Does not include written testimony submitted prior to the public hearing per our COVID-19 Response protocol

STINNER: Welcome to the Appropriations Committee hearing. My name is John Stinner. I'm from Gering and represent the 48th Legislative District. I serve as Chair of this committee. I'd like to start off by having members do self-introduction, starting with Senator Erdman.

ERDMAN: Thank you, Senator Stinner. Steve Erdman, I represent District 47; that's ten counties in the Panhandle.

CLEMENTS: Rob Clements, District 2: Cass County and parts of Sarpy and Otoe.

McDONNELL: Mike McDonnell, LD5: South Omaha.

HILKEMANN: Robert Hilkemann, District 4: West Omaha.

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

DORN: Myron Dorn, District 30: Gage County and southeast part of Lancaster.

STINNER: Assisting the committee today is Brittany Sturek, our committee clerk. And to my left is our fiscal analyst-- analyst, Liz Hruska. For the safety of our committee members, staff, pages and the public, we ask that you-- those attending our hearing to abide by the following. Submission of written testimony will only be accepted between 8:30 and 9:30, in the respective hearing room where the bill will be heard later that day. Individuals must present their written testimony in person during this time frame, and sign and submit written testimony record-- for the record, at the time of submission. Individuals with disabilities can designate a person to submit their written testimony. Due to social distancing requirements, seating in the hearing room is limited. We ask that you only enter the hearing room when it is necessary for you to attend the bill hearing in progress. The bills will be taken up in order posted outside the hearing room. The list will be updated after each hearing to identify which bill is currently being heard. The committee will pause between each bill to allow time for the public to move in and out of the hearing room. We request that everyone utilize the identified entrance and exit doors to the hearing. We request that you wear a face covering while in the hearing room. Testifiers may remove their face

covering during their testimony to assist the committee members and transcribers in clearly hearing and understanding the testimony. Pages will sanitize the front table and chair between testifiers. Public hearings for which attendance reaches seating capacity or near capacity, the entrance door will be monitored by the sergeant at arms, who will allow people to enter the hearing room based upon seating availability. Persons waiting to enter a hearing room are asked to observe social distancing and wear a face covering while waiting in the hall-- hallway or outside the building. To better facilitate today's proceeding, I ask that you abide by the following procedures. Please silence or turn off your cell phone. Move to the front row when you are ready to testify. Order of testimony: introducer, proponents, opponents, neutral, closing. Testifiers' sign-in: hand your green sign-in sheets to the committee clerk when you come up to testify. We ask that you spell your name for the record before you testify. Be concise. It is my request that you limit your testimony to five minutes. We may change that as we go because we have a time constraint on us. We have to be out of here by 1:30. Obviously, the next hearing will start at that time. If you will not be testifying at the microphone, but want to go on the record as having a position on the bill being heard today, there are white sheets at the entrance where you may leave your name and other pertinent information. These sign-in sheets will become exhibits in the permanent record, at the end of today's hearings. We ask that you please limit or eliminate handouts. Written materials may be distributed to committee members as exhibits only while testimony is being offered. Hand them to the page for distribution to the committee and staff when you come up to testify. We need 12 copies. If you have written testimony but do not have 12 copies, please raise your hand now so the page can make copies for you. With that, we will begin today's hearings with Agency 025, Department of Health and Human Services. I guess the first one is medical long-term care, I believe is what's on my list. I don't know if that's the way you guys look at it, but we have today Public Health and Operations, also. So--

KEVIN BAGLEY: Good morning.

STINNER: Morning.

Does not include written testimony submitted prior to the public hearing per our COVID-19 Response protocol

KEVIN BAGLEY: Chairman Stinner, members of the Appropriations Committee, my name is Kevin Bagley, Ke-v-i-n B-a-g-l-e-y. I'm the director of the Division of Medicaid and Long-Term Care in the Department of Health and Human Services. I'd like to begin today by thanking Chairman Stinner, the members of the committee, and your staff for working together with us. Medicaid is a significant portion of the state's budget and has significant impacts on the more than 300,000 beneficiaries currently eligible for Medicaid coverage. Our division is committed to serving Nebraska's most vulnerable residents, and has worked with the Governor on a responsible budget to continue that work. Before I begin, I'd like to discuss some recent developments surrounding our Medicaid expansion 1115 waiver. It's become clear to us, in recent conversations with CMS, that they will not provide a decision on the waiver implementation plan we submitted in December 2020, in time to begin the wellness and personal responsibility requirements on April 1st, as previously planned. While the waiver itself was approved in October 2020, approval of the waiver implementation plan is required before we can put in place the mechanisms that would allow us to have those demonstration participants receive those prime benefits. We're working with our federal partners at CMS to resolve their outstanding concerns so that we can move forward as quickly as possible. The Governor has proposed a responsible budget for the Division of Medicaid and Long-Term Care. The Governor's budget recommendation for state fiscal year 2021-2022 totals approximately $2.8 billion, of which $911 million is state General Fund. For state fiscal year 2022-2023, the Governor's budget recommendation is $2.9 billion, of which $946 million is state General Fund. I would like to highlight a few adjustments to Medicaid's appropriation in our budget recommendation. The department requested approximately $2.7 million general-- in General Fund for the upcoming biennium to cover ongoing CHIP utilization costs, following the phase-out of enhanced Federal Medical Assistance Percentage, or FMAP, for Program 344. The enhanced rate was originally put in place through the Affordable Care Act and expires on September 30 of this year. Additionally, the budget recommendation includes a request for just under $39 million in General Fund for state fiscal year 2022-2023, for increases in the Medicaid Program 348 utilization. This utilization is the result of increased number of individuals eligible for Medicaid, a mix of membership, and resulting increases in the number of services

utilized, as well as payments to our managed-care organizations covering those additional beneficiaries. The Medicaid Division also requested approximately $181,000 in General Fund in state fiscal year 2022-2023, to implement LB323, which was passed in August 2020, which changed the eligibility standards for the Medical Insurance for Workers with Disabilities program. Medicaid did not receive previous appropriations for this program, which has an effective date of October of this year. I also want to provide an update on the status of the temporary enhanced FMAP associated with the maintenance of effort requirements during the declaration of the COVID-19 public health emergency. The department has received an additional 6.2 percent of FMAP since January 2020, which is formally in place until at least June 30 of this year, though the new federal administration has signaled that they intend to continue that declaration of public health emergency through the end of this year, which would result in receiving that additional enhanced FMAP through December 31st of this year. Included in the Governor's budget recommendation was a reappropriation of General Funds generated from the enhanced FMAP in the current biennium, to fund the request in the first year of the upcoming biennium. The department would ask that the Appropriations Committee adopt this approach in the Appropriations budget rather than appropriating new funds. We understand this to be the case with one exception, where the committee appears to fund $117,000 for implementation of LB323 in state fiscal year 2021-2022, with a new appropriation rather than reappropriating the existing funds. Finally, we'd like to provide an update on provider rates Given the uncertain economic forecast amidst the COVID-19 pandemic and the uncertainty surrounding its impact to the Medicaid program budget, the department did not put forward a specified provider rate increase request. The department reviews existing rates against a variety of other state Medicaid programs, as well as other payor sources. Upon request, the department may even conduct a more in-depth rate study for specific services. In the event the department determines a given rate is not appropriate, we are able to take appropriate and responsible actions, and adjust those rates as needed. In conclusion, we support the Governor's budget recommendation, which provides the necessary resources to continue our focus on covering the healthcare needs of our Medicaid beneficiaries, with an eye on improving the experience and outcomes of our population served. Thank you for your

consideration on these items. I'd be happy to answer any questions you have.

STINNER: Questions? Senator Hilkemann.

HILKEMANN: Thank you, Mr. Bagley. I'd like to go back on your third-- on the third paragraph of your testimony, just a little-- a little bit more on the Medicaid expansion waiver.

KEVIN BAGLEY: Yes.

HILKEMANN: It was my understanding, from what-- just what I've read is-- is that-- that they aren't going to approve that waiver.

KEVIN BAGLEY: So it's been an interesting conversation, and that's a great question. So there-- there are a few elements that are all moving at the same time on that. The first is, we received that approval of the overall waiver request in October, and we've been working with CMS since then on our implementation plan. In addition, we received that letter from CMS on the 12th, outlining their concerns with the community engagement requirement, as well as some of the other requirements. We-- we believe those to be the wellness and personal responsibility requirements, though they weren't called out by name in that letter. Regardless of whether or not we received that letter, we were still waiting on that approval of the implementation plan, which appears to be on hold at this point, based on our conversations. So we aren't going to be able to move forward and hit that April 1 date. In addition, as we read that letter from the 12th, we believe CMS may have some concerns with those requirements that we'll need to discuss with them in order to move forward. So really, at-- at this point, I think we are going to need to resolve those questions with CMS before we figure out how we move forward.

HILKEMANN: So is your plan at the present time just to go with the Medicaid expansion program period and not try to put in the wellness program?

KEVIN BAGLEY: So right now, as it's currently set up, we have about three quarters of the members that have come in through that expansion

program in that basic benefit tier. They would continue in that benefit tier until we reach a resolution on-- on the waiver.

HILKEMANN: So you're saying about 75 percent are already in-- into the program?

KEVIN BAGLEY: Yeah, and so--

HILKEMANN: It would be another 25 percent that might be able to be opted into the-- to the other.

KEVIN BAGLEY: So we have approximately 35,000. I'm going to give a pretty approximate number there. I haven't seen the numbers.

HILKEMANN: So the optional services that were being taken-- that were going to be provided if people were part of the wellness program, are they going to be provided to everybody at this point now?

KEVIN BAGLEY: They will not. So about a quarter of the folks that have come in, of that 35,000 that we've seen coming through expansion, automatically qualify for those benefits. They're 19- and 20-year-olds, pregnant women, or they qualify as medically frail. In those cases, they automatically qualify for that prime package. And then the other 75 percent of those folks will remain in that basic benefit tier until we can resolve this with CMS.

HILKEMANN: That's another question I had. Thank you for saying you had 35,000 people. When we-- when this bill was being presented to us as a legislative process, we had members from about the-- I think the low number was 75,000 people that were going to be affected by this. And we had people like 125,000. Where'd they all go?

KEVIN BAGLEY: You know, that's a great question. One of the things that we've seen in a lot of other states, and in the conversations I've had with other states, and my experience in the state of Utah when I worked there, was that there is a little bit of a runway in terms of getting those folks to that number. A lot of other states we've seen that have--have started-- I'll say later in the process-- with expansion, have typically seen 15 to 18 months of build-up before they reach those final numbers. We anticipate that'll be the case here.

HILKEMANN: So you are saying, when you come before us next year, you'll be saying that we will be maybe closer to the 75,000 that we originally had talked about?

KEVIN BAGLEY: I believe so.

HILKEMANN: OK. Thank you, Mr. Chairman.

STINNER: Any additional questions? Senator Kolterman.

KOLTERMAN: Thank you, Senator Stinner. Thank you for being here today. I have-- it kind of plays along those same lines of what Senator Hilkemann was just asking about. When-- when the program was being developed, you came up with an eligibility and enrollment system. What's the status of that today? What are you utilizing to get that? And where do we stand with-- I think originally there were some challenges with Wipro on that. Where does that all stand?

KEVIN BAGLEY: Yeah, there's a-- there were some-- some difficulties with Wipro, and there is continued work on that front. The system we currently--

WISHART: Can you explain what-- can you explain what Wipro is?

KEVIN BAGLEY: So that was-- and I'm going to have to refer to my notes just a little bit since that predates my tenure here. But I believe that was the vendor that was leveraged to do a lot of that system development previously. There were some difficulties in-- in getting that done. My understanding is that we've since moved on from that, and-- and we're working on doing some additional development to replace aspects of our, I would say, antiquated system that we currently use. It functions. It works. It's definitely end of life. So I guess the broad answer to your question, Senator, is there's continued work on that front. It's not impeding our ability to get people into services right now, but there are definitely efficiencies to be gained and increased levels of customer service to be had by moving in the direction of that improved system.

KOLTERMAN: So-- so in essence, when the Wipro situation failed and you cut ties with Wipro, you didn't go out for a new bid to get a different contractor. Is that what I'm hearing you say?

KEVIN BAGLEY: I may have to get back to you on the details on that, Senator. I don't think I'm quite well versed enough in that yet to be able to answer that accurately without potentially misstating anything.

KOLTERMAN: That's fine. Can I continue on?

STINNER: Please.

KOLTERMAN: The other side of that-- and again, it fits right in with-- with all these added people, where will we add on the Medicaid Management Information System?

KEVIN BAGLEY: That's another area where we're continuing to do some development. So in-- on that front, as we look at the future of the agency and where we would like to move to, most of our services are done through a managed-care arrangement, which means that they-- the claims won't need to be processed through an MMIS system. As we look at the services that are not currently in that setup, one of those areas is our long-term services and supports, our long-term care. Many states have moved in the direction of managed long-term services and supports. We believe that that would be a good direction for us to move in. That being said, I think there's a lot of work that needs to be done in order to do that right. We've seen states who have done a poor job of that, and that's come back to hurt providers, and it's come back to hurt members, and we don't want to do that. But we believe it can be done well, and we think that's the direction to head.

KOLTERMAN: So-- so in essence, you're telling me that you haven't entered into any contracts for a new MMIS system?

KEVIN BAGLEY: We have. We've been doing some maintenance work on the existing one. And I may have to get back to you a little bit on the status of any contracts for that, but our hope is that we can move in a direction where all of our services are provided through a managed-care arrangement, which means we would not need to procure a new MMIS system.

KOLTERMAN: OK. And then, my last question. In-- in your testimony here today, you talked about not doing any provider ratings because-- my question to you is, did you have-- have the providers come to you with specific requests to increase their rates?

