**HARDIN:** Welcome to the Health and Human Services Committee. I'm Senator Brian Hardin, District 48, and I serve as Chair of the committee. The committee will take up the bills in the order posted. This public hearing today is your opportunity to be a part of the legislative process and to express your position on the proposed legislation before us. If you're planning to testify today, please fill out one of the green testifier sheets that are on the table in the hallways on either side. Be sure to print clearly, fill it out completely. Please move to the front row to be ready to testify. When it's your turn to come forward, give the testifier sheet to the page. If you do not wish to testify, but would like to indicate your position on a bill, there are also yellow sign-in sheets back on the table for each bill as well. These sheets will be included as an exhibit in the official hearing record. When you come up to testify, please speak clearly into the microphone, tell us your name, and spell your first and last name to ensure we get an accurate record. We'll begin each bill hearing today with the introducer's opening statement, followed by proponents of the bill, then opponents, and finally, by anyone speaking in the neutral capacity. We'll finish with a closing statement by the introducer, if they wish to give one. We'll be using a three-minute light system for all testifiers. When you begin your testimony, the light on the table will be green. When the yellow light comes on, you have one minute remaining. And the red light indicates your time is finished. Questions from the committee may follow, which do not count against your time. Also, committee members may come and go during the hearing. This has nothing to do with the importance of the bills being heard. It's just part of the process that senators may have bills to introduce in other committees. A few final items to facilitate today's hearing. If you have handouts or copies of your testimony, please bring up at least a dozen copies and give them to the page. Please note that thumb drives, CDs, DVDs, oversized documents, books, lists of signatures, and other kinds of items will not be accepted as exhibits for the record. Props, charts, or other visual aids cannot be used simply because they cannot be transcribed. Please silence or turn off your cell phones. Verbal outbursts or applause are not permitted in the hearing room. Such behavior may be cause for you to be asked to leave the hearing room. Finally, committee procedures for all committees state that written position comments on a bill to be included in the record must be submitted by 8:00 a.m. on the day of the hearing. The only acceptable method of

submission is via the Legislature's website at legislature.nebraska.gov. Written position letters will be included in the official hearing record, but only those testifying in person before the committee will be included on the committee statement. You may submit a position comment for the record or testify in person, not both. I will now have the committee members with us today introduce themselves, starting with Senator Riepe.

**RIEPE:** Thank you, Chairman Hardin. I'm Merv Riepe, I represent District 12, which is Omaha, Millard and the fine town of Ralston.

**HANSEN:** Senator Ben Hansen, District 16, which is Washington, Burt, Cuming, and parts of Stanton County.

**FREDRICKSON:** John Fredrickson, I represent District 20, which is in central west Omaha.

**G. MEYER:** Senator Glen Meyer, District 17: Dakota, Thurston, Wayne and the southern part of Dixon County.

**QUICK:** Dan Quick, District 35: Grand Island.

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

**HARDIN:** Also assisting the committee today to my left is our legal counsel, John Duggar, and our committee clerk, Barb Dorn. Also, because they love to stand up and introduce themselves, Demet, Sydney, take it away.

**SYDNEY COCHRAN:** Hi, I'm Sydney, and I am a sophomore studying history at UNL.

**DEMET GEDIK:** Hi, I'm Demet. I study poli sci at UNL.

**HARDIN:** Today's agenda is posted outside the hearing room. And with that, we're going to start with LB866, Senator Ballard.

**BALLARD:** Thank you, Chairman Hardin and members of the Health and Human Services, Services Committee. For the record, my name is Beau Ballard, spelled B-e-a-u B-a-l-l-a-r-d, and I represent District 21 in northwest Lincoln, northern Lancaster County. I'm here to introduce LB866. LB866 proposes to create the Drug Detection and Prevention Cash

Fund and administer it by the Attorney General The purpose of this fund is to support statewide law enforcement to detect, prevent, and respond to illegal fentanyl and other illicit drug activity. The opioid crisis remains one of the most serious public health and public safety challenges facing Nebraska. In recent years, the spread of illicit drugs, particularly fentanyl, has intensified this crisis. Fentanyl synthetic opioids, far, far more potent than heroin or morphine, now account for the growing share of overdose deaths due to its potent-- potency and ease of distribution. Nebraska law enforcement agencies, in partnership with public health officials, have worked diligently to address this threat. As the drug landscape continues to evolve, additional tools can help enhance and support these ongoing efforts. Wastewater testing is one such tool. It provides real-time, community-wide data that can identify increase in fentanyl and other dangerous substances, often before those trends appear in emergency room or criminal incidence data. This information complements existing law enforcement and public health strategies, and supports the coordination with local agencies and federal partners, including the DEA. By strength-- strengthening awareness and enabling early, more targeted responses, wastewater testing enhances the important work already being done by law enforcement and public health professionals across the state. Nebraska is committed to protecting its residents from the devastating effects of fentanyl. Following me will be experienced former high-ranking officials with the uniform-- United States Drug Enforcement Agency, as well as individuals who have conducted wastewater testing for opioids and other drugs. They will be able to address specific questions on wastewater testing and where it has been utilized, and the benefits of for Nebraska. This will be a valuable tool in the toolbox for law enforcement across our state. I understand that there's some [INAUDIBLE] questions which need to be addressed, and I'd be happy to work with all interested stakeholders across the state and local governments. But I ask that you advance LB866 to General File. Thank you, Mr. Chairman.

**HARDIN:** Thank you. Questions? Senator Fredrickson.

**FREDRICKSON:** Thank you, Chair Hardin. Thank you Senator Ballard for bringing this bill. I'm just kind of reading over this, and I'm curious, I see it established as a new fund with, you know, for the opioid settlement funds. Do-- are we currently allowed to use the opioid settlements funds for something like this?

**BALLARD:** So the-- currently, the opioid, we've done a number-- Senator Howard created this fund in 2022, Senator Vargas did some work with the opioid settlement funds for behavioral health and testing. And so we are allowed to do-- creating this fund, we are allowed to use those as the Legislature sees fit.

**FREDRICKSON:** So I guess my question then is, if this is already an allowable use of the fund, why create a new cash fund?

**BALLARD:** So we're, we're very concerned of this unfunded mandate for law enforcement. This is going to be an extra expense for local law enforcements when their budgets are already tight. And so that's what we're going to use this fund for, is to, to work with law enforcement agencies to do this testing.

**FREDRICKSON:** OK. And so this would shift that, because I think traditionally the-- this type of testing is typically done through public health departments, correct? Or--

**BALLARD:** Correct, yes.

**FREDRICKSON:** OK, OK, so this would shift that role--

**BALLARD:** Shift, yeah, to work with law enforcement.

**FREDRICKSON:** --versus public health?

**BALLARD:** Yes.

**FREDRICKSON:** OK, thank you.

**HARDIN:** Senator Riepe.

**RIEPE:** Thank you, Chairman. Thank you for being with us. My question is this. If we're moving funds to help reinforce law enforcement, who are we taking the funds away? Because there's, there's no, no fiscal note here.

**BALLARD:** Yeah.

**RIEPE:** So if we're shifting, moving funds--

**BALLARD:** There's a lump sum in that settlement fund.

**RIEPE:** --who's getting left behind?

**BALLARD:** I don't know if anyone's getting left behind, Senator. I think there's a lump sum, and this is just a what I think is an appropriate use for those dollars.

**RIEPE:** OK. So if you create this new fund, is it Governor-proof?

**BALLARD:** That-- to be swept, you mean?

**RIEPE:** To not be confiscated or something.

**BALLARD:** I think it's Governor-proof, Senator.

**RIEPE:** Oh, OK. OK, we'll hold you to that. Thank you, Chairman.

**HARDIN:** Senator Meyer.

**G. MEYER:** Thank you, Chair Hardin. You know, initially with the opioid funds, that went to counties, you know, it's broken out on counties and it's "tronched" out in various forms from various funds, there's quite a, quite a number of them, initially from my experience. Nebraska had a number commissions and committees to try to decide what to do with the state's share of it. And so they struggled for quite some time to decide just what to use for it at the local level. We could direct it to the regional behavioral health agencies. The counties could donate it there or direct it there, and-- or we could use it in the counties with regard to procuring drug dogs, drug, drug enforcement, those types of things. And so there were specific uses we could, we could utilize those funds for at the county level. Are there any specifics, to your knowledge, that essentially as, as a restricted line item, are there specific uses delineated by the feds as to what we can use it for, to help law enforcement at the county level or at the-- law enforcement of whatever level?

