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

PROKOP: Good afternoon, everyone. Jason Prokop, Legislative District 27, which is west Lincoln and Lancaster County.

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

ARMENDARIZ: Good afternoon. Christy Armendariz, District 18, northwest Omaha and Bennington.

DOVER: Robert Dover, District 19, Madison County and south half of Pierce County.

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

STROMMEN: Paul Strommen, District 47, nine counties, essentially the entire Panhandle.

CLEMENTS: Assisting the committee today is Cori Bierbaum, our committee clerk; to my left is our fiscal analyst for HHS, Mikayla Findlay; and our pages today are Amber Tannehill and Luke Perry. If you're planning on testifying, please fill out a green testifier sheet located at the side of the room for each bill you wish to testify on and hand it to the page when you come up to testify. Online position comments must have been submitted on the Legislature's website by 8 a.m. the day of the hearing to be included in the record. If you have submitted a comment online, we ask that you not testify in person today. If you will not be testifying but want to go on record as having a position on a bill being heard today, there are yellow sign-in sheets at the entrance to my left. These sign-ins sheets will become exhibits in the permanent record after today's hearing. Committee members may come and go during the hearing. This has nothing to do with the importance of bills being heard as senators may have bills to introduce in other committees. To better facilitate today's hearing, I ask that you abide by the following procedures. Please silence your cell phones. When hearing bills, the order of testimony will be introducer, proponents, opponents, neutral, and closing. When we hear testimony regarding agencies, we will first hear from

representatives of the agency, then we'll hear testimony from anyone who wishes to speak on the agency's budget. When you come up to testify, please say and spell your first and last name to ensure we get an accurate record. We request that you limit your testimony to 3 minutes or less. When you begin your testimony, the light on the table will be green. When the yellow light comes on, you have 1 minute remaining, and the red light indicates you need to stop. Questions from the committee may follow. Verbal outbursts or applause are not permitted in the hearing room and may be cause for you to be asked to leave. Written material may be distributed to committee members as exhibits only while testimony is being offered. Hand them to the page for distribution when you come up to testify. We cannot accept oversized exhibits, CDs, or electronic exhibits. If you have written testimony but do not have 12 copies, please let the pages know now so they can make copies for you. With that, we will begin today's hearing with Agency 25, Department of Health and Human Services, and I welcome CEO Corsi. Good afternoon.

[AGENCY HEARINGS]

CLEMENTS: Other questions? Seeing none, thank you for your testimony. We're still on-- anyone wishing to discuss the HHS budget request? Seeing none, we have comments for the record. Position comments: proponent zero, opponents 11, neutral 6. That will conclude Agency 25 hearing. And we will move onto bills, starting with LB1143 with Senator Hardin. Good evening, Senator.

HARDIN: Good evening. Thank you, Chairman Clements, and good afternoon, Senators, of the Appropriations Committee. I'm Senator Brian Hardin. For the record, that's B-r-i-a-n H-a-r-d-i-n, and I represent Banner, Kimball, and Scotts Bluff Counties of the 48th Legislative District in western Nebraska. I'm here to introduce LB1143. LB1143 proposes implementing a money follows the person program to allow for flexible spending of Medicaid funds to assist Nebraskans' transition from institutional to home and community-based settings while still receiving long-term care. This enables eligible individuals to receive long-term care services and supports in the setting of their choice, aligning the Department's federal requirements of supporting person-centered care with the department's ability to manage Medicaid resources responsibly. This bill also addresses an earmark allocating Medicaid spending for institutional facilities, even for members who choose to obtain care in alternative settings. Director Gonshorowski will follow me to provide further details about this bill and is better equipped to answer the technical

questions I know you all have, however, I'm happy to do my best to answer any questions that might contain monosyllabic words.

CLEMENTS: Thank you. Are there questions from the committee? Senator Lippincott.

LIPPINCOTT: What's the upside of this in terms of money being spent per person versus an indus-- institutional care?

HARDIN: Kind of the big idea is I, I think it's just about the fact that today we have more options available to help people age in place than we did years ago. And that opens up flexibilities and money savings, in some cases perhaps $3,000 a month per person because the bottom is that most people don't really want to be institutionalized, they would prefer to age in place, age at home if they can, or if there are other types of community-based scenarios. So it can be a money savings. Part of it is just the fact that technology has changed and, and makes that different, easier than it was, frankly, even 10 years ago. So that's kind of what it's about. It's a money savings experience as well as just more livable for all of us as we age.

CLEMENTS: Any other questions? Seeing none, will you be available for close?

HARDIN: I would love to.

CLEMENTS: All right. We'll invite Director Gonshorowski next.

DREW GONSHOROWSKI: It got chilly in here.

CLEMENTS: Good evening.

DREW GONSHOROWSKI: Good evening.

CLEMENTS: Welcome back.

DREW GONSHOROWSKI: Good evening, Chairman Clements and members of the Appropriations Committee. My name is Drew Gonshorowski, D-r-e-w G-o-n-s-h-o-r-o-w-s-k-i, and I am the Director of the Division of Medicaid and Long-Term Care in the Department of Health and Human Services. I am here to testify in support of LB1143. Thank you to Senator Hardin for introducing this bill on behalf of the department. LB1143 would require the department to submit a state plan amendment for the creation of a money follows the person program for Nebraska Medicaid. The program would aim to help people living in long-term

care facilities who would like to transition back to living in the community by identifying those who are likely able to live independently again. DHHS supports such a program as it focuses on ensuring that patients who require long-term care are served in their preferred setting, whether at home or in a long-term care facility, so long as it is clinically appropriate. The bill provides DHHS with greater ability to ensure that expenditures associated with covering these long-term care services are focused on the setting where the patient is receiving care. Current statutory language provides that the Legislature's intent is to spend the full amount of the nursing facility's earmark. Giving this-- given this limitation, DHHS does not have reasonable discretion to direct funding to alternative settings where patients may choose to be served, such as in their home or community. Within these current limitations, DHHS could end up in a situation in which we spend the full nursing facility earmark and then spend additional funding on long-term care patients in other settings, essentially creating duplicative spending in the Medicaid system. This creates a disincentive to serve clients in settings other than nursing facilities. Instead of moving funding from nursing facility expenditures to other service lines, this currently results in an overall increase in Medicaid expenditures. We respectfully request that the committee advance the bill to General File. Thank you for the time. I'd be happy to answer any questions regarding this bill.

CLEMENTS: Are there questions? Senator Dorn.

DORN: Thank you, Senator Clements. And thank you for being here, Drew. You and I have visited multiple times over this bill already, and I thank you all for the visits very much. I think most of your discussion here centered on the fact of the money follow the patient to where they're going or whatever. As I read this or whatever, that was most of your discussion. What kind of funding or what kind of numbers do you see with that happening--

DREW GONSHOROWSKI: So, so essentially--

DORN: --or what are you estimating, I guess?

DREW GONSHOROWSKI: Yeah, and I, and I, appreciate the question, Senator. I think, I think currently we're, we're not comfortable putting an estimate on how many, how many people will make this decision in terms of-- because, ultimately, this is a question about a conversation with someone that is aging in a long-term care facility or planning on entering into that stage in their life, and where do

they want to end up? That's the question, right? It's ultimately-- I'd, I'd, I'd have to look at the fiscal, but I think this bill didn't have one. And it's, ultimately, to that point is we want to be able to ask that question. And that's, that's sort of what the money follows the person premise is about. It's built off that first question is where do you want to be? Perhaps you're in a facility and you want to figure out a way to sort of be afforded some home and community-based services to age back outside-- back in community or in a home.

DORN: So currently the nursing homes, you have the dollar amounts over here and then you divide it by the utilization rate and you come up with a, a, a dollar amount. I don't know, pick $100 or whatever. So then what you're proposing here is then that if that person is at the nursing home and they decide to move home, then that $100 at the nursing home would have gotten-- that patient's not there no more so they don't get it now, but that that money in that program will follow that patient.

DREW GONSHOROWSKI: Yeah, it's-- it gets pretty complicated pretty quick.

DORN: Yeah.

DREW GONSHOROWSKI: Ultimately, how the-- I'll try to do it justice. The rate setting in the nursing facilities is a day rate. It varies by acuity of the member, and then also by facility. And that day rate effectively is tied to the earmark. And that daily rate effectively still gets calculated tied to the earmark regardless of whether someone stays in the nursing facility or leaves, if that's helpful.

DORN: But your proposal in this part here that is money follows the patient then is to take that day rate and then have that follow that patient into, I call it, their home setting or wherever they're at.

DREW GONSHOROWSKI: Yeah, and, and, and it's-- yeah, that's, that's a fair characterization. It's, it's effectively ensuring that the calculation in the nursing facility is more closely tied to the percentage of cost, and that has an interaction with people leaving or, or choosing a different place in the setting to age. Yeah.

DORN: Are people currently covered under Medicaid when they're at home?

DREW GONSHOROWSKI: Yeah.

DORN: Yeah. Thank you.

CLEMENTS: I have a question, or did you have-- anybody else have a question? I'm familiar with the PACE program, it's one in Omaha, and how would this differ from that?

DREW GONSHOROWSKI: So, so, ultimately, the PACE program in Omaha is, is almost like a-- you can think about it like a day program, effectively. Absolutely wonderful program, had the opportunity to tour Immanuel at this point. I'll get the, I'll get the month wrong, but it was probably 4 to 5 months ago. And, ultimately, this is an, that is an option that is afforded to individuals that are aging and, and, and, and it helps to keep them in a, in a different setting or in a home-based setting when they need sort of extra clinical attention, they can come in for, for the day or come with their caregiver, and, and just an absolutely great option. That fits in this, in this realm. Often that catches people coming in the door, how I would maybe characterize it. Money follows the person, often at least formed from how CMS describes it, is asking, asking questions of folks that are already aging in nursing facilities.

CLEMENTS: They're already in a facility?

DREW GONSHOROWSKI: Yeah, already in a facility.

CLEMENTS: Oh, OK.

DREW GONSHOROWSKI: Yeah.

CLEMENTS: Would the funding for the PACE clients change?

DREW GONSHOROWSKI: I don't believe so.

CLEMENTS: All right. So this is going to be really focusing on people who are already in an institution evaluating if they're able to be treated elsewhere?

DREW GONSHOROWSKI: Yeah, and, and I, I would add to that, too, that, that sort of as a secondary effect it could impact options such as the PACE program in, in the fact that I think the whole premise of this, and, and Senator Dorn did describe it well, which is, you know, this is-- these are limited resources and, ultimately, we want to make sure that those resources are being allocated to the, the setting that the individual wants to choose. And, and that could result in some level

of savings that could afford opportunity to be more flexible in terms of, of different options. Yeah.

CLEMENTS: And does this bill eliminate the mandatory spending of the long-term care appropriation? Did you talk--

DREW GONSHOROWSKI: I would have to look, but I don't believe so.

CLEMENTS: It seemed like you made a comment regarding that spending of the appropriation for long-term care.

DREW GONSHOROWSKI: I would-- I'd have to get back to you on that one, specifically, and just having reviewed a few versions of this bill.

CLEMENTS: I think we had a testifier on HHS budget that was objecting to some striking of some language about the Medicaid funding, but we'll have to-- we might inquire with you about that.

DREW GONSHOROWSKI: Yeah, no problem.

CLEMENTS: Other questions? Seeing none, thank you.

DREW GONSHOROWSKI: Thank you.

CLEMENTS: Do we have additional--

DREW GONSHOROWSKI: Thank you for staying, too.

CLEMENTS: --additional proponents for LB1143? Any proponents? Seeing none, those in opposition? Good evening.

CINDY KADAVY: Good evening. So members of the Appropriations Committee, my name is Cindy Kadavy, C-i-n-d-y K-a-d-a-v-y, Senior Vice President at Nebraska Health Care Association. And I'm here to testify in opposition to LB1143 on behalf of our 171 nursing facility members. Prior to working at the Association, I worked at the department as Administrator of Medicaid State Plan Services. The department sets Medicaid nursing facility rates at the beginning of each upcoming fiscal year using two different numbers. One is the department's understanding of the amount appropriated by the Legislature, and the second one is the department's projection of Medicaid spending on nursing facility services for the upcoming year. As the department's goal is overall to control nursing facility costs during the year, the appropriated amount serves as a cap that directly impacts the rates that are set at the beginning of the year. If the department uses a

different amount than the appropriation, the projected spending cap will be different and the rate set at the beginning of the year will be different. Prior to putting the earmark language in the budget in 2019 and in statute, the department used a lower projected spending cap than the appropriation, because they said the legislative direction was unclear. When the earmark language and the actual appropriation amount were included in the budget, it cleared up the misunderstanding and the department began setting rates that were in line with the legislative direction. It provided clarity and a degree of predictability for providers as everyone was using the same number. The Medicaid director even stated multiple times it was an advantage for them to have the appropriation identified as a specific amount in the budget as it eliminated any misunderstanding. The earmark language has worked since 2019. It's provided clarity to all involved, and helped build trust between Medicaid and providers. The language currently in statute was actually provided by the Medicaid director as a way to preserve the flexibility they wanted and the transparency we sought, which is why the department testified neutral on the bill with their amendment in 2024. Since the earmark was first discussed, Nebraska's had six different Medicaid directors and it is this language that has preserved the intended transparency, even through these changes. Now the department is proposing to change the earmark language in statute and remove it from the budget. The reason for this change is described in their own fiscal note, which says to provide flexibility to deviate from the legislative intent of the amount earmarked for nursing facility rates. This is the very reason Senator Stinner and Dorn fought for this language to be in the budget and in statute to provide rate transparency and predictability and to ensure the department followed legislative intent. It doesn't dictate how much is spent on nursing facility services, it is used to set the rates at the beginning of the year. If nobody's in a nursing home, none of that money will be spent on nursing facility care. So, sorry, thank you. I appreciate the opportunity to make comments and I'm happy to answer any questions.