KEVIN BAGLEY: So we haven't seen specific requests come to us that I'm aware of. There were some rate increases from the previous session that have been implemented. In addition, there have been some temporary adjustments to provider payments, including additional add-ons for our long-term care residential settings or nursing facilities or assisted living facilities, as part of the pandemic and that kind of limited time response. I guess what I-- what I would say to that is that, while we haven't necessarily had a ton of requests come in, I don't think we are coming in opposition to those. When we looked at the budget request back in October, there was so much uncertainty around what the budget would look like, around what everything-- what the status of-- of all of those pieces would be. We didn't feel it would be appropriate to make certain requests at that point. That being said, as the committee looks at some of the requests that-- that I'm aware are coming in, I don't think that we're coming necessarily in opposition to any of those. Rather, we would be happy to implement whatever-- whatever increases or appropriations are passed into law.

KOLTERMAN: So if we-- if we-- if we pass some rate increases for providers, you'll make sure that the money gets paid out to them right away. Right?

KEVIN BAGLEY: So I will-- I will say yes, and I'll add a caveat. Right away is always a little bit trickier. That being said,--

KOLTERMAN: The-- the reason for my question is, I just heard yesterday another one of my assisted-living facilities is--

KEVIN BAGLEY: Sure.

KOLTERMAN: --closing down in my district. I don't have a very big district. And I heard that it's along with two others. It's a three-person chain, so to speak.

KEVIN BAGLEY: Sure.

KOLTERMAN: And in the pandemic, the nursing homes and assisted-living facilities and the hospitals, they're having a hard time making things go. And for us to just turn our back on them and say: Hey, we're not going to give you any rate increase, that's bothersome to me. And we talked about that yesterday; I'm sure you know that. So I-- I think it's important that, if we do pass a rate increase and give some providers some help, that it gets taken care of as soon as possible, because we can't afford to continue to have these places shut down in the state of Nebraska.

KEVIN BAGLEY: Yeah, I think that's-- that's a great point, Senator. And I guess what I would say to that is, anything that gets passed during this session that applies to the upcoming biennium, we believe we have enough lead time at this point to have those new rates in place by July 1. If we needed to implement those prior to July 1, we'd love to have some conversation on how to do that.

KOLTERMAN: OK. Thank you very much. That's all.

STINNER: Senator Wishart.

WISHART: Thank you for being here, Director, and thank you for answering Senator Kolterman's questions that way. That's, you know, it's music to my ears to hear that kind of response that, when we appropriate funds, that your team is going to work on making sure it gets those providers. Really quickly, just dovetailing off of what Senator Kolterman said, the funding for pandemic relief is one time.

KEVIN BAGLEY: Yes.

WISHART: Is that correct? OK.

KEVIN BAGLEY: For the most part.

WISHART: For the most part, OK. I wanted to go back to the conversation around Medicaid expansion.

KEVIN BAGLEY: Sure.

WISHART: And I'll preface this by saying, I recognize that you-- your tenure here has been short so far, you're new, and that the decisions that were made about this waiver were done by your predecessor. But when-- when we were having conversations about expanding Medicaid, multiple senators on this committee and multiple senators in the Health and Human Services Committee warned the department that this type of waiver may not cut it with the feds. So were you given a plan B to be prepared to get these-- this type of coverage to Nebraskans?

KEVIN BAGLEY: So I guess I'll say we always try to have a plan B or a C or a D. You're right, because the reality is, there's a lot of moving parts when it comes to these programs. And I guess the other thing I'll say is, Medicaid is an incredibly large ship to turn. And so once we've-- once we've turned in a direction, it takes a lot to reverse that course. And so one of the things that-- that I've tried to make sure we do here when it comes to this-- this expansion program and the 1115, is to try to be really purposeful and deliberate about the decisions we make. So as-- as we received that letter, as we've had some ongoing discussions around the implementation plan, as it's become clear that we're not going to get the approval in time to continue the implementation that we planned on, I think now it's really a-- we need to have a decision from the feds on which direction they need us to go. And as we have those discussions, once it becomes clear where it is we need to be, we'll move in that direction. But I think the difficulty-- the reality is, any direction we take at this point probably adds months to the implementation.

WISHART: Do you believe that dental and vision care are critical components of somebody's overall health care?

KEVIN BAGLEY: You know, I would say the evidence definitely points in that direction. What-- what our hope is with the current implementation plan-- that is obviously still pending approval, right, by CMS-- is that we'll be able to help provide a pathway for people to leverage those benefits in a more responsible way. Our hope is that what that will actually do is bring down the cost of healthcare while also creating a better experience for the member. This would be similar to a lot of the wellness-type incentive programs we would see in a lot of commercial plans. The difference is, it doesn't change the

cost structure for the beneficiaries. It just changes the behavior and incentive structure around that.

WISHART: So you've got two options. You can battle it out with the feds and-- or, from my understanding, you could just not go down that waiver path, and right now just offer that premium tier to every person with, frankly, a lot less administrative overhead for dealing with that. Why not do that?

KEVIN BAGLEY: Well, like I mentioned, moving that Medicaid ship is a really, really difficult thing to turn. And so even if we were to take that direction, I think we would be realistically probably six months out to be able to make that happen.

WISHART: Why would it take six months to put somebody who has qualified for Medicaid expansion and is already enrolled, why would it take six months to put them in the same plan, except as a woman who's pregnant?

KEVIN BAGLEY: The reality is, the approvals that would need to go through a CMS, the-- the additional work that would need to be done on contracts with our managed-care plans, on rate changes with those plans, the actuarial studies that would need to be done. Medicaid is a cumbersome beast. And so the reality, I think, is, as we've looked at it, it would take several months to make anything happen, short of the path that we had already laid out. And so I think, even at this point, with CMS creating this additional delay, we're still talking about several months, likely. Even if they were to approve the plan in, say, a month from now, I think we'd still be looking at several months to even restart the process that [INAUDIBLE].

WISHART: And again-- and I'll close here-- and again, I don't fault you, because you are new and didn't make a lot of the previous decisions. But when I hear that there is a plan B in place for a waiver that many advocates and senators said is very unlikely to go through-- however great it is, it's unlikely to go through and there's going to be a battle with the feds-- my goal and my understanding would be that plan B is, we're ready to put all these people who have voted to expand Medicaid onto the full Medicaid package; that's the plan B. And so it's frustrating to hear that there is now going to

take six months to put somebody on a plan and expand their services to get vision, which, by the way, is critical for working, if somebody has vision issues. Dental is very important for somebody's overall health. And so that's frustrating. We heard this yesterday as well, that there's a plan B, we've got a plan B. Well, now is the time for the plan B, and it sounds like it hasn't been planned out. And so again, I don't fault you for this, but I-- I-- but moving forward, we need to make sure that, when people vote something in place, that they're not waiting four years for just half of that to happen. Thank you.

KEVIN BAGLEY: Thank you, Senator.

STINNER: Additional questions? Senator Clements.

CLEMENTS: Thank you, Mr. Chairman. Thank you, Mr. Bagley. My question is, in the-- let's see. In this program budget request for the next two years, how many Medicaid expansion people do you-- are you putting in here for us to fund?

KEVIN BAGLEY: So the-- the current request in the budget is roughly the same as it was in the original appropriation for Medicaid expansion. Right now, as we look at the-- as we look at the rate of buildup, we're adding 5,000-6,000, or so, new members each month, with some variation. So for example, we saw a significant amount of applications come in around the same time as the ACA open enrollment period that took place at the end of last year. The current administration has re-opened that open enrollment. Now, it's unclear to us if we'll see a similar spike in enrollment. We may or it may be that-- that we don't see that, because all of the folks that-- that were going to be part of that have already come through in last year's open application period. It's unclear to us, but we'll continue to monitor that, and we'll come back to the committee if we see any significant changes.

CLEMENTS: You didn't give me a number.

KEVIN BAGLEY: I'm sorry. I don't have a good number to give you on that just because I don't recall what the number was last year. But I've heard 75,000 mentioned a couple of times, and-- and--

CLEMENTS: I recall 90,000 estimated, but that's fine. [INAUDIBLE].

KEVIN BAGLEY: And I'm happy to follow up with you on that, Senator. I--

CLEMENTS: Anyway--

KEVIN BAGLEY: I just don't have that in front of me.

CLEMENTS: Yeah. Well, I guess mainly that you didn't-- you did not decrease the amount because of the slow sign-up that we've seen.

KEVIN BAGLEY: No, we have-- we have not requested a decrease in the amount. I believe the initial amount funded only a portion of the year, and so we've continued with the amount that was previously appropriated in this-- this new budget.

CLEMENTS: All right. Thank you.

STINNER: Additional questions? Senator Dorn.

DORN: Thank you, Chairman Stinner. Thank you for being here, Director. I don't know what page you're-- you're on here, but this is the bottom of our second page, where in it-- with the provider rates--

KEVIN BAGLEY: Yes.

DORN: --and how you look at those. And you-- you commented that in the event the department determines a given rate is not appropriate-- well, I've sat on here over two years or whatever, and we've heard a lot about provider rates and so on. And-- and I'll particularly bring up what Senator Kolterman brought up here with another nursing home closing, I think. And since I've been here, we've heard the number, about 15 have closed, and we've had a lot of discussion about their provider rates and-- and how that has affected them. I guess, can you explain what you mean by when the department determines a given rate is not appropriate and then you will increase it?

KEVIN BAGLEY: Sure. So we are always trying to make sure we're-- we're paying appropriately for services. And I guess that's a pretty vague term, so I'm going to try to be as specific as I can on it. But

there's obviously a lot of nuance and variation when it comes to that. Specifically, when we look at long-term care, for example, we have a lot of discussions with the associations there to try and understand what the current outlay is for them. With our nursing homes, for example, we actually have some cost reporting that we evaluate on a regular basis. And so I'll-- I'll note here that I don't have the history here in Nebraska with that exercise. But one of the things that-- that I believe has been done-- and I would like to continue to do as the director here-- is really to make sure that we're monitoring those on a regular basis to really understand what those cost profiles look like. And if there are adjustments that need to be made that we have existing appropriation that we could leverage for, we could make that change. If we don't have that existing appropriation, then certainly we can include that in an upcoming budget request or in discussions here with the committee. So again, I guess we're always on the lookout, and we're always welcoming feedback from providers and others who have concerns on that front. And so I don't have a good specific example, aside from some of our COVID-specific, more time-limited things that we've done, for example, that the add-on for our nursing facilities and assisted living facilities.

DORN: No, I fully realize that, you know, this is-- this past year has been different than--

KEVIN BAGLEY: Sure.

DORN: --what many years are, and COVID is part of that and-- and how that funding has flowed in through here. But are-- are you looking at-- you said you-- I don't know-- do the evaluations, but are you looking at this compared to, I call it, other states? Or-- or-- or are you saying they're getting by and we don't need to fund them anymore, I guess? That-- to me, that's not appropriate.

KEVIN BAGLEY: Yeah. I-- I think it depends on the service, and it'll depend on kind of the nature of where things are. When we look at those cost reports for our nursing facilities, one of the big questions is: Are we able to cover their costs? And if that's not the case, then that certainly raises a red flag. I want to be careful to-- to say, you know, Medicaid isn't the only funding source for our nursing facilities. And I don't want to suggest that it's the role of

the Medicaid program to ensure their viability either. But at the same time, we are a big payer. And so it's in our interest to ensure that there is availability of that service. So I-- I think that's an example where we would want to make sure that we're covering their costs with our rate. And I-- I think we would also look at other states. We would look at other payers' nursing facilities. We are one of the primary payers. So we would probably look at other states, looking at those cost profiles, and try to identify, are we hitting the mark there.

DORN: Thank you.

KEVIN BAGLEY: Sure.

STINNER: Senator Kolterman.

KOLTERMAN: Thank you, Senator Stinner. This'll be my last question, I think. While we're talking about nursing homes, and assisted-living facilities, and things of that nature, what-- where are you at? Several years ago we looked at managed care for our nursing homes. Is that still on the horizon? Is it yet to come? Or are you-- obviously, you have your plate pretty full right now. And I would hope that doesn't just happen overnight, that there'd be a lot of input and participation from our providers in that. But where does that stand? Again, on HHS a couple of years ago, it was getting ready to implement, and then, all of a sudden, boom, it's gone.

KEVIN BAGLEY: Yeah, I see--

KOLTERMAN: And it stays that way for a while.

KEVIN BAGLEY: I think I will gladly and wholeheartedly agree with you. There's a lot on our plate right now. That being said, I think that is something we still look out on the horizon as we look at the future, as we talk about the need, potentially, to procure a new MMIS system. If we were to move in the direction of managed long-term services and supports, that large, one-time, and potentially significant ongoing cost, from an administrative standpoint, wouldn't be there. We believe that we can provide better care and better services to our members if we go the managed long-term services and supports route. But to your

point as well, that is absolutely not something that can happen overnight. I mentioned earlier, in response to Senator Wishart's question, that Medicaid is a very big ship to turn. When it comes to managed long-term services and supports, it is a very big ship to turn, and it has a very significant impact on the lives of those individuals who are particularly vulnerable. And so we want to be extremely sensitive in how we roll that out. It will take, frankly, I think, years of planning to do right. And so that's something that we do believe is in the future. I would say it is not in the short-term future. It will take a considerable amount of discussion with stakeholders across the spectrum to do that.

KOLTERMAN: Well, I guess I'd like to say a couple of things. Thank you for being candid with us about that. I would also-- I know you're relatively new. I would encourage you to reach out to the providers that are here. I mean, just look around this room; there's a lot of providers. You're going to get a lot of input today, I'm sure. But at the same time, I would encourage you, as you move forward, to bring these people together and talk about it, 'cause-- 'cause they've got-- they've been in the field for years, and they've got a lot of experience in running some of these facilities. And if they have the input, they can help you put together a good MMI proposal and make it-- make it so it's a win-win for everyone. So thank you.

KEVIN BAGLEY: I-- thank you, Senator. I'd like to add to that. And I apologize, Senator Stinner, I know you'd like to move on, I think. But one of the things that we're definitely trying to do, as a division, is to have regular discussions. We're working on setting up quarterly meetings with our provider associations, and we're also working to reinstate a medical care advisory council that will bring stakeholders from our beneficiaries, as well as our providers, together to advise the agency on how we move forward better. So I look forward to those conversations and continuing those conversations.

KOLTERMAN: Thank you.