**BALLARD:** I don't believe-- let me check up on that. I don't believe so. I, I just want to reiterate, I think this is an important tool in the toolbox. I support all those, all those uses of funds for county levels. I think this is just a, a important tool in the tool box for more of a prevention than instead of you're gonna hear testimony about how this could be-- we're trying to get as close to the front end of this crisis as possible. But I'll look into that specific, Senator.

**G. MEYER:** And if I may. In an application process when the funds are exhausted on a year-to-year basis, is this a yearly, yearly transfer of funds?

**BALLARD:** Yes, through the-- I believe so through the-- yes, would be a yearly transfer of funds, yes.

**G. MEYER:** And so an application process, first in--

**BALLARD:** All mechanisms, yep, all rules and regs.

**G. MEYER:** OK.

**BALLARD:** Yes.

**G. MEYER:** All right. Thank you.

**HARDIN:** Senator Quick.

**QUICK:** Thank you, Chairman. So and maybe I just haven't seen it yet or don't know, how much are you-- are you asking for a specific amount?

**BALLARD:** No, no specific amount.

**QUICK:** OK, because I, I know like last year I had a bill to, and I think I still have it-- might still be in committee yet, I'm not sure, for the opioid funds for-- I think we asked for a million dollars out of one of the funds to help with treatment, MAT treatment for people who are like in the Lancaster County facility to keep them out of-- keep them from, from reoffending possibly. And so I just wanted to make sure we're doing-- using the best thing we can for these funds, you know. This also for infrastructure too, to make sure we're building facilities.

**BALLARD:** Yes.

**QUICK:** We're gonna have a lack of facilities around the state.

**BALLARD:** Yes, I completely-- yes

**QUICK:** [INAUDIBLE] all the funds for this and not be able to have money for those type of things.

**BALLARD:** Completely agree, Senator Quick.

**QUICK:** Thank you.

**HARDIN:** Other questions? Senator Hansen.

**HANSEN:** Yeah, from my understanding, this is pretty similar to the Health Care Cash Fund. There's the Health Care Cash Fund, right, opioid settlement fund, and then you have these kind of subdivisions of that, just kind of directing where that money can go, for what purpose. And sometimes, you know, and I think it might have been what you were talking about, Senator Quick, the Health Care Cash Fund, like, we can appropriate this amount. Some have it, some don't, just depending on what they're being used for. I think that's kind of what my understanding with this drug detection prevention cash fund is, is-- this use for this specific purpose.

**BALLARD:** Correct. That's exactly correct. Kind of that lump-sum approach.

**HANSEN:** OK. Yep.

**HARDIN:** Other questions? Will you stick around?

**BALLARD:** I'll be here. Thanks, Chairman.

**HARDIN:** Nice. Proponents, LB866. Welcome.

**TIMOTHY SHEA:** Thank you, Mr. Chairman. I appreciate it. Chairman, mem-- members of the committee, I thank you for the opportunity to testify. My name is Tim Shea. I had the honor to serve as the administrator of the drug enforc-- U.S. Drug Enforcement Administration.

**HARDIN:** Could I have you spell your name, sir?

**TIMOTHY SHEA:** Oh, I'm sorry. S-h-e-a.

**HARDIN:** Thank you.

**TIMOTHY SHEA:** It's not the common spelling. There are different ways, like the stadium. Timothy Shea, T-i-m-o-t-h-y, and I had the honor to serve as DEA administrator, working with thousands of agents around the world and across the country, and that was an honor. I also was

the-- I served as the United States attorney for the District of Columbia, which is the largest U.S. Attorney's Office in the country. And it's unique because it acts as the federal and the state prosecutor. So I saw a lot of firsthand effects that drugs can have on a community and how to deal with it through a law enforcement way. Illicit fentanyl remains one of the greatest public safety threats facing our country. While law enforcement has made progress, drug trafficking organizations constantly adapt. To keep pace, law enforcement must rely on timely, accurate data and modern technology. One promising tool is wastewater analysis. This technology can provide near real-time intelligence on emerging drug threats, rather than relying solely on seizures that may reflect conditions from months earlier. That matters because new drugs often appear and spread long before the traditional systems can detect them. This kind of data supports law enforcement operations while it also serves as an early warning system for communities and prevention efforts. That combination is critical. Many parents across the country have lost children who believe they were taking a prescription pill only to ingest fentanyl instead. This crisis affects every community in every demographic across the county. By investing into modern data-driven tools, LB866 strengthens Nebraska's ability to respond quickly, intelligently, and effectively to an evolving drug threat. It supports enforce-- law enforcement, prevention, and public safety at the same time, which is unique. In all the times I've been involved in, in drug control efforts, it's rare that you get a solution that can be-- that can do two things. Prevention is critical. Treatment is critical, but so is law enforcement. So this does the prevention and law enforcement in the same program, which I think is unique. So I see my time is up soon. But, Mr. Chairman, there is a colleague of mine, former colleague of mine, who was the chief of forensic sciences for DEA, was trying to travel here but got-- the planes didn't allow him to do it, so he couldn't make it. But his testimony is submitted and there are some charts in here that are pretty instructive and helpful for the committee, if they want to look at it. I can explain it during questioning, if you'd like it. Or we could just open it up at this point.

**HARDIN:** I would like you to explain it.

**TIMOTHY SHEA:** OK. So if you, if you have these charts, I mean, there's just a couple of slides. This one, the figure 1, this is amazing. And it's always, it always sets people aback, which is fentanyl is, is

such a deadly substance that it takes very little to kill somebody. The powder at the end of this pencil is all it takes to kill a human being. That's it. It's two milligrams of fentanyl. If it's mixed in a pill that looks like an Oxycontin or an Adderall, the child won't wake up, that'll be it. So that, that, that's what this figure illustrates in the fact that it's, it's there. The other thing is, figure 2 is just an example of the authentic and fake pills. Now, when I was administrator, I went to a lot of the DEA labs and saw the scientists testing all the drugs that were seized by agents across the country. And they couldn't even tell the difference between a fake pill and an illicit pill. This is an oxycodone tablets on figure 2. I mean it's impossible to tell the difference and, you know, somebody, when a child-- and I've talked to many parents across the country about this-- have ingested it, whether they think it's an oxycodone or maybe Adderall and it, it has two milligrams of more of fentanyl in it and they never wake up. The parents find them in their beds. And I've, I've gotten to face parents like that that have done it. So this work is very important, as you know. And then the next one is just examples of some of the, the imprints of these fake pills that they, they imprint them as all these, all these other drugs that they can-- the cartels can get money on. They have pill presses mostly in Mexico, but they come up through there and they're seized at the border. But a lot of them get through. So that's why it's, it's a critical, it's a critical problem to face. And then there's emerging threats coming. The last one just shows the Nidazine incidents. Nidazine is an assiduous new trend among-- it's very potent and it can kill somebody even faster than fentanyl can. The other one is, is what they call "tranq" or xylazine. It is basically a veterinary sedative for, for big animals like elephants or stuff like that. The real sad thing about that one is that it doesn't, doesn't respond to Narcan or any of the agents that revive people. We've saved a lot of people in this country by having Narcan available, people that have been overdosed and able to revive miraculously. They come back like within seconds. It doesn't work with xylazine. You take that and that's gone because it's not an opiate. It doesn' work on the same receptors. So that's a problem if that becomes more widespread. You have wastewater testing like this, you're going to be able to see the trends before the bodies start dropping because you'll see these in the wastewater testing. And, and the next speaker will prob-- will get more detail about that. [INAUDIBLE] over, over.

**HARDIN:** Senator Fredrickson.

**FREDRICKSON:** Thank you, Chair Hardin. Thank you for being here and for your testimony. I had a couple of questions for you.

**TIMOTHY SHEA:** Mm-hmm.

**FREDRICKSON:** Part of your testimony, you mentioned this is an opportunity to address this both from an enforcement as well as a prevention perspective. Certainly enforcement perspective makes sense to me. Can you say a bit more about the prevention perspective?

**TIMOTHY SHEA:** Yeah, the other speaker will talk about this too, but if you, if you test-- well, just in general, even if you test in general and you see, you know, xylazine coming in or nidazines or some other new trend that's happening, then you can ramp up and target enfor-- prevention and education efforts to that area, especially if you're testing around a school. You know, the school, you know, has a, you know, a clean record, then all of a sudden you see a spike. Somebody has introduced a drug into that school, and you're not going to know until it's too late.

**FREDRICKSON:** Right.

**TIMOTHY SHEA:** But if you-- but the, but the teachers now, you know, they don't always like to, to know who the problem is because they don't want to see they have a school that has a drug problem. But it's better to know and to use that opportunity to educate the students while, while it's there. Because basically they're getting poisoned because they're thinking it's a real pharmaceutical-grade product, like an Adderall, when it's really not. It's, it's got, it's got fentanyl in it.

