fund, and the intent was to use the funds for health-related purposes only. The Legislature establishes in statute the total amount transferred to the Health Care Cash Fund every year. And in FY '20 the transfer amount is $61.9 million. And that funds close to 30 separate programs and activities and those include, as I mentioned before, the enforcement activities of the Attorney General's, General's Office and the Department of Revenue Biomedical research and stem cell research, there is also base funding for the Children's Health Insurance Program, for Medicaid behavioral health rates, for Developmental Disabilities, public health and mental health. And the base funding for the most part was put in in LB692. And with the exception of CHIP, none of, none of those programs have had additional funding, so it's just a flat amount that we appropriate every year. There, there's no inflationary increases tied to those activities. And there are also many numerous smaller programs and activities that come out of the Health Care Cash Fund. Every other year the State Investment Officer is to project the sustainability of the fund. The chief administrator Investment Officer is here, Michael Walden-Newman, and he can further address the sustainability. But in their last report which was issued last year they did mention that the state will, is at risk if it

continues to expend at its current expenditure level. And I'm sure he can elaborate further on that point. And that will conclude my testimony. If there are any questions.

STINNER: Questions? Senator Dorn.

DORN: Thank you, Senator Stinner. Just one quick question on the Tobacco Settlement Fund, what is the risk? What is that risk or is there a risk of ever losing some or all of that or what, what is known about that in future years?

LIZ HRUSKA: Again, it's the enforcement. There are tobacco companies that were not part of the Master Settlement Agreement but there are conditions in the Master Settlement Agreement that the state must enforce upon them. I'm not an expert in that area. That would be somebody from the Attorney General's Office. The other risk is just if people quit smoking and if value, volume would go down the state would receive less. Beyond that, the manufacturers are required to make these payments to all the states that are part of the settlement agreement and they have come through. They have not contested that at all.

DORN: For years, and for years in the future, there isn't some future date out there we'll land that, that's known in the settlement?

LIZ HRUSKA: No.

DORN: OK.

STINNER: Liz, just for the committee's purpose, on page number 5 you put in a combined fund. You have deposits, what does the deposits represent? Do they represent the amount that was transferred to the, for the tobacco settlement, right?

LIZ HRUSKA: The deposits are the tobacco settlement-- the payments from the manufacturers into the Tobacco Settlement Fund.

STINNER: So really for the last, what, since 2014, we've had $37 million deposited, $37 million, $36 million, $37 million, $41, and $39, and that was all due to this lawsuit? OK. The second one, the column is earnings and that's earnings from the corpus, is that correct?

LIZ HRUSKA: From both the funds, that's the combined Tobacco Settlement and Medicaid Intergovernmental.

STINNER: Medicaid governmental [SIC] will go away.

LIZ HRUSKA: Right.

STINNER: And it's predominately gone now, right?

LIZ HRUSKA: Right.

STINNER: OK. So basically what we have is about $500 million that we need to earn a rate of return on over and above what we get as

settlement money from the tobacco fund or from the tobacco settlement every year.

LIZ HRUSKA: Yes.

STINNER: So if we used an average of, say, $37 million, in order to project out we would have to make a rate of return that would be the difference between the $37 on average and the $61 or $62 that we're spending?

LIZ HRUSKA: Correct.

STINNER: OK, so we can then come back and back into an interest rate.

LIZ HRUSKA: Yes.

STINNER: And I'm sitting on retirement I know that we've done a great job on the investment side. I think long-term we can bank on, and I've asked the director numerous times on this, it's 6.6 percent is what we've kind of averaged as a rate of return. That's just information for the committee. So if I use 6 percent as a number, just backed it back down, on average that would be $30 million up earnings predominantly over a long period of time, that would be what you would have from the $500 million; 37, that's $67 versus $62, there should be without ever increasing any other thing that we do in the Health Care Fund. Is that an appropriate way of looking at it?

LIZ HRUSKA: I think the expert is probably the Chief Investment

Officer.

STINNER: Yes.

LIZ HRUSKA: I would probably refer to him.

STINNER: He has a little definition about sustainability than I do. So in any event, I'll stifle myself from now on. So any other additional questions? Senator Erdman.

ERDMAN: Thank you, Senator Stinner. Thank you for being here. Referring to that page 5 that Senator Stinner just referenced, if you would turn that, Liz, tell me if you can what happened in '16. The earnings were $742,000 down, several million from the prior year and the next year so you know, you know what happened there?

LIZ HRUSKA: Let's see.

ERDMAN: 2016, the second column under earnings.

LIZ HRUSKA: Again, I would refer that to Mr. Walden-Newman. I don't remember what was happening as far as investments from that particular year. But part of this is invested in the stock market. So as, you know, the stock market goes up or down--

ERDMAN: Yeah.

LIZ HRUSKA: --it will, you know, see it returns changing from year to year. But I, again, I'm probably not the right person to respond to

that.

STINNER: Additional questions? Senator Clements.

CLEMENTS: Thank you, Mr. Chairman. Thank you, Ms. Hruska. On page 2 you've talked about the amount transferred into the fund of $61.9 million, the bottom of that page. I guess I haven't heard about the transfers in, then what are the transfers out? Are they a different number than that?

LIZ HRUSKA: The transfer out, this-- the chart on page 4 is the combination of the Medicaid Intergovernmental Fund and the Tobacco Settlement. So the funds transferred out and into the Health Care Cash Fund.

CLEMENTS: And then we transfer money out of the Health Care Cash Fund for these different programs?

LIZ HRUSKA: Those are direct appropriations. So we don't transfer anything out of the Health Care Cash Fund, we just appropriate the funding to the, to the individual programs.

CLEMENTS: All right, thank you.

BOLZ: Page 6, Senator. Page 6.

CLEMENTS: Page which?

BOLZ: Six.

CLEMENTS: OK, I see those. Thank you.

STINNER: Additional questions? I think too that maybe you need to emphasize this is not a trust fund, it's not an endowment.

LIZ HRUSKA: Correct.

STINNER: I think that's an important note for the committee, anyway. You would treat them differently if they were. So thank you.

LIZ HRUSKA: Thank you.

MICHAEL WALDEN-NEWMAN: Good morning. Morning co-chairs and senators. My name is Michael Walden-Newman that's M-i-c-h-a-e-l, the last name is W-a-l-d-e-n-N-e-w-m-a-n, and I'm the State Investment Officer with the Nebraska Investment Council. Most of you know, I'm sure, that the Investment Council is a separate state agency responsible for investing all of Nebraska's public funds. We have $28 billion that we oversee, half of it is the pension programs for state and local government employees. Recently we took over the management of the assets of the Omaha school district. We also invest the state's checkbook, about $3.5 billion which includes the state's General Fund and state agency money, operating money. And we also manage some endowments, and one of them is what we call the Health Care Endowment. And as Ms. Hruska said that's made up of, until now, was made up of the flows from the Tobacco Settlement money and then this now closed account of the Medicaid Intergovernmental Trust. That, as Ms. Hruska

said, that was directed in statute to be depleted. There's a couple thousand dollars left that came in after the end of the fiscal year that we're, we're going to transfer out and zero that account out. The reason I'm here today here is Senator Cavanaugh asked me to come over and talk about what role we have with this, the resolution and the health care fund. And in state law there's reference to the Investment Council, well, the State Investment Officer, me, commenting on the sustainability of the transfers from the health care funds. And we're required by law every even-numbered year to report to the Clerk of the Legislature on the sustainability of the transfers. And as you know, those transfers are, the spending is set by you all in statute. So I've been here now five years, and I was new and, and even-numbered year rolled around and I was looking at my files and I found this and I saw that, that systematically my predecessors had said that the trend that the current spending was not sustainable on. Period. They-- we work with a consultant named Aon, they're based in Chicago, and they help us with the management of the investment program with research and helping with manager selection for the managers who invest the stocks and bonds and the rest of the stuff that this this $28 billion is invested in. And Aon has helped the Investment Council over the years do the study on the sustainability of the transfers. And the way they do it is they, it's very straightforward. We take, and you'll see their, their report from the last even-numbered year, 2018, so we'll do another one next year. So they-- we, we get from the

state the expected deposits into the funds from the Tobacco Settlement money. And then we apply what we think we're going to get from each of the types of investments we make. And those are called capital market assumptions. I'm telling you stuff you already know, I know this. But they're called capital market assumptions and that means what do we think we're going to get for the stocks we're invested in or the bonds we're invested in or the rest? And we do those each year and we use those then as the basis to project what we're going to earn on any of our investment portfolios, be it the Retirement Systems for our endowments. So, so we then put that into this, the report, and that's the report that we rely on to be able to say whether or not we believe the transfers are sustainable. And as I said earlier, I found letters from my predecessors every other year systematically saying, no, they're not. No, they're not. Hence my first letter I just copied my predecessors. We did the study, they weren't sustainable. I wrote the letter, signed it, it was great. But then the next, I'd been there then a couple-- and I was new, right. So a couple of years rolled around and the, and the next time I thought, well, you know, if I were a senator, it's very easy to say they're not sustainable. But I thought I'd probably want to know, well, what is sustainable? If you keep telling us it's not sustainable, what would be sustainable? So the next letter I wrote, I wrote and I said in plain English, simple English: Looks like you're spending $60 million a year. That's too much. I think probably if you spent $55 million a year it could be

sustainable, and we're talking in perpetuity here. We're the same way we invest in the pension funds. Those pension funds are not invested for next year or the next year or the next year. In the case of teachers, we're investing the state's teacher pension fund not just for teachers that are retired or teachers who are in service or to young people who want to grow up and be a teacher. But we're investing for teachers who aren't born yet, that's who we're investing for. And so we were looking at-- I chose to look at the health care and my predecessors the same way, as if it were a trust fund. And, and it's not. So I did though put in the letter, I said, I think maybe $55 million would be sustainable, ran the numbers. But I did add, if you want to be real safe probably $50 million, just knock it back. Then you wouldn't have to worry about if it were sustainable in perpetuity or not. So you'll see that on file from a couple of cycles ago. My most recent filing was last, last year. And last year there was another hearing like this hearing in Omaha but solely of the Appropriations Committee with the same charge. And I went to Omaha and said what then what I'm saying today, is that the numbers from how we're looking at it do not support the level of spending in the-- out of the Health Care Cash Fund. There's a lot of ways to say that, there's a lot of detail, but that's the message. That, that message is on file with the Clerk of the Legislature. The report you have in front of you is from last fall. We'll do another one in in 2020 and we'll file that report. I'm going to give you a little chance to--

STINNER: Additional questions?

MICHAEL WALDEN-NEWMAN: We've, we visited a bit about this in front of the Appropriations Committee before. And we visited as the Investment Council a year ago at one of our meetings, which we call a retreat, it's an education meeting we have each July where we, we don't take action but we take various subjects and really go in depth for a meeting. And we, we talked about the health care fund there and talked about the asset allocation and if we needed to make any changes. As you'll see in the report, it's invested 75 percent in stocks and alternatives meaning a little private equity, a little real, real estate-- which are real estate funds, we're not buying buildings-- we're in funds with other institutional investors who go out and buy and rehabilitate buildings and 30 percent and 25 percent rather in fixed income. The high stock exposure and equity exposure just to try to protect the fund against inflation, and you get that by investing in in the stock market. And to answer Senator Stinner's question and early, because I know one that's coming, it's better sitting here when you have an idea of the questions and you've got an answer ready than-- and that works for the first few, right? And then if we get the question four, I'm not going to have the answer because I only thought of three. But one is, what's the difference between the math he just ran through and the math that we have? And, and I think the difference is in our calculation we treat this as if it is a trust and so we built in a 2 percent inflation factor so that rather than simply

looking at the amount of money you're going to generate on a pure percent basis in order to protect the buying power of that money you have to put in an inflation factor. And so he's-- we do, you see, expect to get mid-six points, so five. I jotted down, and you can see my pencil scratch there, this was just for me but now that we've made copies you all can see it. The expected returns now over the next 10 years are 6.1 percent, a little more than that over the longer term. Last year's return was 6.6 for the fund for the one year. But I think the difference is, is that we would take that 2 percent off that to protect, to build in the inflation factor. And that's the simple difference in the, in the numbers. So bottom line, we-- you're, looks like you're spending 6 to 9 percent and maybe you another to truly-- if it were a trust in the true sense spending there is typically 4, 4.5 percent. But as, as you all know and, and was just pointed out, these, these aren't pure trusts.

STINNER: Additional questions? Senator Wishart.

WISHART: How, so how-- walk me through how the, the math changes in terms of having consistent programs in spending over the years as opposed to us having a few years where we do some one-time investments but that go away after one or two years and then we get back down to that typical amount that we're spending.

MICHAEL WALDEN-NEWMAN: Co-chairs and Senator, that, that's a good question. How about if I just flip it and put my, like, turn your

question into my life.

WISHART: OK.

MICHAEL WALDEN-NEWMAN: So my life is living through stock markets that change and it would be nice if they were very consistent. And it appears that they have been going in a direction for a while, but in the right direction. But we have a year that's a great year, like a 12-month period, but then we also have last December which was not very much fun. But we have long-term assumptions, that's why our capital market assumptions are for 10 years and 30 years, so our eye is out on the far horizon. So for policymakers that kind of perspective can, can handle market shocks from time to time, which would in my mind be the equivalent of one-time spending by the Legislature. You could have one-time spending on something that came up if as long-- if you kept in mind that that needs to then be built in to the longer trajectory of spending. Because stuff happens.

STINNER: Senator Howard.

HOWARD: Thank you, Senator Stinner. Thank you for visiting with us today.

MICHAEL WALDEN-NEWMAN: Sure.

HOWARD: Our paths haven't really crossed that much but, I guess, I'd like you to tell us a little bit about your background and a little

bit about your work. Maybe it would help us understand why we should believe you when you tell us about the sustainability.

MICHAEL WALDEN-NEWMAN: That's a, that's a really fair question, isn't it. Here's the short version of the story. So, again, the Investment Council is a separate state agency and I'm the agency head. So I have a title of State Investment Officer but it's, I'm the director of this independent state agency. And we're not the retirement system, right, we're, we're our own. We're governed by a board of directors, so I have an eight-member board. Five members are business people appointed by the Governor and approved by the leg-- by legislative confirmation. The other three-- and they're on staggered five-year terms. Then there are three other members, the State Treasurer is and ex officio, nonvoting member; the director of the pension system is a nonvoting member; and since the transfer of the assets from Omaha in January of 2017, the director of the Omaha school employees pension system is also a director. So the five, aside from the three who have their roles statutorily, the five governing board members, voting board members who are fiduciaries of the funds are required to have expertise by statute to serve, to be even appointed by, by the Governor. And then they hire me. And I am an at-will employee, if you will, to them and then I'm also my appointment is approved by the Governor and confirmation through the Senate. So my background, I've had four jobs in my life. Eight years I spent in Africa doing, I did a stint in the Peace Corps and I worked for the State Department in the

Foreign Service. Then I came back to the states and for years ran in the state of Wyoming. I'm from the northwest. I was born in Topeka but I'm the cousin who moved as a little boy with his folks out to the northwest to seek their fortune. So we were the family who lived far away. But we came back from overseas and I went to work in the state of Wyoming next door and ran for years the equivalent sort of a blend of who was just here, is it the OpenSky and the Platte? There's a couple of them. I was that guy for the state of Wyoming. There was one group like that and I did that. And for 17 years. And then in 2004 I was asked by the state treasurer to be the first chief investment officer for the state of Wyoming's mineral funds. The state of Wyoming, as you all know, has a lot of mineral production: coal, oil, and natural gas. They save 40 percent of the revenue, tax revenue from that production and invested it, set up permanent funds. And I as part of my job kept an eye on those funds because the income generated was used for state government. And that's why, one of the reasons Wyoming has no state income tax and property taxes that are a fourth of what my wife and I were introduced to in Lincoln when we moved. And I had, and, and we love it here. We do. But I was asked to be the first investment officer to take those funds from a buy and hold bond portfolio in the state treasurer's office that had served the state of Wyoming for 110 years. Great. Very conservative, very quiet, very safe. But those funds had grown over time to the billion dollar mark and by 2004 to the $5 billion mark, and I was serving as a business

adviser to the state treasurer. And all of us knew that those funds needed to be diversified into a broad portfolio because they were growing at $750 to a billion-- million to a billion dollars a year. And so I left this job I loved, took the job and we got busy, and we moved those funds from bonds into a fully diversified stock portfolio very carefully, incrementally, year after year. And those funds when I left to come here in 2014, I'd been there 10 years, those funds grew from $5 to $20 billion. Not because I was a genius but because the mineral money was flowing in. But it had generated hundreds of millions of dollars in income for the state of Wyoming, in part through the diversification that we had. So I've come later to this, I studied it in grad school for sure, but that's what I've been doing. And when I came to interview for the job my board, we got to the end of the interview and they got to the part where they say: Do you have any questions? And I said no. I said, but how about if I answer one you didn't ask? And they were, so they were stone-faced. And finally my board chair said, OK, shoot. And I said, I know you've just seen me on paper and you've just met me through a couple of interviews, but if I was sitting where you were sitting where you're sitting right now I'd be thinking, you know what, I don't know how old this guy is but I bet he was-- and I'm learning about him right here right now. But one thing is, I bet, is certain, he wasn't born with hair that color. And if we hire him, how long do you think he's really going to stay in the job? Because my predecessor had spent five years and their predec--

that, the cycle was two, three, four, five years. So I said I'd be thinking that. And I said, how about 10 years? So, so far, so good. I love it, they're happy, investments are working out. It's a great job and I've got, you know, a little while to go if they will have me. How's that for-- that's more than you want to know.

HOWARD: That's great, thank you.

STINNER: It should be noted though that, I believe, it was last year or maybe even two years in a row he's been cited as one of the top 25 investment people in the United States so great to have you on board. Additional questions? Senator Erdman.

MICHAEL WALDEN-NEWMAN: We'll just put this up to see if my face is the same color. Thanks for that.

ERDMAN: Thank you, Senator Stinner.

MICHAEL WALDEN-NEWMAN: Yes?

ERDMAN: You heard my question earlier about 16, when I asked Liz. Do you have an answer for that, what the problem, what the abnormally was?

MICHAEL WALDEN-NEWMAN: Yeah, right. I got-- I was sitting there thinking I wish I knew the answer right off the top of my head but there are choppy years, right? So I don't know off the top of my-- I'm going to walk out of here and think of it and then I'm going to be

embarrassed I didn't know.

ERDMAN: Looks like you were in farming. That's what it looks like.

MICHAEL WALDEN-NEWMAN: See, there you go. But there are, there are years like that and there are months like that. But again, that's why it's very important for all of us to keep our eye on the far horizon in this.

STINNER: Additional questions?

MICHAEL WALDEN-NEWMAN: I'll end with I have asked the Committee, the Appropriations Committee before flat out if they would just take the Investment Council out of the law because it's awkward to be saying the same thing every other year. And we know it and policymakers know it. And why do it, I thought, if, if we know? But the senators have been pretty clear they, they like having me do this every couple of years so.

STINNER: Senator Clements.

CLEMENTS: Thank you, Mr. Chairman. Thank you, sir, for coming.

MICHAEL WALDEN-NEWMAN: Yes.