CLEMENTS: Are there questions? Seeing none, thank you for your testimony. Next opponent. Good evening.

HEATH BODDY: Good evening. Good evening, Chairman Clements and members of the committee. My name is Heath Boddy, that's H-e-a-t-h B-o-d-d-y, and I'm the President of Vetter Senior Living in Omaha. And I'm here today to testify in opposition to LB1143. Really quickly, let me give some background on Vetter Senior Living. Our company was founded 51 years ago by Jack and Eldora Vetter, both of whom are lifelong

Nebraskans. Our nonprofit company provides senior care in 22 communities in the state. We also provide home health care in hospice in 36 of Nebraska's counties. So basically on any given day, our 3,800 teammates are caring for about 2,500 seniors from Nebraska. I wanted to comment today in my former role as the President and CEO of the Nebraska Health Care Association, and I think I could give you some background. And given the length of the day and all the comments that we've had, you, you have my written testimony. I thought-- you just got to hear from the real expert in this work by hearing from Cindy Kadavy, and I thought maybe we'll just do a quick conversational level set. So the, the, the field at that time was nursing homes were closing, were closing. You, as the Legislature, would work through the legislative process with the Governor and establish a budget for nursing facility rates. When the dollars would come out, we as the profession would say, why are not the rates that the legislative appropriate, sorry, the appropriation, why isn't that carrying through to the department? So we established a meeting with the department, and we couldn't true the numbers up. And so I asked them, and I was in the meeting myself, and I asked about these, these numbers not matching. We're doing a white board exercise, and so I finally just asked, like, what number are you beginning with? And then I had the legislative number, and they weren't the same. And I said, but those aren't the same number. Well, yeah, they knew that. And I said do we ever true these up? Do we ever figure out why they're different? Well, essentially, back then, it was this idea that there was a percentage that was sort of housed on the legislative side, and they would use whatever the spend was the year before and increase it by that percentage. And at that time, there were alluding-- you heard Cindy allude to a utilization percentage. They were forecasting utilization increase, I think it was 2 or 2.5% of the time when it was actually decreasing by about a percent and a half. And so there was, there was a delta there. Long story short, they weren't matching, it was about $7 million a year over the 4 years that we studied it, was about $30 million that was not going into the rates. To me, this is a budget issue. We, we operate a business, I'm sure many of you operate a business, when you set a budget, you expect for that budget to be portrayed unless it can't be, and then there needs to be accountability to that, which is the other part of what the process does now. You're to receive a, a report in December that tells you here's the appropriation, here's how it was spent, was there any variation in that? That's really what makes sense to me in this business. We keep talking about operating Nebraska as a business. That's how we do things in my business. It's not my business, but the

business that I work in. We establish a budget, we expect people to work from that, and then tell us when they have to deviate. I, I don't see any reason that if there's emergencies with Medicaid that things have to be changed or if they have to alter dollars, but there should be an accounting to the Legislature so that you can make those adjustments in the future. So I'd be happy to answer any questions if there are any, but I just wanted to share a little bit of context of what was happening at the time.

CLEMENTS: Are there questions? Seeing none, thank you--

HEATH BODDY: Thank you.

CLEMENTS: --for your information, for your testimony. Next opponent. Good evening.

JAY COLBURN: Good evening, Chairman Clements and the rest of the committee. Sorry we're dragging on so long today. My name is Jay Colburn, J-a-y C-o-l-b-u-r-n, and I'm the Vice President of Long-Term Care Services for York General Health Care Services, and I also serve as the NHCA Board Cochair. And I'm testifying in opposition of LB1143 for NHCA, the Nebraska Hospital Association, and York General Health Care Services. York General Health Care Services does have a critical access hospital and our 127-bed skilled facility. So primary concern has already been covered pretty well. It's really about accountability and transparency around the earmark that's being struck with the bill. Before 2019 and statute 68-949, the department would utilize funds intended for nursing home rates to fill other gaps and programs they preferred. What the Unicameral appropriated was not directed to where it was intended and the dollars were lost in the formulas used by the Nebraska Department of Health and Human Services. What we have now at least provides transparency if the department is getting into the skilled nursing appropriation, which I think is positive. My observation is this bill is to shroud what would be a revenue grab from skilled nursing providers under the guise of money follows the person. And it's coinciding with times that are tight on the budget, which I think kind of lends, lends to that theory. Transparency has provided some improvement to the predictability of skilled nursing rates and if any rate increase in appropriations is, is decided then it has a better chance of making it to the intended recipient under our current statute. Beyond that, listening to all the testimony today, you have some heavy decisions ahead of you as a committee. Appreciate your service to the state of Nebraska, and I wish you all, all wisdom. I do also, as, as a father, I have a daughter who is

attending the University of Nebraska at Lincoln in microbiology to try and either fight cancer in the laboratory or as an oncologist, depending on how that track follows. And that sprung from my son being an adolescent cancer survivor, so I wish you all the best. It's going to be, going to be a rough, rough session.

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

JAY COLBURN: Thanks.

CLEMENTS: Next opponent.

JALENE CARPENTER: Good evening, Chairman Clements, members of the Appropriations Committee. My name is Jalene Carpenter, J-a-l-e-n-e C-a-r-p-e-n-t-e-r, President and CEO of Nebraska Health Care Association, testifying in opposition to LB1143. I wanted to just hit very key points just to reiterate in the handout that was handed out earlier. It does show three scenarios of how utilization works in nursing homes to where the money is appropriated up to the end of the year. But if there is no people living in nursing facilities that money is not spent. There is a required report in the current statute that is back-- sent back to the Legislature to where if they did not spend those dollars you would all be made aware of that, and they could come and ask them to spend those dollars elsewhere. I would also just like to reiterate, we do not oppose money follows the person, but we do oppose person follows the money. And with the language modifications that were made in this proposal, even the fiscal note states, and I quote, the impact of nursing facility rates is indeterminable. The changes may result in an increase or a decrease. The reason the language exists is for transparency and accountability. The proposed changes clearly by the fiscal note take that away and we just want to make sure that we're able to maintain that. And I wanted to make sure and reiterate that that we-- if we want to institute money follows the person that it truly works that way and not the opposite where we take money away from nursing facilities and move it to a different service in hopes that people transition to that level of care. And with that, I'm happy to answer any questions.

CLEMENTS: Any questions? Seeing none,--

JALENE CARPENTER: Thank you.

CLEMENTS: --thank you for your testimony. Other opponents on LB1143? Seeing none, anyone here in the neutral capacity? Seeing none, Senator Hardin.

HARDIN: I appreciate everyone who is invested in this and, and takes care of that part of the world. I appreciate Ms. Carpenter and, and what she's saying in terms of they're not against the concept that they're after here in terms of money follow the person. And so certainly open to if there is anything we can do with potential amendments and what not to make that a better consensus to, to discuss that. So very glad to, to talk with each and everyone about, you know, what is the best thing. We're all getting older and we're all going to get to struggle with this. So what we pass here, we probably get to live with ourselves in a little while. And so we're making decisions for us, I would say, but I, I think that's ultimately what we're after is we're seeing paradigms change as technologies change. We all used to kind of chuckle about the poorly designed commercial years ago, I've fallen and I can't get up. Well, that was about a button that you could push and sort of life could get better. A lot of technologies have since come along that make aging in place different. We're asking different questions now than we were able to ask many years ago. And so it creates other flexibilities in terms of accountability for when do you take medicine when you get older and so forth. And all of this has created some good things, but it's created some confusion. It's hard to create a nursing home or a whole bunch of them or an institution that looks after them. So I appreciate the people who are here that, that that's their world looking after 2,500 of our aging population is a big deal. And so I appreciate the challenges that they have on their plate and-- but I think we're also in an age of some new opportunities in terms of how do we do that? And, ultimately, how can we get people to stay in their, their homes or communities longer and create the flexibilities within that Medicaid system to be able to help people out when they need it?

CLEMENTS: Any questions? Senator Dorn.

DORN: But mine is not a question, so much as a thank Senator Hardin here. I know you introduced this bill and wanted it to go to your committee and I put it in here or whatever, or got it switched to here. Thank you for working with me. Thank you very much for Drew and John Meals and Director Corsi for all the visits we've had. And I've had those with Jaylene, so we will work something. Yes.

HARDIN: It, it was fine Senator Dorn. We actually had 69 bills in this short session in HHS. So the most we've ever had so it, it was helpful. So thank you.

DORN: Thank you.

CLEMENTS: Other questions? Seeing none, thank you, Senator.

HARDIN: Thank you.

CLEMENTS: We have position comments: proponents 11, opponents 9, neutral zero. That concludes the hearing for LB1143. We will next open the hearing for LB1122. Welcome, Senator Bostar.

BOSTAR: Thank you. My remarks say good afternoon, but that feels inaccurate. So good evening, Chairman Clements, members of the Appropriations Committee. For the record, my name is Eliot Bostar, that's E-l-i-o-t B-o-s-t-a-r, representing Legislative District 29. I'm here today to introduce LB1122, legislation to increase the Medicaid appropriation for nursing facility care. LB1122 requests a 3% increase for fiscal year '26-27 and restores intent language that was removed from the administration's budget related to considering the impact of inflation. This language was previously introduced by Senator Dorn, which the Legislature passed in an amended LB130 during the One Hundred Eighth legislative session. LB1122 is necessary to help protect a vulnerable population of aging and disabled Nebraskans. Facilities are experiencing financial strain as they continue to face rising costs for food, medical supplies, and the, the intensive staffing required to operate a 24/7 facility. In order to remain viable in the modern labor market, most facilities must raise wages. Additionally, wages are forced up in order to comply with federal regulatory mandates that have come without additional funding. These pressures impact facilities and, ultimately, families across Nebraska. Without an appropriation increase, it will become even more difficult for vulnerable Nebraskans to receive the care they require. Nursing homes in our state currently accept a rate significantly below the cost of care when they participate in the Medicaid program. According to a report released in 2024 by the American Health Care Association and the National Center for Assisted Living, Medicaid pays approximately 82 cents for every dollar needed for the cost of care. When rates decline, so too does the overall quality of care and, ultimately, the ability for providers to accept Medicaid patients. LB1122 seeks to address this growing gap between rising costs and the ability to provide vital care. According to the Congressional Budget

Office, it is reasonable to expect that inflation will remain over 2% between 2026 through 2028, which will further erode current care levels and even the modest proposed increase in LB1122. In addition to the rate increase, the bill includes language to require the Department of Health and Human Services to file a report describing how the inflation factor is calculated in the determination of nursing home rates. Increasing the rate and ensuring inflation is appropriately calculated will help make sure this committee's work does, in real and practical terms, support the growing need of an aging and increasing vulnerable population in our state. When nursing facilities cannot accept patients, both financial and human costs increase because people may require longer hospital or rehabilitation stays or may return home without the skilled care required, ultimately leading to health emergencies that are costly and difficult on the individual and family. Those expenses also end up increasing costs for both taxpayers and individuals in need of care without the benefit of prevention and stability provided by quality nursing home care. For nursing facilities, Medicaid rates are more than numbers in a business model. Individuals and families seek nursing facility care reimbursed by Medicaid for a wide variety of reasons: unexpected illness, sudden passage of a breadwinner, or tragic accidents. LB1122 prioritizes state investment in the care of our most vulnerable community and family members, whom deserve dignity, safety, and support. And with that, I would urge your support for LB1122. And I thank you for your time and attention, be happy to answer any initial questions.

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

BOSTAR: At this point, absolutely.

CLEMENTS: We welcome proponents for LB1122.