**FREDRICKSON:** OK. My second question for you is, do you know, is this in fact an allowable use of the opioid settlement dollars?

**TIMOTHY SHEA:** I mean, I believe it is. I think that law enforcement is one of the, one of the uses of it. You know, it's, you know, there are a variety of-- I think the way the settlement dollars-- the settlement was written in a very broad way so that the states could decide where it is best suited, because we don't want to have a cookie cutter, you now, from Washington nationally to tell you how to spend money.

**FREDRICKSON:** Yeah. Yeah, I mean, I know research and data is certainly, I think, an allowable use.

**TIMOTHY SHEA:** Yeah.

**FREDRICKSON:** And I think that it specifies collecting and analyzing data to evaluate the effectiveness of abatement strategies. And I guess I just kind of-- what Senator Meyer was kind of hinting at earlier--

**TIMOTHY SHEA:** Yeah.

**FREDRICKSON:** --is sort of not wanting to risk losing funds, just kind of being sure that this is in fact allowable.

**TIMOTHY SHEA:** Right, and like I said, it is prevention, prevention as well. I mean you can, I mean if you, it kind of focuses it and it, and it makes it targeted as opposed to a general saying you're gonna have this campaign that says: we're gonna stop kids from having, using drugs. But if you know there's a specific problem there, you could spend less money by going into that one area and really educating the students. Because I don't think they want to be taking fentanyl either, if they think it's something else.

**FREDRICKSON:** Sure.

**TIMOTHY SHEA:** So it's important for them to know.

**FREDRICKSON:** Thank you.

**TIMOTHY SHEA:** Thanks.

**HARDIN:** Senator Meyer.

**G. MEYER:** Thank you, Chair Hardin. Thank you for coming today. Did you have any trouble flying?

**TIMOTHY SHEA:** I didn't, no. I made it from the East Coast, so it's fine.

**G. MEYER:** I know given the, the remoteness of some of our counties here in, in Nebraska, one thing that from the county level we were targeting methamphetamine labs. And in my particular area was a major problem. And then within the last probably two years, we started

seeing a substantial spike in fentanyl. Are we seeing, nitrazine, is that taking the place now of fentanyl? Or are we seeing the meth, we're seeing the fentanyl, we are seeing these other products-- are we replacing the meth with these other products, or are we moving past that?

**TIMOTHY SHEA:** Right. That's a good question. You know, different areas of the country have different problems that you think would be a national thing, but it really is, is, is localized in some ways. I mean, in the Northeast, it's a lot of the opioids. It used to be heroin. It was a lot the codone-- oxycodone and fentanyl. The Midwest here, and especially here in Nebraska, meth has been the problem. You identified it correct, Senator. That is the problem. What is happening, the trend lately, is to mix fentanyl and meth in the same, in the same dosage, and that, that's where the ODs start happening. So when you see that combination, and we are seeing an increase in that in this area. So I think that's important to, to realize that it's not just, you know, they used to be fairly separate operations, but they're, they're mixing. And that's the new trend. It's not as much [INAUDIBLE] here, but it could happen. So it's good to be aware of that, because you have that confluence that those arteries, those highways. I think it's, what, 29 and 80 that can carry drugs everywhere, and it's not just a transit point anymore. Nebraska's a destination point.

**G. MEYER:** I know with with the specific uses we were allowed to do at the county level with [INAUDIBLE] I happened to be the opioid administrator for the county since its inception when we had those funds. But it was, it was for-- it was for drugs in general. It wasn't specifically, specifically for opioids.

**TIMOTHY SHEA:** Right.

**G. MEYER:** You know, it, it, it encompassed all of it. Are there any special handling with regard to fentanyl, obviously, just being around, and Narcan we, we encourage through Region 4, behavioral health. At one time we were, we were passing out a lot of Narcan to our first responders, the fire departments, police departments, that type of thing. And I encourage anyone that's around high school kids or whatever, I carry an Narcan actually in my vehicle at all times. And I recommend family members have it because you never know where you're gonna find it. But is there any special handling concerns with

the, the new products that are coming out? You know, fentanyl is absolutely big-time dangerous from a handling standpoint. Is there any, anything, because I haven't, honestly, I haven't really heard about these two new products for the most part.

**TIMOTHY SHEA:** Yeah, it depends on what form they're in. So you see a lot of fentanyl that comes in, it could become in the powder form. And then maybe it's broken down when it gets into the United States after it's smuggled through. It's largely from Mexico. And what, what happens is that the drugs come in, the precursors come in from China, either through the United State or directly to Mexico, and then they're mixed in labs in rural Mexico and then brought up. Sometimes they're pressed into pills and, and then distributed that way in Mexico. Because we did clamp down, DEA clamped down on these pill presses and stopped them from being sold in this country. So that's one way, but also that comes in as powder. A pill is less, is less of a problem in the handling, like you mentioned, but if you have the powder substance of any of these, whether it's nitazene or "tranq" or whatever it is, it's gonna be a problem for first responders, but also for the-- even the drug dealers that have to cut it up. I mean, those are the problems. And that's kind of what happens with this program. In a way, what's interesting, and the next speaker can talk about it, but this can, this can distinguish between metabolized and unmetabolized substance. So, you know, you don't want to go after users in a way like this because, I mean, you know, we want prevention and treatment for them. But if you see an unmetabolized sample from a specific area, that means somebody is cutting it up or somebody is distributing it, because it's not going through a human body. It's being washed off of utensils or whatever they're using, or their clothes even. So that's the difference, and I think that's important part of it. But it, it's a good question and the handling of any of those that I mentioned has to be done with care, although it's less problematic if it's already in a pill form.

**G. MEYER:** And if I could just one short question. Is there any antidote like Narcan for the opioids? Is there anything that counteracts the effects of the two new drugs?

**TIMOTHY SHEA:** No, xylazine, that's the real insidious nature of it. I mean, there's nothing that counteracts that. Same with meth, I mean there's no, there's really no medically-assisted treatment for meth, even if you want to get off meth. They haven't approved a really--

like you have this methadone and all these other things for opioids, but there's not medically-approved treatment for meth, which is really, it's kind of sad because once you get hooked on that, it just destroys you, as you know. You see it with your constituents. But in terms, terms of xylazine, Narcan will not revive somebody, it just won't.

**G. MEYER:** Thank you.

**HARDIN:** Other questions? Senator Quick.

**QUICK:** Yeah, thank you, Chairman. And of course most people in the room know that I have a son who struggled with substance abuse for over 25 years and he's used opioids, he's used fentanyl. We've given him Narcan. He's doing well now, he's doing better. But I know one of the things in Grand Island, you know, with-- so our son was taken to the emergency room several times, and I can tell you the law enforcement, they already know what drugs are in our community. I can tell you that. And some of it comes from when they take them in there and they're testing them in the hospital, too. So, you know, for me, I just want to make sure we're using these funds the best way we can for if, if this is a proper use for it, I guess I'm OK with it. But I also want to make sure we're using these funds for treatment and building facilities because we don't have any opioid withdrawal units in our area. And that's something that's really necessary. And I don't know if you want to comment on that.

**TIMOTHY SHEA:** Yeah, I think I've always said even though I'm on the law enforcement side, I said the only way we're gonna solve this, it's a three-legged stool. The only way we're going to solve this problem or reduce it, which we have been in the last year. It's been, it's been-- we've made some progress. But you've got to have prevention, you've got to have treatment and then you've gotta have law enforcement to reduce the supply. Prevention is much more effective than any of those, including law enforcement, having been the head of a law enforcement agency. Because if you can stop kids from using it in the first place or stop them after the first try, you don't get them hooked. And, and so I think money spent on this type of program is very cost-effective and could affect a lot, a lot of people. That doesn't mean you have to not do the other stuff either, but I do think

it's, it makes a big difference if you could, if you do the treatment side of it.

**QUICK:** Do you know or have an idea of how much money you would be ask-- they would be trying to use for a cash fund for, for this?

**TIMOTHY SHEA:** I don't know. I think they're-- we're developing sort of the program and it depends on how widespread or where the problems are, and that will dictate the cost. But I think, you know, having a program that is effective, cost-effective, efficient, and targeted to the right area, you know, will be a cost-effective use of those funds.

**QUICK:** Yeah, because I know you maybe heard me earlier, but I struggled getting just a million dollars--

**TIMOTHY SHEA:** Right.

**QUICK:** --to help with treatment. And so, you know, I just want to make sure we're utilizing the funds.

**TIMOTHY SHEA:** Yeah, and I sympathize, I mean, as a parent, it must-- it's hard to, to see that. And most families in America have had it, you know, including my own, have been-- have had relatives that have been part of that. And seeing it, like I said, I've talked-- one of the hardest things I had to do as DEA administrator was to talk to a group of parents, telling me the story about what, what happened to their child, things like, you now, taking one pill and then not waking up and finding their child in bed, you know, they're dead. I mean, that's, I don't know how you respond to that. So I think the best way is to have the prevention, treatment, and law enforcement. But you gotta have all three or it's not gonna work.