CLEMENTS: Regarding the investment rate, you were expecting the 6.1 percent return. I recall hearing about the retirement funds being projected more like 7 and a quarter percent. Are they earning that or

are they just overprojecting? What's the difference there?

MICHAEL WALDEN-NEWMAN: Yeah co-chairs, Senator, that's-- here's the answer to that question. We just released our capital market assumptions this year. We had a board meeting yesterday. These come out every, about this time each year, and we just posted those projected investment returns. And we are not projecting set-- you're correct that built into the, the actuarial design of the plans is a 7.5 percent assumed rate of return on the investments. That's for the Nebraska Retirement System plan and the Omaha plan as well. They, they were at 8 when I first got here and they've dropped them down to 7.5. And that's their, that's their purview to set that assumed rate. We as the Investment Council do not. But there is that difference between, a 1 percentage point difference between, what we believe we are going to get from our pension portfolio and what they have built in for their actuarial return. Part of what governs our model is that, and for you all on the Health Committee, it's great to see you. I know you're thinking I never met this guy before, but now you know. His-- the state law, the state laws that govern the Investment Council give us flexibility to manage the portfolios as a prudent investor would. So it's broad authority to manage the portfolio. But there is one sentence in state law that Nebraskans put in years ago that does govern how we manage the portfolio. And that is that the Nebraska Investment Council is to manage the investments under its charge with an eye in a diversified manner with an eye to toward avoiding large

losses. And I take that and my board take that to mean that we're to have a conservative portfolio that doesn't, that is less-- has low volatility. And volatility just means how much can it go up and down in any, in any given year. So what we do is we manage with a band like this around that assumed rate of 6.5. So we think that our portfolio, our market assumption is that it will get 6.5 over the long-term. It's now down to 6.2, by the way, for this year with the new assumptions, with about a 12 point volatility, which means any given year it could be a 6 percent loss or we could have an 18 percent year on the upside. And we manage like that. So our roller coaster is a little smoother than some other pension plans who have greater volatility in their market assumption and their plans can go like this and do.

CLEMENTS: Is that why you have 25 percent fixed income to try to help the volatility?

MICHAEL WALDEN-NEWMAN: Right. It's more the converse. Our other endowments are 50/50 stocks and bonds, all the rest of the endowments. So the education endowment, I know we've talked about that, and lands, public lands, we invest that money that's the bulk of the other endowment is the billion in public land money that we manage for schools, right? Those are 50/50 stocks and bonds with an eye, that bond share of 50 percent is there to generate income because there are agencies who live on that investment income. They don't receive general funds. Their, and their operating fund is from the investments

of, of the trust. In the case of the Health Care Fund, the 75 percent and lower bond, the higher stock is to try to inflation-proof and keep the portfolio worth more over time. Because, again, it's not exactly a trust but that's, that's why it has the allocation that it does.

CLEMENTS: Thank you.

STINNER: Senator Bolz.

BOLZ: Thank you, Senator Stinner. Very briefly I just, I want to touch on the importance that this hearing, and I think we had this exchange last time too.

MICHAEL WALDEN-NEWMAN: Sure.

BOLZ: I understand your perspective, you know, it's a little bit of a unique role for you to play. But I want to say to you. But I also want to say it to this committee, the importance of this hearing, this is our oversight function. This is relying on your expertise that we don't have as citizen legislators. Many of us may not be back at the table, I won't be back on the table. There, there are elections that impact our understanding. And if we had another year like 2016, we would want to have that on our radar screen and be thinking about that. And so I just, I needed to address from a process perspective how important it is that we have this hearing and how important it is that you participate in it.

MICHAEL WALDEN-NEWMAN: We're sure happy to do it.

STINNER: Any additional questions? Seeing none, thank you very much.

MICHAEL WALDEN-NEWMAN: Thanks.

STINNER: It's always a pleasure.

MICHAEL WALDEN-NEWMAN: Thanks. Thanks for saying something nice, that was-- you didn't have to do that, but I appreciate it. Thanks, everybody. Good to meet the new folks.

ANNETTE DUBAS: Good morning, Chairman Stinner and Chairman, Chairwoman Howard just got up and left, so and members of the Health Committee and the Appropriations Committee. My name is Annette Dubas, A-n-n-e-t-t-e D-u-b-a-s, and I am the executive director for the Nebraska Association of Behavioral Health Organizations otherwise known as NABHO. Our mission is to build strong alliances that will ensure behavioral health services including mental health and substance use disorder services are accessible to everyone in our state. Our association thanks Senator Cavanaugh for bringing this interim study to help us focus on the Health Care Cash Fund and to do what is needed to ensure it remains sustainable for years to come. We know that in Nebraska one in five Nebraskans have experienced a mental illness in the past year, 15 percent of Nebraska's high school students reported they have committed-- they have considered suicide. In Nebraska suicide is the second leading cause of death for 15 to 34

year olds. We also know that the inability to afford care is a leading reason that keeps people from seeking care. Eighty-eight of our 93 counties are designated mental health work force shortage areas with pay and regulatory burdens contributing factors. Behavioral health is heavily reliant on public payers. Nationally, 62 percent of funding for mental health treatment and 69 percent for substance use disorder treatment, and Nebraska falls well within or even higher than those percentages. The Legislature had the foresight to create the Health Care Cash Fund and to use a portion of those funds to build capacity in the area of mental health and substance use disorder treatment through the behavioral health regions and the juvenile justice system. The funds also supported an increase in behavioral health rates for Medicaid, the regions, juvenile justice, and the child welfare system. In 2001 the Legislature understood the need to increase funding for behavioral health services and used a portion of the settlement dollars to make that happen. The 2019 Legislature saw the same need and supported the Appropriations Committee's budget recommendation to increase rates for behavioral health. And we are sincerely grateful for both of those actions. But rates are still significantly below the cost of providing services and without the base funding we could be, be even further behind. I understand the challenges the Legislature is faced to fund the many aspects of state government. You are charged with maximizing each and every dollar of revenue, scrutinizing every expense, and making sure that the state gets the best return on its

investments. We firmly believe behavioral health, or the lack thereof, touches every aspect of our society. Schools are clamoring for help, our corrections facilities have become de facto mental health facilities, families struggle to afford mental health and addiction services, and this in turn affects job performance and the quality of life. All of these things carry a high price tag. NABHO believes the Health Care Cash Fund is an important component to safeguard the current and future behavioral health needs of Nebraskans. The 2001 Legislature was wise and prudent when they created the Health Care Cash Fund. They understood that investing in the health of our citizens is always a worthy venture that will pay dividends for generations. This interim study resolution and your interest indicate you understand that as well. And we thank you for taking the necessary steps to ensure that the fund receipt-- remains sustainable for years to come. Thank you for your time and I'd be happy to try to answer any questions you may have.

STINNER: Thank you. Questions? I have a question. Back in 2010 a lot of what is now part of the permanent Health Care Cash Fund expenditures were General Fund expenditures to move over into the Health Care Cash Fund with, I think, a four-year sunset. I remember my first year we made it more permanent or made it permanent. Was behavioral health one of those ones that were moved out of general funds to Health Care Cash Fund, do you recall?

ANNETTE DUBAS: Boy.

STINNER: And maybe I should ask Liz that.

ANNETTE DUBAS: Yeah, yeah.

STINNER: Or Senator Cavanaugh. There was-- I'd like to know that group of, that used to be there that are now in the Health Care Cash Fund.

ANNETTE DUBAS: Yeah, you, you're testing my memory which isn't very good. I need to go back and refresh myself.

STINNER: OK.

ANNETTE DUBAS: I seem to remember that as part of the conversation but I couldn't tell you with 100 percent certainty.

STINNER: OK, Senator Bolz.

BOLZ: Thank you, Senator Stinner. Along the same vein, I'm pleased that we have an opportunity to talk about this as HHS Committee and Appropriations Committee because I think that one of the things I struggle with with the Health Care Cash Fund is that legacy, is that legacy of what should from a pure appropriations perspective in my opinion be general funded items that are funded through the Health Care Cash Fund. And some examples of that are developmental disability aid, the children's health insurance aid. Those are programs that we have committed to as a body and as a state. And we should have a commitment to those in the general funds. As it relates to you, one of

the things that is in the Health Care Cash Fund is the behavioral health rate increase. And I think we also need to take responsibility for that from an appropriations perspective. And so I, I don't mean to, to just soapbox here. What I'm trying to get at is that I think in order to achieve the sustainability goals that I think we all share in the Health Care Cash Fund, one of the strategies could be to move some of those things that are general funded back into the overall budget picture while leaving some of the other things that were designed specifically for the Health Care Cash Fund like the EMS tax regulation and like tobacco control and prevention. And so that is maybe just a little bit of an opportunity for me to share my perspective, but would you agree with that basic concept that it would be appropriate to move the behavioral health rate specifically back into the General Fund and see that commitment through the state budget?

ANNETTE DUBAS: And, I believe, Senator Bolz, you and I have had these conversations in the past. I certainly would agree with that if-- there are no guarantees, I understand that. But as I stated, you know, the rates are already so far below the cost of providing services. We at least have this base funding there that is something that we can count on. And would we be able to count on that if we can completely move behavioral health to the General Fund. I believe, personally I believe it should be a General Fund expenditure. As I said, we rely heavily on public payers for a lot of reasons. It's a very fragmented funding source, you know, insurance. There's, there's a lot of reasons

for that but any amount of stability that we can bring to rates I think is an important thing. But I would not disagree with you about the obligation of the state making that a part of the General Fund.

BOLZ: And I appreciate you dialoguing with me about it and I appreciate the chance to talk about that as HHS and Appropriations Committee, because I think what sometimes gets missed in these conversations is that tension. It's the tension between the goal of maintaining stability in the Health Care Cash Fund, the, the short-term pressures on trying to keep up with rates, and that legacy of trying to, to right the ship a little bit, and that concern that if we made that policy decision to right the ship and move those back into the General Fund there that is also a risk. So I just, I think it's helpful to have that opportunity for that conversation.

ANNETTE DUBAS: Absolutely.

STINNER: Additional questions? Seeing none, thank you.

ANNETTE DUBAS: Thank you.

CHRIS KRATOCHVIL: Good Morning.

STINNER: Morning.

CHRIS KRATOCHVIL: Well, thank you for this opportunity. My name is Chris Kratochvil, C-h-r-i-s K-r-a-t-o-c-h-v-i-l, and I have the honor of serving as the associate vice chancellor for clinical research at

UNMC and the vice president for research in Nebraska Medicine. Today I appear on behalf of UNMC, Creighton University, Boys Town National Research Institute, as well as UNL in support of the Nebraska Health Care Cash Funding. We greatly appreciate this opportunity today. These funds are used to save and improve the lives of Nebraska citizens through biomedical research. The scientists that we have invested in represent a net brain gain to the state. These scientists are making discoveries that lead to better medical therapies and better lives for Nebraskans. Additionally, medical research has both immediate and long-term economic impact for our state through new high-quality jobs, new technologies, and startup companies. At UNMC, for example, extramural research funding has grown to $138 million this last year, 172 percent since the start of the cash fund. Research expands strategies to improve safety and health in rural environments to treatments that may soon eradicate viruses like HIV. At Creighton the fund has fueled a 30 percent NIH funding increase since 2005, supporting initiatives like Dr. Henry Lynch's heredity cancer program. This program identified approximately 900 Nebraska families as carriers of the Lynch syndrome gene and 90 percent of cancers if detected early enough are curable. At UNL the funds have facilitated a 35 percent growth in research funding over 10 years to $165 million. This includes a new Rural Drug Addiction Research Center, the only major research center focused on rural drug use in the Midwest. Boys Town National Research Hospital is at a 75 percent increase in funding

over 10 years. One center, for example, focusing on improved communication and academic outcomes for children with hearing loss brought in over $12 million over the course of the center. To help to demonstrate the impact of the Health Care Cash Fund we asked the nationally recognized firm of Tripp Umbach, the report of which you have in the materials I delivered, to perform a study of research funding from 2001 to 2019. Some of the key findings that they've demonstrated is the Nebraska Tobacco Settlement Trust Fund investments have resulted in a cumulative expansion of the state's economy to $5.5 billion over the cost of its life. This has returned $23 to the state's economy for every dollar of Tobacco Settlement dollars invested. For every dollar of research funding from the trust fund nearly nine additional dollars were generated from sources outside of Nebraska, principally federal research support through the National Institute of Health. Trust fund investments since FY 2001 have resulted in creating and sustaining more than 14,000 jobs. The average annual salary of these jobs has been $76,000 and a cumulative state and local tax revenue of $274 million. Of the states that received funding from the 1998 Tobacco Master Settlement Agreement, Nebraska's Unicameral was visionary in choosing to invest its proceeds in biomedical research. This strategy has strengthened the state's response to the health needs of its citizens, fostering robust job creation and economic growth as well as advancing Nebraska's position in biomedicine. We urge your continued support of this remarkable

partnership between the state and our four research institutions. And at this time I'd be happy to answer any questions.

STINNER: Thank you. Questions? Seeing none, thank you.

CHRIS KRATOCHVIL: Thank you.

JEREMY ESCHLIMAN: Good morning, Chairman Stinner and Chairman Howard, about the room and also members of the committee. My name is Jeremy, J-e-r-e-m-y, Eschliman, E-s-c-h-l-i-m-a-n, I'm the health director at Two Rivers Public Health Department, south central Nebraska, serving seven counties: Buffalo, Dawson, Franklin, Gosper, Harlan, Kearney, and Phelps Counties with offices in Kearney and in Holdrege. I'm here today on behalf of Friends of Public Health in Nebraska. The local health departments of Nebraska were established as statewide district health departments after passage of LB692 in 2001 to distribute Tobacco Settlement dollars to the Health Care Cash Fund. Since that time, since that time the original department that covered 20 counties now cover all 93 counties in Nebraska with 18 district health departments. These local health departments provide scientifically based programs depending upon local health needs, and I can't stress that enough. Really, priority is determined by regular comprehensive human health planning processes as directed by each district's appointed board of health. The current 19 district health departments have assumed the leadership role in the coordination and planning to meet the health needs and have been successful in bringing together

local organizations collaboratively to address the public needs of each community in each district that have been identified. We have formed partnerships, task force, coalitions to leverage funds to address the unique public health needs in our local communities. And you see a thread here, local communities and their needs. Whether it's high rates of cancer, smoking, diabetes, heart disease, fluoridation, lack of adequate dental medical, bilingual need, injury prevention, automobile crashes, domestic violence, disease outbreaks, an interesting program in our area is the violence prevention program that we have a pilot in both Kearney and in Lex right now. But really health departments are the leaders in developing healthy communities across the entire state. Health departments have developed a statewide assessment that really enables us to not only identify potential barriers to good health but also to compare this, relatively speaking, across the state and to develop a seamless public health system. This information is used in planning health and prevention-related activities so at the local level resources are available. All health departments contribute to statewide surveillance activities. One of the key functions of local public health department are investigating disease. I was at a training just the other day on lead poisoning, lead prevention. It's really a huge issue that is really untapped across our area, and blood levels are a big issue. But more nationally we hear of things like alfalfa sprouts, peanut butter, E. coli in, you know, whatever the next food item is. That's really where we're at,

boots on the ground investigating those sort of diseases. And it's really important from a public health perspective the sister agencies and systems across the state Nebraska to really be effective in that area. More commonly what we've heard about lately: mumps, measles, rubella, vaccine-preventable diseases, that's we're in the forefront right now addressing those. We also follow up on cases reported to us by the state of Nebraska as local, local hospitals, physicians, clinics, nursing homes, daycares, and schools are all great partners in the local public health system. Public health throughout Nebraska has partnered with the existing agencies to develop plans for bioterrorism threats, other emergency-- emergent natural disasters like flooding. We have all experienced flooding in the Two Rivers area, six of our seven counties experienced major flooding either actually both in March and also in July. And those are things we're still recovering from. We need to focus on prevention to address the biggest economic driver of health care costs in our state: chronic disease. And also to improve the capacity to respond to the current and also emerging public health threats. We've heard about Zika, Zika-carrying mosquitoes. That there's new possibilities every day that we're finding out more and more about. So we urge you to maintain the original intent of the Health Care Cash Fund and to grow the fund to continue to meet health care challenges in the future. Thank you for your time and I'll answer any questions if you have any them.

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

B. HANSEN: Thank you. It seems like, I would think, one of the primary roles of this fund is to make sure that we're not smoking as much. Since that's, since we're getting money from and that's where it originally came from. I notice we have two kind of programs-- Medicaid cessation, smoking cessation and then like smoking prevention and control-- that we, that we pay money out towards. What's our return on investment on that? Has people, has smoking slowed down in the state of Nebraska? Do you think the money that we've spent for that has been used wisely, like is it working in your opinion? I don't know who else to ask, you seem like the right person to ask.

JEREMY ESCHLIMAN: Right. And I'll base it on my personal opinion. So I think what we've seen now is smoking rates have declined some. What we've seen is, if I could use the term "epidemic" of vaping. Yeah, I think that's what we've seen is the evidence surrounding e-cigarettes is becoming stronger and stronger. Two Rivers Public Health Department, our board of health took a position in 2016 prohibiting electronic cigarettes. What we knew at the time, it was limited health data, but we knew it didn't look great. At this point I'm obviously, as you probably know, there's been hundreds now of cases of vaping and poisoning related to vaping. So, you know, I think the, the public health challenges we see, whether it's smoking or whether it's Zika, they continue to evolve as human nature evolves. And to get to your

original question, so I don't miss it. Behaviors of people in general are difficult to change, but it's possible through education. And that's one of the key things we like to tout in local public health is education and prevention. Whether it's, you know, colon cancer, trying to test early enough; whether smoking, trying to prevent our youth from starting vaping, smoking, down that pathway. It's really, that's critical to the long-term success of reducing smoking.