STINNER: [INAUDIBLE] I-- interrupting Senator Hilkemann; I know he has another question. But we built our model on about a 90,000 participants to the Medicaid. We also did some cost analysis of what the prime would cost versus what the basic was. So now that we're not

doing it for another six months, as your testimony is what I hear, we may have to start rightsizing some of the appropriations that we put in. I'm just throwing that out for you as a heads up. We need to do some recalculating and recalibrating. I happen to agree with Senator Wishart. It's hard for me to believe this is the implementation plan, the stuff that you were talking about, actuarial studies and all the rest of that had to be part of the waiver. So that should be set already. You don't have to do that. The implementation plan, I would suggest, to my mind, would be: OK, do you have problems with those two or three items? We're pulling them out and we're going to move ahead with the basic-- or with the next plan. That's how simplistically I look at it. It's logical to me. I guess I get the fact CMS is a different animal, but I would explore trying to get to the next tier as quickly as possible for all the reasons that were stated in this committee. And I think you'll-- you'll hear it from the Legislature. The other thing that caught my attention-- two things. You were talking about-- and Senator Kolterman really covered it pretty well-- in the enrollment and eligibility, we did have a group come in because the interface wasn't in place. We got some federal money for that. Obviously, we had jettisoned that program. And your testimony was that, because of the enrollment and eligibility still needs to be worked on to get it up to date-- I think you mentioned the fact that it was end-of-life technology. Are we working on a plan for that? Are we going to see something from-- from you, asking for appropriations, or is the fed going to contribute to that? Or how does that work?

KEVIN BAGLEY: So there's certainly a significant amount of federal money that comes in on those type of projects,-- excuse me-- typically to the range of 90 percent federal participation. So I'd be happy to-- to get back with you and the rest of the committee, Senator, on-- on the details of that.

STINNER: I just want to make sure that we have an efficient system, that when somebody makes an application, we can process it.

KEVIN BAGLEY: Yes.

STINNER: And we-- you know, some of this 35,000, as opposed to the estimate of 90,000, I hope I don't find out that there's people on a waiting list that are not being processed for 30 days or 45 days. I

haven't heard that, and I don't know if anybody else has. The other thing that really kind of caught my attention is, you made a statement about nursing homes: We-- we don't ensure their survivability-- or viability, excuse me. That kind of sets my hair on fire because I've got-- I'm going to say, outside of Lincoln and Omaha, when you go out and you take a look at the census, we've got nursing homes with 70, 80 percent Medicaid patients, you know. Based on the studies that we have, we're not even close to cost. We tried to get to a breakeven or a parity on cost. I think we're still $9 or $10 per-- per patient, per day away from that. So first of all, let's make up that gap and we'll end up talking about viability beyond that. And I'm going to say this: The location of a lot of those, it's absolutely critical that they stay in place. Now, they may have been designed initially for 100 nursing-- 100 patients. They may only have 60, but those 60 people in those beds in that nursing home, from an economic standpoint, is incredibly important to the small town. So when we talk about viability, yeah, we talk about just covering cost. There's no profitability, there's no excess in there for depreciation and all the rest of that stuff that you need to have. So you caught my attention on that. I just wanted to explain to you that there is a difference between rural and what, maybe, you're seeing in Lincoln in Omaha, where they can pick and choose whether they take Medicaid or not. That's not the case in-- in some places. The other thing, I want to thank you for the $20 dollars per day per person. And I'm going to ask this question. You obviously are seeing something impactful as it relates to COVID. And I'm talking about the fact that people aren't coming into the nursing homes. We have much more vacancy. We still have the fixed cost associated with it. This is a critical time. And I hear right now that one of the-- or one of the three nursing homes or assisted-living are possibly going to go out of business. What I'm asking is: Have you-- have you taken any time to take a look at that? And then, have you done any studies prospectively on how long it's going to take these nursing homes to build that-- build back from where they're at today on vacancies so that they can become more viable?

KEVIN BAGLEY: Yes, I'll say--

STINNER: Too many questions in that. I'm sorry.

Does not include written testimony submitted prior to the public hearing per our COVID-19 Response protocol

KEVIN BAGLEY: That's OK. I guess I-- I will say a couple of things in-- in response to some of those is, right now we aren't seeing any kind of a wait on individuals being able to have their eligibility determined, even-- even with the large influx of individuals coming in. We saw, over the holidays, a huge spike in applications, and we saw at that point an associated spike in the time it took. But even then, I think we were well under a month, certainly. And we're seeing pretty typical turnaround times right now, in terms of getting that eligibility determined. So I guess I want to say we aren't seeing any delays right now in that. And if we start to, I-- we are monitoring that very closely. When it comes to our nursing facilities, I guess I will clarify, it is absolutely in the best interest of the Medicaid program to continue to have that full spectrum of long-term care services from our facility-based care to our home- and community-based services. If we don't have that spectrum, then we're missing something, in terms of our opportunity to serve those individuals; and we don't want to have that. We are definitely seeing a lot of long-term trends as well as short-term trends in changes with nursing facilities. I don't want to speak for those facilities in-- in this setting, but we're definitely seeing, over the long-term, a trend in reduction in that census, where we have a larger facility that just is filling fewer and fewer beds. When we look at long-term trends and the fixed-cost nature of some of those-- those providers, then I think it does call into question, how do we make this work better? Now, I don't think it's the Medicaid's role to make those decisions. We can help provide incentive, and we can help structure our programs such that it assists in that front. But I want to be careful that we're not making those decisions for those facilities. But we are, in the short term as well, seeing a more pronounced decrease in that census, as fewer people want to be admitted to those nursing facilities, with concerns potentially over infection and other things. And I think-- I think we're also seeing a concern on individuals being able to visit their family members in those facilities, and so as vaccinations continue, as things continue to improve slowly but surely, we believe that-- that some of those short-term obstacles will be overcome, but they may have long-term ramifications. And so I think we're continuing to look at that. I mentioned the cost reports that we do. That's something we're continuing to look at. And these cost reports that we're just reviewing and beginning to review right now will include some of that

time under the public health emergency. And so that will be informative to us, in terms of what the short-term impacts may have been.

STINNER: Thank you for that. Senator Hilkemann.

HILKEMANN: I'll pass.

STINNER: I'm trying to manage the clock behind you, too, with all of this. So in any event, any additional quick questions by anybody?

WISHART: Can I have one quick question?

STINNER: Senator Wishart.

WISHART: Following up on M-- the-- it's MMIS, is the-- what, dollarwise-- why would we need, one-time funding, to get you to completely just overhauling, get that system where it needs to be?

KEVIN BAGLEY: I can tell you it would be large, but I don't have a good number that I could give you right now. I'd be happy to follow up.

WISHART: That would be great to know. And it would mainly be one-time funding.

KEVIN BAGLEY: So I can tell you from my experience in the state of Utah, I was part of our MMIS replacement project. Their one-time funding makes it sound like it's a quick turnaround. I worked on that project. I started working on that project nine years ago. It has not quite completed there in the state of Utah. And I can tell you it was significant, in terms of the total amount of dollars being spent.

WISHART: Yeah, OK.

KEVIN BAGLEY: So it-- there would be some one-time, as well as ongoing funding.

WISHART: OK.

KEVIN BAGLEY: I'd be happy to follow up with you on that.

WISHART: That would be happy to know, what the one-time cost is and then what the ongoing would be.

KEVIN BAGLEY: Sure.

STINNER: Seeing no additional questions, or not allowing any additional questions, thank you for your testimony.

KEVIN BAGLEY: Thank you.

STINNER: We're going to run through Public Health and then Operations, in that order, and then we'll take proponents and opponents, and see where we're at with the clock. Good morning.

GARY ANTHONE: Good morning, Senator Stinner and members of the Appropriations Committee. My name is Dr. Gary Anthone, G-a-r-y A-n-t-h-o-n-e. I'm the director of the Division of Public Health and chief medical officer for the Department of Health and Human Services. The Division of Public Health serves the entire population of the state of Nebraska. Public health's critical societal role has become clearer over the past year as we've come together as a state to respond to the COVID-19 pandemic. From testing to contact tracing, and now vaccination, Nebraska Public Health delivers the DHHS mission to help people live better lives. The budget proposed by Governor Ricketts will enable us to continue to prioritize efficient, effective, and customer-focused state government. I would like to thank the members of the Appropriations Committee for including the Governor's recommendation to include funding to implement LB963, which will provide for reimbursement for resiliency training for first responder and frontline state employees. Last year, I asked the committee to support an increase in cash spending authority to allow DHHS to replace its Licensure Information System, which reached the end of vendor support in June 2020. I would like to provide this committee with some updates on that process. Last year, our licensure team issued a request for a proposal that sought to achieve four primary goals: automate the initial license application and the renewal process; improve public access to licensee information; maximize DHHS staff productivity; and improve and modernize the computer system for licensing. After reviewing bids from a variety of potential vend-- vendors, DHHS entered into an agreement in October

2020, with VisualVault, to replace the obsolete Licensure Information System. This replacement has been branded Nebraska LANCE, L-A-N-C-E, or the Licensing and Certification Environment. Since October, the DHHS team has been hard at work with VisualVault in pursuing an aggressive implementation timeline. Project planning and design are in full swing, and with data conversion and testing coming soon. The first project to go live is slated for September 2021, at which point Uniform Credentialing Act professions and occupations, as well as childcare programs, will transition from the old Licensure Information System to LANCE. Two subsequent phases will incorporate community-based services and healthcare facilities and services into LANCE. As of today, this project is on time and meeting budget expectations, with all milestones on track for success. I'd like to thank the Appropriations Committee for including this recommendation last year. Finally, I'd like to thank the Appropriations Committee for supporting Governor Ricketts' budget proposal. This will enable the Division of Public Health to be effective stewards of taxpayer dollars while supporting our mission to help people live better lives. I'm happy to answer any questions.

STINNER: Thank you. Questions? Questions? Senator Hilkemann.

HILKEMANN: Doctor, thank you for your work during this last year, this tough time. and I think that the decisions that over all that have been made, I-- and I've been in contact with the Governor. I think that our state has handled it about as well as any state that I'm aware of. And I thank you for your leadership in that.

GARY ANTHONE: Thank you. And it's been an honor and a privilege.

HILKEMANN: I-- are we-- are we-- are there-- I'm aware that there are a lot of scams now that are occurring, particularly for our senior citizens, threatening [INAUDIBLE]. Have you had a lot of these reported to your department?

GARY ANTHONE: I have not.

HILKEMANN: OK.

GARY ANTHONE: No, I don't really have any information on that right now at all, Senator.

HILKEMANN: OK, great.

STINNER: Additional questions? Seeing none, thank you. The next thing on my list was Operations, DHHS Operations. Morning.

LARRY KAHL: Good morning, sir. Chairperson Stinner, members of the Appropriations Committee, my name is Larry W. Kahl, L-a-r-r-y, middle initial W, last name K-a-h-l. I am the chief operating officer for the Department of Health and Human Services. The DHHS provides 24-hour care for adult patients at the Norfolk, Lincoln Regional Centers, and residents at the Beatrice State Developmental Center. We also provide 24-hour care to youth committed to the Youth Rehabilitation and Treatment Centers in Kearney, Geneva, at the Lincoln Youth Facility, and to youth receiving services at Whitehall Psychiatric Residential Treatment Facility. The Youth Rehabilitation and Treatment Center in Kearney serves high-risk male and female juveniles who were committed to the facility by the juvenile court system. The administrative team continues to strive for improvements in maintaining a safe environment for these juveniles and for the employees. Phase Program Model has been in place since May 2019. It includes the objective daily scoring system, whereby juveniles are rated on their interactions with adults, interactions with their peers, and overall compliance. In July 2020, the Missouri Youth Services Institute, MYSI, added their MYSI Model to the clinical array of treatment tools. This is a unit-based best practice rooted in the engagement of youth by staff at every available, teachable moment, throughout all waking hours of the youths placement. The Youth Rehab and Treatment Center in Geneva is no longer serving female juveniles that we're preparing for reentry. Given the absence of the availability of key programmatic components-- predominantly staff-- the program is currently dormant. The youth facility in Lincoln serves as-- serves the high-acuity male and female juveniles who have been committed by the juvenile court system. This population of juveniles has the opportunity for more intensive, individual-based treatment services, including greater access to psychiatric and psychological services, as well as higher to staff-resident ratios. The treatment program is designed to be short-term so the juveniles can return to the community or a lower

level of care. The Whitehall Psychiatric Residential Treatment Facility, a PRTF, is a 16-bed behavioral health facility which provides intensive, individualized treatment for juveniles who sexually harm. It serves youth ages 13 to 18. The program, in collaboration with Lincoln Regional Center, has enjoyed joint commission accreditation since September 2019. The program has man-- maintained an average census of six youth over the last year. Whitehall is also now home to the Substance Use Disorders Treatment Program. The two programs do not mix. The housing-- they're housed separately in separate facilities. The youth previously served in Hastings successfully moved to this location, to Whitehall, in the fall of 2020. With the adult facilities, the Lincoln Regional Center is a 285-bed psychiatric hospital that provides highly structured treatment for individuals suffering from mental illness. In September '19, LRC underwent the triannual Joint Commission Accreditation Survey for both the hospital and behavioral health programs. The hospital program was determined to have one conditional finding related to national patient safety goals of 15-10.01, which states the hospital reduces the risk for suicide. This led to a $5.6 million request for funds to make facility structural upgrades for ligature mitigation. The conditional finding required LRC to create a mitigation plan that consisted of increased staffing, placing all patients on 10-minute safety checks, continuous bathroom door locking, and observations while the patient is in the bathroom. In order to sustain this temporary mitigation plan, LRC had to increase the number of staff within a 24-hour period by an additional 21 staff. The project is on budget and on target to meet the anticipated completion date. The Norfolk Regional Center, NRC, is a 111-bed psychiatric hospital, consisting of one male psychiatric medical support unit and four sex offender treatment units. NRC provides treatment for individuals that have been adjudicated under the Nebraska Sex Offender Commitment Act or have been committed to inpatient treatment by a county mental health board, for treatment of a sexual disorder. NRC has a new interim leader and is focused on improving a number of quality-of-care metrics in standardized fashion with the Lincoln Regional Center. Beatrice State Development Center is an intermediate care facility, for individuals with developmental disabilities, that provides residential, vocational, and recreational services. BSDC offers both long-term care and short-term care units for the residents. I would

like to thank you, the Appropriations Committee and the Legislative Fiscal Office team for your work on the preliminary budget recommendations and for supporting the Governor's biennium recommendations as it relates to the facilities. We are in support of the Governors and the committee's budget recommendations. I'd be happy to answer any questions at this time.