**QUICK:** Thank you.

**HARDIN:** Senator Hansen.

**HANSEN:** Thank you. I think on that note, I think you're, you're correct, and so is Senator Quick. I think we have already I think four directed uses for the opioid cash fund, and a lot of it, you know, we have a training division cash fund, behavior, health and wellness supports. We have money going to health human services for fatality review teams, money going into opioid prevention treatment cash fund and then also opioid treatment infrastructure cash fund. This might be

the only one we have that deals with prevention, I think, and detection.

**TIMOTHY SHEA:** Right.

**HANSEN:** So I think we get-- talk about the three-legged stool, I think we're missing a leg here. I think this might be one of the ways we can use that, that for that purpose. So I, I, I agree with Senator Quick making sure we're using it for the appropriate purposes and the amount, but this might be the one that we don't have that in our toolbox that might be beneficial for the cash funds. I was gonna ask you a question about the specificity of testing a little bit, but I think that might-- maybe the next testifier might answer that.

**TIMOTHY SHEA:** I can try. If I can't I'll-- it's up to you.

**HANSEN:** You or somebody else can. I just, I throw it out there now so that they can maybe mention that when they come up so.

**TIMOTHY SHEA:** OK. Yeah, I think Ben, he wants to testify in favor, and he has-- yeah, he can explain how, how it's really kind of interesting how detailed you can get with the, the tests. Not only can you distinguish the different drugs, whether it's a, you know, a fentanyl, whether it is nitazenes, or xylazine, or meth, or whatever you're testing for, but you can, even within the opioid space, you can drill down and, and even determine where it was made, where it was manufactured by, by the molecular signatures. So for example, if you want to, you know, if it was the Sinaloa cartel that was made in Sinaloa or Jalisco or whatever it is, that is important too to law enforcement to know, to DEA as well. Because it shows that, you know, what, what cartels are coming in. There's cartels working in Nebraska today, I can assure you of that, and they-- and, and knowing that information on the law enforcement side is very helpful. So it's very, very sophisticated and detailed testing.

**HANSEN:** Thank you.

**HARDIN:** Thank you.

**TIMOTHY SHEA:** Thank you, Mr. Chair.

**HARDIN:** We appreciate it. Appreciate it. Next proponent, LB866. Welcome.

**BEN RENDO:** Thank you, Chairman. Good afternoon. My name is Ben Rendo, spelled B-e-n R-e-n-d-o. Thank you all for your time today. I lead Stercus Bioanalytics. We're headquartered out of Kansas City, Missouri, and we work with our state and federal partners on forensic wastewater testing related to narcotics and public safety. I want to talk today about an urgent threat to Nebraska students, and I think it's already been touched on, and that is counterfeit narcotic pills. As it's been said, these pills are designed to look exactly like an Adderall, Xanax or oxycodone, but often they can contain fentanyl, methamphetamine, and other dangerous substances. Students, for the most part, are not seeking to use these type of illicit drugs. I just want to stress that. What we have seen in the most parts in high schools and dorms across the country, young people are not looking to score a fentanyl. They think they are getting an Adderall that they believe is going to help them study for an exam. Or, you know, student broke up with her boyfriend and wants to try to get a Xanax. They are not seeking the substances that they're being poisoned with, which puts us in a kind of a unique space right now. And that's why it's so deadly. Oftentimes are obtained from a peer, classmate, or friend, and this is what makes it so deadly. Counterfeit pills are inherently unpredictable. Two pills from the exact same source can contain vastly different drug concentrations. For young people with no tolerance, a single pill can stop breathing within minutes. Too often the first warning comes only after a medical emergency or death. Nebraska needs early detection, not after-the-fact response. One effective tool is wastewater analysis trend at school. This approach examines wastewater leaving a facility to identify overall drug presence and trends. It does not identify individuals. It is not surveillance. It is an early warning system. When implemented responsibly, this data allows schools and communities to respond quickly with education, counseling, preparedness before a tragedy occurs. Drug trafficking organizations are introducing new substances, that has already been said. And we want to be part of the solution to stop that before it's fatal. Again, this approach is about prevention and student safety, it is not about punishment. Nebraska has an opportunity to act proactively, and I urge you to consider this tool as part of a comprehensive strategy to protect students in the state. Thank you, I'm happy to answer any questions you may have.

**HARDIN:** Thank you. Thank you for coming. Where else are you doing what you do?

**BEN RENDO:** We are statewide in Missouri, statewide in Tennessee. We also do work in Mississippi, Arkansas, and recently the last National Defense Authorization Act that was passed at the federal level last year, we will be doing work for the Department of War.

**HARDIN:** And what are you seeing in those states, what can we anticipate here in terms of before and after when you all come in and do what you do with wastewater?

**BEN RENDO:** Absolutely. So, Chairman, I will give you an example in one of our states. I'm not going to say what the school is, to protect their identity. But so we test anywhere from two to three times per week at our high schools. The highest per capita, per person methamphetamine rate we had ever seen in a high school prior to this fall was 1.1 milligrams. We got our testing results in from the high schools on a Friday and we saw that the methamphetamine usage rate had jumped to 6.4 milligrams. And that is crystal meth, that is not an amphetamine like Adderall, they're two different molecules. So we started researching to see what the issue was. One of our teammates pulled the academic calendar and we realized that they were conducting the PSAT exam at that high school on Friday. Someone was dealing a large amount of counterfeit Adderalls being strictly methamphetamine to the students. And so the way that our testing works is, and this is crucial, like it's important to find, find the problem. You know that's A. But then what is the after action? That's B. And so historically what we have done is work with public health or our law enforcement partners, we will bring them in as soon as we see that. We will then share our collateral, such as Mr. Shea discussed earlier, because again, most of these kids are not looking to take methamphetamine. They're taking something they think is going to help them do well in the exam. They're talking something that they think it's going to help them relax. And law enforcement or public health partners will then take those resources, deploy into that school, you know, within the next week and educate the students. They let them know what you're taking, it's obviously not what you think you're taking. This is what numbers are-- this is what they were, this is what they are, and this is likely the source. And that's kind of the "ah-ha" moment when students can see that counterfeit Adderall is identical to what I took last Thursday. We continue testing at the

schools weekly afterwards. We see those usage rates fall off a cliff, And so that's why it's important. The other thing is, Mr. Shea said earlier was nitazenes, which I can expand on a little bit. Nitazenes are a synthetic opioid, anywhere from 20 to 40x more potent than fentanyl. The precursors to manufacture nitazenes have not been scheduled via the FAST Act. So what we've been told by DEA is that the cartels are starting to shift some of the production into nitazenes. The concern is that if we don't have early warning systems like this or others, once nitazenes start to make their way into counterfeit pills in the U.S., we will potentially see another opioid overdose death wave. So the ability to have early warnings so action can be taken is crucial.

**HARDIN:** This is a philosophical question, and it's different than the technical aspect of it. But because you find yourself in the middle of it, I'll ask the question. It's a really bad business model when your consumers use it once and they're dead. Who's doing this?

**BEN RENDO:** I can, I can answer, because I asked that exact same question. I asked it at DA headquarters. I said, from a business perspective, why do I-- why does someone want to kill their best customers? That doesn't make sense. And the answer was interesting. So the comp-- the countries that largely manufacture precursors for fentanyl or nitazenes are largely China and India. You know, our belief and, you know, this has been shared at the federal level, is it's being used to destabilize our country. Once it makes it to the cartels, they are not looking to kill their customers. The cartels are looking to maximize their margins. This is strictly a margin business play. And by using some of these synthetic opioids that are incredibly inexpensive, that allows them to reap a greater margin. And, you know, why the tragedy happens in our community that John Smith takes a counterfeit Xanax and passes away, there's going to be 10 guys, guys or gals behind John Smith. And that's the way the cartels operates. While they don't want to kill their customers, someone's going to be right behind them to replace them.

**HARDIN:** So the cartels would rather not kill their customers, they're in the squeeze on this?

**BEN RENDO:** They're in it to maximize the amount of money they can make.

**HARDIN:** OK. Questions? Senator Hansen.

**HANSEN:** I think the idea of what you're trying to accomplish isn't anything new. I think we've used this, the department, DHHS or maybe the USD, I can't remember, uses something similar in wastewater detect, to detect for like measles, for instance, right? I think we're just using this for a different purpose to detect drug use or illicit drug use, I think, right? And so I wanna maybe touch, or you can expand a little bit on the like, how does it work? You mean like, what's like-- do you just open up a manhole and stick a spoon down there and you put it in a cup? Or like what, what, what-- how specific and what's-- how does this actually work is what I'm curious about.