KIERSTIN REED: Well, good evening, Chairperson Clements, members of the Appropriations Committee. My name is Kierstin Reed, that is K-i-e-r-s-t-i-n R-e-e-d, and I serve as the CEO for LeadingAge Nebraska. And we are here to testify in support of LB1122. LeadingAge Nebraska is a statewide association representing about 40 nursing homes in the state of Nebraska, all of which are either nonprofit or locally owned and operated. We are here because the cost of providing nursing facility care in Nebraska has risen significantly while Medicaid reimbursement has simply not kept pace. In fact, nursing homes have not received a Medicaid rate increase since 2023. The gap is growing and it is putting the system that is already under strain into an unsustainable position. Nursing facilities are facing higher

costs across the board. This includes wages, benefits, food, utilities, insurance, medical supplies, and regulatory requirements. Labor alone represents the largest operating cost in our nursing homes, and these facilities are competing for the same workforce that hospitals, clinics, and other industries are. Yet, Medicaid reimbursement does not reflect these labor realities. This matters because 60% of nursing home residents in Nebraska need-- rely on Medicaid for their care. Medicaid is not a small or supplemental payer, it is the backbone of long-term care financing. When reimbursement falls behind the actual cost of care, facilities are required to absorb those costs for every resident they serve. This financial pressure directly impacts staffing. When rates are inadequate, the facilities struggle to meet their average cost-of-living wage. And the communities need to retain staffing at every level, which becomes difficult. This leads to high turnover, more reliance on temporary staffing, and increased stress on those that remain as caregivers. To maintain stability, these caregiver workforces are required to reduce the number of people on Medicaid that they are able to accept. This request for funding is not about excess or expansion, it's about keeping the system functioning. And we encourage you to make sure that nursing facilities have the appropriated budget request. Nebraskans really cannot afford to wait. Thank you for your consideration, and I'm happy to answer any questions you may have.

CLEMENTS: Are there questions? Seeing none, thank you for your testimony. Next proponent. Good evening.

JAY COLBURN: Good evening. Thank you for your time, Chair Clements, and the rest of the committee again. My name is Jay Colburn, J-a-y C-o-l-b-u-r-n. I'm the Vice President of Long-Term Care Services at York General and also serve as the NHCA Board Cochair, testifying in support of LB1122, that's both for NHCA and the Hospital Association and York General Health Care Services. Same song, different verse. It's been challenging, did not have increases while we've had inflation that folks of, of, like, my generation, I'm just about to close it on 50, we haven't really seen big inflation except for the last couple of years, it's been pretty significant, and not seeing an increase for skilled nursing facility rates has been challenging. We do, just like every other household, we're, we're like, we're like a big house. We have to buy supplies, we buy a lot of food, we utilize energy, and then we have staff that need to be paid. So in addition to that, regulatory requirements at the federal and state level have not decreased while our rates have remained stagnant. Recently, skilled

nursing facilities had over 900 new pages from the Centers for Medicare and Medicaid Services of regulations and guidance stacked on top of our previous regulations. The new guidance did not simplify compliance for facilities. The new regulations raised the bar, and good, bad, or otherwise, there is increased cost and compliance burden that comes along with that. So as we kind of look at the future of Nebraska and our seniors and the aging population, I think it's going to take the skilled nursing facilities we, we currently have, if, if not more. I think we need our assisted living facilities and continued growth there. We're going to need programs like money follows the person and PACE programs in the state as well. It's going to take all of us to meet the needs of our seniors as, as they age. And this increase would be a great help for our current day-to-day operations. And as well to help us prepare for our aging population in the state of Nebraska. I'd be happy to answer any questions.

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

JAY COLBURN: Thank you.

CLEMENTS: Next proponent. Good evening.

KILEY GOFF: Good evening, Chair and members of the Appropriations Committee. My name is Kiley Goff, K-i-l-e-y G-o-f-f. I am here today in support of LB1122 on behalf of Emerald Healthcare and the rural community I call home, Cozad, Nebraska. I live in Cozad. I work in Cozad. And every day, I care for people from Cozad and the surrounding areas. This isn't just where my job is, this is where my life is. I serve on the Cozad Community Schools Board of Education, and I'm a member of the Cozad Ambassadors. I believe in investing in rural communities and keeping them strong. I am a licensed nursing home administrator and a trained speech language pathologist. I am the Administrator of Emerald Nursing and Rehab Cozad, where I have worked for 11 years, 8 of those as Administrator. Our facility employs 85 people locally and cares for an average of 60 residents, 85% of those residents rely on Medicaid. These residents are our neighbors: farmers, teachers, parents, and grandparents who built our community. Medicaid reimbursement determines whether they can receive care close to home surrounded by family and familiar faces or whether they are forced to leave their community and find care elsewhere. LB1122 is about stabilizing Nebraska's long-term care system, especially in rural areas like Cozad, where health care options are limited and costs are higher. Nursing homes are a required part of the health care

continuum and Medicaid is the primary payer for long-term care in Nebraska. Long-term care depends on two essential things: people and equipment. We need skilled nurses, aides, therapists, and support staff to provide safe quality care. We also need the right equipment: lifts, beds, therapy equipment, infection control supplies, and technology that supports resident safety and clinical care. Medicaid reimbursement is what allows providers, especially Medicaid providers, to recruit and retain staff and maintain the equipment needed to care for residents safely and effectively. Today, Medicaid reimbursement does not reflect the true cost of care. Providers are operating at a loss, roughly $30 per resident per day below cost. That gap has real consequences. In rural facilities like mine, it directly impacts staffing levels, wage competitiveness, and our ability to replace or upgrade essential equipment. Emerald Healthcare is one of the largest Medicaid long-term care providers in Nebraska, with over 1,000 licensed beds statewide. Reimbursement decisions affect workforce stability, access to care, and economic health across many communities, including mine. Appropriate Medicaid funding is not an expansion, it is a stabilization strategy. LB1122 is a prudent investment in Nebraska's long-term care system and rural Nebraska. I respectfully urge your support. Thank you for your time and consideration. I'd be happy to answer any questions you may have.

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

KILEY GOFF: Thank you.

CLEMENTS: Next proponent.

SPENCER BARTLETT: Good evening.

CLEMENTS: Good evening.

SPENCER BARTLETT: My name is Spencer Bartlett, S-p-e-n-c-e-r B-a-r-t-l-e-t-t, and I was nervous to spell my name this evening. I am-- I, I actually told a lie earlier today, and I'm going on record stating that now. I said I was a fourth-generation Nebraskan. I actually went to Ancestry.com to check and see. I'm a fifth-generation Nebraskan. I'm the nursing home administrator, and the very first nursing home that I operated was the nursing home that my great grandmother spent the last 7 years of her life in. That happened, some would say, by chance. I don't think it was. I love the residents that I serve. And in my current role supporting seven skilled nursing

facilities across Nebraska, I love people who love the residents and I serve them. I chose the degree that I pursued because it had the least amount of math and I'm about to do math with you. Using 2020 to 2022 as a baseline and comparing our 2023 to 2025 costs, my nursing homes saw a 30% increase in costs associated with long-term care, primarily labor, but also supplies and equipment, food, etcetera. I met some really nice senators today who I think wanted to temper my expectations about what we could accomplish with LB1122. They said things like it's going to be a long day, there's not, there's not any more money in the budget, it's a tough-- you know, it's a tough go. And so I'll make a concession, I won't ask for the 30% that my costs have increased in a 3-year period, I'll ask for 3%. And I'll ask you to support the residents of Nebraska that we serve. And I'm happy to take any questions.

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

JALENE CARPENTER: Groundhog's Day. Hi.

CLEMENTS: Good evening.

JALENE CARPENTER: Good evening, Chairman Clements, and members of the Appropriations Committee. My name is Jalene Carpenter, J-a-l-e-n-e C-a-r-p-e-n-t-e-r, and I'm the President and CEO of Nebraska Health Care Association. I'm here today on behalf of our 171 nursing facility members in support of LB1122. Huge thank you to Senator Bostar for introducing this legislation in what is a difficult fiscal environment. I also want to just thank all of you on the Appropriations Committee. It is a very difficult job. The testifiers before me did a fantastic job articulating the difficulties of operating nursing facilities and why we're asking for an investment into long-term care. In your handout, there is a 2025 CPAR report entitled Nebraska's Aging Populations and Implications for Nursing Facility Care. There's a 22% projected increase in Nebraskans 80 or older in the next two decades. And we need to ensure we have a robust continuum of care, which is why we need strong long-term care services like nursing homes, assisted living, all the way down home care, all the services for our aging population. I will call out the CPAR report states, and I quote, analysis shows that such access is limited in many greater Nebraska communities. As a population age 80 and over continues to grow, ensuring that care is available and geographically accessible will be important considerations for both the well-being of the state's aging population and the sustainability of, of communities

across greater Nebraska. In the other handout, titled The True Cost of Nursing Facility Care, you will see that according to CMS cost report data updated in December 2025, Nebraska nursing homes on average have only 25 days cash on hand. That is significantly lower than the national average of 71 days cash on hand. This is also troubling when you look at the operating margins fell into the negative, which is also not sustainable, but also lower than the national average. It's critical that we find ways to invest in this important population. Now I understand it's easy to kick the can down the road, but if we continue to do that, that gap will continue to grow and access for seniors will be limited. So I kindly urge your support of LB1122 and happy to answer any questions.

CLEMENTS: Any questions? Seeing none, thank you for your testimony. Are there additional proponents for LB1122? Seeing none, anyone here in opposition? Seeing none, anyone in the neutral capacity? Seeing none, do we have comments for the record? Senator Bostar, you're welcome to close.

BOSTAR: Thank you, Chair Clements, members of the committee. You know, this, this legislation isn't about-- we talked about closing the gap. This, obviously, doesn't close the gap. In a lot of ways it doesn't even really work in that direction. It's, it's an attempt to keep the gap from getting even bigger, even faster. And the reality is, is we're going to end up paying for this one way or another. If we create a scenario where more and more and more Nebraskans can't receive nursing care, that won't fix the, the, the health issues that, that require the care to begin with, right, those will just become exacerbated. And, ultimately, these individuals will find themselves in much higher levels of care: emergency care, hospital care, care that's significantly more expensive than this. Nursing care isn't cheap by any measure, but it's significantly more affordable than hospitals and emergency rooms. And that's where these individuals will end up, and we'll pay for it. So, you know, as, as you do your work, I think just try to keep that in mind a little bit that while it's expensive, the alternative is more expensive. With that, I'm happy to answer any other questions.

CLEMENTS: Senator Spivey.

SPIVEY: Thank you, Chair. Thank you, Senator, for being here. I just had a quick question. So Medicaid is complicated and nursing home is like a new space for me. How does your bill relate to Senator Hardin's with the-- or if, if it doesn't with the following [INAUDIBLE], I know

that there was some opposition to that bill and kind of mixed feelings of that model. Is your model and what you're proposing here has nothing to do with how they implement it, it's just solely around the 3% increase for Medicaid?

BOSTAR: That's my understanding. I will say I'm not that familiar with Hardin's bill. The extent of my exposure to it was sitting in there while he was kind of closing on it. From what I gathered from that very limited experience, our bills are not particularly related.

SPIVEY: OK. Thank you.

CLEMENTS: Other questions? Seeing none, thank you--

BOSTAR: Thank you.

CLEMENTS: --for your testimony and your bill. We have position comments for the record: proponents 19, opponents zero, neutral zero. That concludes the hearing for LB1122. We will now open the hearing for LB1229 by Senator Strommen.

STROMMEN: We're approaching record territory here. 7:30. I'll try and keep it under an hour so that we give Myron a shot at both of his. How does that sound?

CLEMENTS: Good evening, Senator.

STROMMEN: Good evening. I actually have a couple of handouts, some handouts. OK.

CLEMENTS: OK, LB1229, you may proceed.