STINNER: Questions? I have a question. This rehabilitation in Geneva is no longer serving female juveniles. What are we using the facility for?

LARRY KAHL: At this time, the facility is not being used. It-- we're keeping the power on. We don't want any burst pipes. The facility is being maintained, but it is-- it is dormant. It's empty at this time.

STINNER: Do you have it up for sale?

LARRY KAHL: It is not. We're walking through the discussion process right now. We're looking at a new term that I've learned with-- through the Department of Administrative Services-- VBEL, and looking at that process in terms of how that we might continue to be good stewards of the taxpayers' resources and reduce our overall cost profile.

STINNER: How many youths are now occupying this high-acute facility that we have in Lincoln?

LARRY KAHL: The Lincoln Youth Facility?

STINNER: Yeah.

LARRY KAHL: We currently have six youth, three males and three females,

STINNER: Three males and three females.

LARRY KAHL: Yes, sir.

STINNER: So you've got six. You have 16 beds. Is that what I saw?

LARRY KAHL: At that particular facility. I think that we can house as many as 20. We have 16-bed capacity at the White Hall.

STINNER: My understanding is, this is a leased facility from the county.

LARRY KAHL: Yes, sir, it is.

STINNER: And you're paying how much a year in lease payments?

LARRY KAHL: I would have to get back to you on that, sir. I don't have that off the top of my head.

STINNER: My recollection, it was about $400,000.

LARRY KAHL: Sounds [INAUDIBLE].

STINNER: So doing the math, it's an expensive facility for--

LARRY KAHL: It is.

STINNER: --what we have, but we've abandoned Geneva and we're looking at viability. And I've always wondered, is it because you can get the specialists in Lincoln as opposed to somebody in Geneva to-- to do this high-acuity?

LARRY KAHL: It's-- your point is-- you're exactly correct. In my relatively short tenure here, I've been utilizing a three-legged-stool approach. Facility is-- is very important and critical, updated appropriate facilities to the type of care that we're trying to provide, appropriate number of staff and appropriately trained staff, another key vital component, and the third component is the programing. We are moving across all of our facilities to much more of a treatment-based care than a corrections-based system that it perhaps was in the past, which is true of youth facilities across the country. So all three of those components need to be in place. And the more robust I can make each of those three, the more appropriate the fit is, the better likelihood of us being able to be successful in providing the care to youth. And so, to your point, sir, you're exactly correct. One of those legs of the stool was absent-- the Geneva program. Actually, several were--were absent. The one that was

great was the facility, based on an investment made a few years back that really shored up that building. It's a wonderful building. I'd love to put it on a truck and move it to where I can have the other two resources widely available. Staffing is the primary issue.

STINNER: Overall, the YRTC is supposed to come up with a facility planner and an overall plan for it. And what is that date? Is that April?

LARRY KAHL: Yes, sir. We're due, I think, by the end of March,--

STINNER: End of March.

LARRY KAHL: --that we present that to the Health and Human Services Committee, and it is substantially complete and under review. And so we'll hit our target.

STINNER: So you can't disclose anything to us. Is there an appropriations that's going to be attached to that? Or--

LARRY KAHL: The goal of that-- that statement of work was twofold. One was to respond to LB1140 and to make sure that we were meeting the requirements that were spelled out in that piece of legislation. And the second was to create a five-year plan and to map a course, going forward. And what I am pleased to be able to-- to share is that we've incorporated both of those into the singular document, and that the five-year planning tool, by design, is a living document. So my primary focus, I guess, to be-- to try to kind of summarize it, has been learning the history, doing a thorough evaluation, and providing stabilization. And with those three things under our belt, I think we can begin to do the fine tuning. And that's actually underway now, what we're trying to enhance what we have. But we're not looking at rapid growth, we're not trying to take over the world. We want to make sure that we can sustain what we're doing and that we're doing it in the most cost-efficient way possible. The five-year plan starts to map the course for: Where would we like to be two years from now? Where would we like to be three years from now? And what does that look like? What does it include? And so that's-- would be some of the nature of what's in that five-year planning document.

STINNER: The Whitehall facility, the 16-bed behavioral health-- I got that we got that mixed up with that other one-- but how many children are in that right now?

LARRY KAHL: Today's census, we've got 14.

STINNER: OK. Thank you.

LARRY KAHL: Yeah.

STINNER: Any additional questions? Senator Clements.

CLEMENTS: Thank you, Mr. Chairman. Thank you, sir. Regarding the Whitehall movement from Hastings, what is the Hastings facility being used for now?

LARRY KAHL: The-- the Hastings facility, where the youth were actually housed in Building 3, is scheduled for demolition for this fall. It was a-- while a beautiful, historic building, extremely dated and beyond its meaningful life. And so the Department of Administrative Services has it scheduled to be demolished. The Hastings campus did have good foresight and built additional cottages on-site, and additional facilities for being able to provide schooling, dining, group-- family therapy. And those buildings are currently not being utilized, but we anticipate to be able to use them later this spring.

CLEMENTS: For what purpose?

LARRY KAHL: My understanding is that we have a legislative mandate that we're not to blend the girls and boys at Kearney. And so we would need to move the girls off of that campus. And so we would look at the Hastings center-- facility as being the most appropriate location for us to be able to relocate those girls and meet those legislative requirements.

CLEMENTS: All right. Thank you.

LARRY KAHL: You bet.

STINNER: Thank you. Additional questions? Senator Kolterman.

KOLTERMAN: Thank you, Senator Stinner. I just have an observation, and I know you're new. But I have to say it. If you look at this committee, five of us are from rural Nebraska. County-- the state line doesn't end at the Lancaster County line, going west. You closed up Geneva, you're working on Hastings. Everything shouldn't be moved to Lincoln and Omaha. We have the capability in Geneva of hiring people that could work there. It worked for years. We need to continue to look at rural Nebraska. If we expect the state to grow, we can't think everything is going to happen in eastern Nebraska. Just an observation, but what I'm seeing, what I'm hearing doesn't cut it with me. Thank you.

LARRY KAHL: Thank you for your observations, Senator.

STINNER: Additional questions?

DORN: Yeah.

STINNER: Senator Dorn.

DORN: Thank you, Chairman Stinner. Thank you, Director, for being here. I guess my-- you made the comment about three things you look at, and one of them is staffing or whatever.

LARRY KAHL: Um-hum.

DORN: How-- you're-- you're more facilities. But how-- how does that-- or who reports to you or how does that come up with-- or how is that determination made? Because Geneva was staffing, that we hear that the reason that-- and I-- I know we're having issues and I call it-- other departments within the state is staffing. So how is that related to you? Or what kind of those conversations go on? Or how do you make that determination on staffing? And--

LARRY KAHL: I guess, you know, relative to staffing at-- at any of the-- any of the facilities that we have open positions, we continue to work closely with our human resource partners to actively recruit, and being as creative as we can be to actively recruit-- getting out into the schools. They've tried some things that have surprisingly been pretty effective, drive-in recruitment sessions, which are kind of a foreign thing, kind of a COVID-related thing. But they've had

some success. In Beatrice, in particular, we've had some success with that. Folks come, interview, learn about the jobs, and actually follow through with applications. So far, what I'm seeing overall, sir, is that we're-- at each of our existing operating facilities, our absentee rate, if you will, or our vacancy rate, is-- is pretty much on par with what most of the other industries in the area are experiencing. We do end up trying to hire, especially when we get into specialty staff, licensed staff are much more difficult to recruit, not as difficult to recruit entry level positions for, you know, hand-- some hands-on care or housekeeping or nutritional services. Some of those things are a little bit easier to recruit for. But when we get into licensed professionals, licensed social workers, licensed mental health workers or psychologists and psychiatrists, much more difficult in the rural areas. And I'm-- I completely understand and am very sensitive to what Senator Kolterman is-- is speaking to. And I'm dedicated to continue to look at ways in which that we can, you know, try to make that more viable-- share resources. Technology has been-- through COVID, we've learned some things about technology, that it can actually be useful in ways to us that maybe we hadn't thought about in the past. So looking at telemedicine. So there are-- we're continuing to try to staff where we can and meet those needs. And I think our human resources department, overall, is doing a pretty, pretty good job. I'm looking at about an 80 percent turn rate-- from when we post, they get about 80 percent of them filled in a timely fashion, within acceptable fashion. So it's not been-- not been bad.

DORN: Thank you.

LARRY KAHL: One market I will share-- volunteering maybe too much-- the Kearney marketplace. We have a staffing issue there, but it's because they have such high employment. Their unemployment is next to nothing. And so we're competing for anybody that we get at that location, and we're competing with all the other folks in the-- in the community for the limited number of folks that are there. So we-- we see it on both ends.

DORN: Thank you.

STINNER: Senator Erdman.

ERDMAN: Thank you, Senator Stinner. Thank you for coming today. I've been to the Hastings facility there, and I've also been to the Kearney one. It seems that, since Kearney put that overhang on the fence, they haven't had as many people escape. Then in Hastings, I don't think there's any fencing at all there. Is there?

LARRY KAHL: You're correct, sir. There is not.

ERDMAN: How do you propose to make that work, if you put people there that you want to remain there and not let them get away? How do you do that?

LARRY KAHL: Well, there's-- there's a way that I hope to be able to do it, and there's a way that I may ultimately end up having to do it. What we're hoping to do, in a large extent through the-- the MYSI Treatment Model, is that the staff-to-resident ratios are adequate and appropriate, and that the staff are trained, not so much from a check-the-box corrections kind of a mindset, but from a therapeutic mindset where they engage with the youth, they know the youth, they know the youths' behavior, they know their attitude changes. They can preemptively work with-- hopefully prevent youth from acting out in a way that would-- that would result in them eloping. That's the hope. It may be kind of a high hope. And in all reality, we're also having ongoing conversations right now about looking at what it would take for us to fence an appropriate section of the Hastings campus, because unfortunately, the reality may be that, as as much as we try to to engage the youth, their hearts, their minds, and keep them actively involved in that treatment process and not wanting to go anywhere, the reality is, fear is a strong motivator. And sometimes for kids, rather than change, they like to bolt, that they like to try to escape it. So I think that may be something that will be in our future.

ERDMAN: Well, looking at and remembering how long it took to get a fence in Kearney, you and I both-- both will be gone from this job before we get a fence in Hastings.

LARRY KAHL: I've been learning about the capital appropriations process, and I think it would be of a size that would require us to go through that process. And so that will likely be the process that I'll have the opportunity to learn more about.

ERDMAN: Thank you.

STINNER: I'm going to ask a last question, and I was involved in this decision of moving the maintenance budget to DAS, and apparently that was a big problem as it related to Geneva. Has that been worked out so that we're getting the appropriate maintenance, appropriate and timely-- timely decision-making at ground level to maintain those facilities?

LARRY KAHL: It's a unique relationship.

STINNER: That-- that-- that says a lot.

LARRY KAHL: It's-- it's-- I've just recently begun having regular meetings with DAS staff. I think the gentlemen that are at our facilities are tremendous. I've had the opportunity to meet with some of them and visit with them. Their heart is in what they're doing. They care about those buildings and facilities, and want to maintain them. I think it requires an active partnership. It requires us to come to the table to let them know, in a timely fashion, of what we're-- we see the needs are and what our anticipated needs are going to be. And then on their end, they see themselves as a service organization, and so they need to be responsive. And I have no long-term history of any kind of difficulties with that relationship yet. It's one that is unique in-- in-- by its nature. But I'm hopeful that we'll be able to continue to move forward in a-- in a dynamic partnership that allows us to keep some very nice historical buildings in operational condition.

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

LARRY KAHL: Thank you. Thank you all.

STINNER: I do want to enter into the record written submitted testimony by the agency of Public Health proponent Julie Erickson, American Cancer Society. Letters for the record: the Health Center Association supports Program 502; AARP supports Programs 571 and 347. We have 81 letters in opposition to Program 348. And with that, we'll take additional proponents. Any proponent of any of the agencies?

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MARTY FATTIG: Good morning. Good morning, Senator Stinner and members of the Appropriations Committee. My name is Marty Fattig, M-a-r-t-y F-- as in Frank-- a-t-t-i-g. And I'm the CEO of Nemaha County Hospital in Auburn, Nebraska. I am testifying on behalf of my facility and the Nebraska Hospital Association, and I support a provider rate increase for Medicaid providers. Nemaha County Hospital is a county-owned, 16-bed critical access hospital serving southeast Nebraska. Hospitals receive reimbursement from the government that is less than the cost incurred to provide medical care to Medicaid and Medicare patients. On average, Nebraska hospital-- hospitals experience negative margins of 12.5 percent for Medicare and 17 percent for Medicaid in hospitals that have a disproportionate share hospital payment, or 27 percent without that disproportionate share hospital payment. Disproportionate hospital share payments is a governmental payment-- federal government payment-- and is an additional payment received by hospitals that have a disproportionately large number of low-income patients. Nebraska hospitals-- hospitals lost more than $640 million dollars in 2019, because of the shortfall in Medicare, Medicaid, and other public health programs. Our rural hospitals and critical access hospitals in Nebraska provide for the foundation for health services in rural Nebraska. They provide vital care to the most-- almost 670,000 residents who live in rural Nebraska. Rural areas tend to be-- have an older, poorer, and sicker population. That means that they have a higher percentage of patients covered by Medicare and Medicaid, and almost half of all children living in small towns in rural Nebraska receive their healthcare coverage through Medicaid. 50 percent of Nebraska's critical access hospitals are facing financial stress. Even our large rural and urban hospitals struggle with increasing levels of bad debt and charity care, as well. When hospitals are not compensated at a reasonable rate, they must make difficult choices. They may need to consider discontinuing services, reducing staff, or even-- or even closing. The loss of a hospital immediately reduces local employment and income, and the community has a devastating impact on the prospect for the future of the local economic development. When a hospital closes, the physicians, nurses, administrators, and the entire staff have gone, along with the community's healthcare infrastructure. Local businesses will be the next to leave, and the schools will suffer. The whole town will suffer. There is a whole multiplier effect that could be the death knell of the community. Hospitals are substantial

contributors to the state's economy, as well, providing essential jobs throughout the state, employing over 49,000 Nebraskans and creating a demand for an additional 51,000 local businesses-- new-- I'm sorry-- 51,000 jobs in Nebraska due to the hospitals buying goods and services from local businesses. Nearly 10 percent of Nebraska's entire workforce either works for, or is supported by, hospitals. Nebraska hospitals are directly responsible for nearly $7.4 billion in hospital expenditures, including $3.5 billion in salaries and benefits. And important to note, every dollar spent by a hospital in Nebraska produces another $1.91 in economic activity. Nebraska hospitals welcome all patients and provide the same quality of care to everyone, regardless of their ability to pay. I would like to thank the committee for allowing this testimony, and I ask that they support an increase in the rates paid to all Medicaid providers. Thank you.