**BEN RENDO:** Absolutely. It's a fantastic question. So because it brings me back to a note, because public health was touched on earlier, we are not looking to compete with public health. You know, our goal would be that we can complement, you know, some work that they may not be doing yet. One of the differences about the way that we work is what we can test at wastewater treatment plants, what we have found is in order to make the results and data most actionable, we need to be as close to the source as possible. And so for example in a high school there's going to be one to two outgoing sewage pipes from this high school. Our technicians will pull the sewer mapping of course once we are given approval about the school, and we'll set up our testing equipment at the outgoing sewage pipes from that high school. That means the only thing that we are going to be sampling is from students and faculty in that school. We're not getting run-off from a nearby apartment building or, you know, manufacturing plant. It is only that school. So our equipment lives under there. We take 24-hour composite samples. And after 90 days, we have a baseline of what the average per capita per person usage rate is in that high school. We can test for up to 50 different narcotics. The other states that we are live in, they have used the opioid abatement dollars to fund our work. It's not coming out of general revenue. So once we do that and we see the sudden spike of, you know, it's been already mentioned, nitazenes, or high concentration of methamphetamine, fentanyl, whatever the narcotic is, we will then report those results to whoever our state agency partner is. And we also need to have a, you know, step B for whatever the work we do is. So in the high school, we collect samples, we can collect five milliliters that is analyzed at our lab. Our lab is a Department of Defense and DEA-certified facility, so we often have to submit samples to validate the efficacy

of our testing. We get those results, we populate them to the dashboard, and then we pull in whoever agency we're working with to alert them what's going on and then work through what plan B is. You know, in the case of the counterfeit Adderalls, our recommendation would be the outreach this upcoming week should center largely around this. And this is what rates were. This is what they are now. This is what they're projected to be. That's largely how it would work. Does that answer that question, sir?

**HANSEN:** Yep, thanks.

**HARDIN:** Senator Fredrickson.

**FREDRICKSON:** Thank you, Chair Hardin. Thank you for being here, for your testimony. What other states are you currently doing this in?

**BEN RENDO:** Statewide in Missouri and Tennessee, we are live there right now. We have also worked with operations with DEA in Mississippi, as well as Arkansas.

**FREDRICKSON:** OK. What-- so I know one of the-- the introducer was asked kind of around there was no sort of specific dollar amount allocated in this legislation for this. Ballpark, what type of fee do you imagine you would charge the state of Nebraska would you-- should you be submitting a proposal?

**BEN RENDO:** Sure. Depending on the scope, if it's helpful, I can answer what, what the other states do, so.

**FREDRICKSON:** Sure.

**BEN RENDO:** Like in Missouri, we had a $7 million appropriation, and that is a combination of testing high schools, as well as assisting law enforcement at work. In Tennessee, it is a $3 million appropriation with the Tennessee Bureau of Investigations. And so as far as what, what we would charge, our goal is to serve the people of Nebraska. So if they want us to focus strictly on school testing, that's what we would do. If they want to focus us strictly on law enforcement, that's we will do. It depends on what, what the scope of the work is.

**FREDRICKSON:** OK, sure. And, and Missouri and Tennessee, those are annual appropriations, $7 million a year, is that correct? Or $3

million a year? OK. And are there, are there other companies that provide this service?

**BEN RENDO:** I believe there are other companies that do wastewater testing. To my knowledge, they do not have their own technicians that do law enforcement-sensitive work. And the reason that is important is all of our technicians have to pass state as well as federal background checks. Because when we are in the field, that is something that, you know, we're very sensitive to, that that information is only reported to who it needs to be reported to.

**FREDRICKSON:** OK, sure. So if we were to pass this legislation and pursue this, from what I'm understanding, you're the only company that would be able to provide this?

**BEN RENDO:** At the level of detail of what we do, yes.

**FREDRICKSON:** OK, so would that make this special legislation?

**BEN RENDO:** That I cannot answer.

**FREDRICKSON:** All right, thank you.

**HARDIN:** Senator Meyer.

**G. MEYER:** Thank you, Chair. Just a couple of questions. Do you need permission from the schools to go in and test the [INAUDIBLE]?

**BEN RENDO:** Yes, sir.

**G. MEYER:** And given the aggressiveness of trying to cut down on the amount of drugs coming into the United States that the current administration is utilizing, are we seeing pure drugs? Have we made a dent in it at all? Is it too early to tell? All of the above? None of the above? What's you, what's your analysis?

**BEN RENDO:** So what I would say is the amount of fentanyl being used in the United States, at least what we are seeing, those rates are going down. And that is a result of the FAST Act and other legislation that has made it harder for the cartels to get the precursors they need to make fentanyl. So currently, we are seeing progress with that, you know, from a national drug landscape. The, the concern is that if and when the cartels ship production to nitazenes, a lot of the good work

that this administration and states like your own have done, we're going to see challenges again. Because as Senator Quick referenced earlier with Narcan, nitazenes from what law enforcement has seen seizure-wise-- we've seen some on the East Coast, so Baltimore, Philadelphia. But where it may take one dose of naloxone to reverse a fentanyl overdose, it will take anywhere from three to four-plus to reverse a nitazene overdose, which most people are not going to have. Unless it is a first responder, they're not gonna have three or four doses of Narcan on them. I also carry Narcan in my truck. But that is our primary concern, that doing this type of testing is important. Because we've seen the fentanyl numbers go down. And, you know, my opinion is that we have a false sense of security that it's mission accomplished. And the ability to prepare for emerging drug threats on our landscape is what will keep our, keep our young people, but keep all demographics from being poisoned by these.

**G. MEYER:** Thank you.

**HARDIN:** Senator Quick.

**QUICK:** Thank you, Chairman. Do you know, like, and you may or may not know this, but like the funding sources from the other states, whether it was general fund dollars or was it, was it opioid?

**BEN RENDO:** I do know. All work we have done has been funded by opioid abatement dollars in the states that we're in. And then we're active conversations with six additional states this legislative cycle, I believe all of them are going to use their opioid abaiment dollars. And it is falling under harm reduction because what has been argued in the other legislatures, there's no, no better harm reduction than working with law enforcement in the field to keep these drugs from getting there. Harm reduction also and the ability to have an early warning system to take corrective action before a student dies is falls under the guise of harm reduction.

**QUICK:** OK, all right, thank you.

**HARDIN:** Other questions? Thank you.

**BEN RENDO:** Thank you so much for your time. I appreciate it.

**HARDIN:** Proponents to LB866. Proponents? Opponents, LB866. Those in the neutral. Senator Ballard, while you are coming, it would seem we have 1 proponent online, 1 opponent online, 1 neutral.

**BALLARD:** I'll just be brief. I want to say thank you to the committee for all their very good questions. It's been a fascinating conversation. We all know this is at a crisis level. The opioid epidemic in this state and in this country is, is a problem. And I think I-- I worked three years ago with then-Senator Vargas on a similar legislation to work on prevention and mapping using these funds. And so this is just a progression of, as a testifier said, the three-legged stool, I think is a very good analogy between law enforcement, prevention, and treatment. And so this is just part of that equation. So I look forward to working with the committee on maybe some technical changes. But with that, I'll be happy to answer any final questions on LB866.

**HARDIN:** Questions? Senator Quick.

**QUICK:** Thank you, Chairman. Do you know how, or does DHHS decide, how, how much the funds would be and how that works? Or do we as a Legislature make that decision?

**BALLARD:** Right now it's, it's in the, the Attorney General. So as the legislation is written, it would go to the Attorney General, the fund.

**QUICK:** And OK. All right. Well, and this may be more of a comment than a question but, you know, I struggled getting a million dollars just for treatment and had opposition. And now we're looking at three to seven million. And it's just a comment.

**BALLARD:** No, it's, yeah, these dollars are-- yes, absolutely, I-- yes.

**HARDIN:** Senator Hansen.

**HANSEN:** Thank you. I think ultimately the Legislature has like control over how much to appropriate towards this fund. But I think a lot of times this is almost like a, almost like a pilot program. But then we get an idea of, OK, what's its use? How much funding is needed? And then we get some kind of idea about where, where we need to curtail this or if it's working really well to appropriate more money, or let it go, you know, kind of thing. So it makes sense to kind of-- I think the way you have it structured right now. A question I had, maybe I

can answer it later, is about the information that's, that is being-- that we're getting from this testing. So say it's we're doing it at a high school. Does the high school have-- are they able to get that information, or is it just strictly within law enforcement or DHS? Or it's private, like they won't share it with the public? So like, I know if I'm a parent, my kid is in high school, and all of a sudden they say fentanyl is at zero, and all the sudden they see it at like six, do the parents have access to that? Does the school, the superintendent have access that information? Or is it like, we don't-- law enforcement doesn't want to say anything because they're trying to like investigate it now? So I'm curious about the information part, which--

**BALLARD:** Yeah, we can definitely get you those answers. The-- I think the key is you can't identify the information, which I don't think is the question you're asking.