STROMMEN: Thank you, Chairman Clements, fellow members of the Appropriations Committee. I am Senator Paul Strommen, P-a-u-l S-t-r-o-m-m-e-n, and I represent District 47, nine counties in western Nebraska. Today, I bring for your consideration LB1229, which creates the Rural Health Transformation Fund. This past July, the federal government created the $50 billion Rural Health Transformation Fund as part of HR1. This landmark legislation presents a once in a generation opportunity to strengthen rural hospitals, expand access to care in rural areas and modernized rural health systems for the next 5 years, $10 billion annually will be directed by the federal Centers for Medicare and Medicaid Services to each of the 50 states. For fiscal year 2026, Nebraska's portion of the $10 billion will be $219 million. As my fellow members of the Appropriations Committee know all too well

in a time of budget cutting and fund sweeps where we are looking for every dollar to meet needs, over $1 billion flowing into Nebraska over the next 5 years to address rural health care needs is a true opportunity. It is one Nebraska must take full advantage of to propel rural health care forward. LB1229 provides transparency and visibility into this transformational funding opportunity in three ways: First, it creates the Rural Health Transformation Fund as the cash fund repository for the funds provided annually from CMS. The notice of funding opportunity from CMS requires each state to submit only one official application with an authorized organizational representative designated by the Governor through discussions with DHHS. And as you note on the fiscal note, the concept of a fund creates conflict with how these dollars will be drawn down from CMS. I have worked with DHHS on language to fulfill the intent of the fund that defines it as a budget sub-program that will track and document RHTP funds. I will work with committee staff and DHHS to finalize an amendment. We have started drafting to address that need and avoid the potential to jeopardize any federal funds. Second, Section 2 of LB1229 provides critical transparency for the Legislature, taxpayers and stakeholders regarding the state's application for use of our RHTP funds by requiring public submission of any application for funds to CMS to be reported to the Clerk of the Legislature. It also requires DHHS to post all awards, direct and indirect, and all grants on the website of the Department of Health and Human Services. Annually, a port-- a report on all beneficiaries' outcomes and metrics shall be provided in a report to the Clerk of the Legislature, who shall post that information on the Legislature's website. We are working on amendment language with DHHS to streamline this process and conform to the updated reporting practices adopted by the Legislature as well as sunset the report at the conclusion of the RHTP program. Finally, Section 3 establishes two important parameters to ensure maximum impact of this generational opportunity. First, it specifies that no money spent from the fund will be used to supplant existing rural health spending. This actually aligns with federal guidance that RHTP funds not be used to fill existing budget gaps or underwrite existing state rural health care commitments. This is new funding intended to provide new investment in rural health care. Second, it requires individuals who apply to receive money from the fund to have an approved sustainability plan prior to fund distribution. We're all too familiar in Appropriations Committee with one-time investments that are made with no foresight into how the program would be maintained beyond the initial funding period. Since we know from the start there is a 5-year term limit on the RHTP funds, it is good policy to require

these transformational investments begin with the end in mind and have a sustainability plan in place at the time of program application. Nebraska has been identified as a leader in the RHTP program, as demonstrated by the 8th highest state award and Governor Pillen's invitation to discuss the program alongside President Trump and key cabinet members. It is now the responsibility of the members of the Legislature to provide the necessary oversight of this critical program to maintain our position as national leaders. In the Rural Health Transformation Program, Nebraska should adopt these best practices as other states have already done or are considering. Three states have already adopted legislation similar to LB1229, Pennsylvania adopted legislation in November of 2025 before the grants were even announced, and both North Dakota and South Dakota adopted RHTP funds specific legislation in January of this year. Six other states, including our bordering states, Iowa and Kansas, as well as Arizona, Indiana, Oklahoma, and West Virginia, have legislation creating RHTP-specific funds in various stages of consideration. I have provided a handout for your reference with the details of each state considering similar legislation. There will be stakeholders who follow me who will discuss more specific aspects of the program, how it is working so far and the value of this proposal to ensure successful implementation and utilization of these funds. We must not squander this amazing opportunity that has been afforded Nebraska to invest in rural health care. I thank you for your support for LB1229 and welcome any questions you may have. I shared with Chairman Clements earlier, this is the language that we received from DHHS and we're working on that with ourselves and--

CLEMENTS: Senator Prokop.

PROKOP: Thanks, Senator Strommen for being here. OK, so, so set me straight on this, maybe I'm just not getting it. So in the fiscal note prepared by DHHS in that second paragraph, it says the fiscal impact has created a significant risk of federal noncompliance and then the rest. But then you provided examples of other states that have essentially done the exact same thing. So how would we be in federal noncompliance and they've gotten around that or is that what the amendment is going to do?

STROMMEN: So the amendment takes care of some of that. We have had those questions as well, and we're trying to work through that. We know that this, I think, has been stated before, this is not a block grant, so my best guess would be that they created a program and funded that themselves, but we don't have any clarity on that, but

maybe some of the folks behind me do and might be able to better answer that question.

PROKOP: OK.

CLEMENTS: Other questions? Senator Spivey.

SPIVEY: Thank you, Chair. Thank you, Senator, for being here. One of the-- this reminds me of, like, the north and south Omaha recovery grants, right, like, that was really important to my community. And one of the things I think I have learned coming into this role is the agency is responsible for the administration. And sometimes there's not that transparency that we would hope for as legislatures that are appropriating and overseeing the implementation success. And have you thought about adding in amendment language that also looks at the decision-making criteria? Because I think it's one thing to show the list of people who applied, but how they actually make the decisions on a matrix or grading scale to say, like, this is the awards that we're giving, I think is also helpful.

STROMMEN: My understanding is that there is specific, specific criteria for the awards, so that's already been delineated out. And my understanding is that we don't actually have the ability to change that, because those are guidelines that were set by the federal government.

SPIVEY: Which is fine, I'm just saying how that is administered. Because within, within the guidelines someone is still making a decision yay or nay to a project and so just something, something to think about from an amendment perspective of if this goal-- part of the goal is transparency around the funds and the awards, also that decision-making and, and capturing that could be helpful, again, from the experience that I'm seeing with that grant, so.

STROMMEN: Gotcha. Thank you.

CLEMENTS: Other questions? Seeing none, will you be staying to close?

STROMMEN: Yes, sir.

CLEMENTS: All right.

STROMMEN: Got nowhere else to go.

CLEMENTS: We welcome proponents for LB1229. Good evening.

JUSTIN WOLF: Good evening, everybody. Good evening, Chairman Clements and members of the Appropriations Committee. I'm Justin Wolf, J-u-s-t-i-n, Wolf, W-o-l-f, the CEO of Memorial Community Hospital in Aurora. I'm here in support of LB1229, a bill to provide transparency around the Rural Health Transformation Program. As your colleague, Senator Lippincott, can hopefully confirm when you talk about rural health care in Aurora and the Hamilton County region, Memorial Community Health [SIC] is what comes to mind. A century ago, the residents of Aurora and Hamilton County established the first hospital in a wooden framed house. In 2026, Memorial Community Health [SIC] is a diverse modern health care system that includes three family medicine clinics, a critical access hospital, outpatient specialty and diagnostic services, assisted living facility, long-term care facility. We are rural health care in a rural community. There's not an aspect of rural health that we don't touch. Running a rural hospital requires a precarious balance to maintain the financial liability needed to provide affordable access to a wide range of services for patients in all stages of life and health conditions. As a locally governed independent hospital, we navigate changes to federal and state policy in a rural context. HR1, passed last July, made a number of changes that could have a disproportionate financial impact on rural hospitals, including changes to the future of the direct payment program and Medicaid. To blunt the financial impact of those policy changes, the Rural Health Transformation Program provided a $50 billion infusion of funds to stabilize rural hospitals and rural health care access. As Nebraska learned at the end of December, we will be receiving $218 million to fulfill those objectives this year, with similar greater amounts through the future of the program. Those funds are subject to clawback if not used properly. Due to widespread coverage of the program and Nebraska's large award, communities across the state are counting on the Rural Health Transformation Program to provide the lifeline they need to keep health care access close to home and affordable. LB1229 provides critical transparency and provides engagement for all Nebraskans in this opportunity to transform rural health care in Nebraska. Each community has unique needs and financial circumstances, clear visibility in how these funds are deployed, and encouraging feedback in how to maximize these funds allocations ensures Nebraska makes full and best use of this opportunity. I ask for your support of LB1229 and welcome any questions you have.

CLEMENTS: Questions? Seeing none, thank you for your testimony. Next proponent. Good evening.

TREVOR TOTEVE: Good evening. Glad we made it, right?

CLEMENTS: Yeah.

TREVOR TOTEVE: All right. Good evening, Chairman Clements and members of the Appropriations Committee. I'm Trevor Toteve, T-r-e-v-o-r T-o-t-e-v-e, a Policy Analyst with OpenSky Policy Institute. We support LB1229 because it would bring transparency and accountability and help ensure the efficient use of taxpayer dollars through the Rural Health Transformation Program. With these federal dollars, the Legislature has a responsibility to ensure the money is utilized in a way that is consistent with federal guidelines and Nebraska values. While the Centers for Medicare and Medicaid Services requires reporting on finances, performance, beneficiary and system outcomes, there's no guarantee in these federal regulations that the information will be provided to the Legislature or the public. This is a relevant point because the federal government has brought authority to reduce, terminate, or even claw back rural health funds if a state is found to be out of compliance with its application. This bill would give both the public and the Legislature comparable visibility into the efficacy of the state's use of funds that CMS requires. In addition, LB1229 strengthens accountability because it mirrors CMS requirements that rural health funds be spent strictly as approved in our application. It releases the application to the Clerk of the Legislature, establishes safeguards to ensure the funds are not transferred to other programs or cash funds, and the funds are not used to supplant prior spending on rural health care. From the fiscal note, we understand the department has concerns with noncompliance. We're here today supporting the transparency and oversight provisions of the bill. Thank you, and I'm happy to answer any questions.

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

MICHEAL DWYER: Good morning. OK, give me 10 seconds.

CLEMENTS: It will come soon enough.

MICHEAL DWYER: The midnight riders, maybe, [INAUDIBLE]. Good morning, Chairman. Excuse me. Good afternoon, Chairman Clements and members of the Appropriations Committee. My name is Micheal Dwyer, M-i-c-h-e-a-l D-w-y-e-r, and I appreciate the opportunity to testify in full support of LB1229. Thank you, Senator Strommen, for bringing this incredibly important bill. I'm a retired 42-year active volunteer firefighter and

EMT. I'm also cochair of the Nebraska EMS Task Force. However, the positions in this testimony are my own and don't necessarily reflect the position of the Task Force. I'm offering three reports for you today. One is the report that I emailed to the offices this morning. It's the fifth version of the Future of EMS in Nebraska. It has a full section on the Rural Transformation Program in addition to information on Nebraska and 12 other states specific to emergency medical services. And that'll be most of my testimony today. Also in front of you is a synopsis of specifically the Rural Health Transformation Program and how it affects EMS. Tries to break down each of the categories and, and give a little bit of an idea of how much EMS, particularly in rural areas, obviously will be able to do. And, finally, the last report is my recommendations for a sustainability plan, six kind of pillars or posts, and I'll speak about that in a minute. And I want to spend the remainder of my time trying to convince you that EMS is essential and that we must commit to finding a way to sustain it, which thus far we have never been able to do. One, Nebraska Statute 38-1203 says EMS is a, quote, primary and essential health care service. EMS is required to respond all the time by that essential designation and the inherent assumption that when a citizen calls 911 and asks for medical assistance that EMS will respond effectively. Two, EMS is a 24/7, all-hazard service. EMS touches virtually every piece of health care in rural Nebraska, including children, OB, mental health, aging, cardiac, stroke, difficulty breathing, gastrointestinal issues, muscle pain, and lift assists and medical alert alarms, and an occasional mosquito bite. Three, EMS has become the frontline of modern health care. As patients age, communities shrink, and health care options diminish, rural residents more and more frequently are turning to EMS out of convenience and desperation because at times there aren't any other options that are quick, readily effective, and inexpensive. Finally, sustainability must come first. The RHTP requires proof of sustainability, and that's a good thing. However, the deadline to prove sustainability for a system that's not currently funded is incredibly short. And, and LB1229 seems to suggest that sustainability must be proved before DHHS can apply for the money. I'll speak a little bit more about the timetable, except that I have a red light. All of this for a current system that's not funded. I appreciate all of the information and the questions that came up earlier on the funding for DHHS. Happy to answer any of those, and, again, I appreciate Senator Strommen and would be happy to take any questions. Thank you.

CLEMENTS: Are there questions? Seeing none, thank you for your testimony, Mr. Dwyer. Next proponent. Good evening.

HOLLY WOLFF: Good evening, Chairman Clements and members of the Appropriations Committee. My name is Holly Wolff, H-o-l-l-y W-o-l-f-f. I am the CEO of Jefferson Community Health and Life in Fairbury. It's a 17-bed acute care critical access hospital, and I'm here in support of LB1229, a bill to provide transparency around the Rural Health Transformation Program. Jefferson Community Health and Life is the center for rural health care in Fairbury and the surrounding rural communities. We provide inpatient, outpatient services, surgery, emergency, therapies, and screenings. We also provide a rural health clinic for family medicine, long-term care, a fitness center, home health services, and supporting numerous educational programs and community support groups. With over $1 billion coming into Nebraska over the next 5 years to support rural health care, our facility has a vested interest in understanding how those funds are deployed, how best to utilize them and to maintain the viability of rural health care facilities and really maintaining access to rural patients that we serve. Nebraska is set to deploy over $200 million through the RHTP in the next 10 months. An amount of money that large has the potential to be truly transformational. This puts this Legislature at a crossroads, provide the necessary transparency and tracking to ensure these dollars have the impact that is intended or merely hope that the funds are spent well and Nebraska's allocations of the next 4 years of the program are not reduced or federal clawbacks of spent funds required. It is critical as legislators that you understand the tight timelines of the RHTP award and going forward. As you can see from the handout provided, there were only 2 months to develop an application for a billion-dollar program. During that time, guidance evolved almost weekly during a government shutdown the month of October. Between submission of the application and the announcement of the awards, the state withheld its application from public view leaving stakeholders little opportunity to partner with DHHS to promote an effective and transparent deployment of funds. Since the award announcement, much remains to be known by rural health care organizations like mine about funding procedures, how and when dollars will be deployed, and even how to participate in this generational opportunity to, to secure rural health care. LB1229 is straightforward. It simply requires for transparent and public accounting of all funds received via the RHTP. The visibility provided by LB1229 invites public participation, encourages input from rural communities, and helps Nebraska's RHTP execution be among the best in

the nation. I encourage your support for this bill and I welcome any questions you may have.

CLEMENTS: Senator Armendariz.

ARMENDARIZ: Thank you. Only question. On your timeline, it says October 31 of '26 through '29 funding amounts announced. My, my understanding is that funding needs to be spent by October 31.