STINNER: Questions? I-- I need to unpack this $640 million. Your testimony is that the hospital's normal rate would-- for-- for a procedure is X amount of money.

MARTY FATTIG: Exactly.

STINNER: And what you're getting reimbursed from Medicare and Medicaid does not cover what you project your cost is,--

MARTY FATTIG: That-- that's-- that's correct.

STINNER: --and that across the board, for--

MARTY FATTIG: Across the board.

STINNER: --all hospitals,--

MARTY FATTIG: All hospitals.

STINNER: --it's $640 million.

MARTY FATTIG: Yes.

STINNER: OK. You know, when I was covered under Blue Cross Blue Shield, they had a rate schedule too, that if you accept Blue Cross Blue Shield, they'll reimburse you at that rate. And I noticed on my

bill many times, I'd get the bill, and normally it would be $2,000 for this procedure, but Blue Cross Blue Shield's rate was $1,000. So in essence, the hospital said they were charging off $1,000 on that bill. Is that kind of the same analysis here?

MARTY FATTIG: It is the same. Yeah, some of it's the same. It depends on if you get-- as I've heard it said several times here, it gets complicated when you start trying to determine cost about, you know, what comes off your-- your chargemaster and what you get paid. So I mean, there's people playing funny numbers, you know, playing games with-- with some of the numbers, but in reality--

STINNER: So I'm-- I'm going to ask this question. If I had Medicaid stacked up against Medicare, stacked up against, you know, Blue Cross or whoever,--

MARTY FATTIG: Um-hum.

STINNER: --is there a significant difference between what Blue Cross pays and reimburses the hospital versus-- and what-- what do you think that gap is?

MARTY FATTIG: Yes, the gap is-- first of all, it's commercial insurance and Blue Cross are the-- pay-- pay us the best, and then the next is Medicare, and then-- and then below that is Medicaid.

STINNER: OK. And that probably gets back to my-- my question is: How far is Medicaid out of step with what-- what Medicare pays?

MARTY FATTIG: Yeah, and I honestly don't have that information.

STINNER: OK. I'm trying to mine some of that data. And the other thing that I always hear about. You're a county hospital, so you have-- in order to keep your not-for-profit status, how much do you have to do in charity cases? Or that may be a bad word for it. You may have a-- the appropriate name for it, but don't you have to do a certain amount of--?

MARTY FATTIG: We used to. We used to have a certain amount that was set, and that came through the Hill-Burton program, that they required a certain amount. Right now, we essentially have to approve all

charity care that comes to us. You know, if people will apply for financial assistance-- we like to call it-- we have-- you know, we're obligated to provide that financial assistance to these people.

STINNER: So what was your experience at your hospital, as it relates to COVID and the extra costs that you incurred versus how much you were reimbursed by the CARES Act? Is there a-- what I call-- a COVID gap between you ended up having $100,000 of extra costs get reimbursed at $80,000, and so you have a gap there?

MARTY FATTIG: In our facility, no. We-- first of all, though, we do not care for the extremely ill COVID patients. So those-- those patients are-- are transferred to some-- a higher level of care. So that did not happen. We did receive, of course, some federal funding that-- that offset some of those lack of reimbursement-- shall we say-- or or gaps between what we were predicting, because our volumes went down dramatically when COVID was at its highest. So we did receive some federal funding to help some of us-- some of the critical access hospitals through those things. And it really depended on your financial strength as you went into the-- into the COVID pandemic as how-- it determined a lot about how you came out of that pandemic.

STINNER: OK. Additional questions? Senator Kolterman.

KOLTERMAN: Thank you, Senator Stinner. Marty, thanks for coming.

MARTY FATTIG: Thank you.

KOLTERMAN: Critical access hospitals--

MARTY FATTIG: [INAUDIBLE].

KOLTERMAN: --there's an abundant amount of those throughout the state. They-- they get-- do they get reimbursed at a higher level for Medicare than any other hospital? Do you get a little bit of a bump because you're critical access?

MARTY FATTIG: What-- what-- what the medic-- what the critical access hospital program allows is for the hospital to get reimbursed their allowable costs for taking care of Medicare and Medicaid patients. So if it was assumed that all costs are allowable, then of course, what

you do, essentially, is break even on Medicare and Medicaid from a critical access hospital point of view.

KOLTERMAN: Right.

MARTY FATTIG: But of course, not all the costs are allowable. There's a lot of things that the federal government does not allow. So we do well. What I'm really concerned about, and the reason I'm sitting in this chair, is because we require the larger hospitals to be very viable because there's a lot of things we can't care for. So we need them to be very, very-- in a very good state. So when our patients need to go somewhere else, they can go and have the services available to take care of that patient. You know, these large hospitals many times have a book of business, and-- and some of the things lose and some of them gain, as you know, just like every business does. Well, when-- when things start getting tight, some of those services that may not be carrying their own weight, they may-- they may cease to exist, and those might be services that we really need to have those hospitals provide.

KOLTERMAN: The point-- the question is kind of getting to is, is there a difference though? I know Medicare is a federal program.

MARTY FATTIG: Um-hum.

KOLTERMAN: Medicaid is a state program, but a lot of that money comes from the federal government. Do you get reimbursed differently as a critical access hospital than, say, Bryan or St. Elizabeth's?

MARTY FATTIG: Absolutely.

KOLTERMAN: So-- so you get a little bit of a higher rate?

MARTY FATTIG: We do.

KOLTERMAN: That helps you out as a critical access, but it doesn't do any good for them.

MARTY FATTIG: Doesn't do a thing for them.

KOLTERMAN: OK, and then-- that-- that's all. Thank you

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MARTY FATTIG: OK.

STINNER: Additional questions? Senator Erdman.

ERDMAN: Thank you, Senator Stinner. Thank you for coming today. So you're a county-owned hospital. Do you get tax dollars from the county?

MARTY FATTIG: We do not.

ERDMAN: How long has it been since you did?

MARTY FATTIG: The late '60s.

ERDMAN: OK, so you're standing on your own?

MARTY FATTIG: We are.

ERDMAN: I appreciate that. So how did CARES Act money treat you? You don't [INAUDIBLE].

MARTY FATTIG: CARES Act treated us very well. I have to admit, they treated us very well.

ERDMAN: So if your hospital is like the one in my county, it's vital for that hospital to remain viable.

MARTY FATTIG: Absolutely.

ERDMAN: And I appreciate that. I appreciate what you do.

MARTY FATTIG: Yep.

ERDMAN: Thank you.

MARTY FATTIG: You're more than welcome.

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

MARTY FATTIG: See you this afternoon.

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STINNER: Good morning.

HEATH BODDY: Good morning. Good morning, Chairman Stinner, members of the Appropriations Committee. My name is Heath Boddy; that's H-e-a-t-h B-o-d-d-y. I'm the chairman-- excuse me-- I'm the president and CEO of the Nebraska Health Care Association. And on behalf of our 423 nonprofit and proprietary nursing and assisted-living facility members, I'm here today to testify in opposition to the Medicaid budget because it does not include a provider rate increase. I've been--

STINNER: Heath, we're on proponent's still.

HEATH BODDY: Oh, excuse me, Senator.

STINNER: Yes.

HEATH BODDY: I apologize.

STINNER: That's OK. We are on proponents still. I'm sorry about that. Any additional proponents? Any opponents? Thank you [LAUGHTER]. Transcriber would go crazy; I would.

HEATH BODDY: My sincere apologies; I should pay better attention. So I've been in front of you before and talked about facilities struggling to serve a growing Medicaid population with rates that are significantly below the cost of care. You also might recall that in 2018, Nebraska experienced 12 nursing and assisted-living facility closures, which then jumped to 22 closures in 2019, and thankfully only saw two closures in 2020. The last budget included increases for Medicaid providers, and I want to thank you for that support. The reality is, like any business, facility costs increase every single year. However, unlike other businesses, providers cannot just raise their prices to pass on these cost increases to consumers when Medicaid is the primary payer for 55 percent of the nursing facility care in our state. According to our accounting consultant, in 2008, the gap between the average cost and the average Medicaid nursing facility reimbursement was about $20 a day. For 2020, the gap is estimated to be over $30 dollars a day, and you're going to hear some examples today of specific facilities and what that-- what that number

looks like. Data for assisted living is limited, but an example of that would be a provider with 22 percent of their residents reliant on Medicaid. Their private-pay residents must pay an average of $938 more each month in order to make up the Medicaid shortfall. Recently, we learned that Medicaid plans to implement a temporary COVID-related rate add-on for facilities through June 2021. And while we're extremely grateful for this, what we're asking of you today is an increase in funding to continue to close the gap between Medicaid rates and the cost of care. That funding, the funding that we're talking about today, would begin after the temporary funding would end. A business model based on serving a high percentage of Nebraskans reliant on Medicaid that requires a few individuals paying privately to supplement the shortfall is just not sustainable. We owe it to Nebraskans to ensure there's continued access to nursing and assisted-living services by continuing the effort you undertook two years ago to get Medicaid rates closer to the cost of care. You may have heard me say before that we take our responsibility seriously, not just to ask for funding, but to work toward solutions. In the past couple of years, we worked together with Medicaid team and members of the Legislature to develop and implement a new nursing facility reimbursement methodology that's cost efficient, incentivizes quality, and sustains access. We're committed to continuing these efforts. If you're wondering what it would take to fix this shortfall, historically, facility costs have increased between 2.5 and 3 percent per year. So if we think about a 4 percent annual increase, we would at least get ahead of the yearly increases, and take a little bit more out of that gap, and get us closer to the cost of care. Therefore, I urge you to include an increase for Medicaid providers in the budget with the nursing facility appropriation identified as a dollar amount. And be happy to answer some questions.

STINNER: Thank you. Question? Senator Erdman.

ERDMAN: Thank you, Senator Stinner. Thank you for being here. So in the CARES Act, did you-- those nursing homes receive some CARES Act money?

HEATH BODDY: They did, Senator.

ERDMAN: Did it make them whole?

HEATH BODDY: The CARES Act money would have been for COVID-specific expenses. And I think the experience, based on the facility, would matter on what that facility experienced. So said differently, if facilities had higher levels of COVID outbreak, that would have-- the dollars would have a different effect than facilities that had lower levels of COVID outbreak.

ERDMAN: So let me ask it a different way then. Generally speaking, did it bring them up to breaking even with what they were experiencing?

HEATH BODDY: I don't have that data specifically. I would say the CO-- the CARES Act dollars were critical to help in the increased costs for COVID, which would not necessarily get at the gap that we're speaking of here.

ERDMAN: So then there's talk of another contribution from the federal government, and that one is significant as well. Have you reviewed that to see if you'd be eligible, that nursing homes would be eligible for any of that?

HEATH BODDY: Senator, I'm not sure which gap. If we're talking about the next stimulus package, my understanding is, Nebraska would receive a substantial amount of money. How that would manifest into individual facilities, I don't think is clear. I would like to think that we would have some discussion, as a state, in how we can channel some of those dollars to that.

ERDMAN: Yeah, thank you. Appreciate it.

STINNER: Senator Kolterman.

KOLTERMAN: Thank you, Senator Stinner. Heath, welcome.

HEATH BODDY: Thank you.

KOLTERMAN: I just heard yesterday that three more assisted living facilities are closing in the state. Are you aware of that?

HEATH BODDY: Senator, I understand one of them. But if they're of the same ownership, I'm aware. I think they have five in the state.

KOLTERMAN: OK. Well, when that happens-- So as an example, that's happened in York, Nebraska.

HEATH BODDY: Um-hum.

KOLTERMAN: There's only one other facility in York. If they can't take care of them, do you just move wherever you can find a facility? Or how does that work?

HEATH BODDY: Thanks for the question. And it's an incredibly important question, as we look at some of these closures, as we know, over the last years have been in rural markets. I think you're going to hear some testimony behind me that will speak to that a little bit, but let me say this. If there's-- the other options, if assisted living goes away in this example, the other options would be more costly levels of care. And often our-- our colleagues in the hospital environment, depending on what the care scenario is, would end up having some of those Nebraskans reside there. I think the other part that we have to acknowledge, maybe not quite as brilliant of an example in the York market, but when we talk-- [INAUDIBLE] about some of these greater areas-- Senator, you referenced, you know, Mitchell and Bayard before-- we get out on some of these expansive part of the states and a facility goes away, we're talking about extreme levels of distance that families will need to go to participate in their loved one's life and their loved one's care. So I-- it, of course, has an economic impact. It, of course, has a family and a social impact with them, as well.

KOLTERMAN: When Senator Murman did a lot of work to keep Red Cloud open, helped facilitate that a couple of years ago, I believe. And that was privately-owned. And that's-- that's, I think, working out well. But you're right, that's a challenge. And we need to continue to at least fund so they're-- so at least they'd break even because when you-- you're right, when we close down these facilities in a small town, it-- and not-- it places a big impact on the economy of that community.