**HANSEN:** Yeah, not so much a person--

**BALLARD:** Not the person, but yes.

**HANSEN:** --but like the facility is being tested, and if it is a public school [INAUDIBLE].

**BALLARD:** Yes. And who has access to that information. Yep.

**HARDIN:** Senator Fredrickson.

**FREDRICKSON:** Thank you, Chair. Thank you, Senator Ballard. So yeah, look, I think this is a-- I like the idea, I think it's important to do. Obviously it's a part of a larger sort of larger part of approach to addressing what we're seeing. I am curious to hear though, you know, I was speaking with a previous testifier, did you have any-- do you have any thoughts on this, the idea of this being special legislation? Do you know--

**BALLARD:** I think we have different definitions of special legislation, because I think in special legislation you're talking about building a road and you say, we're going to appropriate a million dollars to the East Beltway. This is all very discretionary, all optional, and it's-- you don't have to go with this specific company. And it all at the-- administered by the Attorney General.

**FREDRICKSON:** Do you know of other-- did you research if other companies provide this, if we were to appropriate funding for this?

**BALLARD:** So I-- not at this time, as the previous testifier said. But it's other companies have done similar testing, but it's not specific to this company, as not in statute say we have to use company A and can't use company A, B or B or C.

**FREDRICKSON:** Thank you.

**BALLARD:** Yep.

**HARDIN:** Senator Hansen.

**HANSEN:** I think maybe what, what Senator Fredrickson is alluding to is the idea of special legislation saying we're going to-- this is crafted around one specific area and we actually will see the name of the company. I ran into this with my school mapping bill when I had-- with the, the security fund that we had. And so we set up the characteristics, OK, this is what we're looking for, this is what the funds can be used for. And whoever can fulfill those, you know, characteristics of the bill that we're, we're putting into place, then they're eligible, so long as they're filling out whatever the bill is crafted around, right? So I had, had one, but then eventually another one kinda came along, so we had other people who were eligible. Which I'm assuming is probably the same thing with this.

**BALLARD:** Correct.

**HANSEN:** So if another company comes along and can do the same thing, or fulfill the qualifications of the legislation, they're eligible for it too, right?

**BALLARD:** Correct.

**HANSEN:** So to the discretion, I think, of the AG--

**BALLARD:** Correct.

**HANSEN:** --where you ultimately ask.

**BALLARD:** Yes.

**HARDIN:** Other questions? Senator Meyer.

**G. MEYER:** Thank you, Chair. If this funding is coming from where our county funding, and it may be a totally different funding source regarding opioids, but we would know specifically that it's on a schedule. What comes and where it comes from, how much the periodically when it's, when it's dispersed. And, and there are continuing lawsuit settlements that, that add to the funds, so it's dispersed over a period of years. That may be totally different than the source of these funds. If it's similar to that, do you have some idea of a continuity from a sustainability standpoint? And that would be the concern if we initiate something, looking at the sustainability of a program like that. I think it would be a great program, absolutely. But just the sustainability and the source of the funds and, and, you know, how we can structure it on that basis.

**HARDIN:** Other questions? Senator Quick.

**QUICK:** Just one more. Do you know how much is coming in each year from that opioid settlement?

**BALLARD:** I'll have to do-- I do not, off the top of my head. I'll get that information for you.

**QUICK:** And then I think it doesn't go on forever, right?

**BALLARD:** Correct.

**QUICK:** I mean, at some point, it stops. I don't quite know how many more years.

**BALLARD:** Correct. Yes. I'll get that information for you. I think that's easy. Yeah.

**HARDIN:** Thank you.

**BALLARD:** Thank you, Chair.

**HARDIN:** This concludes LB866. We'll be moving on to LB912.

**FREDRICKSON:** All right, looks like we're shuffling a bit. And I think we are mostly shuffled. So Chair Hardin, you're welcome to open on LB912.

**HARDIN:** It says, "During your opening, say your first and last name."

**FREDRICKSON:** That's correct.

**HARDIN:** "And spell for the record." Thank you, Vice Chairman Fredrickson, and good afternoon, fellow senators of the Health and Human Services Committee. I am Senator Brian Hardin. For the record, that is B-r-i-a-n H-a-r-d-i-n, and I represent the Banner, Kimball, and Scotts Bluff Counties of the 48th Legislative District in western Nebraska. I'm here today to introduce LB912. LB912 seeks to adopt the Community Health Worker Training Endorsement Act. Specifically, this bill would establish a statewide process for the Department of Health and Human Services to endorse community health worker training programs that meet minimum standards of quality and core competencies determined by the department. This consistent approach strengthens Nebraska's current and future workforce, supports safe and effective practice, and helps expand access to preventive services and care coordination. So what is a community health worker? Community health workers are trusted community-based public health workers who help people connect with health care, behavioral health, and social services. They provide non-clinical support such as outreach, health education, care coordination, navigation, patient advocacy, and social support. A growing body of evidence shows that community health worker interventions can lead to improved clinical outcomes, including chronic disease control, increased management in care, and better follow-through on treatment and prevention plans by fostering trust and bridging gaps between individuals and health systems. Community health workers also help address workforce shortages by allowing licensed health care professionals such as nurses and primary care workers to work at the top of their scope by taking on non-clinical community-focused roles that free clinical staff to focus on tasks that require professional licensure and clinical training. In Nebraska, community health workers serve as a vital extension of the health system, connecting residents to needed resources, and reducing system bottlenecks that can arise due to the workforce shortages, especially in rural parts of the state. So what's the bill do? LB912 authorizes DHHS to implement a transparent practical endorsement process for community health worker training programs. The process should ensure statewide consistency while allowing flexibility for local training providers to adapt instruction to community needs. Endorsed training programs should equip community health workers with core competencies needed to provide effective non-clinical services

and to work appropriately alongside licensed pros. A question we're all asking this session, what is the fiscal impact? LB912 contains no direct appropriation. Any administrative costs associated with establishing an endorsement and renewal process may be offset, in part, by reasonable application and renewal fees as authorized in the bill. Additionally, evidence suggests that community health worker interventions can be cost-effective and can generate a positive return on investment. Some studies have shown that more than $2 is returned for every $1 invested through reduced hospitalizations, better chronic disease management, and avoided high-cost care. In closing, supporting community health workers through consistent training standards can lead to improved health outcomes and more efficient use of health care resources, aligning with broader goals of fiscal responsibility and high-value care. I will have some great testifiers following me who can outline this policy further and provide good examples for the committee. However, if you have easy questions, I will gladly take the easy ones now.

**FREDRICKSON:** Thank you, Chair Hardin. Any questions in the committee? I'm glad to see you have strong faith in your testifiers. All right, we'll take our first proponent for LB912. Welcome.

**ASHLEY NEWMYER:** Thank you. Good to see everyone. OK, good afternoon, Chairman Hardin, but also Vice Chair Senator Fredrickson, and members of the Health and Human Services Committee. My name is Ashley Newmyer, A-s-h-l-e-y N-e-w-m-y-e-r, and I'm the director of the Division of Public Health in the Department of Health and Human Services. I'm here to testify in support of LB912. Community health workers serve as trusted community members and connect public health, health care, behavioral health, social services, and the communities they represent. They build strong relationships and link individuals to services through outreach, education, support, and screening. Community health workers help prevent avoidable emergency department visits and hospitals-- hospitalizations by supporting care coordination, medication adherence, and ensuring follow-up. Studies show community health worker programs can reduce emergency department visits by up to 30% and hospital readmissions by 25%. Additionally, community health workers improve medication adherent-- adherence rates leading to better chronic disease management and lower healthcare costs. At this time, there are no requirements regarding the type or length of training needed to use the title community health worker. As a result, there is wide variation in training across Nebraska, which

can make it difficult for community health workers to move between employers and limit workforce capacity for organizations seeking to hire and integrate community health work. Statewide assessments completed by the UNMC College of Public Health in 2022 and Partners for Insightful Evaluation in 2025 found that community health workers felt their was not well understood or respected within health care teams, and concluded that consistent statewide definitions and core competencies are needed to support shared understanding and stronger integration across systems. By creating the Community Health Worker Training Endorsement Act, LB912 establishes a consistent statewide process for recognizing community health worker training programs that meet minimum quality and content standards. This act will also meet a legislative action of Nebraska's Rural Health Transformation Program which is to obtain legislative authority for state community health worker certification. The intended impact of this action is to minimize barriers of entry for community health workers to be certified and grow the workforce. To best align with the rural health transformation program implementation, we ask to revise the date for regulation promulgation to July 1, 2027. We respectfully request that the committee advance the bill to General File. Thank you for your time. I would be happy to answer any questions on this bill.