HOLLY WOLFF: Right.

ARMENDARIZ: It says on here announced and then spent in '26 through '32.

HOLLY WOLFF: Sorry, I'd have to look them up. Can you repeat your question?

ARMENDARIZ: On your timeline here, it says your funding amounts are announced October 31, 2026, when they actually--

HOLLY WOLFF: Oh, you're talking about the next one.

ARMENDARIZ: --would be spent.

HOLLY WOLFF: So we have--

ARMENDARIZ: So after this one?

HOLLY WOLFF: Yes. Yes, sorry.

ARMENDARIZ: OK. Thanks.

HOLLY WOLFF: Mm-hmm.

CLEMENTS: Other questions? Seeing none,--

HOLLY WOLFF: Thank you.

CLEMENTS: --next proponent, please. Good evening.

RYAN McINTOSH: Good evening, Chair Clements, members of the committee. My name is Ryan McIntosh, R-y-a-n M-c-I-n-t-o-s-h, and I appear before you today on behalf of the Nebraska State Volunteer Firefighters Association and the Nebraska Fire Chiefs Association in support of LB1229. I would like to give a thank you to Micheal Dwyer, who served as a cochair on the EMS Task Force and participation with Nebraska

Hospital Association over the last several years. He's been a tireless advocate for volunteer fire and EMS. The cost has skyrocketed for training and equipment. We have a growing EMS desert across the state. The-- this funding is, is critical to continue to provide care so that we have volunteers and paid individuals that answer the call when it's needed. I know there's been questions on how this funding will work, whether it's going to be solely a reimbursement basis or whether there's an opportunity for grants. Rural and suburban fire protection districts, particularly operating volunteer rescue squads, have very meager budgets and no funds to expend on high-dollar equipment later to be reimbursed. Even if Nebraska banks wanted to extend zero interest loans, this is largely prohibited under state law. Frankly, a, a grant program is the only way that this will work for-- to provide coverage for EMS. We understand other states are perhaps doing grant programs. We appreciate Senator Strommen's leadership in looking into that. And we would encourage the committee to push back as much as possible on any limitations for reimbursement versus grants. So with that, I'd be happy to answer any questions.

CLEMENTS: Any questions? Seeing none,--

RYAN McINTOSH: Thank you, Senator.

CLEMENTS: --thank you for your testimony. Are there additional proponents? Good evening.

LYNN REX: Good evening. Senator Clements, members of the committee, my name is Lynn Rex, L-y-n-n, R-e-x, representing the League of Nebraska Municipalities. I also am a member of the EMS Task Force. I'm not here speaking on behalf of the Task Force. I'm here speaking on behalf of the League of Nebraska Municipalities to underscore how critically important EMS is across the state. For those of you that live in an area that have paid firefighters, paid EMS workers, you're in a different scenario, perhaps. But once you're outside of that area, basically throughout the rest of the state of Nebraska, they're looking-- you're looking at basically having volunteers, EMS workers across the state there to assist you. And I think it's critically important to understand how critically-- how they play such a critical role in EMS across the state. And this is a tremendous opportunity for them to basically, for the first time, really have some significant funding to deal with what is the front line of rural health care across the state. We have 526 cities and villages in the state, 376 are villages, population 100 to 800, some give or take, some of them actually have populations below 100, so we think this is a critical

way in which to move forward. I really hope that you take the time to read the six points of sustainability that Micheal Dwyer handed out to you because I think it's a very thoughtful piece in terms of how this could be sustained for EMS. And, again, really can't thank Senator Strommen enough for introducing this. We appreciate the transparency, the accountability, and know that we are looking forward to partnering with DHHS and others to move forward to make-- really make a difference in the state in terms EMS. They have always been underfunded. And one of the major parts of this is to deal with attraction and retention, whether you're dealing with something like the firefighter cancer benefits act, whether you're dealing with the first-- pardon me-- the first responder retention and attraction act. Those are all really important things all across the state. And on the State Fire Marshal's website, you'll see that there are roughly 15,000 volunteer firefighters, roughly 5,000 paid firefighters. All of them are involved in EMS. We also have others involved directly in EMS as well. So I just want to underscore for you the importance of this. This can really be transformational. I know from my colleagues in other states, other states are really focusing on EMS and other efforts in which they can make sure that just like Nebraska, so much of their areas across their states basically are, are in desperate need of funding. So with that, I'm happy to respond to any questions that you might have.

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

LYNN REX: Thank you so much for your consideration.

CLEMENTS: Are there additional proponents? Good evening.

JON REINERS: Good evening, Chairman Clements, members of the committee. My name is Jon Reiners, J-o-n R-e-i-n-e-r-s. I'm the CEO of Chadron Hospital, a critical access hospital in Chadron, Nebraska. And I'm here tonight to support LB1229, a bill to provide transparency around the Rural Health Transformation Program. Given Chadron's location in the Panhandle, we are really kind of the access point for the rural health care in our region. Our facility provides medical and surgical care, obstetrics and newborn care, a basic level trauma center for emergency care, and rehab services. We also bring specialist care close to home with visiting specialists. As an independent critical access hospital, our clinical team, local board of trustees, and support staff work tirelessly to provide care to our community. It's well documented that operating funds are tight and

workforce challenges are great, but we remain focused on our mission to provide excellence in health care by promoting health and well-being for the communities in our service area. The Rural Transformation Program was adopted by Congress in July 2025 to provide critical financial support to rural hospitals and the communities they serve. As it was well reported at the time, changes in the community eligibility requirements from Medicaid recipients could have a disproportionate impact on the financial sustainability of rural hospitals and the $50 billion RHTP was created to blunt some of those potential impacts and to provide an infusion of funds for transformational projects that would shore up rural health care and secure the future of rural hospitals. With the announcement of Nebraska's $218 million award for 2026 and the expectation of over $800 million more over the following 4 years, the state's well positioned to have a once in a generation investment in rural health care. For Chadron, these funds represent an opportunity to secure access to critical health care services for our patients in a frontier geographic area of the state. How well these funds are utilized over the next 5 years can literally mean the difference between care being available in the community or requiring patients to drive 60 miles or potentially more to access medical care. One of our core values at Chadron Hospital is fiscal responsibility and effectiveness. And our board must make decisions that will ensure the long-term viability of the organization while providing quality services at a reasonable cost. Independent critical access hospitals across Nebraska support LB1229 as one step to ensure this generational opportunity operates with the same level of fiscal responsibility and transparency in a manner visible to all stakeholders and taxpayers. The requirement of a sustainability plan for funded programs guarantees that these projects truly are transformational, not temporary crops that become long-term liabilities. I encourage your support of LB1229 and would welcome any questions that you have.

CLEMENTS: Are there questions? Senator Dorn.

DORN: Thank you, Senator Clements. Thank you for being here and coming from Chadron.

JON REINERS: Thank you.

DORN: How close are you to the next closest hospital?

JON REINERS: So Alliance is the next closest at about 50 miles south of us. As far as tertiary facilities that we would transfer out to,

we're about an hour and a half from Scottsbluff and about an hour and half from Rapid City, right in the middle between the two.

DORN: Thank you.

CLEMENTS: Seeing no other questions, thank you for your--

JON REINERS: Thank you.

CLEMENTS: --testimony. Are there additional proponents for LB1229? Seeing none, anyone here in opposition? Seeing none, anyone here in the neutral capacity? Senator Strommen, you may close.

STROMMEN: All right. Well, I think we all understand just how important this is. We, we really do have to get this right. It's a lot of transformational money, could significantly change the health care landscape in Nebraska. And, as stated earlier, 6 hours earlier, that if we get this wrong it could result in clawbacks and moving forward reduced rewards and we don't want to find ourselves in those situations.

CLEMENTS: Are there questions for Senator Strommen? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Your analysis from other states, those states that are creating these funds, did they maybe perhaps possibly work more closely in partnership in the application process?

STROMMEN: I can't say-- either way it's possible.

M. CAVANAUGH: Do you know if their applications were made public to the health care industry in those states?

STROMMEN: I think some of them were, yes.

M. CAVANAUGH: OK. Thank you.

STROMMEN: It's my understanding.

CLEMENTS: Any other questions? Seeing none, we have position comments for the record: proponent seven, opponent zero, neutral zero. That concludes the hearing for LB1229. Next, we'll open the hearing for LB946.

ARMENDARIZ: Welcome, Senator Dorn.

DORN: Good evening. I think this challenges some of us for how long we can sit in one spot at one time.

ARMENDARIZ: I tried to get him to go a little earlier, but he was holding out.

DORN: I couldn't believe Senator-- Chairman-- Senator-- Chairman Clements has been here the whole time. Good evening, Chairman Armendariz and Chairman Clements and fellow members of the Appropriations Committee. My name is Senator Myron Dorn, M-y-r-o-n D-o-r-n, representing District 30, here to introduce LB946. LB946 would appropriate, appropriate funds for Medicaid waiver assisted living facility services under Program 348. In 2021, the Department of Health and Human Services contracted with a third party to carry out a rate study of Medicaid waiver services by conducting a detailed cost analysis and rate comparison with other states. LB946 would apply the department's own steady recommendations to do two things: provide parity between rural and urban facility rates and increase the daily rate to $78.45. During last session, this committee passed an increase to only rural assisted living communities to increase our daily rate of $62.73 to match the urban assisted living rate of $73.91. This was very extreme-- this was extremely meaningful to these rural providers. We got closer to that rate study recommended rate, but not quite there yet. This increase was made using the Medicaid excess profit cash fund, which is not a sustainable or permanent solution. While the Governor's recommendations from the mid-biennium budget adjustments extend this approach for one more year without a permanent appropriation, rural rates will fall back to $62.73. LB946 would appropriate the funding necessary to increase the Medicaid waiver assisted living rates to the level recommended in the study's preliminary report, which 4 years ago identified a significant gap between the current payment for these services and the actual cost of care. A gap that has continued to grow since 2021. Based on conversations with assisted living providers in my district and other parts of the state, it is important that Nebraskans, especially those who rely on Medicaid, are able to accept-- access assisted living services when they need assistance but don't require 24-hour nursing care. Following me will be Jalene Carpenter, representing the Nebraska Assisted Living Association, and several providers who will share their perspectives and available to respond to any questions. Thank you for your attention.

ARMENDARIZ: Thank you, Senator Dorn. Are there any questions? Seeing none, I welcome the first proponent for LB946. Welcome.

KIERSTIN REED: Good evening. I think we should all, like, shake our feet and, and try to-- hope we don't get any blood clots or anything. OK, well thank you for having us. We appreciate the opportunity to be here today. My name is Kierstin Reed. That's K-i-e-r-s-t-i-n R-e-e-d. I serve as the CEO for LeadingAge Nebraska. We are a statewide association representing about 60 assisted living providers in the state. And we are, obviously, very interested in supporting LB946. As, as Senator Dorn already said-- you know, he set that up really well, we are very thankful that we got the appropriation last year for the rural assisted living and that has made a world of difference. I mean, some of these folks will be able to, to really tell you about that, but it's made a significant difference for them. For our urban assisted living providers, they have not had an increase in their rates since September of 2023. So that has continued to put them behind. So over that 4-year period, the entire rate increase for 4 years has been 5%, in 4 years. And that was already behind. So we're just going further and further behind. In that same time period, the room and board rate has increased 13%. That's the portion of the bill that is paid by the recipient of the services, usually based on social security or those kinds of things. That's gone up 13% in that same time period. Minimum wage in Nebraska has gone up 40% in that same time period and all those other costs of doing business have gone up. So including the room and board portion, our providers are paid $3,140 a month for 24/7 care, essentially, for the entire month. Their private pay rate is, on average in Nebraska, is at least double that amount. So these are providers that are choosing to serve people on Medicaid. Most of these providers have a, have a private pay rate before they get to that point. So all this bill is doing is increasing it by $4.54 a day. The only other thing that I wanted to mention was that these providers of Medicaid waiver services also have an entire extra rule book then other assisted living providers. So if they are an assisted living provider, they have to follow the regulations for assisted living. These providers have to follow a whole nother rule book, includes additional background checks, additional things that they have to do that cost them more money. So we would like for them to get this reimbursement. I know that it's a big ask in a really difficult session, but we really feel like making that funding permanent would be a, a great investment in Nebraska and keeps people out of higher cost services. So happy to answer any questions you may have.

CLEMENTS: Are there questions? Seeing none,--

KIERSTIN REED: Thank you.

CLEMENTS: --next proponent for LB946. Good evening.