HEATH BODDY: I completely agree, Senator, I appreciate your thought there. One good thing about this part of healthcare is, we-- we know what the costs look like. We have the ability to-- these costs are

audited. They're capped, so they're only allowable costs. We have an ability as a state to understand what we're looking at as those changes happen. And so if these costs continue to increase between 2.5 and 3 percent, we can look at that, we can audit that, we can-- we can understand what our responsibility would be from the state's perspective to care for those Nebraskans.

KOLTERMAN: Thank you for being here.

STINNER: Could you give the committee some kind of understanding about what's happening in the nursing homes, as it relates to vacancies, and just what that trend looks like, and predominantly how long it's going to be for the nursing facilities to get their population or their census back up?

HEATH BODDY: Thank you, Senator Stinner, for the question. And certainly we've seen in the news that, from a COVID perspective, nursing facilities and assisted-living facilities have been hit incredibly hard, which means that the family members, the residents across the state also, were more-- were more impacted. So from an occupancy perspective, we saw some decline early in COVID, but where it really hit was in the fourth quarter of 2020. And so what we see now, we see, anecdotally, 15 to 17 percent occupancy declines as people have been affected or the life cycle has taken its course. And now consumer confidence is down, based on restricted access, restricted visitations, family members saying: Boy, it's really hard for me to want to take my loved one to a congregate care facility when I'm not sure I'm going to be able to see them, touch them, hug them, kiss them for a while. And so it's had a detrimental impact. When I talk to the experts nationally, my guess is, nobody's certain. But I'm hearing 12, 14, 18 months to make significant climbs out of these occupancy issues. And as-- as we've talked in this committee before, the extreme concern I have for the-- especially these rural facilities is to say the reserves likely aren't there for that kind of-- of a cash loss or-- or the lack of revenue for that long. And what's that going to look like to the fabric of post-acute care, for long-term care across our state? I think we are in for a real challenge here, from a-- from a business model perspective, over the next 12 to 18 months. It really emphasizes again-- and I-- I appreciated Director Bagley's point about, you know, he was trying to process, is this-- is

the viability of those facilities Medicaid's purview or their lift? But I think to-- to whether it was Senator Kolterman or you, Senator Stinner, that made the point, so many Nebraskans rely on Medicaid for their financial support to live in those facilities. That's the commitment we've made to them as a state. It certainly is part of our responsibility, in my mind, as the state of Nebraska, to say we've got to find a way to to close that gap, to make sure that Nebraskans who use their own funds to pay for care aren't picking up the difference of what we're not covering between care and the reimbursement for care.

STINNER: And that gets a little bit back to what Senator Erdman was asking about, is the COVID gap that maybe was incurred initially. And then obviously, there's some funds from the federal government that will come in, probably get-- the nursing homes will get to participate in that, as well. And we're trying to measure that as well, but I think, based on your testimony, $9, $10 is a gap we're dealing with starting out, pre-COVID. So we've got that to deal with. We've got the COVID to get our arms around and what-- what the status is of the nursing homes and then, prospectively, where we go with this. And the federal government, I think, will probably close some of that gap as it relates to COVID, but I don't think it's going to cover all of it. My understanding was-- and several-- depending on where you were located, you had to test your people sometimes once a week, sometimes once a month, sometimes even more so. And that was an extra heavy cost to a lot of the nursing homes.

HEATH BODDY: That's absolutely right, Senator. In fact, at one point, I think three quarters of the counties in Nebraska were red counties, meaning they were higher than 10 percent COVID positivity in the county, which meant, based on Centers for Medicare and Medicaid Services requirements, facilities are required to test their team members two times a week with what I call the old brain scrub, the PC-- the PCR test. And so you can imagine as a team member, one, it's a high cost. And Nebraska did a brilliant job. Governor Ricketts did a great job trying to help us with-- get those tests and have those out there. But from a-- from a quality of life perspective, residents and team members getting these tests ongoing really got to be problematic. So we have the cost perspective, but we also have this-- you know, I'd like to capture consumer confidence, but this desirability aspect that

if you're going to be in an environment, if you go home, you don't have to deal with those things. And so it really makes it a tough equation.

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

HEATH BODDY: And I apologize again for the error.

STINNER: No, that's all right.

DARCIE BRINK: Good morning.

STINNER: Good morning.

DARCIE BRINK: Or is it still morning?

STINNER: It is still.

DARCIE BRINK: OK, good. Senator Stinner and members of the committee, my name is Darcie Brink, D-a-r-c-i-e-- c-i-e B-r-i-n-k. I'm going to take this off, sorry. It's probably easier.

STINNER: Please.

DARCIE BRINK: I'm so used to wearing it. I'm vice president of finance at Tabitha, here in Lincoln, Nebraska. Thank you for the opportunity to be here today to speak on behalf of this. Tabitha has been a Medicaid-certified provider since 1972. We operate three skilled nursing facilities and two assisted-living facilities here in Lincoln and also in Crete, Nebraska. In 2020, Tabitha provided care for 200 Medicaid beneficiaries. As you know, the proposed biennial budget does not include an increase for Medicaid providers. As a provider who works diligently to protect the health and safety of Nebraska's most frail and vulnerable citizens, we are devastated by this failure to recognize the precarious state of our industry. Genworth's most recent "Cost of Care Trends" report, which includes the impacts of COVID-19, identifies the following key factors contributing to the rising cost of healthcare: labor shortages; wage pressures; employee recruitment and retention challenges; regulatory changes; and of course, personal protective and equipment costs. Three of these factors are directly attributable to the unprecedented labor shortages we are living

through. For nursing facilities, approximately 75 percent of our operating cost is labor. With Nebraska's unemployment rates remaining very low and substantial growth projected in the senior age cohort for another decade, labor costs will continue to rise and providers will be forced to offer more pay and higher benefits to fill positions. Under normal conditions, nursing is considered one of the most stressful careers. Under COVID, direct hands-on caregiving became an extremely dangerous job. Layoffs in the restaurant and other hospitality industries did not create a surplus of candidates turning to long-term care facilities for jobs. Although Tabitha recruited aggressively in this impacted sector throughout 2020, very few hires resulted from this. Competition for healthcare workers also increased. In 2020, Tabitha experienced an uptick in employees recruited by hospitals. Certified nursing assistants making more than $15 per hour in our communities were left-- they left to pursue $20 and higher wages offered by local hospitals. Current Medicaid reimbursement falls short of what is needed for Medicaid providers to remain competitive. Even before the worst pandemic in generations, Nebraska's long-term care facilities have been struggling to stay afloat and provide quality care. Now, with COVID-necessitated requirements, Tabitha is spending an additional $2,300 per day for personal protective gear, and the cost of staffing resources allocated exclusively for COVID activity is estimated at $6,400 a day. We, today, ask for no less than a 3 percent increase in provider rates. Thank you for the opportunity to be here with you today, and I'm glad to answer any questions that you may have.

STINNER: Thank you. So you incurred up to $6,400 estimated COVID activity cost. How much was your reimbursement? Do you-- have you quantified that?

DARCIE BRINK: So we received CARES money, as was spoke about earlier with Heath, and what we're seeing right-- we don't have a gap currently in what we receive from CARES money in comparison to what we're spending. But our-- as he spoke also-- our census has declined, starting in the fourth quarter. And we continue to see that even currently today. And so we're expecting that by, you know, June or going on throughout the rest of this year that those monies will deplete, and we won't have enough reimbursement to cover the costs.

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

DARCIE BRINK: Yeah, thank you.

JANET SEELHOFF: Good morning, Senator--

STINNER: Morning.

JANET SEELHOFF: --Stinner and Appropriations Committee members. I am Janet Seelhoff, J-a-n-e-t S-e-e-l-h-o-f-f. I'm the executive director for the Nebraska Association for Home Healthcare and Hospice, representing our home health, hospice agencies, and personal care private duty companies across the state of Nebraska. I'm here to testify on behalf of our members to respectfully ask for adjustments in the Medicaid home health and waiver reimbursement rates. We know that has been at least ten years since we've come before you and asked for an adjustment. And I have distributed a couple of documents to help give you some data around that. One is, first of all, that we engaged Roger Thompson from Seim Johnson to do a study for us. And he looked at an analysis of what the current Medicaid reimbursement rates are, published on the state's Medicaid fee schedule, compared to what the actual costs are to deliver healthcare services in the home for Nebraskans. And he also analyzed the rates for waiver. And he looked at 12 agencies across the state, both urban and rural settings, with home health visits ranging anywhere from 3,600 to 65,000. And that was done over the end of eight-- 2018 through June 2019. And as you looked at that, we looked at staffing salaries, travel costs, cost per visit and overhead, and also factored in a 3 percent inflation rate. It's important to note that some of our home health patients have been longtime patients. These are individuals that have been getting care for 10, 15, even 20 years. And then we have many patients who get what we would call intermittent services. So for example, someone who's recovering from knee replacement surgery that needs just a few in-home therapy visits. The overall findings concluded that for home health agencies, adjustments are definitely needed in direct skilled nursing. That would be RN and LPN services, as well as our home health aides, physical therapy, occupational therapy, and speech therapy services. And for waiver clients, it would be adjustments in the hourly rate for RNs and LPNs. And we've given some recommended numbers on the

spreadsheets to help get to where we need to be to cover our members' costs. We have had numerous discussions with DHHS about this, in particular with Jeremy Brunssen, deputy director of finance, and he was kind enough to share with us the utilization rates from 2018 through 2020, and that's also there for you to look at. And what the department has identified is that there is about an $11.1 million gap of where we need to be to cover services. We are asking for that adjustment because we feel like this cost study clearly shows what's required and overdue to serve Nebraskans. We do recognize that this committee has very difficult decisions to make, competing priorities with many healthcare providers, and we know there's limited funding. So we would entertain a phased-in approach that would help us to get to that target over a certain period. For example, perhaps 25 percent each of the next two years to help address that gap. We also understand that DHHS has not preferred-- performed an internal study or analysis of the services or rates, and we are committed to continuing working with them on that. And in talking with DHHS, I think it's their plan to get back with us in March with at least a high-level look at an assessment, and continue that conversation. Most importantly, this is about access to care for Nebraskans. Home healthcare is the low-cost option for delivery of care in the home. We are seeing an uptick of services across the state; there's no question about that. More and more Nebraskans needing the services, our agencies have higher censuses than they've ever had. So it's a little bit different than what you've heard from some other testifiers. And we are absolutely committed to keeping people independent and safe in the comfort of their homes for as long as it makes sense to do that. And I've got a couple members behind me that will share more specific examples of the impacts on their agencies, serving everyone from children to the elderly. And I'll be happy to answer any questions that you might have.

STINNER: Thank you for that. Questions? Senator Wishart.

WISHART: Well, thank you for being here. And I really appreciate the work that your association has done in preparation for this. And this is very helpful. Quickly, you mentioned that the department is going to be looking at doing, potentially, a rate study. Wouldn't that be duplicative to the work that you've already done here?

JANET SEELHOFF: I think that it will be helpful because we honestly have a lot of questions about the utilization rates that they've shared with us, and we want to have a clear picture of-- does this really encompass everything in home health? And if they can also help us forecast what they think the growth will look like over the next several years, that would be very helpful.

WISHART: OK. When did you come to the department with this information?

JANET SEELHOFF: We first met with them October 23 of last year.

WISHART: OK. So what was their reasoning if they believed that an adjusting of the $11 million would be needed to address the gaps between the actual costs and the state's current reimbursement rate? What was their explanation for not asking for those dollars this year?

JANET SEELHOFF: They've simply said they've had a full plate with other priorities.

WISHART: OK. And then one other question I have is, when we met you mentioned that there may be legislation that's working on this. There have been some issues with requiring like nursing certification for giving somebody a bath that have caused additional costs. I-- I don't know if you wanted to go into that or somebody can talk a little more to that. But I-- my understanding is that some of the requirements for home healthcare agencies are-- are troublesome for-- for staff who have done services in the past, because they require a certain level of expertise or certification for something that-- am I-- am I tracking?

JANET SEELHOFF: I think you might be referring to our personal care home care companies that are not required to be licensed for services.

WISHART: Yes.

JANET SEELHOFF: And they're very restricted in what they can do in the home,

WISHART: OK.

JANET SEELHOFF: Bathing and some other-- what we would call activities of daily living--

WISHART: OK.

JANET SEELHOFF: --are things they're able to do.

WISHART: OK.

JANET SEELHOFF: There has been some discussion with the Public Health Division on whether they may want to move towards licensure requirements for those providers in the future. And we're in the middle of that conversation. As far as home health, licensure is very strict. And so anything that's deemed skilled care has very stringent requirements.

WISHART: OK, thank you.

STINNER: Additional questions? Seeing none, thank you.

JANET SEELHOFF: Thank you.

SEAN BALKE: Senator Stinner--

STINNER: Morning.