**FREDRICKSON:** Thank you for your testimony. Any questions from the committee? Senator Riepe.

**RIEPE:** Thank you, Chairman. Thank you for being here. Is this a matter of adding additional workforce? Are there new, new employees involved with this?

**ASHLEY NEWMYER:** So this is a path to add more community health workers in Nebraska, yes.

**RIEPE:** OK.

**ASHLEY NEWMYER:** Yeah.

**RIEPE:** Is that in the training side, or is that in a process of holding hands and nurturing them along or what?

**ASHLEY NEWMYER:** So initially it is there are resources in the Rural Health Transformation Grant to support adding more training so that we

can get additional community health workers out there. But we would like to have an endorsement of that training.

**RIEPE:** I guess my question gets to be, is it the training or just the access of having a person versus a person to train? First you have to have the person. I'm not, you know, everything I've read it's just a workforce shortage, more than it is a workforce lack of training. Correct me where I'm wrong here.

**ASHLEY NEWMYER:** So if I'm understanding your question correctly, Senator, so are you asking if there's people interested in being trained as community health workers?

**RIEPE:** I'm just saying, is this a layering kind of a deal of a workforce development over a workforce that maybe isn't there?

**ASHLEY NEWMYER:** Well, I believe there is a workforce there, and I think maybe some of the, the folks behind me can speak to that. What's important to us is that we have a workforce that does have a standardized training process so that it's clear to those that are maybe using community health workers or that are wanting to hire community health workers, that everyone knows this is the services that they provide.

**RIEPE:** OK, so we're talking at some level below physicians and nurses.

**ASHLEY NEWMYER:** Mm-hmm.

**RIEPE:** OK, OK, well I'll be eager to, eager to learn more. Thank you.

**ASHLEY NEWMYER:** Yeah, you're welcome.

**FREDRICKSON:** Other questions? Senator Meyer.

**G. MEYER:** Thank you, Vice Chair. Welcome.

**ASHLEY NEWMYER:** Thank you.

**G. MEYER:** Nice to see you again. I know that the application process will be coming up relatively soon. I hope we have guidelines and stuff for that. And the funds have to be dispersed or committed by October of 2026. The timeline is very short and there's a lot of dollars there. Will, is-- will it be the state's responsibility to initiate programs to attract, incentivize workers to go into the rural

communities, somewhat like our, out paying for those that are serving in rural communities, providing health care in rural communities, we're paying down some of their student loans.

Mm-hmm.

**G. MEYER:** Can that be part of the process whereby-- for an incentive to go into a rural community to provide that health care? Is that something we could, we could, could utilize in our rural communities?

**ASHLEY NEWMYER:** So yes, there is, there is a track in the Rural Health Transformation Grant to help develop workforce in rural areas, yes.

**G. MEYER:** And hopefully that's sustainable, so OK. Thank you.

**ASHLEY NEWMYER:** You're welcome.

**FREDRICKSON:** Other questions? Senator Quick.

**QUICK:** Yeah, thank you, Chairman-- or Vice Chairman. So I know it talked about scope of practice, but what can they actually do in a community? I mean, versus what a, a nurse or nurse practitioner or a CNA?

**ASHLEY NEWMYER:** So as Chairman Hardin mentioned, their primary purposes are the non-clinical aspects. So, they don't-- they do not have a healthcare license specifically. So, it's, it's screening. I think specifically a good example is the medication adherence, so checking in with folks to make sure that they're staying on their blood pressure medication, their diabetic medication, things like that.

**QUICK:** So will they take the place of like a home health nurse? I mean is that what--

**ASHLEY NEWMYER:** They are not trained to the level of a nurse, so not necessarily. But I think there is opportunity where those two types of services can work together to help, to help make sure that there's a good quality care.

**QUICK:** And then how like-- so how do they know where to go or which people need? Do they just come to your door or how does-- what happens with that process?

**ASHLEY NEWMYER:** So I think some of the-- I think one of the local health directors probably has a much better example than I do from rural world that she can offer to you.

**QUICK:** All right. All right, thank you.

**FREDRICKSON:** Other questions? Senator Riepe.

**RIEPE:** Thank you Chairman. I'm looking for clarification. It seems to me that there's a trend this way. I know many of the many Medicare Advantage-- Medicare Advantage people are trying to do this too, is they want to come into your home to, I don't know what they're looking for, but that they want do that. Is that-- is this somewhat similar, so that they can see if you have stairs and you're older and they can identify some of this stuff? Is this part of what this program is?

**ASHLEY NEWMYER:** I don't-- I'm not familiar with the Medicare Advantage program.

**RIEPE:** You're not old enough.

**ASHLEY NEWMYER:** What?

**RIEPE:** You're not old enough.

**ASHLEY NEWMYER:** Thank you, yeah. So I don't know that I can speak to that accurately.

**RIEPE:** OK, OK. It just, it seems like commercial is doing it as well.

**ASHLEY NEWMYER:** OK.

**RIEPE:** And that's my connection. Thank you. Thank you, Chair.

**ASHLEY NEWMYER:** Yeah, sure. You're welcome.

**FREDRICKSON:** Other questions? Senator Ballard.

**BALLARD:** Thank you, Senator. What are the dangers if this committee opts not to pass this legislation? Do we lose funding? Do we--

**ASHLEY NEWMYER:** So, so in our rural health transformation program, if we do not have, if we do not meet the legislative action to certify

community health workers in Nebraska, there is a risk that the feds will claw back that funding dedicated to that initiative. Yes.

**BALLARD:** OK. So we could just-- we could pass this and give the opportunity to certify, but not, not have any certified health workers in the community, and that would still satisfy the, the program?

**ASHLEY NEWMYER:** Not--

**BALLARD:** Or is there a requirement you have to have so many?

**ASHLEY NEWMYER:** So there is, so sev-- so there's several steps involved. One is to make sure that we have the legislative authority to have certified community health workers, and then having that endorsed training, making sure those community health work are trained so that eventually community health worker network and infrastructure is built out across the state to expand care. And then that moves into the sustainability piece where the next phase is a Medicaid spa is applied for.

**BALLARD:** OK, so I think some of my colleagues had similar questions of if there's no, if there is no health care workers in rural Nebraska, we'll still satisfy the requirements because we have the framework. Am I understanding correctly?

**ASHLEY NEWMYER:** So to the best of my knowledge, yes.

**BALLARD:** OK.

**ASHLEY NEWMYER:** Yes, that, that would be, that would meet the initial expectations of the rural health care transformation grant.

**BALLARD:** OK, thank you.

**FREDRICKSON:** Other questions? Senator Quick.

**QUICK:** Thank you, Vice Chairman. So I know there-- like it was all divided up, so there's so much money that goes towards this, right?

**ASHLEY NEWMYER:** Yes.

**QUICK:** Only so much money. So how much money actually went towards this portion of the, of those dollars?

**ASHLEY NEWMYER:** So there is $20 million allotted to the community health worker initiative.

**QUICK:** OK, but that has to be spent, the whole dollar amount has to be spent by that time. So in other words, we are going to have to have workers, a workforce to utilize those dollars, right?