GAYLEEN BRADLEY: Good evening, members of the Appropriations Committee. I want to start off thanking Senator Dorn. Oh, well, I guess I need to tell you my name first. I'm Gayleen Bradley, G-a-y-l-e-e-n B-r-a-d-l-e-y. And I am the Administrator of Orchard Park Assisted Living that is here in Lincoln. And I, like I said, wanted to start off to thank Senator Dorn for presenting LB946. This bill is very important to the communities who are caring for Nebraska residents who need assistance paying for their needs and assisted-- in assisted living, both in rural settings and in our cities. The cost of living has increased significantly over the last 3 years since the last rate increase was made. It was increased enough that Orchard Park, where I am the Administrator, has had to scale back the number of Medicaid waiver residents we are able to care for. We have 49 residents at Orchard Park, 4 years ago 80-85% of our community was on the waiver program. Today, we only have 11 residents on waiver. We now require residents to have at least 1 year of private funds before transitioning to Medicaid waiver due to the increase in living expenses. We will have several residents who will need waiver assistance this year. They will be transitioning. This is a trend we are seeing across communities in Lincoln that previously accepted waiver residents upon move in. The need for the waiver program across Nebraska continues to grow. Almost all residents who have moved into our community in the last 2 years will run out of resources within 1 to 2 years. I have personally spoken with team members at local homeless shelters who have expressed grave concerns about the number of seniors reaching out because they do not have a place to live. Some of the seniors they are able to help are sleeping on the floor due to the lack, the lack of available housing options. Currently, Orchard Park receives approximately $3,116 per month per waiver resident. Our private pay rates are $3,750 per month for small rooms and $4,050 per month for large rooms. Orchard Park was founded with the vision of being a blessing and resource to the community, not a place focused on generating profit. Even with that mission, the current waiver reimbursement remains well below the true cost of providing care, in addition to funding challenges, the growing administrative burden and lengthy processing times to get residents approved for Medicaid waiver, discouraging communities from participating in the program. Many communities simply do not have the resources to navigate the delays and red tape involved. While the rate increase is appreciated, it amounts to about $140 per month per resident or $1,680 per year. This will still make it challenging to accept as many waiver residents

into our community as we want to serve, especially as the need across our state continues to grow. I am hopeful this committee will see the need to pass this bill to help the communities who are caring for Nebraska's most vulnerable residents and to help ensure access to assisted living care that it remains available across our state. Thank you. Are there any questions?

CLEMENTS: Any questions? Seeing none, thank you for your testimony. Good evening.

BECKY BRUCE: Good evening, Senator Clements and the Appropriations Committee members. Thank you for the opportunity to testify in support of LB946 today. My name is Becky Bruce, B-e-c-k-y B-r-u-c-e, and I am the Administrator of Cedarwood Assisted Living in Fairbury, Nebraska. I have a 65-bed facility. I am also a nurse. And every day I see the physical and emotional needs of our tenants and seniors across Nebraska up close. I am here to share the human impacts of underfunded Medicaid rates and the real struggles faced by Nebraska seniors. At Cedarwood, we serve seniors who have worked hard their entire lives. We see resilience in their eyes and the quiet dignity that they carry. They have a strong generational belief that they don't want to take a hand out. They still call it welfare, something they feel very uncomfortable accepting after a lifetime of hard work and independence. The truth, however, is that assisted living costs and a lot of other costs in health care are simply out of reach for most Nebraskans. We take their retirement, we take their life savings, we take every penny that they've earned over the decades of hard work that they have done, earned in a life that, that most of us no longer can imagine. When those resources are gone, Medicaid becomes their last protection and current reimbursement rates do not meet the real cost of dignified assisted living care. As providers, we often have to increase the rent for private-pay residents to help cover the significant financial gap created by Medicaid reimbursement rates. For every Medicaid resident, I am losing $57.75 per day per person. In my rural facility, which is very small, it adds up to $231,866 annually in my small community. One of our tenants came to us as an emergency placement from Adult Protective Services because his family wasn't able to take care of him anymore. I stepped up to help DHHS, even though I was already over in my allotted Medicaid waiver rooms, what else was I to do for this vulnerable senior? We accepted him into our home. But because his Medicaid approval was delayed by 3 months, even though I did them a favor and took this guy in when he needed care, it cost us $19,000. And now we operated a daily loss of $57.75 for his continued care. There are so many more seniors like him struggling to

survive on their own, often without family support. And we want to help all of them, but we can't because we're losing money providing care. We're forced to make impossible choices of who we can admit and who we can't. I have to tactfully start most conversations when people call with, if you don't have money, I'm sorry I don't have a room for you. These are elders who have worked hard, raised families, and contributed to our communities, and yet we can't safely take care of them because it doesn't-- the system doesn't provide fair funding. The challenges don't stop there. On average, it takes 3 to 4 months for a resident to qualify for Medicaid waiver services. Multiple caseworkers, lost documents, and delays, leave families and providers in limbo. In the last 6 months alone, I've absorbed $66,000 in waiting costs just for approvals alone. Meanwhile, our Medicaid waiver waiting list is 23 people long in my small rural community. These seniors deserve care, but we can't provide it without adequate funding. LB946 proposes an increase, just $4.54 per day. It's not a luxury, it's our lifeline. I just have a little bit more, is it OK if I continue?

CLEMENTS: Yes, please continue.

BECKY BRUCE: This small increase allows providers like Cedarwood to offer safe care right there rooted in their communities and ease an unsustainable financial burden. I love my job, I love my tenants, I take pride in being a good steward of this community, but I'm really tired of turning people away and watching families despair, knowing that we could help more people if we had better funding. I respectfully urge your support of LB946 and continued investment in Nebraska's Medicaid waiver infrastructure. Thank you for allowing me to testify and it's been really eye-opening for me to see the decisions you guys face on a daily basis so God bless you for trying to--

CLEMENTS: Are there questions?

BECKY BRUCE: --delineate money. Do you have any questions?

CLEMENTS: What community are you in?

BECKY BRUCE: Cedarwood Assisted Living in Fairbury, Nebraska.

CLEMENTS: Fairbury. All right. Thank you.

BECKY BRUCE: Thank you.

CLEMENTS: Thank you for your testimony. Are there additional proponents? Good evening.

LISA NIELSEN: Good evening. Chairman Clements and members of the Appropriations Committee, good evening. My name is Lisa Nielsen, L-i-s-a N-i-e-l-s-e-n, and I'm here in support of LB946. And I'd like to thank Senator Dorn for introducing this bill. I serve as cochair of the Nebraska Health Care Association Reimbursement Committee. And I'm the managing partner of three assisted living facilities, one in Ord, Gothenburg, and Doniphan. Our Medicaid occupancy ranges from 12-40% in these facilities. And the rate directly impacts our ability to operate sustainability. LB946 would increase the assisted living rate from $73.91 to $78.45, which is the amount that was identified in the 2022 DHHS cost study as the true Medicaid cost of care. Despite that finding, the rate was not adjusted and rising operating costs since 2022 have widened the gap even further. This increase is overdue and essential. Assisted living is a critical part of Nebraska's long-term care system, especially as rural nursing homes continue to close. To provide safe, quality housing and care, we must be able to invest in our buildings, retain staff, and meet residents' needs. Without reimbursement that reflect actual-- that reflects actual cost, these goals become increasingly impossible. LB946 is a reasonable data-driven step that aligns the waiver rate with the state's own cost study and helps ensure continued access to assisted living across the state. Thank you for your time and I'd be happy to answer any questions.

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

LISA NIELSEN: Thank you for your service.

CLEMENTS: Next proponent. Good evening.

STACEY WHITNEY-GREENFIELD: Hello. It's very nerve-racking in this chair. My name is Stacey Whitney-Greenfield. Oh, and thank you all for being here and letting me come here and testify in front of you. My name is Stacey Whitney-Greenfield. That's S-t-a-c-e-y W-h-i-t-n-e-y. I am part of the family ownership of the Lexington Assisted Living Center in Lincoln, Nebraska. I'm also the Administrator there. I'm here today, and dead last, because I'm in support of LB946. The good thing about being last is that everybody has said everything that I need to say. So, therefore, maybe I can humanize it just a little bit more in the path of the Lexington, which is our, our building. The

Lexington is here in Lincoln, and we've been open for 24 years. This is our 25th year anniversary. Just this year. We had our, our 8th resident, I can't mention her name because of HIPAA, but our 8th resident, her two daughters came to live at our building. They're both Medicaid waiver and there's nowhere else in this town for them to go except for the Lexington. Thankfully, they never wanted to go to anywhere else except for the Lexington, but nobody else is taking direct entry Medicaid waiver. We are 104 beds, 98 rooms. And we have two buildings, one in Denver, Colorado, and that one has 108 beds, 100% Medicaid waiver in Denver. We used to be 100% Medicare waiver here in Lincoln at the Lexington. We are now the low 60% Medicaid waiver. It kills me when I hear people like Gayleen say that she's at 11% Medicaid waiver at 49, at 49 beds. It kills me to hear, you know, Lisa telling us that she's, she's down to below 40% and they fluctuate 17-40%. The disservice that we have here for our Medicaid waiver providers of assisted living here in Lincoln, Nebraska, here in Nebraska, period, is that we can't afford, we can't afford to accept more people because it's just not sustainable. It's a mission for my family. We feel it. We live it. All of our residents are our family. And it is very difficult to turn people away every day. 20 to 30 people calling us up every day, Med waiver, Medicaid here in town. They have to leave their communities. It's difficult. It's hard. This increase is really important. It's a start. It's a start. Thank you. Any questions?

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

STACEY WHITNEY-GREENFIELD: Thank you.

CLEMENTS: Are there additional proponents?

JALENE CARPENTER: Good--

CLEMENTS: Good evening.

JALENE CARPENTER: I know. Hi. Good evening, Chairman Clements, members of the Appropriations Committee. My name is Jalene Carpenter, J-a-l-e-n-e C-a-r-p-e-n-t-e-r. I'm the President and CEO of Nebraska Health Care Association in support of LB946 on behalf of our 219 nonprofit and proprietary assisted living community members across the state. Big thank you to Senator Dorn for introducing this legislation. The previous testifiers did a fantastic job articulating the need for funding. I will reiterate what I said before, we have demand that is

only going to grow and we have to start figuring out a solution for long-term sustainability for access to care, whether that be home care, assisted living, nursing facility, that population is only growing so we need to start figuring out how to have robust options at every level of care. And as they so nicely articulated, it should be available to all seniors, no matter their socioeconomic status or whether or not they have financial resources or if they have outlived their financial resources that they planned for. Assisted living is a residential care setting where there's food, shelter, personal care assistance, medication, activities, housekeeping, laundry, transportation, a whole plethora of services. And at this time the funding, the one-time funding, of what is in the Governor's budget is to have parity with rural and urban, which makes it $73.91 a day. It's a bit late, so I apologize if I'm being a bit flippant. But in comparison, I did a very quick Google search of our hotels across the state. To stay at the Cornhusker, it's $148 a night. The Holiday Inn Express in O'Neill is $168 a day. The Edgewood Suites in Fairbury is $125 a night. These assisted livings are providing far more than a single night of shelter. They provide a lot of important care and services. And so this very small increase is a very small step in the right direction. And so I would ask you to please support Senator Dorn's bill to use the department's own study recommended rate of $78.45 a day as a step in the right direction, not all where we need to be, but definitely a good step. And thank you so much for having me join you for so many times tonight, and I'm happy to answer any questions.

CLEMENTS: Any questions? Seeing none, thank you for your testimony. Are there additional proponents for LB946? Seeing none, anyone in opposition? Seeing none, anyone in a neutral capacity? Senator Dorn, do you wish to close? Senator waives closing. We have position comments: proponents 13, opponents zero, neutral zero. That concludes LB946. We will now open the hearing for LB1031. Senator Dorn.