B. HANSEN: Thank you.

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

KATHY SEACREST: Good morning. Members of the Appropriations and Health and Human Services Committee, my name is Kathy Seacrest, K-a-t-h-y S-e-a-c-r-e-s-t. I'm the regional administrator for the behavioral health, health care region in southwest Nebraska. I'm pretty happy that there's been a lot of rural people up here today by the way. And I'm testifying today on behalf of the Nebraska Association of Regional Administrators. Thank you for your continued support regarding the appropriation of Health Care Cash Fund. These dollars play an integral and crucial role in the behavioral health system. They help each of the six behavioral health regions maintain a robust infrastructure of treatment, rehabilitation, emergency services, and recovery services for residents across the state. Annually, a total of $10,599,660 is allocated to Program 38, designated as community-based aid for mental

health and substance use disorder services. These funds help provide a consistent provider network of services giving your constituency access to the mental health and substance use disorder care they need. Research proves that consistency and reliability are key ingredients in a system of care. You have helped us create that by your continued support, be it the Appropriations Committee and the Health Care Cash Fund. Through your work we provide reimbursement rates to behavioral health providers, support community-based services, sustain emergency services. If the six behavioral health regions did not have access to these funds there are only two places we would have to look for the funding. First we would have to receive additional funds from our county members whose primary source of revenue is property tax. Or second we would have to look at reducing the types and allocation of services that we currently provide. The annual appropriation of the Health Care Cash Fund represents 9.8 percent of the total dollars in state and federal dollars allocated through the Division of Behavioral Health to the Regional Behavioral Health authorities. And as a reminder, publicly funded behavioral health dollars are capitated. We have to live within our budget. These dollars support community-based services for low-income indigent individuals that lack health insurance coverage, including Medicaid, lacking Medicaid. Additionally, the $10.6 million you appropriate out of the Health Care Cash Fund is used to fund 44 different services across the state. These dollars support mental health services with access to emergency

protective custody for the-- supports those who seek substance abuse treatment. They provide access to do a diagnosis care, therapeutic community, residential treatment, short-term residential and non-residential services, and medication management, outpatient services, community support, and other crucial services that help all of your constituents stay healthy. It's also critical to consider at this time the appropriation of the Health Care Cash Funds dedicated to rate increases. The availability of that to increase and sustain higher reimbursement rates is crucial to ensure that services stay viable. Without sustainable rate increases service capacity decreases, programs close, and access is negatively impacted. Regions are facing an immense struggle with the proposed $4.3 cut in half by 2020. This cut was proposed in response to the implementation of Medicaid expansion which was planned to pick up the services offered now through that appropriation. Due to the delayed rollout of Medicaid we believe that maintaining these funds is critical to the ongoing work of providers. I also want to note that Medicaid will not pay for many of the services the regions provide and will not be the safety net that the regions provide by their system work. The regions were created to meet the needs of the residents in their area and they have the unique and important ability to design and maintain what works for their population. That is the important and insightful decision made by your predecessors and maintained by you that has allowed Nebraska, Nebraska to meet the challenges presented from the western edge of the

state to the eastern edge, from north to south. Health Care Cash Funds help make this happen and we thank you for them. And I just want to quickly put a little face on this. Imagine for a minute you're 25 years old and you've been in jail and you've almost died three times from an overdose, and that you have no access to health care and you barely function. You find your way to community-based services and you are now 40, 10 years sober, owning your own business and a healthy individual. Those are the folks that we are there to provide services for, and I don't ever want to lose sight of the face of those clients because that's what it's about. It's not about any of us. Appreciate the opportunity to discuss the role of the Health Care Cash Funds serve in making behavioral treatment and rehab services available. Happy to answer any questions. Thank you for your time.

HOWARD: Are there questions? Seeing none, thank you.

KATHY SEACREST: Thank you. Appreciate all of you.

HOWARD: Morning.

ANDREA SKOLKIN: Good morning. Chairwoman Howard, members of the Appropriations Committee and the Health and Human Services Committee, my name is Andrea Skolkin, A-n-d-r-e-a S--k-o-l-k-i-n, and I am the chief executive officer of OneWorld Community Health Centers in Omaha. I'm here today representing the Health Center Association of Nebraska, our seven federally qualified health centers, and the over 100,000

individuals, Nebraskans served by our health centers annually. I would like to share with you the profound impact funding from the Health Care Cash Fund has had on improving access to health care across the state. Nebraska's health centers have historically experienced one of the highest rates of uninsured patients compared to other health centers nationally. In 2018, 47 percent of Nebraska health center patients were uninsured, the second-highest rate in the nation. We are not free clinics. Uninsured patients contribute to the costs of their care based on a sliding fee scale calculated by the total income and number of individuals in the household. Health centers cover the uncompensated portion of that care through a combination of federal, grant, and state appropriations. Specifically, the total of $750,000 from the Health Care Cash Fund for seven health centers is directly tied to the number of uninsured patients seen and is critical to meeting the ongoing needs for access to care. Health centers of had a 10 to 12 percent growth in their patient population over the past five years. The funding received from the Health Care Cash Fund is crucial to ensuring that health centers have the capacity to meet the ever-expanding patient population and that low-income individuals have access to preventive primary medical, dental, and behavioral health care. In addition to supporting access for care for uninsured patients Minority Health Fund dollars work to address health disparities and improve clinical outcomes for minority patients. It is well-documented that people of color are more likely to face barriers to access care

and fare worse with most outcome health measures and are significantly likely to be uninsured. At OneWorld 81 percent of our patients were racial or ethnic minorities in 2018. In addition to an overall increase in our patient population we experienced a 15 percent increase in the number of diabetic patients and a 35 percent increase in hypertensive patients last year. In spite of these increases, OneWorld saw an increase in both of the number of patients in control of their diabetes as well as the number of patients in control of their hypertension. Minority Health Fund dollars support screening, case management, education programs that are integral to improving the overall patient health and decreasing health disparities. The Health Care Cash Fund is a unique resource that has served to advance and protect the overall health of Nebraska's citizens. Entrusting a portion of those funds to health centers continues to be a cost-effective, comprehensive approach to addressing the health care needs in our state, improving access to care, addressing health disparities, and enhancing services for our most vulnerable citizens. This funding is vital to supporting the high-quality care provided at our centers, ensuring that we can meet our mission of serving all who seek care while continuing to provide innovative programs to meet the most critical needs of our patients. Thank you for your time and I'm happy to answer questions.

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

today. Our next testifier.

JULIA TSE: Little rusty. Good morning, members of the Appropriations and Health and Human Services Committee. For the record, my name is Julia Tse, J-u-l-i-a T-s-e, and I'm here today on behalf of Voices for Children in Nebraska. And I'm here to speak specifically about the Children's Health Insurance Program. When families are unable to afford private health insurance, public health insurance programs protect children from developmental losses, poor educational attainment, and even premature death. When children miss key preventive screenings and treatment we can't go back and do-- and treat them. They are much more likely to suffer from serious or chronic illnesses that can require costly treatment for a lifetime. CHIP has protected the help of low-income Nebraska children for over two decades. CHIP provides health insurance for children in low-income households that earn too much to be eligible for Medicaid coverage but would otherwise be unable to afford private health insurance coverage. And since CHIP was first authorized in 1997 the number of uninsured children in our country has been cut in half. Today, only 5 percent of Nebraska's children are uninsured. And together, Medicaid and CHIP provides health insurance coverage to nearly one in three Nebraska children. Although children account for about 80 percent of our public health insurance enrollees the average monthly costs for children is the lowest among any enrollee at just under $300 per month per child. States receive federal funding in the form of a block grant and are

responsible for administering CHIP in accordance with federal law and regulations. A certain level of state matching funds is required for states to receive their federal allocation. To meet this annual state match Nebraska has historically utilized a mix of general and cash funds, including the Health Care Cash Fund. To my testimony I have attached a table that lays out the appropriations for CHIP from FY 2018 to FY 2020. In the most recent budget cycle General Fund appropriations were increased for the biennium. In anticipation of a reduction in the federal match rate or FMAP states saw a temporary increase in their CHIP FMAPs with the ACA that will phase out next month and then be eliminated next year. The rate of uninsured children in our state is at a historic low. However, that rate has stagnated for the last few years and newly released data from just last week shows that for the first time in a decade our country is reversing its course and progress on reducing the number of uninsured children. From 2017 to 2018 there was a reduction of 425-- or there was an increase of 425,000 uninsured children in our country mostly attributable to Medicaid and CHIP. And especially so for young children. While we await the release of additional state level data we do know that in the previous year the number of uninsured children in Nebraska increased by a thousand. There are a number of statutory and administrative changes that would strengthen CHIP for Nebraska's children to reduce administrative burdens, to stabilize and streamline coverage, and to enroll the 15,000 Nebraska children who are currently

uninsured but likely eligible for Medicaid or CHIP. As the Legislature considers the long-term fiscal sustainability of the Health Care Cash Fund we would urge members to prioritize our state's continued investment in the health of our children. Stable and strategic funding for CHIP is a wise, long-term investment in our state's future. When Congress last reauthorized CHIP the Congressional Budget Office which has the ability to create dynamic fiscal notes came out with a note that I think many members and many folks in this room would be envious of. They estimated that a 10-year reauthorization would actually save the federal government $6 billion based on estimates of what it would cost to enroll children in other, in the marketplace or through Medicaid. And with that, I will close and be happy to answer any questions. We want to thank Senator Cavanaugh for her commitment to this issue and the members of the committees for their time and consideration.

HOWARD: Thank you. Are there questions? Seeing none, thank you for your testimony today.

JULIA TSE: Thank you.

HOWARD: Senator Cavanaugh. Oh, sure. Come on up.

NICK FAUSTMAN: Thank you very much. I'm Nick Faustman with the American Cancer Society Cancer Action Network. My name is spelled N-i-c-k F-a-u-s-t-m-a-n. The Health Care Cash Fund has been an

extremely important tool for funding state programs since its creation in 2001. Of importance to ACS CAN are the fund's programs that help combat cancer, the state's tobacco prevention and control program, the funding that ultimately benefits cancer research at postsecondary educational institutions, and the funding utilized by public health departments to detect and treat cancer across the state. It should be noted that in short the Health Care Cash Fund relies heavily upon moneys received from the Master Settlement Agreement with tobacco manufacturers. The settling states intended the MSA to further the policies designed to reduce youth smoking, promote public health, and secure the monetary payments to the setting states-- settling states. It is, therefore, only common sense that a top priority for these moneys should be funding tobacco control efforts. However, Nebraska's still lags far behind the Center for Disease Control and Prevention's recommended spending for tobacco prevention and cessation programs. Excuse me. Current funding for the state's tobacco control program, which is called Tobacco Free Nebraska, is approximately $2.6 million, only about 12 percent of what the CDC recommends. ACS CAN realizes that the state of Nebraska faces significant budget challenges year after year. We will work with legislators to find solutions that are proven to be effective. For example, extensive research shows that raising tobacco taxes regularly and significantly is one of the best ways to curb tobacco use. And new revenues from these taxes can be utilized in a way to address the long-term fiscal sustainability of

the Health Care Cash Fund. We encourage the Legislature to consider the benefit that such a proposal would have on the fund and ultimately the health of your constituents. As you can, as you consider the importance of the fund keep in mind that there will be an estimated 9,780 new cases of cancer this year and, unfortunately, 3,520 deaths due to cancer in Nebraska this year. The only way that we can reduce cancer incidents and mortality in our state is through adequate funding for our programs proven to prevent cancer, detect it early, and ensure access to quality programs.

HOWARD: Thank you. Are there questions?

NICK FAUSTMAN: Senator Hansen, I do have the information and data on return on investment for those programs. I'd be happy to share with the committees.

HOWARD: Thank you for your testimony.

NICK FAUSTMAN: Thank you for the opportunity. Appreciate it.

HOWARD: Any other testifiers? Seeing none, Senator Cavanaugh.

CAVANAUGH: I do have tobacco fact sheets that-- Senator Hansen you had asked a question about the, the revenue and this is a spreadsheet that you all will be getting that shows the revenue from 1990 to 2017. So just I think it's something helpful for everyone to have to reference. I would like to thank all of our testifiers today. Liz Hruska for

doing her due diligence and in representing the Fiscal Office. It's an important update that she gives us every year. And Michael Walden-Newman from the Nebraska Investment Council. I appreciated learning more about this process from him, and I think it's worth acknowledging that we have, and myself included, five freshman senators between the two committees. So having this, these updates are really important for us to get a better handle on what it is that we are here to do. So thank you to the Appropriations and HHS Committees for being here this morning. I'm standing between you and lunch so I will just talk really slowly and make sure that you're all really hungry and frustrated with me. Just kidding. I think we, we've heard a lot about the longevity of the Health Care Cash Fund and there are obviously concerns, we heard from Mr. Walden-Newman about the, the investment and how to grow our Health Care Cash Fund. And also we heard about some of the great things that the fund currently does for our state. Senator Stinner had asked a question about items that had moved from the Health Care Cash Fund-- from the General Fund to Health Care Cash Fund in 2010. I got the expert advice from Ms. Hruska and it is CHIP and Medicaid. CHIP was, was maintained at the new amount and Medicaid was for two years only. So he's not here, but that answers his question. So we have an opportunity here to look at how we can be strategic moving forward in the Health Care Cash Fund. And I think that there are a few different options that we as the two committees could consider moving forward in this next legislative cycle, perhaps,

to make sure that we're securing the longevity of the fund. I come from the nonprofit world, and if you're a lucky enough nonprofit to have an endowed fund that is a real windfall because it means that you have the longevity for your organization. And when we establish an endowed fund those funds are protected, the principle is protected. And I think that it is worth us as a Legislature to consider if that's something that we want to do. We call this a trust fund but we don't treat it as an actual trust fund. So it is something that I think is worth further discussion about whether or not we should create this as a true protected trust fund where we are just drawing off of a percentage of the revenue that is generated annually. And Mr. Walden-Newman had mentioned 4 percent, and that is pretty typical for the nonprofit world as well to draw off 4 percent of the interest that is accrued annually. And that's how you build your, the longevity of your programming. And that also would, you know, ultimately secure the programs that we are, that we heard about today that are being funded. And I think that there's some great information that was shared with us today about the return on investment that we get from the programming that we're seeing. We heard from Dr. Kratochvil on some of the things that the university does and that return on investment is pretty substantial. So just one kind of closing thought for you all. As far as the tobacco fact sheet goes, in 2002 you'll see that we as a state increased the tobacco tax and we saw a drop of 16 million packs, packages of up tobacco-- or cigarettes, sorry, that were purchased

from one year to the next, but an increase in $22 million in tax revenue. So the idea with raising the tobacco tax, Senator Hansen, is in fact to decrease smoking which we saw happen, while also getting a bump in revenue that can help with the Health Care Cash Fund. And so over the, the 15 years, from 2002 to 2017, we've seen an additional 24 million packs fewer sold annually in 2017 than that were sold in 2003. And we've seen a drop in $15 million in that revenue. So we were at $45 million in 2002 and now we are at $52 million, so our revenue went up and now it's starting to decrease. But also our health care outcomes are starting to get better because fewer people are smoking. So just to speak to that issue. Some additional opportunities that we have with the Health Care Cash Fund is to establish new revenue with any number of other health care-related tax dollars that we would as a Legislature want to introduce. And there was again the conversation about moving things out of the Health Care Cash Fund into General Fund so that we have a more clearer picture of what we as a state are funding through the General Fund. So with that, I will take any questions if you have them.

HOWARD: Are there questions? Senator Walz.

WALZ: Thank you, Chairman Howard. I just wanted to verify, you said in 2016 there was a drop of $24 million in--

CAVANAUGH: Twenty-four million packs of cigarettes.

WALZ: Packs of cigarettes.

CAVANAUGH: Purchased.

WALZ: Thank you, that's all.

HOWARD: Senator Clements.

CLEMENTS: Thank you, Madam Chairman. Thank you, Senator. The bottom of this chart says $52 million of net taxes were collected in 2017. I'm not sure how much of that goes into the Health Care Cash Fund. Does all of that go in there?

CAVANAUGH: It does, but then we make it disbursement from the Health Care Cash Fund to the General Fund. We've been doing that I don't know how many years now, but we definitely do it in 2019. I think we dispersed, yep, we dispersed $10 million for FY '18 and '19 from the Health Care Cash Fund into the General Fund to have a balanced budget. So some of that-- but there are also items within that revenue, within the Health Care Cash Fund that are general fund-related, so yeah.

CLEMENTS: So we put the $52 million, all of that in the Health Care Cash Fund but then some transfers out.

CAVANAUGH: Yes.

CLEMENTS: To general. I didn't recall for sure how that worked.

CAVANAUGH: Well, I, I guess I can't 100 percent speak to the time line

of that. We may actually put some into the General Fund and not go through the Health Care Cash Fund. I don't, I would have to look at the-- what is it, cosmic orange?

CLEMENTS: Do you know what the amount of tax increase was in 2003?

CAVANAUGH: You know, I did, I had it all memorized. We are at, we are at 64 cents right now. And I am going to look behind me to see if anybody knows. No, nobody knows. So our tax is 64 cents right now. I'm not sure, but I'll find out and let you know.

CLEMENTS: OK, I just wasn't sure how. You might be able to calculate it from these two different figures.

CAVANAUGH: I think I have it somewhere pretty readily available.

CLEMENTS: That's not critical, thank you.

CAVANAUGH: Yeah.

HOWARD: Any other questions? Seeing none, thank you, Senator Cavanaugh. This will close the hearing for LR116 and we'll be back at 1--.

STINNER: Everything got quiet all of a sudden. We don't have-- I don't know if we have a quorum or not, but we're going to start anyhow because it's past-- past 1:30. But I want to welcome everybody to the joint session on-- joint hearing with the Appropriations Committee and Health and Human Services. My name's John Stinner. I'm Chairman of the

Appropriations Committee. To my right is my esteemed colleague, Sara Howard, who is Chair of the HHS committee. We will start today-- this afternoon's hearings with self-introductions, starting on my left, Senator Dorn.

DORN: Senator Myron Dorn, District LD30, which is Gage County and the southeast part of Lancaster.

CLEMENTS: Rob Clements, from Elmwood. I have District 2: Cass County and parts of Sarpy and Otoe.

BOLZ: Senator Kate Bolz, District 29.

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

HOWARD: Sara Howard, District 9: midtown Omaha.

WILLIAMS: Matt Williams, from Gothenburg, Legislative District 36: Dawson, Custer and the north portion of Buffalo Counties.

WISHART: Anna Wishart, District 27 in west Lincoln.

McDONNELL: Mike McDonnell, LD5, south Omaha.

STINNER: I'm sure we'll be having the other members join us. They may move in and out, they may have another LR in another committee meeting. Also with us today is Brittany Bowl-- Bo--

BOLZ: Bohlmeyer.

STINNER: Bohlmeyer-- wow. I would have said Bullhammer [LAUGHTER] but it's Bohlmeyer, our clerk, and she's been with me quite a while so that shows you how old I am. I can't remember anything [LAUGHTER]. There are green sheets on either side. Before you testify, I'd ask you to fill that out and hand it to our clerk. If you have testimony and don't have 16 pages for us or copies, please raise your hand and Kenny will try to get 16 copies made for you. As a matter of procedure please turn off your cell phones or deaden your cell phones. What else am I missing here?

BOLZ: When you come to testify.

STINNER: When you come to testify, please say and spell your first and last names. That way we can make sure that the person who records all this gets-- gets it right.

HOWARD: [INAUDIBLE].

STINNER: And we will limit this to just invited test-- testifiers and we will allow the introducer an unlimited amount of time, also in closing. But during the interim part of that thing the testifiers will be limited to five minutes. Yellow light will go off a minute before the five minutes. That's kind of your early warning signal and otherwise when it hits the red, please conclude your testimony or I will throw something at you. [LAUGHTER] How's that?

HOWARD: Sounds good.

STINNER: But in any event we'll now open our hearing with Senator Quick, LR184. Senator.