SEAN BALKE: --and committee, thank you so much for having me today. My name is Sean Balke, spelled S-e-a-n B-a-l-k-e, and I am president and CEO with a company called Craig HomeCare. And I'm here in opposition today of the preliminary Medicaid budget, and in support instead of the reimbursement rate adjustment proposal that the Nebraska Association for Home Care and Hospice has recommended. And really, instead of reading to you, you're going to have my testimony. My, really, position here today is to speak with you to illustrate the-- some examples in the kind of critical nature of the access-to-care crisis that exists today for really a specific subset of the Medicaid population. My organization, Craig HomeCare, has been providing services, hourly nursing services in Nebraska since 2006. And we specialize in pediatric, very medically complex, very medically fragile cases. We also serve some adults that have similar conditions. Those are typically the aged-out cases. They were pediatric cases that

we moved to adult cases. And in addition to that specialty, my organization is the only one that focuses on serving rural Nebraska in addition to the urban areas. We certainly provide services in Omaha/Lincoln areas, but we serve every inch of Nebraska. We have cases in Sidney. We have cases, I mean, in very hard to reach, remote places. And our organization has struggled considerably to try to make this model work with that mission of making sure that children that are extremely medically complex, that, as my testimony illustrates, very sick children, very sick adults in some cases, that are on medical technology to stay alive. They're on ventilators, they're on-- they have tracheostomies, they have feeding tubes. Think of it as a, for pediatric cases, a neonatal intensive care unit in a hospital. Right? You look at what that type of level of care is. We're replicating that type of an environment in a home setting, so that children that are medically ready-- they're stable enough to be able to come home-- that they can actually make a transition back to the home- and community-based setting where they can be cared for at a much more affordable level than what it costs to keep a patient in an acute-care or rehabilitation hospital. And in addition to those benefits to the-- to the child, in that sense, there's tremendous benefits to the family by not having their child in a long-term-care, acute-care hospital or an institution of some sort, but having them in the community. You can see a list of some of the services that we provide. We-- we only hire and employ RNs and LPNs in our business. So it's-- it's a licensed, skilled, certified level of care. And the crisis that exists is at the bottom of my first page that I'm going to start with, to give you some statistics on what we're facing right now. On average right now, because of the reimbursement rate. It simply has not kept pace, and it's-- it's not even with like what other states are doing; it's market conditions that have been-- been talked about already by some other conferees. Market conditions are difficult in the state of Nebraska, and the rates have not kept pace. Competition is very intense. And yet these areas that need service, especially some of the rural areas, simply cannot compete with even the other entities that are out there today that are-- that are looking to-- to hire nurses, as well. So as a result, only about 51 percent of the medically necessary and approved authorized service hours-- those are hours that the physician says they need, the state says is OK, the managed-care organizations authorized and approve, say

this is what they need to be able to come home. Right now, on average, about 51 percent of those are able to be provided. Now that's across the state. You look rural, and rural families are even more impacted. Those numbers drop to 42 percent or less of the medically-authorized services for those patients that are able to be provided. Consequences of that are we have children-- and I say children, because this is the most often initial transition from an acute-care hospital-- they may sit, they're-- they're ready to come home, family's been trained to care for them when we can't, because that's part of the deal when they come home. Ready to come home but, because we can't have enough nursing to cover what's needed, they stay there for-- we've seen days, we've seen weeks, we've seen months, and we've seen years where the child sits in an acute-care hospital or a rehab hospital ready to come home, but they can't because there's no ability to hire nurses for that service. So that obviously increases tremendous cost to the Medicaid system when those children are sitting in those types of institutions rather than a home care setting. And they also utilize-- the emergency department utilization goes way up because the families don't have help. They're-- they're tired. They have to choose between sleeping, eating, caring for other kids. And they-- maybe they miss a medication dose, they miss a care. These children then have issues. They escalate. They don't notice that there's a symptom of pneumonia potentially creeping in there. And there's kids that are on ventilators. They don't notice it. Child escalates, goes to a hospital. When they go to a hospital, they don't go for a day or two. They're there for weeks or months sometimes with those conditions. So it's tremendous cost to the system. So the cost savings on my-- on the second page of my testimony, I indicate some examples. We've done some work to under--understand what the DRG or daily--

STINNER: Sean, we have-- the red light's on.

SEAN BALKE: Oh, it is. I'm so sorry.

STINNER: Can you close?

SEAN BALKE: I'll wrap up. Gives you an idea of some of the cost differences between $2,600 to $4,800 a day for a hospital-- us about $550-- huge difference in cost savings there. When you get to the impact on families and so forth below, it's just-- it's just-- you

know, if you go to our Web site, craighomecare.com, there's a video called "Kelly's Letter," written by a Nebraska mother who receives these services, tells and shows everything about what she-- her and her family experienced related to caring for a very medically complex child at home. And so thank you for hearing my testimony, and I'll be happy to stand for any questions.

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

SEAN BALKE: OK. Thank you.

STINNER: Just for my-- I'm trying to keep a head count here. How many people have yet to testify or want to testify? How many do we have? I've got this girl--

_____: We have seven-- seven.

STINNER: Seven? OK, we're OK still.

WISHART: Can we go through lunch? Can we go through lunch?

STINNER: Yeah.

WISHART: OK.

KARI WOCKENFUSS: Good morning. Chairman Stinner and members of the Appropriations Committee, my name is Kari Wockenfuss; that's K-a-r-i W-o-c-k-e-n-f-u-s-s. I'm the administrator of the Louisville Care Center and a board member of the Nebraska Health Care Association. I am entering my 29th year as a long-term care administrator-- 17 years of those have been at the Louisville Care Community. I am here to testify in opposition of the proposed Medicaid aid budget recommendation. Louisville Care Community is a not-for-profit, city-owned nursing facility located in Louisville, which is 15 miles south of Omaha. In 2020, Louisville Care Center had 12,164 Medicaid census days in our nursing facility. Louisville Care Center's actual cost, per Medicaid resident day, was $215, but we were only reimbursed $189. Therefore, we experienced a shortfall of $26 per Medicaid day, for a total shortfall of over $316,000. Currently 68 percent of my residents in the nursing facility and 22 percent in our assisted-living facility qualify to receive the Medicaid benefits. We

currently have 73 members on our staff, with a total annual payroll of $2.5 million. But in addition, last year we spent well over $500,000 on contract labor that we are forced to use to fill our professional nurse and certified nurse aide open shifts. In addition to staffing shortages, rural communities such as ours are competing with urban wages and hospitals that can further-- that further impacts our staffing. We do not receive any supplemental funding from the city of Louisville. While we are supported and very appreciative of the $20 per day increase to help with the COVID-related expenses, this is also temporary. Approximately 70-- or 65 percent of our referrals come to us that's already qualified for Medicaid funding. Louisville is one of the few facilities that will accept a Medicaid participant without an obligation for the potential resident to pay privately for a set number of months or even years. If Louisville cannot financially afford to take Medicaid-eligible people, where will they go? Facilities such as ours must be available to meet the needs of the underserved. While we believe in serving all who need care, regardless of the payer source, we are also a business and we need to maintain our operations. I strongly encourage you to include a provider rate increase for both nursing facilities and assisted-living facilities in the next biennial budget. Thank you for your time and consideration, and I will answer any questions if you have any.

STINNER: Questions? Senator Clements.

CLEMENTS: Thank you, Mr. Chairman. Thank you, Mrs. Wockenfuss. Appreciate your good work that you do in Louisville, in my district.

KARI WOCKENFUSS: Thank you.

CLEMENTS: Could you say again what your current ratio is of Medicaid patients?

KARI WOCKENFUSS: We have 68 percent currently, and that's been low. We've ran as high as 80 percent.

CLEMENTS: During the last year you've been that [INAUDIBLE]?

KARI WOCKENFUSS: We've been right about 68 to 73 percent.

CLEMENTS: All right. And how did the COVID affect you? Did you get funding for your extra expense?

KARI WOCKENFUSS: We did. We actually were one of the-- up until last week, we did not have a COVID resident, but last week we received our first one. So-- but going forward, that CARES money is going to help what we're experiencing right now.

CLEMENTS: And how is the gap that you said you have a $26 per day loss on Medicaid-- has that been the last several years about the same number?

KARI WOCKENFUSS: No. We're-- that's actually low for us. We've been as high as about $50 per person per day. I'm not sure, at this moment, where that loss is derived from.

CLEMENTS: OK. And did you have a decrease in population that other people have mentioned?

KARI WOCKENFUSS: Yeah. Right now our population is like sixty 67 percent. So we're down 23 percent.

CLEMENTS: 33 percent of the beds are--

KARI WOCKENFUSS: Thirty-three, yep.

CLEMENTS: --vacant.

KARI WOCKENFUSS: Correct. We have six apartments right now, which usually we're full in our assisted living.

CLEMENTS: Oh, very good. Thank you for being here,

STINNER: Senator Erdman.

ERDMAN: Thank you. Senator Stinner. Thank you for coming today. So where do the people go?

KARI WOCKENFUSS: I'm not sure. Right now maybe Omaha area-- I-- but I can't. I don't know that for sure.

ERDMAN: Do you think they went to other facilities or just went home?

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KARI WOCKENFUSS: I think there's a little bit of both, but I know probably a lot of it went home right now because they cannot see their loved one.

ERDMAN: I don't blame them. That'd be exactly what I would do, too.

KARI WOCKENFUSS: Yeah.

ERDMAN: Yeah. Thank you.

STINNER: Questions? Seeing none, thank you.

KARI WOCKENFUSS: Thanks.

LANA WOOD: Good morning, Senator Stinner and fellow members of the Appropriations Committee. My name is Lana Wood, L-a-n-a W-o-o-d. I'm the administrator of Home Nursing with Heart in Ralston. My agency provides Medicare and Medicaid skilled services in the Omaha/Fremont/Blair surrounding area. And piggybacking on Janet and Sean, we do mainly adults where Sean does the children. So I'm not going to repeat some of the things they said, just tell you a little bit about the patients we're seeing. In the last 27 years, I've been providing home healthcare services to Nebraska, and a majority of them, Medicaid recipients. Some of these patients I have taken care of for 23 years. These patients or the Nebraskans you see out in the community, they go to work every day. They're in our stores, our schools, our churches. Many are there because a Medicaid home healthcare agency went to their homes and got them up out of bed that morning. They transferred them, they gave medications, they fed them. They got him in their mobility devices, and we got them up out of the house for the day. We go back and see these clients again at noon, in their workplaces or at their schools, and help them with their toileting. We make sure they get their new medications, that they get fed, that they're repositioned to prevent any pressure ulcers. We see these patients again at bedtime to bathe them, to get them back into bed, to make sure all their personal care needs are met. We administer IV antibiotics, we change complicated dressings, we provide strength training, we help them with safe transferring. And we also help them with their mental health issues when they may not otherwise follow through with proper treatment. We teach them how to be more

independent in their own settings. We facilitate appropriate communication with their healthcare providers, which may not happen otherwise, and we prevent inappropriate uses of emergency room and hospitalizations by having a 24-hour on-call RN, who can troubleshoot any concerns. Because of our home healthcare agencies, these citizens have the freedom to live outside the confinements of facilities. The gaps are increasing between what home health services are costing us and what we're being reimbursed. Our skilled providers that we have, have a lot of options out there, and we want to continue to ensure that home health can provide qualified professionals to our Nebraskans. That's all I'm going to talk about right now. If anyone has any questions, if you have questions about the home health agent-- home health aides, I can see if I can answer those.

STINNER: Any questions? Seeing none, thank you.

LANA WOOD: Thank you.

STINNER: Morning.

JEREMY NORDQUIST: Good morning, Chairman Stinner and members of the Appropriations Committee. Thank you for your service on this highly esteemed committee. I am Jeremy Nordquist, N-o-- J-e-r-e-m-y N-o-r-d-q-u-i-s-t, government affairs director for Nebraska Medicine. Nebraska Medicine is a nonprofit, integrated healthcare system affiliated with the University of Nebraska Medical Center. We have over 9,000 employees and 1,000 affiliated physicians, and our providers perform over 1 million outpatient visits annually, and about 100,000 emergency room visits every year. Nebraska Medicine opposes the current budget recommendation to keep provider rates flat, and asks the committee to reconsider this appropriation. Medicaid is a critical program for Nebraskans and an equally important revenue stream to sustain our healthcare system across our state. While Medicaid is an important revenue stream, it is not a profit generator, and our uncompensated care from Medicaid continues to grow. Federal disproportionate share hospital audits for Nebraska Medicine show that in 2016, our Medicaid shortfall was $23 million. That grew to $31.5 million, and 2018 is projected to be over $35 million this year. These are actual audited numbers of the costs to provide the care versus what Medicaid reimburses us. Mr. Chairman and members-- I know Mr.

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Chairman likes numbers, so I brought a few specific examples to some of the questions he had earlier. An average MRI for a Medicaid patient costs Nebraska Medicine $560. Medicaid reimburses $458 on average. An endo-- endoscopy costs about $1,400, and Medicaid reimburses $1,270. An average emergency room visit for Medicaid, a Medicaid patient costs $711; Medicaid reimburses $382. And the average vaginal delivery for Medicaid-- a Medicaid patient-- costs $5,272; Medicaid reimburses about $2,800. So it really-- you hear-- you hear a top-line number of, you know, Medicaid's, you know, only reimbursing. at 70 percent. It really varies by services. Those-- you know, the MRI and endoscopy, you know, they're reimbursed at 80-85 percent. But on something high-cost, like a delivery, they're reimbursing, you know, 55 percent. As Medicaid reimbursements fall farther behind, it makes it difficult for health systems like ours to keep our talented healthcare providers and attract new providers. This committee knows very well, with the efforts you've done in the past, that Nebraska is facing a nursing shortage. And having the revenue to provide, at minimum, cost of living salary increases is essential to keep those employees with our systems in our state. Especially post-COVID now, it's been highly competitive to-- to keep nurses staffed. We've also seen in other states that have provider rates deteriorate too far, large numbers of providers will refuse to participate in the Medicaid program, placing a larger financial burden on the remaining health systems. In closing, I know you have very many, many difficult decisions prioritizing the needs of our state. I'll just say that, you know-- you know-- and you know this well. The state dollars you invest in Medicaid provider rates are matched one to one, two to one, or more by the federal dollars. And those dollars are then invested in our communities, paying our providers, our nurses, our medical assistants, and all of our healthcare heroes. So we appreciate your consideration of increasing Medicaid provider rates in the biennial budget. Happy to take any questions.

STINNER: It's good to see you came back to Nebraska.

JEREMY NORDQUIST: Yes. Great to see you.

STINNER: I have two empty seats here, if you want--

JEREMY NORDQUIST: I'm retired from being on that side.

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

JEREMY NORDQUIST: Thank you.

STINNER: Good morning.