DORN: Thank you. Thank you much. I-- before I really start on this, I just want to thank the whole committee for being here at 8:00. I won the bet this time with my staff, I said it would be after 8:00, she said it'd be before 8:00, so I won the bet with her. But thank you for the committee and for our fiscal analysts and everybody for being here this whole time. This is-- we hear of other committees that go to 9:00, 10:00 or whatever. This is one of the times that we sure did, too, so thank you for all being a part of this. So LB1031. Chairman Clements and members of the Appropriations Committee, my name is Myron Dorn, M-y-r-o-n D-o-r-n, and I represent Legislative District 30 in

southeast Nebraska. I'm here today-- I am here today to open on LB1031, which will sound very familiar to you because this bill was introduced last session, included in the budget, passed by the Legislature and signed by the Governor. The Medicaid Division and Department Health and Human Services opposed LB55 last session and told us that there was not funding and, by golly, there wasn't and they did not implement it. Briefly the intent of the bill was to fill a gap between rates paid to Licensed Independent Metal-- Mental Health Practitioners or LIMHPs in the Medicaid-- Medicare federal system and rates paid in the Medicaid state program. These low-income elderly Nebraskans are considered dual eligible in these health care systems with Medicare being the first payer. Two years ago, the federal government made a decision that was supposed to expand mental health and substance use services by changing policy and allowing them to reimburse in the Medicare system. Unfortunately, in Nebraska, this change did not expand access to services, but rather reduced it because state Medicaid rates are higher than the federal Medicare rates. LB55, last year, and LB1031, before you today, are designed to fill that gap to ensure access to services. Testifiers behind me will provide additional details that will again sound familiar on how this works and what the dramatic reduction and rates have meant to them since the budget item was not implemented July 1 of 2025. Providers and my office have heard different stories from the Medicaid Division on why the appropriation and intent language included in the budget was not implemented. First, it was because the Legislative Fiscal Office did not include the appropriate language in the final budget bill, and that the Medicaid Division told them that before pass-- that-- they told them that before passage. When it was determined that that reasoning was false, the next reason was given by the DHHS department liaison that the hospital assessment cash fund that the bill tapped had no funds. This excuse given after the budget bill was signed was accurate for a couple of months since the hospital assessment SPA was in limbo as a new administration took over in Washington. The assessment process was approved late last summer and shortly thereafter money flowed to the state that would have funded the $17.5 million carve out which was tapped to fund the $1.5 million that was approved for this bill. Weeks passed and my office as well as providers checked in with the Medicaid Division. Finally received word the money had already been spent. I continue to support these providers because we do not have enough of them in the rural area to serve Nebraska and do not want to lose them. Now let me talk about the fiscal note. The Medicaid Division shows an overall cost each year to about $6.5 million and $6.55 million, respectively. With the federal

match, however, the state cash fund carve out would be $2.7 million the first year and $2.7 the second year. It is interesting that the numbers have changed since the Medicaid Division told providers originally that the cost would be under just-- under the $1.5 million in state funds, which is, if you look at the fiscal note, that was the original number in, in this bill. There's additional language in the fiscal note for a state plan amendment. Last year, we brought to you documentation from the CMS website that showed that this would not be needed and the department could make this determination on their own. By the way, when the federal Medicaid program made the decision to include LMHPs as reimbursable providers with-- which started this, this whole process, our state Medicaid Division agreed to delay implementation 6 months. They did not have to file a state plan to implement that delay. The intent of LB59 [SIC] and now LB1071 [SIC] is to protect behavioral health services in rural Nebraska that depends heavily on LMHPs. Available to answer questions or comments. [INAUDIBLE], I think most people know that there was enough bills to use all that $17.5 million. No one received any funding because the department-- because the wordage was such that they interpreted that they could, they used all that $17.5 million so--

CLEMENTS: Senator Armendariz.

DORN: --none of those bills were funded.

ARMENDARIZ: Thank you, Senator Dorn.

DORN: Yeah.

ARMENDARIZ: And I remember this very well. When do, when do we plan on implementing the recommendation from CMS?

DORN: I, I guess I don't quite understand that. What do you mean, that we use the funding or--

ARMENDARIZ: Well, once they included the LMHPs to reimburse at the Medicaid rate, when do we plan on complying to that?

DORN: I'm, I'm not sure I still understand it. We may have to have somebody here behind me explain that a little better.

ARMENDARIZ: OK.

DORN: Yeah. Yeah.

ARMENDARIZ: I guess my concern is if we don't comply with CMS recommendation of Medicare rate, do we get dinged on our Medicaid, because we know we got dinged last year saying that, oh, it seems the state's doing really well, we can pay these higher rates so we'll probably reimburse you at a lower rate--

DORN: Right.

ARMENDARIZ: --and we get dinged on our Medicaid reimbursement, altogether, if it appears that we have extra.

DORN: If it appears that we have extra. Well, as you know, and in the big beautiful bill that was passed this summer, part of that there says that slowly we're going to decrease funding in the next 5 years, and then there won't be-- the hospital assessment part of that, there won't be funding for that, so. But I know Jon here and other people will give you a better answer on that.

ARMENDARIZ: OK.

DORN: I apologize for that, but--

ARMENDARIZ: OK. Thank you.

DORN: --I'm not sure I want to venture into that area and give a wrong answer.

ARMENDARIZ: OK.

CLEMENTS: Are there other questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. In your opening, you talked about the hospital assessment money and the $17.5 million that was spent and where was it spent?

DORN: That was based on the assessment that we were supposed to get from the hosp-- from the hospital part of it.

M. CAVANAUGH: Right.

DORN: Yes. Specifically, we had the DHHS people in our office several times and asked Director Corsi that and he point blank said, well, if we wouldn't have used it in our funds and used it for other appropriations, we would have had to come to the body to ask for General Fund appropriations. Even though the bills were passed, they

determined that they could just use those funds. But in their-- and a little bit in their defense, they told us as we were going through the whole process there were no funds there. They already had made that determination to use those.

M. CAVANAUGH: So the hospital assessment funds were essentially used as discretionary funds to backfill a deficit because they didn't request enough funds to begin with.

DORN: It was used in their budget for other things so that they didn't have to come and request the Appropriations Committee for those funds from the general funds. Yes.

M. CAVANAUGH: And was there any reason given that they couldn't just ask for a deficit request of $1.5 million to implement your bill that they're required to do by law?

DORN: I, I did not ask him that, specifically.

M. CAVANAUGH: Well, maybe I'll get a chance to.

DORN: I did not ask him that question. But if you look at it this year, we're-- we have a deficit. So why-- if they came and asked for us to make up that $17.5 million by, by appropriating the funds for those bills that were passed, I'm going to ask you, what do you think the odds are of us passing $17.5 million to fund them? Yeah.

CLEMENTS: Yeah.

M. CAVANAUGH: Yeah.

CLEMENTS: We don't answer questions for [INAUDIBLE].

DORN: Oh, you don't? OK.

M. CAVANAUGH: Well, do you want me to start answering?

DORN: No, then I'll answer it. We probably wouldn't have passed it.

M. CAVANAUGH: Right.

DORN: Yeah. So, yeah.

CLEMENTS: Any other questions? Seeing none, will you stay to close?

DORN: Oh, I'll waive that again.

CLEMENTS: Really?

DORN: Yes.

CLEMENTS: Let's invite proponents for LB1031.

JON DAY: Well, this has been a long day, but hopefully we'll end it on a good note here. Good evening, Senator Clements and the Appropriations Committee. I'm Jon Day, J-o-n D-a-y. I'm the Executive Director of Blue Valley Behavioral Health. We're Nebraska's largest outpatient behavioral health provider. We provide a variety of mental health and substance abuse treatment to over 6,000 adults and youth to 16 mostly rural counties in southeast Nebraska. I'm here today to seek out for your support for LB1031 that will appropriate $1.5 million for both the current 2025-2026 and following 2026-2027 fiscal years from the Hospital Quality Assurance and Access Assessment funds to the Division of Medicaid. LB1031 is a follow-up to the LB55 budget bill that was approved last legislative session and was to be, and was to be implemented this past fiscal year, July 1. However, the Division of Medicaid chose not to comply. These Legislature-approved funds were to help resolve the dramatic rate reduction that was unintentionally provoked by recent changes in Medicare. In 2024, Medicare increased access to behavioral health counseling for their members by credentialing more master-level counselors. However, this decision had an unintentional impact on a subset of Medicare participants who have both Medicare and Medicaid, otherwise known as dual eligible. The primary demographics of this population are those over the age of 65 and have low income. The unintentional effect created involved having a larger number of licensed therapists who were previously, who were previously not credentialed by Medicare and subsequently paid the higher Medicaid rate when treating dual-eligible individuals. Medicare now mandates credentialing these same counselors and having them accept their much lower reimbursement rate from Medicare. To put this in-- to put this reality into perspective, prior to Medicare expanding its behavioral health provider base, we at Blue Valley Behavioral Health only had 3 counselors who met the Medicare credentialing requirements and 31 who did not. At that time, when these 31 counselors were seeing those with dual eligibility, they were reimbursed at Medicaid's established rate. When Medicare mandated credentialing for all these providers at a significant lower rate for all of them for Medicare resulted. The outcome was staggering. Last year, almost 200 people and over 1,900 therapy sessions were paid at almost half the rate than previously was received, which was about $200 difference-- $200,000 difference. When this occurred, providers

such as us had three different options: Number one, continue to treat dual-eligible clients at half the previous reimbursement, which in, which in this case, would be a financial decrease of approximately $200,000. Option two, choose to not treat dual-eligible clients, which in our case would mean almost 200 people and over 1,900 therapy visits not being provided. Or option three, find an alternative solution that would be at no extra cost, that would be at no extra cost for Medicaid in paying for the difference that was previously, that was previously reimbursed and continue to treat those with dual eligibility needing behavioral services. As a business and a provider of highly needed services, we chose option number three, a very practical win-win solution. This option would be of no extra cost for Medicaid, and providers would continue to see those with dual eligibility.

CLEMENTS: Your time is up. Could you wrap it up?

JON DAY: Sure. The solution was written into LB55, approved last year by the Appropriations Committee, the full Legislature, and then the Governor. LB55, as does LB1031, allows $1.5 million for both this current and next fiscal year to distribute the nominal amount allocated from the hospital quality assessment fund. We at Blue Valley Behavioral Health along with a number of behavioral health providers throughout all of Nebraska ask for your support for LB1031. Your final support will be the, the final decision-making on this mental health-- whether we are able to provide this mental health therapy or not. Thank you, and be available for questions.

CLEMENTS: Senator Armendariz.

ARMENDARIZ: Thank you. Thank you for being here.

JON DAY: You bet.

ARMENDARIZ: Do-- so those-- I'm trying to organize it all, those providers that take the dual-eligible patients.

JON DAY: Those who have to have-- I'm sorry, can you say that question again?

ARMENDARIZ: Those providers that are treating the dual-eligible patient, both Medicare and Medicaid, do those same providers treat just Medicare patients?

JON DAY: Mm-hmm, they can.

ARMENDARIZ: And then they get paid the Medicare rate?

JON DAY: Correct.

ARMENDARIZ: OK. That's all. Thanks.

JON DAY: And to kind of add a follow-up to that.

CLEMENTS: Go ahead.

JON DAY: Those who were not Medicare-- who, who were seeing just Medicare before, same process that you would not-- you would bill Medicare and you would not be paid because you weren't approved, but there is a Region 5 element to this, which is another part of the story. So we're just focusing just on the dual-eligible population, not just the Medicare.

ARMENDARIZ: So they did not get paid for Medicare?

JON DAY: We did not get-- no. Correct. We got--

ARMENDARIZ: Because they weren't qualified as a care provider, so they got paid from regional funds.

JON DAY: Correct. For Medicare only.

CLEMENTS: Other questions? Senator Dover.

DOVER: What are the two rates, Medicare and Medicaid?

JON DAY: Medicaid pays the rate of around $175, $180 an hour and Medicare pays about $90.

DOVER: All right. Thanks.

JON DAY: It's about half.

CLEMENTS: All right. I had a question about using the hospital quality assurance fund for behavioral health. Does that fall within the definition of the use of that money?

JON DAY: Yes, the $17.5 million that was available was allowed for discretionary funds. And so our funds would have come from that amount, which would have been allowed.

CLEMENTS: All right. And if you treat a Medicare client, are you able to bill any extra for your costs above the reimbursement or you're contracted just for that rate?

JON DAY: Correct. We have to comply with-- in this type of situation we-- well, there's debate about this, but right now Medicaid requires those clients who have dual eligibility that they will reimburse on the Medicare rate, which is half, rather than the Medicaid rate. But we have documentation that says that, you know, if a person has dual eligible, that Medicaid should pay the higher of the two amounts.

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

JON DAY: Thank you. Sorry to run over a little bit.

CLEMENTS: It's OK. Next proponent. Good evening.

CHASE FRANCL: Good evening. Saving the best for last. My name is Chase Francl, C-h-a-s-e F-r-a-n-c-l. I'm grateful to have the opportunity to speak to Chairman Clements and members of the Appropriations Committee tonight. I serve as President and CEO for Mid-Plains Center for Behavioral Health Services, which is headquartered in Grand Island. We served our communities for more than 50 years and provide services to more than 3,200 Nebraskans annually across all our service areas. Testifying today on behalf of my agency and of NABHO in strong support of LB1031, which would once again attempt to rectify the payment gap in therapy services provided to dual-eligible populations. As the committee has already heard about the causes and background of this problem, I'd like to use my time to provide a bit more context to our efforts at remedying the situation and to more fully highlight the fallout that we and our patients have already experienced. From my agency's perspective, we understood the risk we were taking in continuing to serve the dual-eligible population without imposing any restrictions or wait listing. Our early projection showed that we stood to lose between $80,000 and $100,000 the first year of this change. We believed our responsibility to the community that supports us was to continue providing these services as long as we could afford to or for as long as there was still hope for the payment problem to be solved. This committee's support for LB55 last year seemed to reward our optimism. However, it has already been shared that the department was either unable or unwilling to implement that clear direction, which is why we're once again back here together today. As we have held out hope for this situation to be remedied and as one of

the last agencies in our area still serving this population, we do find ourselves now at that decision point. Despite having lost more than $182,000 since July of 2024 and resulting in having to cap wage increases to our staff, our priority remains to find a way to avoid cutting off services to those who need them. And it's a need that's made more acute when we know that no one else is waiting to stand in the gap. This is a program where we also have wait lists and could easily be serving those whose payer aligns more closely with the actual cost of the service provided. This is the decision facing everyone in our sector regarding whether or not to serve dual eligibles. And I can't blame those who've been forced to make a different choice. Having personally served in leadership roles in NABHO now for almost a decade, I can attest that even where we've disagreed, we've previously always enjoyed a long history of good faith partnership with DHHS. However, I regret to say that the department's failure to implement their own solution or to follow the direction given last year through LB55, many providers like myself are left to question whether we truly share the same mission any longer. As was true with LB55, LB1031 proposes to use targeted funds to provide a targeted solution to a targeted problem. Outpatient therapy offers arguably the most impact for the least cost in the entire behavioral health service array. Failing to support it isn't saving money, it's recklessly depriving individuals of care they need and paving longer roads back to being healthy and productive members of our community. As it is now, the federal legislation that was intended to open more doors for treatment of this population has barred them shut instead. While Nebraska didn't create this problem, it's the responsibility of true leaders to identify and, more importantly, to actually implement solutions. This is a very real problem, and LB1031 repeats a clear and obvious solution. Thank you for your time and consideration, be happy to answer any additional questions to the best of my ability.