QUICK: Good afternoon, Chairman Stinner, Chairwoman Howard, members of the Appropriations Committee and Health and Human Services Committee. My name is Dan Quick, D-a-n Q-u-i-c-k, and I represent District 35 in Grand Island. I introduced LR184 to determine a sustainable funding source for the public health districts in the state of Nebraska to provide financial support for their efforts and strategic-- strategically implementing preventative health strategies in communities across our state. Last year I brought LB480, which was seeking to fund each of the 18 local health departments by additional $50,000. And quite frankly, even that proposal was too modest for all the things we ask and expect these departments to do. Because our system of public health does such a great job in preventing an array of diseases, public health is one of our public services that has been taken for granted. With the recent weather disasters across our state, I think Nebraskans will find a greater need for the services our public health district provide. Our 18 public health districts go directly to the people by educating and empowering workplaces to promote preventative health strategies that battle chronic diseases. Their mission is to prevent diseases and provide public health education. These districts work to license physicians and healthcare

professionals in our areas where they're in high demand. They test drinking water and keep our drinking water safe. They provide immunizations and health screenings. They inspect nursing homes and investigate outbreaks of disease. And this is just the beginning of a long list of services they provide to ensure our core public health functions. I have had the opportunity to visit the Central Health District department [SIC] in Grand Island. They serve many needs in an area that includes Hall, Hamilton, and Merrick Counties. I was provided-- provided a tour of the facility and found out about all the important services they provide. Every health district located throughout our state provides the same important services. And I think that's-- that providing a sustainable and adequate stream of state funds would be most importantly a benefit-- but most importantly, benefit Nebraskans who don't have access to their healthcare needs. This is smart public policy. Adding a modest amount of regular state funds will advance smart, efficient, community public health efforts that will save lives. Preventing a chronic disease is the most cost-effective, fiscally responsible expenditure that we can make. As stewards of our state's budget, we should be putting our money and the smartest programs to ensure the long term health of our citizens-- state's citizens. Following me are several people that can talk specifically about their experience in public health departments, as well as their history. These people have worked diligently to make our state safer, and I hope they are able to show you that now is a time

to add resources to our system of public health across the state. I look forward to working with the committee to find a way we can help our public health district perform their function, keeping Nebraska citizens safe and healthy. And I'm happy to answer any questions you may have.

STINNER: Questions? Did you tell me-- did you say how many public health district--

QUICK: Eight-- eighteen.

STINNER: Eighteen? Thank you. All right, Senator Dorn, go ahead.

DORN: Thank-- thank you.

STINNER: Good to see you, buddy.

DORN: You introduced a bill a year ago, you said, not this past year?

QUICK: This past year.

DORN: OK. And that just never made it out of committee, then?

QUICK: LB480. Yeah, it's still in committee [INAUDIBLE].

STINNER: I should remind the senator anything with a fiscal note kind of died a natural death.

QUICK: I remember that. Yeah.

STINNER: Just wanted to bring that up.

DORN: I just kind of wanted to get on record where it was still at it, just kind of--

STINNER: Good afternoon.

JUDY HALSTEAD: Good afternoon. Chairpersons Stinner and Howard, thank you for having a hearing today. Members of the Appropriation Committee and Health and Human Services Committees, my name is Judy Halstead, spelled J-u-d-y H-a-l-s-t-e-a-d. I'm here today to testify on LR184 as past director of the Lincoln-Lancaster County Health Department and on behalf of Friends of Public Health in Nebraska. I've been asked to share a brief history of the creation of the local public health system in Nebraska. I was honored to be at the Health Department when LB692 was passed. Local public health departments in Nebraska were established as district departments as a result of the passage of LB692 in 2001 and funded through the Health Care Cash Fund. Senator Bolz, it was one of the original pieces of the Health Care Cash Fund. As you are aware, the Health Care Cash Fund was developed with funding from the national tobacco settlement dollars and Medicaid intergovernmental funds. Prior to 2001, only 22 of the 93 counties in Nebraska had local health departments to provide services to their county. You should receive a handout that has a map of 2001 and the current map of local health departments in Nebraska; it's one of the handouts provided. At the time of the passage of the Health Care Cash

Fund, Senator Jim Jensen and Senator Dennis Byars, who were the Chair and the Vice Chair of the Health and Human Services Committee at that time, prioritized the creation of local health department system in Nebraska with a legislative intent to do three things. First of all it was to create a statewide system of local health departments that was not in existence at the time, in order that all persons in Nebraska would have access to a local health department and public health services. The second thing was directing local health departments to work with local providers and community partners to assure a full range of public health services. That's to assure the services; it didn't mean that all of the local health departments had to provide all of the services. They needed to partner with community agencies and health providers to make sure that those services are provided. And the third thing was to define and direct local health departments to carry out core functions of public health, including assessment of health priorities, policy development, prevention of illness and disease, and assurances of services. The purpose of having those core functions in statute was to be able to define across the state what the basics or the minimum that the local health departments would do as part of that statewide network. Since that time, the network of 18 local health departments funded and created as a result of LB692 in 2001 have become, in fact, a statewide system that covers all 93 counties. Local public health district departments are not part of the Nebraska Department of Health and Human Services. Departments are

governed and advised by a local board of health as directed by state statute. Members of those boards include physicians, dentists, county commissioners, community members, other elected officials, And the services required to be provided by the local health departments are in fact found in state statute. And local health departments are required to provide an annual summary based on the programs and services that they provide and how their state funds are being spent. By statute, those departments must also publish an annual report for their communities so their communities are aware of how those funds are being spent. The statewide summary is also provided to the Health and Human Services Committee of the Legislature and it identifies across the state how funds are spent. Eighteen years ago, when LB692 was passed, the original funding for public health initial planning and infrastructure was set at $5.6 million. That's to be shared across the 18, that's not $5.6 million per health department. The funding was designed to recognize that all local health departments have similar administrative costs-- it was called infrastructure funding-- while population size does play an important factor in addressing local needs. So per capita funding was also allocated, and you should be receiving a chart indicating what the current funding is. In 2006 the Legislature appropriated ongoing funding of $1.8 million from the General Fund, shared among the local health departments for epidemiology and for data capacity. Total local public health funding provided by the state for these functions right now is just over $7.5

million, shared across those 18 departments. Much has occurred in the last 18 years, and you heard some of that this morning when Jeremy testified. You're going to hear more from the folks who are following me today, but suffice to say that a local health department today is not providing the same services they provided 18 years ago. In addition, the cost of providing those services, just like the costs of any other personnel costs, service costs, equipment costs, have also increased over those 18 years. The funding has not, so local health departments continue to play a key focus, and we are working very hard to make sure that the leading driver, which is chronic disease in Nebraska, is being prevented by your local health departments. You talked about a number of those this morning and, because of time, I won't go into a lot of those details, but new dollars towards this ever increasing workload will allow our communities and their public health departments to build the capacity to respond to the emergent public health threats and provide critical resources to address their statutory responsibilities. Thank you for your time today, and I'm happy to answer any questions you might have.

STINNER: Thank you very much. Questions? Senator Wishart.

WISHART: What is-- well, first of all, Judy, thank you for being here and for your years of leadership with the Lancaster County Health Department. It's a really great one. So thank you.

JUDY HALSTEAD: Thank you, Senator.

WISHART: What is the relationship that you've experienced with our-- with our regions-- our behavioral health regions?

JUDY HALSTEAD: I would say that most of the local health departments have worked with their behavioral regions in some capacity or another. But I would say that the behavioral health regions have the lead in providing and assuring the behavioral health services, whereas the local health departments are responsible for assuring that the public health services are provided across the state. So when you think of, for example, restaurants and you look, you think of food inspections that are occurring in your restaurants, those are typically provided by a local public health agency.

WISHART: OK.

JUDY HALSTEAD: The local health departments are helping to convene and to help bring together partners in the community as defined by statute. So as we're talking about youth suicide, for example, or we're talking about other mental health needs that are occurring, health depart-- public health departments are certainly partners in the community to deal with those issues. But I would say and I would think some of the other local health directors would say that behavioral health regions take the lead, where we are a key partner in helping to do prevention and helping with communication and

collaboration.

WISHART: So being on the ground level, you've seen the-- you've seen firsthand that the regions are taking the lead in terms of behavioral health and mental health.

JUDY HALSTEAD: I can speak to the Lincoln-Lancaster and I believe-- area, and I believe that they are, in that-- in that regard. I believe, though, that depending on where you are in the state, in some areas that may or may not be the case. But I do believe that behavioral health providers, including the region, obviously are working to take the lead in behavioral health.

WISHART: And then one last question for people who are maybe tuning in and listening to this hearing. What would you say when they say, well, we've got a Department of Health and Human Services that oversees, you know, healthcare needs in the state.

JUDY HALSTEAD: Uh-huh.

WISHART: Why do we need also local health departments? And is there any-- is there a duplicative sort of services happening, or can you just explain that?

JUDY HALSTEAD: You bet. I can-- I can begin, and again you have to acknowledge that my-- my wealth of experience comes from 22 years at Lincoln-Lancaster. I've not been in all the health departments across

the state. But what I would tell you is that boots on the ground is really what makes a difference in public health. You are aware that, for example, we have one individual who media shared that is a college student who has mumps. That individual has to be quarantined. Somebody has to do that, and somebody has to assure that that individual is in fact being quarantined. That individual also-- also has to, and we ask at local health departments that they help provide us who their most close contacts would have been during that incubation period to make sure that, if that mumps is spread, we know who that may have been spread to; we can ask those people to be quarantined. As we move through that, that has to happen at a local level. When you look at things like the measles outbreak, you cannot expect that the state is going to be able to do that in the-- in the staff-intensive, time-sensitive that that has to occur. I also don't think that you want to build the state's capacity to have to do that in 93 counties in the, you know-- in the state of Nebraska. Same kind of thing when we're work-- working at health promotion and prevention. You're not going to be able to have the resources at the state level to address all of those counties, and they're best addressed at the local level where those connections and those contacts are being made.

WISHART: Thanks, Judy.

STINNER: Additional questions? Senator Clements.

CLEMENTS: Thank you. Thank you for being here. You made a comment. You

said that you prevent chronic illness--

JUDY HALSTEAD: Uh-huh.

CLEMENTS: --and I think of treating chronic illness but not preventing. Can you give examples of what--

JUDY HALSTEAD: That.

CLEMENTS: --you've prevented?

JUDY HALSTEAD: You spoke quite a bit this morning about tobacco and tobacco use. Perfect example is being able to keep individuals, particularly young people, from starting to smoke helps prevent chronic disease, whether that be lung cancer, COPD, other respiratory ailments. That's an example-- for example, of prevention. When we talk about physical activity and we talk about healthy eating, that's a way to prevent diabetes. We know that individuals who are obese, who have type 2 diabetes, are more likely to have heart disease, other vascular problems. Those individuals who where we can prevent that have healthier life and a longer life. And that's part of what we do in public health.

CLEMENTS: Thank you.

JUDY HALSTEAD: Uh-huh.

STINNER: Additional question? I have one. You've said that $7.5

million--

JUDY HALSTEAD: Uh-huh.

STINNER: --was the total amount of public funding provided by the state. And in this handout you gave me, total funding was $5.5 million. Am I missing something?

JUDY HALSTEAD: We-- let me look, Senator. Senator, I can't answer that question. I will have to get back to you on that.

STINNER: OK. Because your-- you hit a cross section and, and you're talking about preventing chronic--

JUDY HALSTEAD: Uh-huh.

STINNER: --illnesses, is there other types of funding that you get, either from the federal government or from societies? And is there a way that I can put all of that funding that comes together so I can take a look at all the sources?

JUDY HALSTEAD: Yes, we would be happy to provide those. We've-- we've had that as a document prior to this time. It becomes a little overwhelming--

_____: Uh-huh.

JUDY HALSTEAD: --because that-- when you're talking about 18 local health departments that are potentially funded in a variety of

different ways, I can tell you that the funding that's received from the state in these particular programs are specifically for their infrastructure and per capita dollars. There are other-- are other grant funds that could be applied for. Generally those are competitive grant funds. Generally those are from the federal dollars in those larger dollars. But Nebraska Department of Health and Human Services does provide some additional grant funds that agencies may apply for. And in answer to your question, yes, it certainly is possible that the departments provide for you. For example, what we've done before, Senator, if this would be acceptable, is for Lincoln-Lancaster. I could tell you how much is appropriated by the city of Lincoln to the Lincoln-Lancaster County Health Department, how much the county appropriates, how much is appropriated from state funds, how much are federal funds, how much are fees, because many of the local health departments also provide funding through their fees. So does that--

STINNER: Yes.

JUDY HALSTEAD: --would that be helpful?

STINNER: That would be extremely helpful to me. Because you're asking for more state dollars, I want to understand a total picture of what's happening out there.

JUDY HALSTEAD: Absolutely. And Senator, I just realized what-- the handout in front of you is specifically for the infrastructure funding

and the per capita funding--

STINNER: OK.

JUDY HALSTEAD: --that comes from LB692. In the testimony, you will also see that there was another $1.8 million that was allocated specifically for data and for epidemiologists. And those are General Fund dollars, as identified in my testimony. I apologize. I looked at-- after you and I were talking, I looked back at it and realized what's different [INAUDIBLE] to us.

STINNER: Well, thank you.

JUDY HALSTEAD: So I apologize for that.

STINNER: Additional questions? Seeing none, thank you very much.

JUDY HALSTEAD: Thank you, Senators.

GINA UHING: Good afternoon, Chair Stinner, Chair Howard, and members of the Appropriations and Health and Human Services Committee. My name is Gina Uhing, G-i-n-a U-h-i-n-g, and I am the health director of Elkhorn Logan Valley Public Health Department in Wisner. I've been there for nearly 15 years and I've been the director for about seven years. As a health director for local public health departments, I have countless examples of the necessity of my department to respond in a crisis situation. I wanted to share with you a recent and relevant example experienced by my department following the floods in

spring of 2019. On one March morning, we received notification that one of our offices was temporarily shut down, as it was in the evacuation zone in Norfolk. That night, I received another call that the power to our main office in Wisner was going to be turned off because the water was approaching the building. In the days following, we had shorthanded staff due to their own homes being in the evacuation zones, and several others who couldn't appear to work due to closed highways and county roads. With 80 percent of our staff unavailable, the remaining 20 percent had to field the phone calls, organize well water testing events to be held in less than three days, distribute the testing containers that came with those well testing events, organize and plan for tetanus vaccine clinics, all while continuing to offer the critical functions of the department, like communicable disease surveillance duties, activities that must continue regardless of what else is going on. The issue faced by us was that at the point that our disaster struck, we were put in the position of having to drop other obligations and divert attention to the disaster at hand. And this is an "all hands on deck" situation, especially with 20 percent capacity of staff. We have to go into each disaster and hope that FEMA reimbursement comes through for us. Even when FEMA reimbursement is an option, only 75 percent of those expenses are reimbursed to us. The remaining 25 percent-- percent presents a burden, as those funds have already been earmarked for basic operational expenses, like utilities and insurance, for example.

And even worse, if FEMA reimbursement does not come through, we have to consider more unappealing options, such as furloughing staff or cutting hours. When we have dedicated staff, that's a real gamble, because we don't want to lose our trained tap-- our trained employees because we had to cut hours or-- or take desperate measures like that. When we have to gamble our small operating budget on the disaster response efforts, figuring out a way to backfill the hole that was created from digging into those funds is not easy. One unanticipated outcome, an example of our flood response, was that the flooded wellheads in our area were-- were yielding a 30 percent positive rate for bacterial contamination, and that went up to 50 percent positive to the north of us. When several hundred wells are being tested and 30 to 50 percent of those are positive, it was apparent that this was-- service was needed, and it was needed right then. There wasn't time to weigh out options because people's health was immediately in danger and action was necessary, and it was our duty to respond. I firmly believe that the prompt identification of this well contamination and the follow-up education saved people from illness. Public health work is more than a job or career to us, it's a commitment. We very much appreciate the opportunity to serve our communities and your constituents. This commitment continually presents unfunded duties to our scope of work, and there is a critical need for additional resources. I ask that you carefully consider the findings of LR184 and know that funding local public health in Nebraska is critical, and

issues like the one I shared have only been increasing as we go through 2019. Thank you for your time and I'd be happy to answer any questions that you have.

STINNER: Questions?

CLEMENTS: Two.

STINNER: Senator Clements.

CLEMENTS: Thank you. On the well testing-- is there a fee to the well owner for testing?

GINA UHING: No, in this case there was not. The state of Nebraska and the EPA-- they brought their portable well testing van to us and we distributed the testing containers. But there was no fee. And they did that un-- intentionally, I believe, because it was so critical that, even now with the follow-up testing, it was supposed to-- after the wells were disinfected, the retesting was supposed to happen in 30 days. And we're finding that only 10 to 15 percent of the follow-up tests actually occurred because those were at the cost of the constituent. And you have to get your sample to a lab within 24 hours, so there's overnight postage expenses that go on to it. So those can be anywhere from $70 to $100 a test. So we did not charge, no. But if you go to a lab now, there would be charges from those labs.

CLEMENTS: You collect the sample and then forward it on, or-- how--

how's that process work?

GINA UHING: Right. When we were doing this in March, they collected-- the EPA came with the portable testing unit and so they were testing the samples and processing them right on site. So within 24 hours, the results were coming right out of that van in the parking lot where the constituents were bringing their samples. But now if-- since that van has been sent back to Kansas City, then now yes, they would have to be sent in for processing.

CLEMENTS: Thank you.

GINA UHING: You're welcome.

STINNER: Additional questions? Did you coordinate any of your testing on water with the NRD?

GINA UHING: We did not. I'm speaking on behalf of our department, though, and maybe others in the state did, and I can ask and I could get that answer back to you, but I don't know for sure if any of my counterparts had.

STINNER: OK. Because they have the ability to test. Anyhow, additional questions?

WALZ: I have a quick question. Thank you for coming. Thank you, Chairman Stinner. I'm just interested in how you collaborate, then, locally with medical facilities and other organizations.

GINA UHING: Like in a flood response effort--

WALZ: In a--

GINA UHING: --or just on an ongoing basis?

WALZ: Actually more so, in an ongoing basis.

GINA UHING: OK. Well, like we had explained earlier, we do have a physician on each of our boards, so we do have that oversight, but a lot of us have-- I should say all of us have very close working relationships with the providers in our area and clinics. We are a referral source for them, so when they have a problem patient or a concern with somebody that's sitting in front of them, we get calls a lot. Do you-- you know, this person needs medication assistance or this person doesn't have any running water in their home. We get calls from our clinics all the time. I would say that our working relationship across the state is very close with our providers.

WALZ: Thank you.

STINNER: Additional questions? Seeing none, thank you very much.

GINA UHING: Thank you.

STINNER: Good afternoon.

KIM ENGEL: Good afternoon.

STINNER: Thank you for coming all the way.

KIM ENGEL: Thank you.

STINNER: Yeah.