JEFF FRITZEN: Good morning, Chairman, Stinner and members of the Appropriations Committee. My name is Jeff Fritzen, J-e-f-f Fr-i-t-z-e-n. I'm the executive director at Gold Crest Retirement Center and a member of the-- a board member of the Nebraska Health Care Association. I'm entering my 11th year as a long-term care nursing home administrator at Gold Crest. I'm here to testify in opposition of the proposed Medicaid aid budget recommendation. Gold Coast Retirement Center is located in Adams, Nebraska, 30 miles south of Lincoln and considered rural. On April 1, our facility was one of the first facilities in Nebraska to have a COVID outbreak. And we were able to see, in a short amount of time, what a COVID outbreak can do in a facility. At that time, PPE was harder to come by. Testing was still a challenge in the state. There was a lot of challenges that we have overcome today that we were not able to overcome In April. We saw large census drops from residents being sent to the hospital, a lot of negative media coverage, increased expenses, and drops in revenue or decreases in revenue. During our COVID outbreak that spanned over three months, our facility saw a $300,000 loss in revenue. Some of the conversation today has been about CARES Act money. In that same quarter, our CARES Act money was about $242,000. So it kind of shows in that particular month where our CARES Act went to and how it kind of helped with the facility and the de-- and the loss of revenue that we saw during that quarter. And then, talking about the census, some people were questioning kind of where census had gone in the facility at that quarter. We saw a lot of fear with our residents. So the ones that didn't get COVID, we saw families pulling them out of the facility at that time. And then we also saw, you know, just over general lifespan, you know, you're just going to have that natural volution of residents passing away, so that census decrease, on top of people leaving, you know, created obviously a census challenge. We're a stand-alone nonprofit facility with 52 nursing home beds, 20 assisted-living apartments, 18 independent living rentals, and we also do a child daycare, which at the same time of the outbreak, we decided that we should close the child daycare until the outbreak was kind of

under control and contained. So I think we closed the daycare for about 30 days. And we have-- we serve an occupancy of 76 children. 41 percent of our nursing home residents are currently utilizing Medicaid funding. And on our assisted living, we currently have 40 percent of our residents using Medicaid funding. Last year we had around 6,881 days of Medicaid census on the nursing facility side, and 1,813 of Medicaid census on the assisted living side. We lost, on average, $40 a day per Medicaid beneficiary, for a total of $315,000. And this data came from our 2019/2020 fiscal year, which is July to June. So facilities have seen a large increase in expenses due to price increases in general supplies, increases in wages to retain and recruit staff, pandemic supply costs, increase in contract labor prices and usage to fill staff shortages. As we continue to get more upside down with the current $40 a day on Medicaid funding, I'm concerned that there will be a placement issue when it comes to vulnerable Nebraskans on Medicaid. Many operators are already having to limit Medicaid admissions in order to try to keep their business profitable. We're the-- the closest facility to us is 30 miles away, so, you know, if we would limit Medicaid funding, they would at least have to travel 30 miles to the nearest facility, and sometimes further than that, obviously, as a Medicaid person has challenges trying to find a bed. Gold Crest employs about 100 employees, or a payroll of $2.3 million in wages. The biggest thing I've seen over the last years, we're no longer competing with hospitals and schools as we had in the past for staff. We're competing with Walmart, Target, HyVee, all those places that have seen, from what I'm hearing, revenue increases during the pandemic, so I see them offering higher wage-- base wages, offering bonuses to their employees, and offering all those different things that are making it challenging to-- to ask our staff to risk themselves, to care for our elders instead of maybe going to a Target and making the same or similar money. So that's been a challenge to the business. And like those businesses, they can raise their cost of goods and services. We are unable to do that with our Medicaid residents' rates. And so Medicaid resident-- Medicaid rates are not paying for the entire [INAUDIBLE]. Residents' expenses during the middle of a pandemic has made it a challenge to recruit and retain staff, cover operating expenses, and still operate in the black. While we appreciate the least-- the latest $20 Medicaid add-on to help cover our current costs, a future increase in Medicaid rates is needed to

help offset future cost increases in wages and benefits, staffing challenges, census and census jobs to avoid facility closures, and provide access to care for all Medicaid residents. I'd be happy to answer any questions at this time.

STINNER: Any questions? Senator Erdman.

ERDMAN: Thank you, Senator Stinner. Thank you for coming today. So those residents that went home or went somewhere else, did any of those return?

JEFF FRITZEN: If they have returned, it hasn't been by their choice. Most of those have not. We really saw it a lot in the assisted living. I wouldn't say as much on the nursing home side-- a little bit. But most of those nursing home residents, it's harder for them, for the family members to care for them at home. But assisted living was where I really saw the dramatic census changes at that time of our outbreak.

ERDMAN: Just an observation that seems kind of peculiar to me. I have several friends who have people in those facilities. They can't go see them. They can't visit them. But yet all the employees go home at night and come back the next day. When they call me and we talk about that and they ask if, in fact, the employees go home and return the next day, why couldn't I go see my family member? So if I had someone in those facilities, I'd take them out, too.

JEFF FRITZEN: Yeah.

ERDMAN: You have-- you have an opportunity there that you can't overcome an obstacle. It's just impossible for people to continue to put their loved ones in facilities like that that you have no control over how they can visit. That-- it's absurd.

JEFF FRITZEN: Yeah, I think that's been one of the hardest challenges with the pandemic is, where's the line of protecting the elder and the seniors, but then still making it enticing to have a family member there for care? I think that's been a hard line we've tried to walk for the last year to figure out where the protection is and where and how to keep them safe, but then, also, allow them opportunities to interact with family and be a part of the community. I think that's

been some of the things I've seen, too, is-- not only just families, but they feel isolated from the community.

ERDMAN: Right.

JEFF FRITZEN: In a center like ours, we had 100-130 volunteers, through pastors, through bingo, through music groups, through all sorts of things that essentially ceased in April. And I-- you know, that's one of my biggest questions I posed to my team is: Will we be able to get those volunteers back? If we can, how many of them will we get back to come back into the facility and make it the place that our residents enjoyed being at, you know?

ERDMAN: This conversation usually goes like this. If I have to make this decision again, I'm not sending my loved ones there or anyone else--

JEFF FRITZEN: Yeah.

ERDMAN: --'cause if that can happen to me once, it could happen to me again.

JEFF FRITZEN: Yeah

ERDMAN: We have a problem. Thank you for coming.

JEFF FRITZEN: Yep.

STINNER: Senator Dorn.

DORN: Thank you, Chairman Stinner. Thank you, Jeff. You and I have visited regularly, I think, through this, from the first COVID patient you had down there, which was one of the earliest ones in the-- I call it the nursing home care business-- in the state. And now I-- the conversation earlier there from Louisville that they just finally had one. I just find that-- I'm very, very thankful-- but amazing. What-- how-- how is your capacity, or what-- what are-- what is the future looking like? Or do you see that-- how long for rebounding?

JEFF FRITZEN: Yeah, I think we've seen a lot of ups and downs in census in our building, so it's really hard to trend line. In June and

July, I was at the lowest census I'd seen in 10 years that I'd been at the facility. But then I also-- there was a portion in the fall here-- winter-- that I saw some of the highest census we've had. So it has really fluctuated. And I have no idea how we've gone months where we've had a lot of people to care for, and then we've had months where we've been wondering if, like, I'm like: OK, how is this going to go in the long term? So since this has definitely fluctuated for our building, but that's not been the norm for other facilities in our area, I think some of that is due to a local facility nearby that has had some challenges. I think that has driven some census to us that we normally wouldn't have seen. I think that's part of why we see that increase at our facility in the last three months or so. But I don't-- I don't know that that's going to sustain. And that's, like I said, all in six months time. I've seen the lowest census, and I've seen some of the highest census in six month's time at our facility.

DORN: OK.

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

JEFF FRITZEN: Thank you.

MARK SROCZYNSKI: Good afternoon, Chairman Stinner and the rest of the Appropriations Committee. My name is Mark Scroczynski, M-a-r-k S-r-o-c-z-y-n-s-k-i. I am the vice president of Emerald Healthcare. We have buildings in Cozad, Columbus, Grand Island, and Omaha. Our patient population right now is 50 percent Medicaid. We're asking for a four percent increase in that Medicaid provider rate. As it stands, that 49 percent equals about 162 patients per day that we have. It's really a difficult situation. You've heard about the care, you've had some good questions with family members out there, and it's it is it is the most challenging. I have been in these nursing homes all the time. Quite frankly, why I haven't caught COVID, I have no idea-- none whatsoever. Our occupancy in all these four buildings ranges from sixty four to sixty seven percent. If I were a betting man, I would say that it's going to be longer than 12 months or 18 months before we get back to normal. If I could guess, and if I knew in 12 months, that would be the case, we could weather the storm. And yes, we have received Cares Act funds, but the federal government's questions about what is COVID- related is-- is difficult and questionable. Things like

when we have a COVID unit, in its own separate unit, we have to staff that with its own separate staff. We struggle just to staff it with what we have, and then you throw in a COVID unit, your own dedicated RN, your own dedicated housekeeper, your own dedicated CNAs, Compassionate Caregivers Act was one of the best things that Nebraska has come out with, credit to Heath Boddy and other people. That 4 percent is going to help us and, yes, we have a $20 Medicaid rate that's going to, in the short term, help us as well. But that's not sustainable. You've heard from my other colleagues on these same matters. Everything else I would say is be redundant at this point, but I'm in these nursing homes. I may have the title vice president, but I assure you I'm in these nursing homes and I see what goes on. So I'll end up with that. Are there any questions I can answer for you?

STINNER: Questions? Seeing none, thank you--

MARK SROCZYNSKI: Thank you

STINNER: --for being here.

ERDMAN: Thank you.

MATT ROSS: All right. Good morning, Chairman Stinner and committee members. My name is Matt Ross, M-a-t-t R-o-s-s. I'm the vice president of Rural Health Development. Our company has been helping nursing homes in small rural communities in Nebraska for 31 years. We are currently managing nursing homes in the following Nebraska communities: Beemer; Benkelman; Bertrand; Callaway; Crawford; David City; Humboldt; McCook; Mitchell; Stuart; Verdigre; Wauneta; Whiteclay; and Wilber. While these communities represent a diverse geography across our state, the nursing homes we serve in them are all nonprofit, stand-alone facilities, doing their best to care for the frail and the elderly in their small towns. I come here today to advocate on their behalf. It's well known that the Medicaid rate paid to nursing homes to care for residents receiving Medicaid does not cover the cost of their care. In order to stay open, therefore, many nursing homes are put in the position of needing to charge private-pay residents more than their fair share of the cost. This problem is compounded by the increasing percentage of nursing home residents who are on Medicaid, especially in small rural towns. Many of our

facilities consider it their mission to care for their community elders, regardless of payer source. In order to keep homes like this alive, we need to push for proper funding. I would be remiss to not mention COVID-19 and how it has disrupted all life as we know it. That becomes an understatement when we talk about the nursing home industry. Nearly every aspect of caring for our elderly has been impacted, and this hardly touches upon the psychosocial impact on our residents. We are so grateful for the provider relief funds and CARES Act money that has been allocated to the facilities. But we cannot rely on this money to continue to flow in to offset lost revenue and increasing expenses. In order for Nebraska nursing homes to be viable into the future, we need our Medicaid rates to come closer to matching the cost of caring for those elders. The cost of providing care continues to rise, so a Medicaid funding that remains flat digs us deeper into a hole. In parting, I'd like to reflect on some advice I've received over the years from my dad. Many of you know my father, Ron Ross, president of Rural Health Development. In between starting our RHD in the early 1990s and now, he took some time away from the company when Mike Johanns asked him to be the director of Health and Human Services for five years. Whether he was working for the state or with RHD, his philosophy has remained the same: Do what you can to put others in a position to succeed. I hope that our efforts today are impactful towards that goal. Thank you for having me. If you have any questions, I'd be honored to have the conversation.

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

MATT ROSS: Thank you.

ANDY FUSTON: It looks like you made it to the end of the line

STINNER: It's after 12:00, so it is the afternoon.

ANDY FUSTON: Yes.

STINNER: Good afternoon.

ANDY FUSTON: Yes. So good afternoon, Chairman Stinner and members of the Appropriations Committee. My name is Andy Fuston, A-n-d-y F-u-s-t-o-n. I'm a director of facility operations for Vetter Health

Services. I am also-- I have also served as mayor of the city of Lyons, Nebraska, for the last 14 years. I'm here to testify in opposition to the proposed Medicaid aid budget recommendation. In May 2015, the Lyons Nursing Home closed its doors. As mayor, I instantly felt many things, but surprise wasn't one of them. The facility had been through six owners, and each time it sold, you felt more nervous about its future. It wasn't, however, until the last company, Deseret, took over that I felt the end was near; and that end came quickly. The state had to step in so that residents and employees were taken care of. In the end, our nursing home had an unceremonious demise. Two years later, an attempt to resurrect the nursing home ended unsuccessfully. It was awful, and I was angry because I knew what it meant for my little town. The loss of our second largest employer had ramifications beyond our community's ability to care for our own elderly. The nursing home was a good utility customer. When they closed, the city instantly lost a revenue source that helped pay for projects the city couldn't otherwise necessarily afford to do. Also gone was the sales tax revenue the city received in the business provided to the local business owners. What we gained, however, was a sense of uncertainty about the future-- the future of the property, the care of our elderly, and the uncertainty of not knowing how much Lyons would suffer from this loss. Now many factors went into the decline of my nursing home, but one must question the role insufficient Medicaid funding played in its story. Had there been adequate Medicaid funding support, would the facility been able to stand financially on its own, or been more attractive to a financially stable, high quality buyer? Could higher Medicaid reimbursement have helped the company that tried to breathe new life into the building succeed? I would have to say "yes" to all of the above. Sufficient Medicaid reimbursement may have helped the Lyons nursing home survive and continue to help our community thrive, as well. We have better health services provide care to approximately 10 percent of Nebraska's Medicaid long-term care seniors. That care is provided in facilities which are also considered part of the fabric of their community-- communities like Lyons. Sufficient Medicaid funding will help those facilities remain anchors in their community and help prevent what Lyons went through with the closing of its nursing home. So my ask of you today is to please consider an increase in Medicaid provider rates for each of the next two years. Without it, Nebraska could experience

more stories, as we've already heard today, and like the one I've just told you; and I don't think anybody wants that. Thank you for your time and consideration. If you have questions, I'd be more than happy to answer them.

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

ANDY FUSTON: You betcha.

STINNER: Any additional opponents? Seeing none, anyone in the neutral capacity? SSeeing none, that ends our hearing on Agency 25.