CLEMENTS: Senator, Senator Lippincott.

LIPPINCOTT: Thank you for driving here all the way from Central City.

CHASE FRANCL: [INAUDIBLE] go.

LIPPINCOTT: It's very much appreciated. Medicaid rates vary from state to state. How does Nebraska rate compared to some of our neighboring states?

CHASE FRANCL: It's a great question. Nebraska does have higher rates for our behavioral health service array. That's something we're, we're proud of. We've come to this committee many times and, and expressed the, the clear need for that. Some of the, the criticism that falls with that is looking and saying that we're already overpaid for those rates. The challenge with that I think is when you, when you look at the wrong data, you're likely to come to the wrong conclusions. Nebraska is actually, depending how you slice it up, somewhere between 32nd and 41st in per capita spending for Medicaid for behavioral health. So we are by no means leading the way in, in how we're providing that for our, for our members. There's a lot of other funding mechanisms outside of just Medicaid fee schedules that states use to supplement where, where funding is, is insufficient There's supplemental payments. There's value-based contracts. We have CCBHCs now in the state that all sort of exist outside of that. And outside of just the, the payment side, there's the cost side where, where not all service definitions are the same, not all costs are the same. So it's, it's a, a gross oversimplification and it can be kind of a misleading line of arguments to just say we have really high rates, therefore, we're doing everything that we should. So I, I really want to caution the committee, if, if we were to revert to Medicare rates, it, it would be, it would be catastrophic for our behavioral health system. Thank you for the question.

LIPPINCOTT: Mm-hmm.

CLEMENTS: Senator Armendariz.

ARMENDARIZ: Yes, thank you. Thank you. I was going to ask that question as well, but I'll ask a little bit deeper. What are the rates of the other states, maybe even our surrounding states? Have any states gone to the Medicaid-- Medicare rate?

CHASE FRANCL: I'm not an expert on that. I know where Nebraska's rates fall into about-- there's comparisons between Medicaid rates and then versus Medicaid to Medicare rates. So I believe Nebraska's Medicaid rate, like for outpatient therapy is about 167% of what the average Medicaid rate is. I hope I'm stating that correctly. There's other states that are, that are up there above that average, certainly. I don't know for sure if it's any of our neighboring states, though.

ARMENDARIZ: And do you know of any states that have transitioned to the Medicare recommended?

CHASE FRANCL: Yes, there are certainly a number of states that, that do the Medicare rates as well. We hear about those with our national council membership, states that are struggling mightily with workforce and the other downstream effects you might expect of when you don't have sufficient mental health coverage, you're seeing more people get to your jails, more people coming through our emergency rooms as folks talked about today. Those costs trickle elsewhere.

ARMENDARIZ: Thank you.

CHASE FRANCL: Yes.

CLEMENTS: I had a question. The loss of $120,000, is that compared to if you would have received the Medicaid rate?

CHASE FRANCL: Correct. So as, as Jon had referenced, there's a couple different manifestations of this problem. So purely the dual eligible, if we've been paid at the Medicaid right that we were prior to this change, that would have been about $120,000 shortfall. All in for us, it's been closer to $182,000 because of how some of the other nondual eligible but related to those Medicaid or the Medicare rates becoming enforced. Just not specifically the dual-eligible population.

CLEMENTS: And, evidently, Medicaid rate is profitable or exceed your costs. How much would you have lost compared to your cost?

CHASE FRANCL: I'm sorry, can you ask that one more time? Not sure I followed.

CLEMENTS: Is-- does Medicaid-- the Medicaid rate cover more than your costs?

CHASE FRANCL: Very much depends on the service. There are--

CLEMENTS: The profit margin.

CHASE FRANCL: Correct. There, there are services where it does. I would say it's, it's possible if you have enough workforce, large enough size, and enough efficiencies that you can, you can operate off Medicaid rates alone. The reality just doesn't quite work out that way because you're dealing with private insurance and copays and deductibles. It's, it's just probably not the, the cleanest way to think about it.

CLEMENTS: OK. All right. Thank you.

CHASE FRANCL: Yes.

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

CHASE FRANCL: All right. Thank you, all.

CLEMENTS: Are there additional proponents for LB1031? Seeing none, is anyone here in opposition? Good evening.

DREW GONSHOROWSKI: Hey, good evening. Good evening, Chairman Clements and members of the Appropriations Committee. My name is Drew Gonshorowski, D-r-e-w G-o-n-s-h-o-r-o-w-s-k-i, and I am the Director of the Division of Medicaid and Long-Term Care in the Department of Health and Human Services. I am here to testify in opposition to LB1031. LB1031 would redirect $1.5 million from the Hospital Quality Assurance and Access Assessment Fund for the purpose of enhancing rates for certain outpatient behavioral health services for dual-eligible Medicaid beneficiaries. The services that would be targeted by this funding are crossover claims, meaning that Medicare is the primary payer. Medicaid's long-standing policy with crossover claims is to pay the lesser of either the beneficiary's cost sharing obligation or the difference between the Medicaid allowable amount and the Medicare rate after Medicaid-- after Medicare pays first. In effect, these behavioral health providers who offer services to dual-eligible beneficiaries are now being paid the Medicare market rate for these services, plus the standard coordination of benefits amount from Medicaid. DHHS is testifying today to share our concerns about how this rate increases funding through this bill. The HQAA Fund currently does not have the available funds to pay for this rate increase. The entirety of the money specified in this fund is currently obligated to cover the state General Fund share cost of the federally mandated continuous eligibility for children. Should this HQAA funding be used instead of-- instead to increase payment rates for these behavioral health crossover claims, the Legislature would need to appropriate additional state general funds to cover the cost of children's continuous eligibility. The department is concerned that the precedent of creating a special payment mechanism for a specific group of providers only for services they provide to dual eligible is inefficient from a program-- programmatic perspective. We respectfully request the committee not advance the bill to General File. Thank you for your time. I'll be happy to answer any questions on this bill.

CLEMENTS: Any questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. You oppose this bill because of the funding source or because of the policy or both?

DREW GONSHOROWSKI: Both.

M. CAVANAUGH: OK. So just as a general rule, it's kind of frowned upon for agency directors to come in and oppose policy because that's not your job. Your job is to execute the policy that the Legislature passes. And the Legislature passed this policy last year and you are not in compliance with the law even though the funding mechanism is at question here, but it's not your job. It's the opposite of your job to come in here and testify in opposition based on policy. It's not your job. Your job is to execute the policy. So if there's a question or a concern about the, the mechanisms, that's what we should be hearing from you about, is the mechanisms not the policy, and that's been a long standing how things function. Has that not been made clear to you? Because other members of the state agencies have not come in and testified in opposition specifically to policy, especially policy that's in statute. So is that not how you understand your role?

DREW GONSHOROWSKI: I'm reflecting my testimony from last session in terms of that response.

M. CAVANAUGH: That doesn't make it, that doesn't make it the right thing to be doing. Do you not understand your role as the Medicaid Director?

DREW GONSHOROWSKI: No, understood.

M. CAVANAUGH: What is your role as the Medicaid Director? Is it to set policy or is it to enact policy?

DREW GONSHOROWSKI: Yeah, operationalize.

M. CAVANAUGH: Operationalize policy?

DREW GONSHOROWSKI: Yes.

M. CAVANAUGH: It's, it's not to set policy? Answer the question. Is your, is your job to set policy or is your job to operationalize policy?

DREW GONSHOROWSKI: No, it's to operationalize policy, yes.

M. CAVANAUGH: Then why would you come in testifying in opposition to policy?

DREW GONSHOROWSKI: I was, I was responding in reference to my testimony last session as well.

M. CAVANAUGH: Why did you come in last session and testify about policy?

DREW GONSHOROWSKI: Because this bill specifically bypasses one core function in Medicaid, which is Medicaid is the payer of last resort and our coordination of benefit.

M. CAVANAUGH: But that's a policy decision that Senator Dorn brought to the body of the Legislature and the Legislature voted on and made a decision and it was enacted into law, therefore, that's our job. There's very clear delineations of what the roles are in government and right now you seem to be very much overstepping. So if there was no issue on where the money came from, if we were in a different financial time and we had $1.5 million in some seat cushion somewhere to do this, then would you be doing it?

DREW GONSHOROWSKI: The, the issue here is that continuous eligibility for children, which is a federal mandate from the Consolidated Appropriations Act of 2013.

M. CAVANAUGH: That's not actually-- that's not the issue here.

DREW GONSHOROWSKI: That, that--

M. CAVANAUGH: No, you are, you are pitting two different issues against each other to make an argument again for policy. The question here is if the money is available to execute the policy that the Legislature passed and enacted into law, what's the problem?

DREW GONSHOROWSKI: The money is obligated to an allowable use as passed in [INAUDIBLE].

M. CAVANAUGH: I'm trying to get to the point of if we as appropriators find the money somewhere else, if we find some other, other than the hospital quality assurance assessment, will you follow the letter of the law when we appropriate the funds to enact Senator Dorn's legislation?

DREW GONSHOROWSKI: Yes.

M. CAVANAUGH: Because you have not to date done that.

DREW GONSHOROWSKI: Yes.

M. CAVANAUGH: So we don't need to actually pass Senator Dorn's bill, LB1031. We just need to appropriate as part of the bigger budgetary issue the funds from something other than the Hospital Quality Assurance and Assessment-- Access Assessment, and then you will do your job and you will follow the letter of the law.

DREW GONSHOROWSKI: Yes.

M. CAVANAUGH: Fantastic.

CLEMENTS: Are there other questions? Senator Armendariz.

ARMENDARIZ: Thank you. Thank you. I asked earlier to Senator Dorn, has CMS shared with you any kind of implication of us paying above and beyond what their recommendation is in this area, how to, how, how to have Medicare be the first payer?

DREW GONSHOROWSKI: Yeah, I appreciate that question. It's, it's-- it gets pretty complex pretty quick, but effectively what had happened in this space was in, I believe it was 2024, in, in covering the service specific in Medicare, it brought it into how Medicaid operations occurs across all service lines, which is Medicaid is the payer last resort, there's a coordination of benefit, and Medicare as the first payer, we sort of utilize that rate. The issue here, which is, I think, rare for Medicaid programs, is that the Medicaid rate has doubled the Medicare rate, and that has created the, the friction we're occurring here. That's, that's--

ARMENDARIZ: Have they shared with you-- I, I know we got a bill from CMS from Medicaid that we, we were more profitable in Nebraska, had the finances to pay more of our Medicaid share last year. Have they shared with you any kind of disparities in the rates we pay could result in that kind of justification in the future?

DREW GONSHOROWSKI: Not currently from CMS, and I, and I would say that these rates sort of sit within behavioral health rates within how they would compare them to Medicare, sit within what was called the upper payment limit. And since that's calculated by setting rather than service line, sort of these discrepancies and rates given their federal regulations doesn't fall to their attention, currently.

ARMENDARIZ: Can I have one more question?

CLEMENTS: Go ahead.

ARMENDARIZ: And as we did in, I think, ABA services you, you had a chart of where we're at in those payments. Do you have that for this?

DREW GONSHOROWSKI: Not for this, no.

ARMENDARIZ: OK. Thank you.

CLEMENTS: Other questions? You're talking about Medicaid being the payer of last resort and Medicare the first payer.

DREW GONSHOROWSKI: Mm-hmm.

CLEMENTS: So is there a conflict with us-- with the state paying the Medicaid rate for a dual-eligible person?

DREW GONSHOROWSKI: Not necessarily in terms of what is allowable. Ultimately, it would be an exception to our coordination of benefit across all our service lines.

CLEMENTS: It would be an exception to our what?

DREW GONSHOROWSKI: Coordination of benefit. So--

CLEMENTS: Coordination--

DREW GONSHOROWSKI: --for, for other, for other payers, whether it's Medicare or private, this would be-- I would have to confirm it, but this would be the only exception that we wouldn't pay under that specific process.

CLEMENTS: All right. Other questions? Seeing none, thank you for your testimony. Anyone else in opposition to LB1031? Seeing none, anyone here in the neutral capacity? Seeing none, Senator Dorn waives closing. And we have comments for the record: proponents two, opponents one, neutral zero. That concludes LB1031. That concludes our agenda for the day. Thank you, all, for your patience.