KIM ENGEL: Thank you. Senator Stinner, Senator Howard and both Committees, thank you for allowing me to testify today. My name is Kim Engel, and I'm the Director of Panhandle Public Health District. PPHD covers the 12 most western counties of the state, with 21 staff. Since 2002, PPHD has used evidence-based planning methods to identify community health needs, strategies to address these needs, and coordinated implementation. But PPHD, like all other health-- local health departments, is operating at its max. I'd like to give you an idea of the depth and breadth of the local public health department, so I'm going to give you a glance at a typical week. We launched the Community Health Survey with a letter to the editor and distribution of surveys to all communities. This input informs the Community Health Improvement Plan implemented by public health hospitals and community partners. We coordinated and hosted a Kids Fitness and Nutrition Day in Scottsbluff, where 437 third-graders participated in physical activity and nutrition stations to learn about lifelong healthy habits. We hosted a regional Opioid Crisis and Response Summit with national experts, including our own Senator Howard, to teach about addiction, recovery, and stigma reduction. The Panhandle is identified as one of the five high-burden areas for drug overdose deaths. We

coordinated de-escalation training for area hospitals as part of our role as a Regional Medical Response coordinator and in conjunction with the opioid prevention work. We hosted the annual Worksite Wellness conference where Governor's Awards were presented to three work sites that have made a difference for their employees by changing policies and physical environments to make the healthy choice the easy choice. We provide work site wellness technical assistance to 50 businesses. We finalize plans with Child Protective Services for a child welfare adaptation for Healthy Families, an evidence-based home visitation program proven to increase parent-child interaction and attachment to prevent child abuse. We currently serve 60 families. We met with two area schools and the ESU 13 to confirm their desire to implement Hope Squads. These are peers trained to prevent suicide among fellow students. We provided suicide prevention training, or QPR, to over 50 members of the local business and professional women monthly meeting. We developed policies for lead testing, as two staff will become certified as lead inspector/risk assessors in the coming week. PPHD is currently working with 18 children with high blood lead levels. We are partnering with our area development district to address lead rehab in our aging housing stock. We ran a successful awareness campaign in the Panhandle Prep about vaping. We featured four standout students, athletes, who spoke out against it. We also celebrated with Central Health Department for their ordinance to ban public vaping. Staff convened the tri-city Active Living Advisory

Committee, made up of Scottsbluff, Gering, and Terrytown. This committee works to make the area more friendly and safe for walking and biking. We facilitated strategic planning for the poverty task force in Box Butte County to address social determinants of health. And we ongoingly trap mosquitoes in 4 of the 12 counties in the jurisdiction for ongoing surveillance of West Nile virus. The Panhandle is often one of the areas of the highest incidence of human cases. We also addressed access to care issues and chronic disease. To increase dental at-- care access for schoolchildren, our public health dental hygienist screened over 3,200 children and applied 1,500 varnish applications and 750 sealants in the last school year. PPHD promotes and provides support for people with chronic illness by training Living Well leaders to teach classes about management of chronic illness. We also maintain a system of trainers for the National Diabetes Prevention Program, assuring fidelity to the program and collecting data for reporting to the CDC. Disease investigation happens every day. This includes both school and hospital surveillance for flu-like illness, but also disease like mumps. We average nearly 300 investigations each year. Education alerts are provided to schools as illness outbreaks arise. This was truly an example of the first half of our September. As the hub in the district for health, we have many roles: facilitator, partner, moderator, collaborator, information center, resource identifier, data collector, to just name a few. Local Public Health serves as a vital hub for communities, making the "Good

Life" even better. Thank you.

STINNER: Thank you. Thank you for coming. Any questions? Senator Howard.

HOWARD: I don't have a-- I don't have a question, I have a comment. I'm really grateful that you came all this way, and I have a new respect for how long it is [LAUGHTER]. I had met Kim at a conference earlier this year. And she said, oh, you Omaha senators never come out and see us [LAUGHTER]. And I said, oh, I'll come out if I'm invited. And I did the drive there and back in two days and it is something else. So I'm really grateful that you came to talk to us about everything that you're doing in the Panhandle--

KIM ENGEL: Thank you.

HOWARD: That's wonderful.

STINNER: Senator Walz.

WALZ: I have a question too. Thank you, Chairman. You are cracking the whip out there, aren't you?

HOWARD: Oh yeah.

WALZ: It's kind of busy. [LAUGHTER] You are really busy. I'm impressed with everything that you've done in a couple of weeks. That's a lot of-- that's a lot.

KIM ENGEL: It was sort of an extraordinary couple of weeks. It was a great example when I was asked to do it. [LAUGHTER]

WALZ: Well, it is awesome work. Thank you.

KIM ENGEL: Thank you.

WALZ: I'm-- I'm just kind of curious. What is, when you say you're partnering with our Area Development District to address lead rehab in our aging housing stock, what does that mean?

KIM ENGEL: Well, we've had a planning process about lead poisoning for children, and it's been several months now that we're working with key partners. And our PADD, Panhandle Area Development District, is-- often have projects about housing rehab, and we've really zoned in on lead. So what we're preparing to do is-- is to prepare a proposal to HUD, specifically about that, and we know that they've done a lot of groundwork in PADD. They know that they're able to use some of the match money that communities have in their CBD-- CDBG grant, I might have those initials wrong, but they can use some of those funds to match the HUD grant that also requires a match. But that-- that is going to entail a lot of preparation because in the Panhandle, from our assessments we know that not many of the contractors or not many of the do-it-yourselfers anymore know how to adequately do a remodel on a house without stirring up dust and causing that problem. So that's part of the plan, is to provide that education to-- and add

some kind of an incentive that will want to make them come, besides a penalty. So we know there's a lot of steps involved that will help us get there, too.

WALZ: So that grant money will go to rehabbing individuals' homes.

KIM ENGEL: The one that was available this year, actually, could be for home-- or owner-occupied homes, but it could also be for rentals, and it might be the cut-- the city's housing units, you know. But it doesn't have to be governmental homes. It's really identifying children at risk for lead poisoning.

WALZ: All right. Thank you.

KIM ENGEL: Uh-huh.

WALZ: Thanks for all you do.

KIM ENGEL: Thank you.

STINNER: Additional questions?

KIM ENGEL: I did want to address Senator Wishart's question about the regions. We work really closely with our region, and in fact, a lot of this opioid prevention work we're doing is in collaboration with them. They're subawarding us funds to-- to bring that kind of training out and to do the assessments and get the Narcan to our first responders. And so I-- they're the lead, but we're the feet on the ground.

WISHART: That's good to know.

KIM ENGEL: Uh-huh.

STINNER: Kim, you might want to talk about setting priorities, and how you guys--

KIM ENGEL: Yes.

STINNER: --put all of that together with the survey work and the providers that you get together.

KIM ENGEL: Right.

STINNER: Maybe that'll give a little bit more understanding about--

KIM ENGEL: So that first--

STINNER: that--

KIM ENGEL: --item I mentioned about the community health survey, every three years, local public health-- some do a three-year, some five. But it happens on a regular basis. We do it three because that's what is required of our hospitals, and we do it together.

WALZ: Uh-huh.

KIM ENGEL: So it's a-- it's a four- or five-step assessment process, and one of those steps is a survey. It also includes focus groups and includes gathering the data about the health of the community and

really looking what is our vision. And it's a yearlong process and at the end of that year, everyone involved comes up with three or four common goals or priorities. And all of these things that happened in that week period fit within those goals. So that really helps us, as a region, know what it is we need to work on, how we can collectively bring resources together, not just from Panhandle Public Health, but from the hospital side, from ESU, from other organizations in the area, and really focus in on that. And then there is an evaluation piece that goes with that on an annual basis also. And it-- and we put it out on a dashboard on our Web site-- don't everybody look, we don't want it to crash but [LAUGHTER] we, you know, we have measures that we track to make sure that we're making progress that way. So--

STINNER: One of the things I did want to ask. We had the canal breach, the tunnel-- mental health became truly a big issue, and I know the University of Nebraska stepped up and did some outreach. Is that something that you crossed over into, as well? Or--

KIM ENGEL: Not specifically to the canal break, but we were in planning meetings with UNL about that, and we--

STINNER: OK.

KIM ENGEL: --on a-- maybe more on the sideline, but we provided the QPR training for those professional women, and really got it out there that we are a resource for that in the area. But as we all know,

suicide and mental health is just a huge concern in rural areas, and it's a huge concerns in our schools. I mentioned the Hope Squads, and I don't mean to get too far away from your question, but we kept kind of bringing up this idea of training students-- it's an evidence-based program-- for a couple of years and never really had any of the schools nibble on to our bait. And this year, we have four schools that are ready to go. So the awareness is out there, that there is a need and now we just need to get the resources in place. So--

STINNER: Thank you. Additional questions? Seeing none, thank you again for--

KIM ENGEL: Thank you very much.

STINNER: --traveling all this way.

JAMES MICHAEL BOWERS: Senator Howard, and Senator Stinner, and members of the Health and Human Services and Appropriations Committee, my name is James Michael Bowers, J-a-m-e-s M-i-c-h-a-e-l B-o-w-e-r-s. I appreciate the opportunity to testify on behalf of the Lincoln-Lancaster County Board of Health in support of providing a sustainable and adequate stream of funding to local public health departments. I've been a member of the Board of Health for the past four years and currently have the privilege of serving as president of the board. And I really want to emphasize the word "privilege" and tell you in a few words why I've become such a devoted advocate of

public health. I came to our board with little knowledge of public health, but with a desire to become an effective board member. And it didn't take me long to realize that those two small words, public health, have enormous implications for everyone in our community. I was blown away by the scope of public health, and today, if someone tells me that our health department doesn't impact them, I ask them if they drink our water. Do they eat in our restaurants? Do they have a licensed pet? Do they appreciate our smoke-free buildings? Do they bring their kids to a childcare center, or pay attention to the tremendous toll that preventable chronic health-- chronic diseases are having on people that they know? Public health touches absolutely everyone, every single day, in many different and important ways. People need to know this, to appreciate it, and to recognize that financial support for public health is imperative. I've seen firsthand the hard work that the dedicated public health professionals accomplish every day to keep our city and county safe and healthy. They're efficient with their resources, passionate about their causes, and effective in their results. As a board member, I've the opportunity to voice approval of policies and ordinances that are critical to the health of our citizens, provide input on the direction that programs may take, and learn about the impact that the department's programs are having on the health of our community. For example: our community is increasing physical activity; more at-risk children are receiving dental care regularly; resources are being

sought to combat the rising incidence of sexually transmitted infections; the goal of diverting 100,000 pounds annually of hazardous waste from the landfill is within reach. Local public health is the community leader in addressing current and emerging health threats to our communities. I can't emphasize to you enough the need for strengthening our public health systems to continue to address and improve the health of our citizens. Senators, I hope that I've conveyed my dedication to public health and convinced you that the need for funding public health is great. I urge you to appropriate funds to each one of the health departments in Nebraska.

STINNER: Thank you. Additional questions? Seeing none, thank you.

JAMES MICHAEL BOWERS: Thank you.

STINNER: Would like to conclude, Senator?

QUICK: Thank you. So you've heard of a lot about what the public health districts do in our-- throughout our state, and with-- and the kind of services they provide. I had the opportunity this last Monday before I came out west to visit you, Senator Stinner, out in Scottsbluff-- and I went to McCook as well-- but I visited the-- I went to their board meeting. And they talked about some of the things that they've been-- that they're working on, and some of the issues that they've had, with the recent flooding and those type of things. One of the things that came up was-- a little bit to do with

infrastructure. So like their phone lines-- and that's vital to them, for people who call in who need assistance or need information-- so their phone lines went down, because with the high water table come out and-- and knocked out the phone. So they had to scramble to find another provider. That cost a little bit of more money to do that, but they were able to get their phone lines back up and running. So that was one thing they talked about. Of course, since I had the bill on vaping last year we talked a lot about vaping, and they're looking at vaping as a chronic illness, and how it's going to affect our children who've-- who have been vaping and other-- and even adults as well, to see what the healthcare effects are going to be from-- from using vaping products and tobacco products as well. They also talked about their WIC program, and that's going to be up and running here-- well, it is running, but I mean, some of the things that they're doing with that. We talked about flu shots starting up and what they're doing with that. And then they also talked about, with the recent flooding, and our ground water table so high, you have standing water in a lot of places, so the mosquitoes are terrible. So they talked about spraying for mosquitoes to prevent diseases from mosquito bites and those type of things. And they talked about how they trap the mosquitoes, send them in for testing so they can find out if there's any, you know, like a -- a chronic or a specific disease from those mosquitoes. I know the-- and then they also talked about well testing for over in the south part of Hall County, in the Doniphan area, Amick

Acres. We had a lot of flooding. The river went into one of the sandpits there. The water level came up around those homes around that lake and got in, also, into the-- into their wells, because they're not-- they're-- they have private wells, so it contaminated a lot of their wells. So they were doing water testing to make sure that that water is safe to drink, to consume. So those are the most of the things that they talked about at that meeting. I can tell you, one of the things that the city of Grand Island did, we-- we had our own well system. I was part of that, working for the city of Grand Island. And I also-- our department helped maintain the wells and the reservoirs, and we-- you had to have a water license to be able to take the samples to send in, and we would take those samples to the Central Health District [SIC] to be tested, to make sure that it was safe for consumption. So every time we did maintenance on a-- on a, on a, on a well, on a reservoir, or on a line, we had to send-- do testing and send those--had to take those in to have those tested. I think the one big thing you hear is prevention and I can tell you from my experience, even working in the power plant, we did preventative maintenance because that's the way you save money; that's the way you save your cost. And you know, downtime on equipment, if we can see that piece of equipment and see that it's going to be-- it's going to have failure, we can fix it before it actually goes down and and causes a -- causes a catastrophic failure. And then it takes a lot more time to repair that, it's a lot more costly to repair that. So I

see this as, you know, prevention is big. I also sat on two committees there, a safety committee and a health insurance committee. And on the safety committees, we looked at preventative ways to prevent accidents in the workplace, to reduce our work comp claims, and also to prevent employees from being off work for any number of days, which was a cost savings to both the employee and to the employer. And sitting on the health insurance committee, we looked at preventative ways, you know, doing your wellness visits, how we can-- how can we say we were self-insured. So we looked at ways that we could reduce our costs by preventative healthcare, like I say, through-- through wellness visits, going to the doctor before you got so sick you end up in the hospital, and those type of things. So I think prevention is big and I think that's one of the services that the Central Health Districts provide. And I think investing in those Central Health Districts is going to save us money in other-- in other areas. So I know the Legislature created these public health districts to keep our citizens safe and healthy. We should give them the resources they need so they can do what they do best. So thank you and--

STINNER: Questions? I think it would be helpful for me before the next session if you could give me-- I'm going to say the like-kind states, but surrounding states, what they're doing and so we can make-- compare and contrast the dollars. The other thing, and I should have asked this, is the infrastructure funding part that's on this chart that they gave me. Define infrastructure. Is that code for overhead,

or is that--?

QUICK: That, I'm sorry, I couldn't answer.

STINNER: OK.

QUICK: But we can find that out for you, I'm pretty sure.

STINNER: Per capita funding and infrastructure, I'd like to understand what that-- what that means. It's got to be code for something that I can relate to.

QUICK: Yeah.

STINNER: I'm looking at Kim. I'll probably--

QUICK: Yeah. Yeah.

STINNER: --probably end up asking her or so--

QUICK: Well, I'm willing to work with but--

STINNER: --if I could get that, I'd--

QUICK: Yeah. And I'm willing to work with the committee, with anybody, to see what we can do.

STINNER: Yeah. I appreciate it. Any additional questions? Seeing none, thank you very much.

QUICK: All right, thank you.

STINNER: That concludes our hearing on LR184. We're going to jump ahead to LR234, Senator Bolz. And this will be invited testimony only.

[BREAK]

STINNER: [RECORDER MALFUNCTION] Bolz.

BOLZ: Thank you, Senator Stinner. Good afternoon, committee members. This legislative resolution is focusing on two major areas as it relates to Behavioral Health services. The first is, last legislative session, the Appropriations Committee and the full body approved a 4 percent rate increase for behavioral health providers. And that was in response to the Division of Behavioral Health and some excellent work that they did to analyze where we're at in terms of funding different kinds of behavioral health services. So that might be family counseling or that might be inpatient or outpatient services. And what the Division of Behavioral Health found was that the--the rates paid to behavioral health providers, folks who are those mental health practitioners in all of our communities, were between 7 percent below the actual cost of providing services to 35 percent below the actual cost of providing services, and that the average rate paid was 18.1 percent below the actual cost of providing services. And particularly for our HHS Committee members, I have the fact sheet on the bill that we brought last year that increased those behavioral health provider rates by 4 percent. So basically, we recognized that the behavioral health rate study said that we were underfunded, and what we were able

to do as a body last legislative session was to move the dial by 4 percent. But obviously, given those statistics I just shared with you and that you can check out on a fact sheet, we're not there yet. We've still got work to do in terms of fairly reimbursing behavioral health providers. So the first thing that I hope to accomplish in this interim study hearing is to hear from the Division of Behavioral Health and Probation just about the implementation of that 4 percent rate increase. The Appropriations Committee, in particular, but I think the body overall has had questions about the implementation of rate increases in nursing facilities and other areas. So the first is a due diligence. We provided those rate increases. How is that going? Is it flowing through, and is it helping? That's the first thing we want to talk about today. The second thing I want to talk about is, what is the next bite of that apple? What's the next thing that we need to do to implement the behavioral health rate "right-sizing?" What else do we need to do to take that data that was begun by the Division of Behavioral Health and make sure that we're paying the right rates for the right service at the right time? And we are-- we are starting to get a better understanding of what that looks like. I think it is important that we continue to provide rate increases because we know that we're not actually providing an increase, we're actually just trying to work to get closer to the actual cost of providing care. But the other thing is we wanted to do an analysis of the rates that were most disproportionate, the ones that were most off

base, and understand better how the providers were handling that and what they were struggling with. And so I hope that by the beginning of next session, we'll have a short list of the behavioral health rates that most need our attention. But for today I want to say that the lowest rates are the most disproportionate rates. The rates that are most off base in terms of actual cost of providing care are in the co-- cot-- co-- co-occurring disorder area. In other words, services that cover both mental health and substance use treatment. So that's something we need to take a look at in the next legislative session. And this is a preliminary list, but some of the rates that are most disproportionate include: established patient evaluation for an outpatient visit, so assessing where somebody is at in terms of their mental health; established outpatient evaluation for those who are-- not just those who are coming in for that visit, but those who are highly complex-- that's a different rate that is also not quite where it should be; evaluation management in nursing facilities is not where it should be; individual psychotherapy, both shorter sessions and longer sessions, are disproportionately funded; and then, initial diagnostic interviews are another service area that we've begun to identify that is in that list of rates that are disproportionate. So that was maybe a longer introduction than was necessary. I'll have Kenny hand out these sheets, but I hope that we can talk about how our previous work to increase rates is a-- is going, and talk a little bit about where we need to go next.

STINNER: Just wanted to ask this, and maybe you can enlighten the committee. The authoritative source-- well, you cite this-- this study, and you may want to elaborate on where that study comes from, the authoritative source it comes from, and how they compile all of it.

BOLZ: Yeah. You bet. So Sheri Dawson is actually here today, and I'll let her talk--

STINNER: Oh.

BOLZ: --a little bit about that work, 'cause-- because they really deserve the credit. The Division of Behavioral Work did that work. What we did in the Appropriations Committee was look at that work and respond to it. But I would also say that as we're analyzing what rates are disproportionate, we both need to look at the Division of Behavioral Health's study and how it compares to reimbursement rates for insurance, because that's, I think, that's a fair-- that's a fair comparison. If-- if I'm using my Medica insurance card, what rate am I getting-- is my provider getting paid for-- for an evaluation? And how does that compare to what we're providing to? And this is-- this is important: these rates apply to Probation, the Division of Behavioral Health, and Child Welfare. So we're kind of looking across systems and saying, if we're doing outpatient evaluation, whether it's a-- it's a kid or whether it's in Probation or whether it's in Division of

Behavioral Health, we still need to provide a fair rate.

STINNER: Thank you. Questions? Senator Wishart.

WISHART: This is more of a statement to kind of put in perspective the conversation, not just around mental health, but also around our corrections facilities. We just had a meeting with the Department of Corrections for another interim study, and our head of Corrections passed out a book about how in this country we are criminalizing mental health. And so I just wanted to connect, you know, both of the interim studies that we're working on. When we don't fund behavioral health in the community, we end up with a lot of people who have mental health issues attached to substance abuse as well, in our corrections system. So you know while it may be an ask for an initial investment, we're spending those dollars in our corrections system if we're not doing it up front.

BOLZ: Yeah, I think, Senator Wishart, and I would join director Frakes in recommending the book "Crazy" by Paul [SIC] Earley. But one of the things that-- that that book is illustrating is that there are systemic problems in preventing people from-- with mental illness from getting into treatment, instead of correctional facilities or institutions. And that's why, I think, the note that one of our most disproportionate-- disproportionately paid services is evaluation, because if we can't get those folks that evaluation and say, oh, that's a diagnosis, here's treatment or medication, or, here's an

alternative service, they're set down on a-- a downward spiral that doesn't help anybody and cost a lot of money.

STINNER: Do we have a number on how many are in our prison with mental health problems?

BOLZ: It's-- it's a really good question. The last time I looked at it, it was over 80 percent. But I think we-- it's important that we make the distinction between those in the system that have severe mental illness and those who have a less severe diagnosis like depression, and I don't know-- I don't have that off the top of my head. So we know that a lot of folks are mentally ill within our corrections system.

WISHART: And I believe that the-- really quickly, I believe the last time I looked at a statistic around substance abuse or somebody being in a corrections facility who also has a substance abuse issue, it was in the 90 percent, so it's an issue.

STINNER: Senator Dorn.

DORN: Thank you, Chairman Stinner. Question. You talked about the provider rates--

BOLZ: Uh-huh.

DORN: --and finding out how they're implemented and that.

BOLZ: Uh-huh.

DORN: Are you going to give us some kind of report today, or by the next session or what-- what-- what's the time line?

BOLZ: Yeah.

DORN: Or what do you hear, I guess?

BOLZ: Yeah. Yeah. Thanks, Senator Dorn. Following me are: Sheri Dawson, and-- Sheri-- Sheri Dawson with the Division of Behavioral Health; Deb Minardi, with Probation; and we have a representative from the Nebraska Association of Behavioral Health Organizations. And I'm hopeful that they'll be able to touch on how things are going in terms of spending out that-- that effort to "right-size" the rates, and what their-- their future needs are.

STINNER: Additional questions? Senator Clements.

CLEMENTS: I was curious as to why they did this study. Were they directed by the Legislature or do they do this regularly on their own?

BOLZ: That's a really good question, and Director Dawson might have more color commentary on that, but it's my understanding that this was a study that they decided it was-- it was important to provide updated information.

CLEMENTS: All right. I'll expect--

BOLZ: Yeah.

CLEMENTS: --her to give that answer.

BOLZ: Yeah.

CLEMENTS: Thank you.

STINNER: Additional questions? Seeing none, thank you.

SHERI DAWSON: Good afternoon.

STINNER: Good afternoon.

SHERI DAWSON: I'll get situated here. So good afternoon, Senator Stinner, and Senator Howard is not here right now, and members of Appropriations and Health and Human Services Committee. My name is Sheri Dawson. S-h-e-r-i D-a-w-s-o-n and I serve as the Department of Health and Human Services's Director of the Division of Behavioral Health. The fiscal year '19-20 and '20-21 biennial budget reflects an appropriation of five-- oh gosh, I didn't hand these out. You all are just going to let me do that, huh? [LAUGHS] I should have just kept going [LAUGHS]. Sorry about that-- $5,786,602 state general funds for the biennium to the DHHS Division of Behavioral Health for provider rates and for certain cost model services, in addition to the General Fund appropriation of $72,495,360 for fiscal year FY '20, and $69,102,240 for FY '21. The division's cost model project based rates on our approved service definitions, which include staffing

requirements and the cost information submitted by the providers. DBH approached the study as an opportunity to really determine the reasonable costs for the staffing and activities required by the state-defined service definition, including administrative costs, for ensuring quality service and outcomes are documented and reported. Funding for services should be fiscally conservative, meaning that excess costs have been removed or redirected, and yet still be sufficient to ensure providers remain available and accessible to those that need them. As the rates paid by DBH had not been reviewed since their establishment in the late 1990s and early 2000s during behavioral health reform, providers repeatedly indicated that the rates were not sufficient, given changes in recordkeeping practices and changing administrative requirements. For example, changes in scope and quantity of data to be provided and reported, costs for required accreditation and so forth, along with inflationary and wage increases. So the cost model process adopted by DBH involved a consultant who gathered information from the providers for the services, such as: staffing, staffing costs, payroll, service operations, capacity, program management, and indirect administrative agency costs. Information was collected on a tool standardized for each service and refined the information to the service under review. The information was compiled and analyzed to draft a cost model based upon specific caseload staffing ratios to establish a rate. And once that rate was drafted, there was an analysis of the potential impact

on consumer access, available funding, sustainable funding, and cross-payer system impact. The full cost of implementing the cost model for the completed phases and services reviewed was to be $6.63 million, with approximately $1.42 million funded by redirecting existing funds used to support certain services above existing rates. The redirection of 038 funding was based really on a principle that specific rates based on cost of services, according to the service definition, would minimize the need for paying additional expense-based reimburse-- reimbursement for certain providers and decrease the need for additional funding that was being used to enhance rates. This resulted in a request of $5.2 million per year, and the Legislature approved and the governor signed the additional $5,786,602 for the biennium to be allocated, which supports the implementation of a portion of the cost model rates. The budget reflected a 4 percent overall increase directed at provider rates for specific behavioral health services. Rather than picking and choosing which service would or would not receive an increase, the division applied the new appropriation proportionally across all cost model services based on a percentage. And what this means is that if the new rate under the cost model would have used 12 percent of the total funds needed, then 12 percent of the appropriated funds were assigned to that service. And this allowed for every service and the cost model work to receive a proportional increase. Cost model funds were intended to pay for increased cost per unit. For example, if the rate

for the fiscal year '19 for a unit of service was $10 and the cost model increases to $10.50, the appropriated cost model funding would support the $50 increase because the other $10 is supported by funds that already existed prior to the cost model work. So you have an attachment to the testimony that provides the rate increases. Cost model work will not meet the needs of every provider. As in any business, costs may vary by size, service lines within the agency, program and administrative supports, clinician and scheduling productivity levels, location, and so forth. Some providers may have added staffing or processes above that required by the service definition. DBH is continuing to work with the regions and providers to ensure that in the capitated system, that funding is efficient and effective. The cost model funds appropriated and implemented serve to address service costs for providers of these critical services and serve as an important step to ensure access to those that need behavioral health treatment. So I appreciate the opportunity to be here for LR234 and I'll answer questions.

STINNER: Thank you very much. Questions? There was a concern that was expressed related to this and that happens to deal with Medicaid expansion and what we had put in our projections, and there was a fear that they're actually going to get less money with Medicaid expansion--

SHERI DAWSON: Uh-huh.

STINNER: --as opposed to where we're at today. Could you talk about that?

SHERI DAWSON: Sure. So--

STINNER: Have you compared the Medicaid rates against this, I guess?

SHERI DAWSON: OK. So those are two separate issues. So let me answer the first one--first part first. So in 038, which is the Division of Behavioral Health budget for fiscal year '21, overall in 038, there is a decrease in funding because with Medicaid expansion and beginning, then the individuals that typically would have been served by us, some of those individuals would be now Medicaid eligible. And so that reduction-- it was a fairly conservative percentage, and I can't tell you that right off the top of my head, Senator. But the reduction of our overall funding in '21 is related to people being served by a different payer. When you talk about the rates, one of the things that we did do early on, and you might remember when we started the cost model project in 2015, we did look at two services that were way below Medicaid rates. And so, Halfway House and Medication Management in 2016 were funded because they were so far below, and we were able to do that within our 038 appropriation. However, if you look at the list of services, we knew that we needed to continue the cost model study, but we really needed to get that bigger picture of what the impact would be with more services. And so the rates, we always look at Medicaid. We also look at Probation because in a behavioral health

system that has multiple payers, you don't really want to incentivize a provider to serve the higher rate payer. You need to be within range and competitive, is at least our view so that we have more individuals that can access services. We always want to maximize federal funding, for example. And so we did do a comparison to Medicaid and then continued to work with Probation as they carried out their work as well.

STINNER: One part of this equation is rate. The other part is utilization. How is your utilization model? Is that holding up or are you seeing overages or--

SHERI DAWSON: Uh-huh. You know, every year when we do our budget, and in particular, looking at the regional budget planning, that is a huge part of really looking at utilization of services. Which services overproduced, in other words, they, the providers had more people come than we actually had money for? And for the last few years we've been able to pay for those overproduced units. And then for those services that really aren't being utilized, can we redirect those funds or was this a unique year? And so, typically, the regions and the division look at a trend to really look at those utilization patterns.

STINNER: So if a region ran out of money or got to the eleventh month or tenth, didn't have enough money, would you have resources to-- yeah, what-- what's the process that they need to go through?

SHERI DAWSON: Sure. So over the last few years, and I will say, that when I became director, if we looked at the 038 balance as a whole, there were several million dollars left on the table.

STINNER: Right.

SHERI DAWSON: And so one of the things we looked at is, why is that? Because we know we have people waiting, and we know we have people that need access to service. And one of the processes was that there may be a region and their provider network that didn't need their full allocation for whatever reason. You can never predict the number of people that, you know, might come to a particular door. And so we really wanted to make sure that we could use the money in 038. So we started doing a cross-region amendments and transfer of funding, and at the spring of the year starting, really looking in March and April, look at those overproduced units. So which providers are serving more people than they actually have money for, so that we can at the end of the year do a contract shift and provide those units a service? Now we did focus that only on the services that were on a rate, either a region rate or state rate, because those providers put in a budget, they look at their utilization trends, and they are paid by the unit. We have other providers that do non-fee-for-service. So they say, these are our operating expenses and we prioritize those that we're on rate over the non-fee-for-service or operating expenses.

STINNER: Thank you for that. Additional questions?

DORN: Go ahead.

STINNER: Senator-- Senator Clements.

CLEMENTS: I am going to repeat my question about why you decided you needed to do this study now or if it was directed by the Legislature.

SHERI DAWSON: It was not directed by the Legislature. As the Division of Behavioral Health continued to talk with providers, we continued to hear that our rates hadn't kept up. And in fact, it had been a very long time since we had done a cost model. They did it at the time of reform, so it'd been a number of years. Plus we're asking for more information. We really are moving towards outcome data, and are we making a difference with our funds. So there's more data, you know, administrative kinds of things. So we wanted to account for that in our cost model in addition to the actual service definition.

CLEMENTS: And had-- have rates been increasing some over the last 20 years?

SHERI DAWSON: Yes. Yes, they have.

CLEMENTS: Without-- without a detailed study, though.

SHERI DAWSON: Correct. The-- the Legislature over a number of years would do a certain percentage, you know, maybe 1.5, 2 percent. I have that history in here somewhere. But there were also tough budget years

where the providers did not receive a rate increase.

CLEMENTS: Thank you.

SHERI DAWSON: Uh-huh.

STINNER: Senator Dorn.

DORN: Thank you, Chairman Stinner and thank you very much for coming.

SHERI DAWSON: Uh-huh.

DORN: On your handout, here, it's the top paragraph on the second page there, a little bit. The numbers there, just to go over them a little bit, you know, the provider rates and the enhanced rates, and then the request of $5.2 million per year.

SHERI DAWSON: Uh-huh.

DORN: And then we only ended up funding the $5.78 million biennium,--

SHERI DAWSON: Correct.

DORN: --which looks like it's almost well, we do that each year, but we didn't. Explain all of that.

SHERI DAWSON: So what-- first of all, there's the-- the redirection part of the original ask. Right? So the total cost was going to be $6.63 million, but when we looked at our funding, we were paying for particular providers to have additional funding, and some of those

categories or expenses were what we called Capacity Access Guarantee or a service enhancement. And so there's a-- a history to the Capacity Access Guarantee. Many of you are from rural areas and you obviously want to have statewide reach, right? You want to have places for people to come in. And so, at one time a lot of those Capacity Access Guarantees was really the primary payment for those particular providers. And over time, as rates were established for some providers, there was a combination of a rate and then still having operating expense. And now, as again, one of the things that was important to me and our team, to serve more people, we really had to look at why certain providers were getting additional funding, when if you looked at that same service across the state, none of the other providers got the additional funding. So we started again asking for, what are we getting for our dollars? You know. What are those outcomes? What's making a difference? The other thing that's been on the table is really looking at a system standpoint. So if we have a clinic in a small town that is open, we're not the only-- region-funded people are not the only people coming. For example, there could be people that have insurance, people that are funded by Medicaid. And so we didn't want to continue to use our dollars for particular providers having additional extra funding when, if we think about how we can use that funding differently to have expanded access-- and I'll give you an example. If you had $50,000 that you were paying to a particular provider as either a service enhancement

or that was their expensive-- expenses for Capacity Access Guarantee, $50,000 would convert to about 708 medication management units. If you converted that to psychiatric residential rehab, it would be about 374 units, which would be two peep more-- two more people served. If you looked at other kinds of services for that extra expense for a particular provider, we at a statewide level have to look at that access. And over the last three years, the Division of Behavioral Health has been successful in serving more people for the last three years.

STINNER: Additional questions? Seeing none, thank you very much.

DEB MINARDI: Senator Stinner and members of the committee, my name is Deb Minardi, D-e-b M-i-n-a-r-d-i. I am the probation administrator with the Nebraska Supreme Court. The Administrative Office of the Courts and Probation is very grateful to Senator Bolz for including the judicial branch in this ongoing discussion concerning behavioral health, and in particular, rate adjustments. We are also appreciative to the Appropriations Committee for the funds appropriated for this current biennium that permits us to make the rate adjustments. This is a first time for us. Probation did considerable work dating back to 2017, when we-- when we started the process of comparing our rates with our system partners. In particular we looked at Medicaid, we looked at the Division of Behavioral Health, we looked at Child and Family Services, we looked at some of the insurance rates, and we

found very clearly that we were way behind. Based on this comparison, we were actually able to make some minimal rate adjustments ourself [SIC] through our own budget just this past January of 2019 and July of 2019. Prior to this, probation had never been in a position where we could financially make adjustments over the years. Upon the passage of this year's biennium budget, we quickly went to work again to create the necessary IT programming that required us for our system authorization and our financial payment process. Once we had those two IT components in place, we then put the new rates into effect, as well, that went into effect to-- September 1. We have since started the review process again, and we are prepared to again provide those rate increases that are set to take place July 1, 2020, that have been allocated, and we are doing our very best to make sure we can stay consistent with our system partners. I do need to mention, however, that the appropriation toward the rate increases that-- the Administrative Office of the Courts and Probation will use additional dollars from our existing budget. Had these additional rate adjustments not been made, a 4 percent increase for behavioral health services alone would have resulted in Probation still paying significantly lower rates. So I hope that illustrates to this committee that our-- we are committed to behavioral health services and having probation service rates be as consistent as possible with our system partners. Probation very much values our partnership with the behavioral health community. As a matter of fact, those of you on

the Appropriations Committee may remember that on numerous occasions we have been before this group to testify in favor of behavioral health services and rate adjustments. And while the rate adjustments will help, we hope it's just a start as well. We believe that these rate adjustments in turn help us with our clients on probation, both our youth as well as adults. I would be remiss, however, if I didn't mention that service availability in our rural communities still remain a concern. Recruitment of providers still remains a concern. Waiting lists still remain a concern. And we have not yet begun to examine the emerging issue-- issues that we're seeing in behavioral health for adults and juveniles that are facing our future, but I think that's probably a discussion for another day. So with that, I would thank you again for your time and be happy to answer any questions.

STINNER: Questions? So the shortfall that you're seeing in terms of services have to do with the rates that you're able to pay? If you're given extra money to pay a rate, would you find more services or more people to service?

DEB MINARDI: I think that in general, in the state in Nebraska, we need to do a better job recruiting providers, and I think a lot of that has to do with the rates that we're paying.

STINNER: OK.

DEB MINARDI: I think some of the struggles that we have in terms of waiting list has to do with the uniqueness of services. As an example, it may not be a good business practice to do intensive outpatient rural communities because they may not have a large enough pool to have an intensive outpatient program, but yet that doesn't suggest that intensive outpatient program isn't needed in a rural community. So we have those barriers as we think about services, and we have those barriers as we think about providers. But I hope that that doesn't stop us in terms of trying to be creative because the services are still very much needed and the rates are a step in the right direction.

STINNER: Thank you for that. Additional questions? Seeing none, thank you.

ROBERT SHUEEY: Good afternoon--

STINNER: Good afternoon.

ROBERT SHUEEY: --Senators. My name is Robert Shueey, R-o-b-e-r-t S-h-u-e-e-y. I'm the director of operations and corporate compliance officer at South Central Behavioral Services in Hastings. I am testifying today on behalf of the Nebraska Association of Behavioral Health Organizations, or NABHO. Thank you for the opportunity to testify regarding the impact of provider rates on rural Nebraska. I would like to start by saying the rate increase-- increases authorized

by the Legislature and the Governor this spring were sorely needed and have been instrumental in keeping our programs open and running. I would like to thank you all for your work to get these bills passed. In some programs, we have even been able to consider raises for our still-underpaid direct care staff. Both our agency and the workers there are grateful for your efforts. Unfortunately, while the Division of Behavioral Health has likely followed the letter of the law, to my mind it has not been able to follow the spirit of the law, which I believe was intended to increase funding for behavioral health services to sustainable levels. While some of our services continue to operate at a loss due to the Division of Behavioral Health not being able to fully implement the cost study, and due to cost increases in the years since the cost study was initiated, the increases they have provided will allow some services that were being considered for termination to continue for at least another year or two. A great example of one of the problems faced by our agency regarding rates is in our psychiatric residential rehabilitation program. This is a program that endeavors to help Nebraskans diagnosed with the most difficult to manage severe and persistent mental illnesses, like schizophrenia and bipolar disorder, learn to live successfully in the community rather than in expensive group homes or hospitals. We have a long history of successfully achieving that aim. This is also a program that operated at a loss last year. While the daily rate paid by DBH has increased-- was increased significantly according to the

cost model for this program, this program was and still is partially funded by Capacity Access Guarantee or CAG money. The CAG money in our contract for this program this year was reduced from last year's allocation, to the point that it will offset the rate increase provided. This means that at the end of the day, this program is being funded at nearly the same total dollar amount that it was being funded at prior to the rate increase, and it will likely operate at a net loss again this year, in spite of the rate increase. Additionally, the Medicaid rate for this service remains below the cost of care established in the department's rate study, in spite of the recent Medicare-- Medicaid, excuse me-- provider rate increase. Other agencies that receive CAG money across the state have reported they were treated the same way, so this is not an isolated example. This is particularly frustrating in the context of the discussions that we have had with DBH. While the rest of the medical world moves away from the outdated fee-for-service model, which rewards only volume, DBH is intentionally moving toward this outdated model and eliminating the more flexible CAG and expense reimbursement funding methodologies, which allow the regions to have the agility and flexibility which they need in order to adequately serve the Nebraskans in their service areas. When I asked DBH leadership if there were any services they believed should not be moved to a fee-for-service model, they replied that no, all of DBH-funded services need to and should be moved to a statewide fee-for-service rate. This flies in the face of industry

best practices and ignores the obvious difference in service delivery between Omaha and Oxford, for example. Rural programs are simply not able to leverage the same economies of scale that are available in more urban areas. If implemented, this methodology will cripple our crisis and emergency-level services across rural Nebraska. Every single call to these services represents a potential Nebraskan life saved. These services need to continue to be available 24/7, regardless of how many people call or access this service. And these services need to be funded in a way that is not dependent on the volume of calls received. Our agency needs to be able to pay a therapist 24/7 if we want them to provide crisis services 24/7. We have to pay them the same salary, whether we receive one call or one hundred calls. So how can the payment methodology work on a fee-per-call or similar basis? I fear that we will be unable to continue these and other services under a strict fee-for-service model. I would ask that you continue to push forward with proposals to increase funding for behavioral health services to a sustainable level and ask the Department of Behavioral Health to acknowledge that there are real differences in service delivery and volume between rural and urban Nebraska, so a uniform state provider fee-for-service rate may not make sense for all services in all regions. Thank you, and I'm available for questions.

STINNER: Questions? Senator Cavanaugh.

CAVANAUGH: Thank you. Thank you for being here today. You mentioned at the end of your-- your statement about the fee-for-service and the 24-hour call. So has that been addressed at all with your organization as to how that would work? Because you'd have to pay a staff person for that. So is it truly that you would only, like, be reimbursed if you have a whole lot of people calling?

ROBERT SHUEEY: Well, that's the way it sounds. This hasn't actually fully been implemented yet and we're hoping that something can be done to prevent it.

CAVANAUGH: And how does it work right now?

ROBERT SHUEEY: Well, it-- our crisis servicers are-- are compensated on a expense reimbursement system, so we track all of the expenses required to provide the service and we're reimbursed for that cost. And there are certain things that are allowable and certain things that aren't. But at the end of the day, we-- they pay us what it costs to do the service.

CAVANAUGH: OK. Thank you.

STINNER: Senator Walz.

WALZ: Thank you, Chairman Stinner. I'm--I'm just curious. Can you describe what South Center Behavioral Services in Hastings is? What-- what do they do? Could you describe the services, I guess?

ROBERT SHUEEY: Yeah, and I would apologize. That is a typo on there, it should be South Central--

WALZ: Oh.

ROBERT SHUEEY: --Behavioral Services, not South Center. Yes, we're a Community Behavioral Health Organization, a nonprofit, and we provide outpatient counseling services for both mental health and substance use. We also provide psychiatric residential rehab for individuals with severe and persistent mental illness. We have an ACT team for individuals with severe-- severe and persistent mental illness. And we also provide community-based services, such as day rehab and community support for individuals out in the community and try to keep people out of the hospital.

WALZ: OK. How do you-- how do you get your referrals or how do people get to you, I guess?

ROBERT SHUEEY: A lot of different ways. And we have really close working relationships with Probation and so on. On the SA side we get a lot of our referrals from them. We also get a lot of-- we've worked very closely with the hospitals, particularly in Hastings and Kearney, and-- and they provide a lot of referrals to us, and we have close working relationships and are-- are involved with the health department in the region.

WALZ: Thank you.

STINNER: Tell me, who-- just trying to figure out what you're trying to say here. You got a daily rate increase due to this cost study, but you're saying that this Capacity Access Guarantee money was actually reduced, which kind of offsets all of the increase. Who reduced the CAG money?

ROBERT SHUEEY: Well, it came through the region, but from the department-- the Division of Behavioral Health. So they were providing us both the daily rate and the Capacity Access Guarantee money--

STINNER: Right.

ROBERT SHUEEY: --which the Capacity Access Guarantee is only accessible if our expenses exceed our income. Then we're able to show expenses and being reimbursed for those.

STINNER: Did they change the methodology or the formula for the CAG money? Is that what it was?

ROBERT SHUEEY: The CAG is capitated. They give us a line item on our contract for CAG and it's set a certain dollar amount that can-- we can't exceed that. That amount was lowered in almost exactly the amount that we gained by having the rate increase.

STINNER: What was the rationale for it?

ROBERT SHUEEY: That if they're paying us a better rate, we won't need

that money.

STINNER: How much of your budget is associated with this kind of activity?

ROBERT SHUEEY: I-- I wouldn't want to quote you a number, sir, without checking.

STINNER: Is it a large number? Is it medium-sized or just really small?

ROBERT SHUEEY: It's-- it's fairly large, I would say.

STINNER: So it's going to have a fairly significant impact on you because you still have salary increases and people that you have to pay an operating cost to go on and so on and so forth.

ROBERT SHUEEY: There are services that we simply may not be able to continue on a strict fee-for-service basis.

STINNER: [INAUDIBLE] OK. Anybody else? Senator Walz.

WALZ: I just have a couple of other questions. I don't know what CAG money is, where it comes from. What is-- what-- what is that? [LAUGHS]

ROBERT SHUEEY: It's Capacity Access Guarantee and it-- and much like Director Dawson spoke about, it was originally in place to support particularly more rural providers who may not have the volume of service to-- to be supported by a rate.

WALZ: State?

STINNER: Absolutely.

ROBERT SHUEEY: So as they-- as they take that money away and move to a statewide rate, you know, I have a feeling that that rate is like an average of different providers and the cost study. And it just simply costs more to attract people to work in a rural environment. There are economies of scale that we just can't access. There aren't as many people at our day rehab program in Kearney. That doesn't mean we shouldn't have a rehab program in Kearney.

WALZ: So then, if that money was taken away, was it disbursed to other programs? Or do you know what happened to it?

ROBERT SHUEEY: Well, I don't know exactly all the budgeting details, but I do know that in our-- specifically, in our psychiatric residential rehab program, it was almost a dollar for dollar move from the rate, from the money we will be able to bill with the rate, it was subtracted from the CAG. So at the end of the day our budget stayed flat in spite of the rate increase. Now some of the money, I think, went to help other programs. For instance, we were able to get a rate enhancement for our day rehab program, which has-- which has been very helpful. So I don't think that the division was-- is doing anything tricky.

WALZ: Uh-huh.

ROBERT SHUEEY: I just think that they have a certain amount of dollars to work with, and they're trying to do the best they can with it. Does that answer your question?

WALZ: Uh-huh.

STINNER: But in total, you're not getting an increase.

ROBERT SHUEEY: Not for that program specifically.

STINNER: How about for the-- in your total operation?

ROBERT SHUEEY: In our total operation we're not really getting an increase either--[INAUDIBLE]

STINNER: Because of the decrease in this, regardless how big of a budget. It was really put in place to keep-- because we don't generate enough volume in rural Nebraska to keep that program, which is an essential program, you are telling me--

ROBERT SHUEEY: I am.

STINNER: --in place. I just wanted to get that right, I think, Senator Dorn.

DORN: Thank you. Thank you for coming today. What-- what happens when you eliminate a program? What happens to the people that you serve?

ROBERT SHUEEY: Well, fortunately, we've not yet faced that-- that situation where we did have to terminate a program. We were-- we were seriously considering terminating our psych-- psych "res" rehab program, and it's been brought up in several board meetings, but we've always found a way to-- to keep it going through a-- through taking from other services and from other programs and-- but we can only do that so long.

DORN: Well, if the decision does come to eliminate a program, then where do they go?

ROBERT SHUEEY: Well, I imagine some of them would end up in jail. Some would end up in the hospital or group home settings. You know, I would hate to speculate, but I don't think it would be good.

DORN: But-- but they wouldn't be-- they wouldn't be served by the state then. Or is there another program out there somewhere that--

ROBERT SHUEEY: I believe there are three providers in the state of that particular program psych "res" rehab, of which we are one. I don't believe that there is capacity in those other programs to simply absorb the people we serve. Generally, we have a waiting list. So I would imagine they do, too.

DORN: Thank you.

STINNER: Additional questions? Senator Wishart.

WISHART: You mentioned having a waiting list. So what are the people doing? I'd imagine that that's a very immediate need if, somebody needs that service. So what does somebody do while they're waiting?

ROBERT SHUEEY: Well, we have community-based services in place, like community support. They do their best to keep them stable where they're at until they can get in. Some people are at the hospital until they can get in. Some people go to group homes for a period of time, but it's never-- it's never our intention to just park someone at a group home who could live successfully in the community. So we're-- we're constantly looking for those opportunities to get someone out of a group home environment who-- who has the potential to live on their own if they just get the skills they need.

WISHART: Yeah.

ROBERT SHUEEY: Did I get to your--

WISHART: Yeah. One other question. Do you-- we experience-- and it's a little off topic but since I have you here, I'm interested because some other legislation we've been working on-- do you ever experience when your patients or your clients are-- have found a medication sort of cocktail that works for them, that somehow they're no longer able to get certain kinds of medications, so they find something that works but they're through Medicaid, I think, or-- and all of a sudden, Medicaid isn't going to cover that specific drug anymore, so they have

to find something else and it disrupts their life?

ROBERT SHUEEY: Absolutely, and not just medications, particularly with Medicaid. This doesn't happen through our other services, generally, because the division is not just trying to cut every penny, I don't think, whereas the managed care organizations are. But they will, yeah, they will deny meds that have been working for a client for years because they need to try them at a different-- different medication if it's cheaper. And then oftentimes, they'll end up rehospitalized, they'll deny services for our ACT program, which was originally intended to be a service for life. Now we're lucky if we can keep a person in for a year or two, because the managed care organizations will-- will say we need to try them at a lower level of care. They generally end up being rehospitalized and then sometimes make their way back to us. Sometimes they never recover. The sad part of it is that sometimes they never get back to the same baseline they were at, when-- when they had our support in place. You know, a psychotic episode isn't something you just come out of and everything's fine.

WISHART: Yeah. How much is it for somebody to stay in your residential care, as opposed to a hospitalization? Do you have those numbers? I'd imagine they're pretty stark, in terms of how much more it is to hospitalize somebody.

ROBERT SHUEEY: It's certainly much more to hospitalize a-- I couldn't

quote you a number.

WISHART: OK, thank you.

STINNER: Any additional questions? Seeing none, thank you. Senator.

BOLZ: Senator, I-- I want to just briefly close because I think, sometimes, with these rate and rate methodology conversations, it's hard to walk away with-- with a clear takeaway. So as I see it, some of our takeaways are as follows. The first is the rate methodology, the rate update, is very important and sorely needed and a long time coming. So I think we can feel-- feel positive about, from a policy perspective, that that was well formulated, much needed, and that it was important that we move that forward. I think we also heard today that the fact that we applied that across the three systems, Probation, child welfare, and the Division of Behavioral Health, was also very important because we don't want to create false incentives for any of those different programs. So as we talk about rate changes, we need to bring all three along. The third takeaway is that there are still significant needs in services and specific individual services, like the Evaluation Services that we talked about earlier, that-- that most need an increase and that we need to look at in terms of where we go next to try to make our behavioral health system work better. And the last is what you heard from the last testifier, which is, well, I think some of our work achieved the goal of improving individual rates for individual services based on the rate study. We also have work to

do in terms of figuring out how our rate methodology not just helps improve individual rates, but also helps increase the resources for providers that sorely need them overall, especially those rural providers who do-- don't have the same efficiencies that you can see in urban areas. So I'm hopeful that those four takeaways are things that-- that come clear out of this afternoon's conversation and that we'll be able to continue to work on them together.

STINNER: Thank you. Questions? Questions? Seeing none, thank you very much.

BOLZ: Thank you.

STINNER: And that concludes our hearing on LR234. We will now proceed to LR179. Senator Cavanaugh. That's disappointing.

WALZ: It's terrible.

[BREAK]

STINNER: Senator, please.

CAVANAUGH: Good afternoon, Chairman Stinner, Chairwoman Howard. My name is Machaela Cavanaugh, M-a-c-h-a-e-l-a C-a-v-a-n-a-u-g-h. I represent District 6 in west-central Omaha, and I am here today to introduce LR179, an interim study to examine the fiscal impact of the Supplemental Nutrition Assistance Program, or known as SNAP, and childcare subsidies. I am once again standing between you and the end

of your day [LAUGHS], so I will talk very slowly and I will have 20 people behind me. No, I'm kidding. I think I have six people testifying behind me, so we-- we will all be home in time for dinner, hopefully, unless you have a longer commute, but both of these programs, SNAP and the childcare subsidies, play a critical role in helping support working families trying to pull themselves out of poverty, ensuring that they can feed their children and afford childcare for when they are at their jobs. At the same time, the increased household spending from these programs has a dramatic impact, with estimates of up to $1.70 in increased economic activity for every dollar of SNAP dollars spent. Similarly, the average childcare cost in Nebraska is approaching $8,000 a year. Childcare subsidies make it possible for one- or two-parent households to stay in the work force and contribute to the economy. Our current eligibility requirements create a disincentive for families to remain in the work force. This is commonly called the cliff effect, where families turn down promotions, raises, and so on, because the added income is much less than the benefits they will be forced to give up. Expanding our eligibility criteria and establishing a way for our families to slowly come off of the program, rather than falling off all at once, will strengthen both working families and Nebraska's economy. The testifiers behind me will go into more detail about the aspects and present data and solutions on how to solve the issues faced by beneficiaries of these programs. Thank you for your time and

I'm glad to answer your questions.

HOWARD: Thank you. Are there questions? Seeing none, our first invited testifier.

KATHY SIEFKEN: Good afternoon, Senator Howard and members of the Committee. My name is Kathy Siefken. K-a-t-h-y S-i-e-f-k-e-n. I am the Executive Director and registered lobbyist for the Nebraska Grocery Industry Association. And Senator Cavanaugh asked if-- that I come today and share information with you. Generally speaking, the grocery industry does not testify in support of expanding SNAP benefits. We stay away, generally speaking, from doing this simply because our members are the ones that directly benefit when those SNAP dollars are increased and spent in our stores, and our members do not want to be viewed as being so self-serving that we come here to ask you for additional funds. We don't think it looks right. We don't think it feels right. We try to represent our members in the way they expect us to. And generally speaking, typically we are here asking you to contain costs. However, what is happening out there in the state of Nebraska is-- is rather interesting, especially in rural Nebraska. Some of the numbers that I wanted to share with you are that $241 million are spent across the state in grocery stores and in farmers' markets that are authorized to accept SNAP payments. That is a lot of money. One hundred percent of that $241 million-- 100 percent of it-- comes from the federal government. Those benefits do not cost the

state of Nebraska. Nebraska's share, or cost, is only in the cost of distribution, and USDA picks up half that cost. So when you consider that we're getting $241 million that is spread across the state of Nebraska and our only cost as a state is half of the cost of distribution, I think we're getting a good deal. The people that benefit are the SNAP recipients because they can feed their families. Other people that benefit are the retailers and the communities in which they reside, because they are the folks that have the jobs and-- and provide those products to people in the community. So in that regard we believe that this is-- the SNAP dollars that we get are a very good thing for our state. But there's another thing that I want to talk about, and Senator Cavanaugh mentioned it, and it is the cliff effect. And we are experiencing that in businesses, in our retail stores. It is no secret that we are an entry-level industry. We take people with no skills. We train them. We give them skills. They move up. They move on. Again, we are-- we are entry-level. What happens in our industry is our owners and our store directors are offering promotions. They're offering raises. They're asking people to work overtime. We have a labor issue out there. And the people that are using benefits are refusing to work those extra hours. They're refusing to take increases in their pay. And the reason for that is, if you-- if someone is getting $200 a month in benefits and you offer them a 50 cent an hour rage-- wage increase, which is a pretty decent increase in, say-- in a raise. What happens is that 50 cents, if

they're working 40 hours a week, turns into $20 a week extra, which is $80 a month. But it puts them over the limit. They become ineligible for benefits. They lose $200 worth of benefits for an $80 wage increase. They can't afford to be promoted. They can't work their way off the system. And this problem will not go away until Nebraska changes the-- the federal-- or the poverty-- level from our current 130 percent up to 185 percent. So there have been bills introduced in the past, and I would urge you strongly to look at those bills, because it will fix a problem that in the long run will cost everyone less. It will raise people up and it will-- it will fix things better than anything else we're doing. So if you have any questions, I'd be happy to answer.

HOWARD: Thank you. Are there questions?

KATHY SIEFKEN: I was that thorough?

HOWARD: Seeing none, thank you for your testimony today.

CLEMENTS: I have a question.

HOWARD: Oh, Senator Clements.

CLEMENTS: You mentioned-- 185 percent-- is the next level or the 158?

KATHY SIEFKEN: One eighty-five would be ideal. And maybe you have to stairstep it to get there, but 185 percent of the federal poverty level is really where we need to be where we don't-- where we get rid

of the cliff. As long as the cliff is there and people are making less money or they have-- let me-- they bring in less revenue--

CLEMENTS: Yeah.

KATHY SIEFKEN: --through benefits or income they won't take those jobs and they won't work the extra hours.

CLEMENTS: Is 185 the maximum federal allowable percentage?

KATHY SIEFKEN: Someone behind me might be able to answer that.

CLEMENTS: All right, [INAUDIBLE].

KATHY SIEFKEN: I-- I really don't know that.

CLEMENTS: Thank you.

STINNER: Additional questions? Seeing none, thank you.

KATHY SIEFKEN: Thank you.

STINNER: Good afternoon.

TIFFANY FRIESEN MILONE: Good afternoon. Chairperson Howard, Chairperson Stinner, members of the committees, my name is Tiffany Friesen Malone, T-i-f-f-a-n-y F-r-i-e-s-e-n M-i-l-o-n-e, and I'm policy director at OpenSky Policy Institute. I'm here to speak to the economic-- impact of the Supplemental Nutrition Assistance Program within Nebraska. Excuse me. SNAP functions as an important

public-private partnership, helping families afford a basic diet while also generating business for retailers. The more than 1,200 authorized retailers in the state redeemed roughly $234 million in benefits in fiscal year 2018. According to Moody's Analytics and the U.S. Department of Agriculture, $1 in SNAP spending generates about a $1.70 in economic activity during a weak economy. This means that had Nebraska been experiencing a weak economy in 2018, the $234 million received by retailers would have generated $398 million in overall economic activity for Nebraska. This is called a multiplier effect. The multiplier effect works as follows: in an economic downturn, many households have less money to spend, causing business at local stores and restaurants to decrease. These businesses now have less money to spend, furthering the downturn. To get by, some households may enroll in SNAP, which gives them more money to spend at the local grocery store. Every dollar spent there helps the store recover. More revenue means the store can hire back staff, make improvements, and purchase more food from farmers and distributors to meet increased demand. As the increased spending from SNAP flows through the economy, each sector receiving a share of that additional money is able to spend more. A May 2019 study by the USDA looked at the impact of SNAP redemptions on county-level employment-- found that during the Great Recession, one job was created for every $10,000 in SNAP benefits redeemed within nonmetropolitan counties. Further because SNAP benefits can only be spent on food, money is often freed up for other

goods and services, helping other local businesses recover and raising sales tax revenue for state and local government entities. As many economists are predicting a national recession in 2020, the state may want to consider using SNAP to put itself in the best position to recover quickly. We could do this by broadening eligibility to those with higher incomes through what's called broad-based categorical eligibility. Forty-two states have this type of eligibility and use it to alter SNAP rules in a number of ways, including changes to asset and income limits. Nebraska currently uses broad-based categorical eligibility to increase the asset limit for some households but hasn't used it to increase income limits to expand eligibility. We're one of nine states to have kept the gross income limit at 130 percent of the federal poverty level. One hundred thirty percent would be about $2,720 a month for a family of four, 17 other states have expanded all the way to the 200 percent maximum, which would be $4,292 a month for a family four. And the states that have gone to 200 percent include Colorado and North Dakota. The remaining stick-- 16 states have a gross income limit of somewhere between 130 percent and 200 percent. Expanding SNAP income limits doesn't come at a high cost to states because, as Kathy said, the federal-- federal government pays 100 percent of the benefits and splits the cost of administering the program with states. For reference, more than $220 million in benefits were issued to Nebraska residents at a cost to the state of $19 million in administrative expenses in fiscal year 2019, which means

that for every $1 the state spent, Nebraska residents received $12 that contributed to the local economy. Increasing the gross income limit will also smooth out what's known as the cliff, where an increase in earnings causes a household to lose eligibility. If the increase in earnings was less than what the household was receiving, in benefits, the household would see a decrease in its total income, which is earnings plus SNAP, once it became ineligible for SNAP. Using this drop-off would allow workers to accept higher paying work or increased hours without worrying about losing eligibility. SNAP is proving to be a strong stimulus during economic downturns. With the recession on the horizon, we think it's worth exploring an expansion of SNAP, which would have minimal cost to the state but significant benefits to Nebraska's residents and economy. With that, I'm happy to answer any questions.

STINNER: Thank you. Questions?

WALZ: I have a question.

STINNER: Senator Walz.

WALZ: Sometimes my questions are just so simple. I'm just wondering, what would be the-- what would be the downfall, except for the administrative expenses, of increasing the federal poverty rate to 185 percent? What would be the other downfall to that? Does that question make sense?

TIFFANY FRIESEN MILONE: It does. I don't know that I see a downfall. I think the increase in administrative expenses would be minimal and there is a bill in 2015. I think it's LB411 that would have increased it to 185 percent of the federal poverty level and it would have affected, I think, just under 5,000 families at a cost to the state of under $500,000.

WALZ: OK. Thank you.

STINNER: I have to make a comment. My Republican side is just killing me right now. [LAUGHTER] The $200 million coming out of the federal government, his tax dollars. The federal government's running a deficit; that would increase the federal deficit. That's the downf all. Thank you.

TIFFANY FRIESEN MILONE: Categorical eligibility does comprise a small percentage of overall SNAP spending at the federal level. It ranges from 2 to 5 percent.

STINNER: Thank you. Additional questions? Thank you.

[BREAK]

JULIA TSE: Good afternoon. For the record, my name is Julia Tse, J-u-l-i-a T-s-e. And I'm here to-- T-s-e, and I'm here today on behalf of Voices for Children in Nebraska. While we support efforts to strengthen both SNAP and childcare, I'm going to focus my comments

specifically to childcare but would be happy to answer questions on both. We all know that quality early childhood programs give children the best chance to be successful and productive later in life. But balancing work and childcare is challenging for many parents. The childcare subsidy program, sometimes referred to as Title XX, helps put childcare costs within reach for working parents who are struggling to make ends meet. But current policy prevents many Nebraska parents from accessing it. Over the years Voices for Children has heard from many Nebraska parents who are distressed by the cliff effect and the childcare cliff effect is particularly steep in Nebraska. One of the biggest issues is that eligibility for childcare assistance in our state is far out of line with a living wage. Eligibility for the subsidy in Nebraska is currently at one of the lowest levels in the country. There are only a couple of other states that have it where we have it, at 130 percent of federal poverty, and all of our surrounding states have set it at a much higher level. Secondly, Nebraska is one of the least affordable states for childcare when compared with average median income. For example, a single parent of one infant working full-time at an hourly wage of $12 would not be eligible for a single cent of childcare assistance, even though her costs for home-based care would be well over half of her annual income. To my testimony I have attached some data that has information as specific as if you'd get it to legislative district that might fill in some of the questions that you have about how it looks in your

district. The consequence of this failure in public policy is significant for Nebraska families and for our state. Parents of young children are faced with a couple of very difficult choices to choose from: take on a second and sometimes a third job to cover the costs of childcare, spending even more time away from their children; they can turn away a raise or promotion that might offer more stability tomorrow in order to pay the bills today. They might also choose an unlicensed childcare provider where there-- they might not be sure that that person is trained or has the capacity to adequately care for their child. I've shared a recent report that includes stories of how some Nebraska parents have made these exact decisions. Just over 4,200 Nebraska parents quit, did not take, or significantly changed their job due to childcare issues in 2016. Data suggests that this contributes to significant administrative overhead and instability for families and workers. Parents receive subsidies for an average of just seven months in Nebraska before they lose eligibility, and indeed, a 2014 federal report found that nearly two-thirds of families that were applying for assistance had already previously applied for and received assistance, but for some reason were kicked off of the subsidy program. The effects of Nebraska's childcare crisis have compounding effects for our state's economy and budget. A recent study found that the national economic impact of this crisis is $57 billion lost annually in lost earnings, productivity, and tax revenue. Similar economic impact studies have been conducted at a state level and

confirm those same findings for state economies and state tax bases. The most effective solution to the childcare crisis in our state is to restore initial eligibility for childcare subsidies in Nebraska, and I say restore because, up until 2002, we offered childcare subsidies to families earning up to 185 percent of federal poverty, but then-Governor Johanns line-item vetoed this program with the promise that someday in a better budget year we'd get back to supporting working families. And there's been some conversation about what's the right level. Generally 185 percent to 200 percent is much closer to a living wage. And because we have a lower cost of living generally in Nebraska, 185 percent is a great number to start with. Childcare subsidies, much like SNAP benefits, are offered at a sliding fee scale, so any families newly eligible under a-- a change would be required to make a copayment in order to receive the subsidy. A new Urban Institute study modelled the-- the impact of raising childcare eligibility to just 150 percent of federal poverty. And in Nebraska, researchers estimate that 1,500 Nebraska mothers would enter the work force and 3,300 fewer Nebraska children would be living in poverty For an overall reduction of 6 percent in our child poverty rate. We want to thank Senator Cavanaugh for her commitment to this issue and the members of the committees for their time and consideration. I'll be happy to answer any questions.

STINNER: Thank you. Questions?

CLEMENTS: Hey.

STINNER: Seeing none-- oh. Excuse me, just--

STINNER: [INAUDIBLE]

CLEMENTS: --[INAUDIBLE] The handout you-- where did you get most of the information, I guess, or how, so forth--

JULIA TSE: Sure.

CLEMENTS: --[INAUDIBLE] numbers?

JULIA TSE: Yeah. So I will go column by column. The first column is census data. So that is true-- that is real information by legislative district; some of these are county-level data. The second column-- or sorry, the fourth column, three- to four-year-olds in school is also census data. The fifth column, childcare capacity, so that would be the number of spaces that are available in your county, the counties that your legislative districts overlap in, per 100 children under 6 with all available working parents-- with all available parents working. And that's another thing that I failed to mention is that Nebraska is generally in the top five for work force participation. So that's really great to see. The children in poverty is also census data. And then the last two are-- they are based on market rate surveys that the department completes every two years. And so that is information that they collect from all of the providers in the state.

And I think that that one, that number is the 50 to 70-- 75th percentile. So that represents, like, your average costs. The footnote should explain our assumptions: how many days and how many hours per year we would assume.

CLEMENTS: Thank you. Thank you.

JULIA TSE: Uh-huh.

STINNER: Thank you. Questions? Seeing none, thank you.

JULIA TSE: Thank you.

STINNER: Hello.

JENNNIFER CREAGER: Hello.

STINNER: Good afternoon.

JENNNIFER CREAGER: Good afternoon, Chairman Stinner, Chairman Howard, members of the committees. I'm Jennifer Creager, J-e-n-n-i-f-e-r C-r-e-a-g-e-r, senior director of public policy at the Greater Omaha Chamber. I'm also authorized today to offer this testimony on behalf of the Lincoln Chamber of Commerce, as well. We want to thank Senator Cavanaugh for bringing this to the committee. Over the last several years, as we've seen rebounding economic growth, employers in Nebraska have an increasing number of positions to fill, and that has led to more and more businesses becoming aware of the conundrum of the cliff effect problem. Excuse me. Employers are offered promotions, pay

increases, and additional hours, and some employees are faced with very difficult decisions, and you've already heard that in testimony today. Take the promotion, take the pay increase, move from part- to full-time, but losing the assistance that-- that has been helping to get them by. For some that becomes really no choice at all. As much as they want to do this, the earnings increase does not come close to covering the costs of expenses such as childcare. Although we know the cliff effect exists in other public programs, we do hear most about the childcare expenses. As you have frequently heard, probably it's often a family's highest single monthly outlay. When I had two children in day care, I used to call it my beach house. It was more than my mortgage. And that is why we consider this a priority in finding a solution. We're certainly not experts in this area of policy, but as we have talked about this, one concept we have favored is moving from cliffs to a more gradual step-down in assistance. That could be extending the initial income eligibility limit and then instituting a stair-step lowering of the subsidy as income rises. Perhaps that starts at 140 percent of poverty and reaches to 200 percent. The exact parameters might depend on finding an appropriate level of pay that approaches meeting average childcare costs. Maybe this is done through the present copay system, again by extending the initial eligibility limit and then gradually increasing copays until the family is able to cover the costs. As you consider this, we would ask that you also look to the overall economic effect that this would

have. Low-income families do pay taxes; higher earnings for those families mean that they would be paying more in taxes. This should be part of as-- of the estimating what this might cost. In the bigger picture, though, there is an immeasurable value-- excuse me-- immeasurable value in getting people on career paths that need-- that lead to economic stability. This involves everything from state revenues to the general quality of life in Nebraska that comes with getting families out of the poverty cycle, even if it is one family at a time. Fixing one of the assistance cliffs is not going to solve everything, but it's one of the pieces of the puzzle. Put together the combined efforts of the Legislature, nonprofits, and the business community can go a long way. Thank you for your time today.

STINNER: Questions? Do you recall Senator Cook introduced legislation either my first or second year--

JENNNIFER CREAGER: Yes.

STINNER: --to deal with at least one step-down. Where are we?

JENNNIFER CREAGER: So that was LB81 in 2015--

STINNER: OK.

JENNNIFER CREAGER: --and that passed, and-- I'm-- anything I say on this policy specifics you should take with a grain of salt because, obviously, this isn't my usual wheelhouse, but as I recall, that

instituted a two-year transitional period up from 130 percent of initial eligibility. But then if you passed 130 percent, up to a 185 percent you had to 2-- 24 months to be able to continue receiving the assistance if you went over that initial income level. I -- I believe last year the Legislature passed a bill, due to some conforming with some federal changes, that got rid of the two-year eligibility period, just the time limit. But I think it, if I'm correct, and again, please double-check me, that they can still remain-- still remain-- as long as they initially are under 130 percent when they apply, if they go up to somewhere below 185 percent they can continue to receive those benefits, and not just for 24 months but for as long as there are-- I think until they exceed 185 percent, so--

STINNER: OK. Any additional questions? Senator Clements.

CLEMENTS: Thank you, Mr. Chairman. Thank you for being here. I had a question about the businesses, we've heard are really looking for employees and are having trouble retaining them. Has the Chamber found that businesses are more apt to start subsidizing childcare through the business or--

JENNNIFER CREAGER: Yeah, I think-- I--

CLEMENTS: --providing benefits?

JENNNIFER CREAGER: I do think we see that as a talent-- just as a talent recruitment piece in lots of different companies. I think

there's companies that offer childcare on-site and people-- companies that offer just some kind of childcare assistance as part of their benefits package. So I think companies-- I know everyone is competing for workers and they're all just trying to get more creative in ways that it makes a difference to people, you know, to make the employment of that company more attractive than a different company.

CLEMENTS: Thank you.

JENNNIFER CREAGER: Sure.

STINNER: Additional questions? Seeing none, thank you.

JENNNIFER CREAGER: Thank you.

JORDAN RASMUSSEN: Good afternoon, Chairman Stinner and Chairwoman Howard, members of the Committee. My name is Jordan Rasmussen, J-o-r-d-a-n R-a-s-m-u-s-s-e-n. I serve on the policy team at the Center for Rural Affairs. In rural Nebraska, where our food is grown to meet the needs of the nation and the world, food security is a challenge for some of our residents. The Supplemental Nutrition Assistance Program exists to alleviate the prevalence of food insecurity. Yet in our rural areas of the state, participation in SNAP remains low, despite our social-- socioeconomic shifts that have increased the need. While Nebraskans who participate in SNAP have incomes in line with national figures, overall participation rates fall below national trends. Nebraska ranked 39th in SNAP partition--

participation in 2016, with 76 percent of eligible SNAP households participating. Nationally, 83 percent of those eligible for SNAP participate in the program. When consideration is given to the rural-urban residency of Nebraska-- of Nebraska's SNAP participants, further variances emerge. According to five-year averages, in 2017, 8.8 percent of the state's households enrolled in the SNAP program. In rural areas, that was only 6.4 percent. The percentage of rural Nebraska households enrolled in SNAP is particularly concerning when compared to the percentage of households that are at or below 100 percent of the federal poverty level. In the state's rural areas, 11.6 percent of households are at or below the poverty line. And this figure does not account for those that may currently be eligible for SNAP with growth-- gross incomes at 130 percent of poverty before deductions. Returning to the report that Tiffany referenced before that was released-- released by the Department of Ag earlier this spring, it took a look to see how-- how SNAP impacts our rural communities. SNAP participation grew exponentially between 2001 and 2013, obviously coinciding with the Great Recession and its aftermath. Participation in our state peaked in 2013, when more than 170-- 179,000 Nebraskans received SNAP assistance and it protected thousands of our residents from the extremes of poverty in that moment of crisis. The impact of this investment for a rural community, though, is multifold. The report found that for every $22,000 in SNAP redemptions during the recession, an increase in one rural job

resulted. In 2010, the rural Nebraska counties of Cherry, Sheridan, and Dawes saw the state's greatest levels of SNAP spending per capita, increasing access to food necessities and employment. The analysis also identified a glaring gap in rural Nebraska's ability to utilize and multiply the benefits of their SNAP dollars, as 36 of the state's 93 counties have fewer than four SNAP retailers. Nationally, the same level of redemptions during this period of time in urban areas increased employment by only .4 jobs. Through the recession, SNAP spending had the greatest impact on local employment of all government assistance programs, including infrastructure projects. This impact has lessened in subsequent years. What the report affirms is what we see in rural Nebraska. SNAP dollars are spent immediately in our local grocery stores and retailers, and kick-- kept in our community as assets for all residents. SNAP purchases stimulate employment in food prossing-- processing and distributing industries, which are also concentrated in rural communities. There are further radiating impacts of SNAP participation, including improved health outcomes for our children and elderly, as well. As we continue to look at our rural and agricultural economy remaining relatively bleak here in the coming years, the need for nutrition assistance in our rural communities is going to continue to increase. And we ask that the Legislature continue to be observant of that and make investments of, and-- and expand-- expand our opportunities to participate in the SNAP program.

STINNER: Thank you.

JORDAN RASMUSSEN: Thank you for your time.

STINNER: Questions? Seeing none, thank you.

JORDAN RASMUSSEN: Thank you.

CAVANAUGH: Thank you--

STINNER: Senator.

CAVANAUGH: -- Senator Stinner. So I think we've heard some interesting information about both SNAP and the cliff effect, and I wanted to comment on a few things that we heard today. So as I think everyone knows, I have children, more than just the one [LAUGHS]. I actually have three children: Della's five, Harriet is four, and Barrett is, unbelievably, 14 months now. And Della, my true baby, started kindergarten this year, which I'm still trying to grapple with that [LAUGHS] change in my life. But-- I worked full-time and my husband worked full-time, and then on January 8, I resigned from my job because I worked for the university. And I was sworn in on January 9-- so I became a still-- what I would consider a full-time employee of the state, just paid not very well. So it's no secret that the Legislature makes $12,000 a year. My childcare costs, when I had all three children in childcare during session last year, was over $3,000 a month. So after taxes I make $911 a-- a month. So for the bankers,

mathematicians, it's been-- it's been challenging, and my family-- not even at 185 percent would not qualify, which I'm grateful that my husband makes enough that we can cobble together paying for these things. But I understand how real that struggle is, and I make well above-- our family income is well above the poverty level and we don't do too many activities outside of visiting family across Nebraska. So it's-- it's a real-- it's a real issue. And to think that my husband, if-- if we had to-- that my husband would have to turn down a pay increase or God forbid, the Legislature gets paid more, then I would have to turn that down, is-- is disconcerting because I would hate to have to do that. I would hate to have to off-road our professional development, just so that we could continue to afford childcare. So thankfully I'm down to two kids in childcare [LAUGHS]. But it's a-- it-- it-- it's tough, it's very tough for families, and I understand that very, very, well. Chairman Stinner, you had asked-- well, actually I think Senator Walz asked a question about the downside to expanding SNAP and you mentioned the federal tax dollars. And I just wanted to add to that statement that yes, these are federal tax dollars that we all pay. They're federal tax dollars that everyone pays across the country, and we currently are not drawing down tax dollars that we are paying into the system at the same rate as other states. So in effect we are subsidizing what other states are doing by not participating at the same level. And we are also losing income tax revenue at both the state and the federal level when we aren't

allowing our work force to take an increase in-- in pay. So it's-- it's-- it's complicated, basically. So there's-- there is the downside of we are increasing federal spending, but there's also the downside of we are losing out on income tax revenue, both state and federal. And I just wanted to highlight that for everyone. So the reason I brought this interim study was, we've had a lot of conversation in the body about, you know, fiscal notes. Fiscal notes are kind of a dirty word in the Legislature, and we all try to avoid them. We're trying to be judicious with the spending that we have for tax dollars. But I thought we had an opportunity here to think creatively and think about ways that we can not only address the fiscal note issue, but also address the revenue problem that we have in the state. And increasing individuals in the state, increasing our work force's ability to make money and increasing our work force's ability to have economic security and stability is only good for the state. So I think that this is a good opportunity for us, as-- as legislators, to think about how can we be creative in not just extending benefits but also addressing that cliff effect that we've heard about. There are other states that are doing some creative things, especially with SNAP, where, like, your first automobile doesn't count as an asset against your benefits, so that you can get to work and not be penalized for your benefits for that. Or allowing you to not-- when you get a pay increase, to not have that count against your benefits for six months so that you are saving money, so that you're preparing for when your

benefits are stepping down. So just some longer term strategic planning things that we're seeing in other states across the country, and I think it's an opportunity for us in Nebraska to do some creative thinking, as well. We're a state that places-- places a pretty big premium on families and hard work, and there is a great deal to be said about dignity and work, and people who are receiving these benefits want that same dignity that everyone else wants. They want the dignity to provide for their families and to know that their kids are taken care of when they're at work and when they're part of the work force, and that they can work hard and get promoted and that that's not going to hurt their families. So I appreciate everybody's time today, and I know it's been a long day. So if you have any questions--

STINNER: Questions? Seeing none, thank you.

CAVANAUGH: Thank you.

STINNER: We will enter a letter to the record on LR1-- LR179 from The Women's Fund of Omaha. That concludes our hearing on LR179 and our hearings for today. Thank you for [INAUDIBLE].