**ASHLEY NEWMYER:** Yes, the money has to be definitely obligated and money going out the door, yes, by October.

**QUICK:** Does it all have to be spent by October 1st or you just have to be spending it?

**ASHLEY NEWMYER:** My understanding is it has to be fully obligated.

**QUICK:** Obligated.

**ASHLEY NEWMYER:** Yes.

**QUICK:** OK. OK.

**FREDRICKSON:** Other questions? Seeing none, thank you for being here.

**ASHLEY NEWMYER:** Thank you.

**FREDRICKSON:** Next proponent for LB912.

**JESSICA DAVIES:** Good afternoon, Senator Fredrickson and Chairman Hardin and members of the Health and Human Services Committee. For the record, my name is Jessica Davies, J-e-s-s-i-c-a D-a-v-i-e-s, I'm the director of Panhandle Public Health District, and I'm here today on behalf of the Nebraska Association of Local Health Directors in strong support of LB912. Thank you to Senator Hardin for introducing this important legislation. Across Nebraska, local health departments and health care partners are facing persistent workforce shortages. Even as demand for preventive services, care coordination and health navigation continues to grow. As chronic disease rates rise and our population ages, communities need a workforce that helps people access services, understand care plans and follow through over time. Community health workers or CHWs are frontline public health workers who build trust within the communities they serve and act as critical links between residents and health and social service systems. They provide non-clinical support that connects people to care and helps

ensure plans don't fall apart once someone leaves the clinic. In local health departments statewide, CHWs are active members of community-based teams, and their work reflects local needs. In the Nebraska Panhandle, our CHWs see the whole picture, build bridges between systems, and turn limited resources into real solutions. For example, one client was struggling to control her blood pressure after an accident limited her mobility. Through personalized coaching, she made manageable nutrition and physical activity changes that fit her new situation. Over time, those small, supported steps improved her blood pressure. Another CHW connected several local entities to support a grandmother whose grandchildren were missing school. Transportation was the root problem. Grandma's van had broken down. Without it, the kids couldn't get to school and grandma couldn't get to work, putting food and utilities at risk. The CHW connected the middle school, Head Start, and community partners. Head Start helped cover their repairs to the van and other partners provided food and utility assistance. Today, the children are missing far less school and the family stabilized in a critical moment. In a third example, CHWs in our district work with correctional facilities and community partners to support people who are newly released or soon to be released from incarceration. CHWs help connect individuals to recovery programs, prescription assistance, housing resources and community meals. During a critical transition period, CHWs help ensure people are released into a plan, not a crisis. LB912 supports all of this work by authorizing endorsement of CHW training programs that meet defined core competencies while preserving CHW roles as accessible entry points for individuals committed to serving their communities. This training endorsement creates consistency and accountability for employers and payers without sacrificing the flexibility that makes CHWs effective in local settings. For these reasons, on behalf of my health department and local health departments statewide, I respectfully urge the committee to advance LB912.

**FREDRICKSON:** Thank you for your testimony. Are there questions from the committee? Senator Meyer.

**G. MEYER:** Thank you for coming today. Do you have a process in mind of finding community health workers? Do you some structure anticipated to utilize these dollars?

**JESSICA DAVIES:** Yes.

**G. MEYER:** And could you share that with us?

**JESSICA DAVIES:** Yep, we're actually really excited for the opportunity. Because we, we cover 12 counties and 15,000 square miles, we're looking at people that really know their communities best and are trusted in their communities. And so they may be working remotely, they may be working close with the health system is what we're, we're looking at. We're working with all of our hospital systems now to have the discussion to say what does this look like for you and how does this benefit you? And what's the capacity you have at your facility to then either have that CHW on site and they work closely with us and closely with the health system for referrals, et cetera, for discharge, you know, different examples of that. But yes, we, we have, have a plan in place to start recruiting and getting the word out there for that. We do see that there will be-- we feel like there will be interest in it because of the excitement around it.

**G. MEYER:** If I may. We have such a shortage of labor in our rural communities and so are we going to attract people from other jobs? I mean, maybe it's not fair to ask, and what, what kind of pay scale are we looking at? What kind of compensation--

**JESSICA DAVIES:** Yeah.

--would have to be relatively attractive to attract people? Of course working from home is, is quite attractive also, so.

**JESSICA DAVIES:** Yep, that's, that's an option, and we want to be flexible with people to meet that need for them. We certainly have our salary schedules but, you know, they are on a lower end, but they-- it's an attractive pay, pay scale.

**G. MEYER:** OK, thank you.

**FREDRICKSON:** Other questions? Senator Riepe.

**RIEPE:** Thank you, Chairman. This is a little follow-up, I think, that Senator Meyer's, and that is in your comments you said that personalized coaching has made manageable nutrition and physical activity changes. So they have to have some comprehensive knowledge about dietary and, and you know, a lot of skills of a dietitian, if you will.

**JESSICA DAVIES:** Not to that level though. That specific example, that community health worker it does have training and specialties in that.

**RIEPE:** So are they like, mother, eat your vegetables and that?

**JESSICA DAVIES:** That one does have very specific certifications with that, that she's coaching with that. And so if that is of interest or the passion of that community health worker, that's when we've been able to grow that for them.

**RIEPE:** So they can vary significantly based on the skills of the individual.

**JESSICA DAVIES:** Very much so. And, and that's why it is a very nice grow-your-own model as far as how it can look for that individual and the strengths that they bring and the capacities you can build into them.

**RIEPE:** Wpw. I think the matchup would be a challenge, but thank you.

**FREDRICKSON:** Senator Quick.

**QUICK:** Yeah, thank you, Vice Chairman. And this probably would have been a question better for Director Newmyer, but maybe you'll know the answer, because I just thought of it-- or the question. But anyway, so will the money flow through the public health districts then? The money would be obligated to each public health district, or does it-- or is there other ways that they're going to distribute that, those dollars out?

**JESSICA DAVIES:** So for the community health worker piece specifically, it's going from DHHS to the local health departments.

**QUICK:** OK, and then so for each health district, is it based on the population that that public health district serves, or like maybe the number of workers you train or like the dollar amount that you receive?

**JESSICA DAVIES:** I actually don't know that at this, at this point. We've just completed the what they had for a request for applications, their RFA, for the community health worker and the rural health piece.

And we'll know it more in February as health departments what is allocated to us as health departments.

**FREDRICKSON:** OK, thank you.

**JESSICA DAVIES:** Mm-hmm.

**FREDRICKSON:** Other questions? Seeing none, thank you for being here.

**JESSICA DAVIES:** Thank you.

**FREDRICKSON:** Next proponent for LB912. Welcome.

**CHERYL WILLIS:** Welcome. Vice Chair Fredrickson and members of the Health and Human Services Committee, my name is Cheryl Willis, C-h-e-r-y-l W-i-l-l-i-s. I am here today testifying as a volunteer on behalf of AARP Nebraska in support of LB912. I graduated from the University of Nebraska Medical Center in 1999 with the master of nursing in psychiatric and mental health nursing, and my nurse practitioner license in 2000. I currently have my Nebraska RN license. I graduated in 2025 from the University of Nebraska Community Health Worker, CHW, Program with my certificate. This program is very important, especially to older Nebraskans in the rural parts of Nebraska. I practice as a health ministry director and faith community nurse at my church. My current CHW project is with Creighton University College of Nursing on an advanced care planning program for older adults in the community. CHWs play a crucial role in bridging gaps in nursing shortages, primary care, mental health professionals outside of metro centers, community health workers, improve access to care, reduce healthcare costs, build trust, and cultural competence. They strengthen support for older adults and improve health care outcomes. Establishing certification for CHWs training programs will strengthen the workforce, protect the public, and ensure uniform standards. This consistency leads to more reliable, high-quality care for community members, a creditable and sustainable workforce trained with the same evidence-based competencies. This leads to employers, health care providers, and policymakers who will have increased competence. Thank you to Senator Hardin for introducing this legislation, and thank you for the opportunity support. We would ask the committee to support and advance the legislation to the floor. I would be happy to answer any questions.

**FREDRICKSON:** Questions from the committee? Senator Riepe.

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

**CHERYL WILLIS:** Thank you.

**RIEPE:** And thank you for your work as an RN. Would you be overqualified to be a community health worker?

**CHERYL WILLIS:** Currently, I'm retired, so I only do volunteer work.

**RIEPE:** But with-- it sounds like what you're doing, in part, with your church.

**CHERYL WILLIS:** Right.

**RIEPE:** You're kind of filling-- you're doing kind of-- it sounds to me like you're doing kind of what they're talking about. Someone that's out there and alerting people or identifying issues.

**CHERYL WILLIS:** Right.

**RIEPE:** So, but that doesn't take an RN degree.

**CHERYL WILLIS:** No.

**RIEPE:** No. OK, I just, OK.

**CHERYL WILLIS:** And I maintain my RN Nebraska license because of my faith community nursing work that I do. And we accrue community education units for our work to renew our licenses.

**RIEPE:** Do you think a person going into this community worker needs to have some health care background as opposed to like being a programmer on computers or, I mean, some human skill going on here?

**CHERYL WILLIS:** What-- the program that I went through at the University of Nebraska, they gave you specific training in different components of health education so that you were given the basic understanding of like nutrition, things like that. You did not get any type of clinical education. I had that education already, but there were people in my class that were, say, you know, retired from

business jobs, things like that, that wanted to continue to work in their community to help especially the older adults.

**RIEPE:** And do you do blood draws? That's just a curiosity question.

**CHERYL WILLIS:** Me?

**RIEPE:** Yeah.

**CHERYL WILLIS:** Oh no, you don't want me to do any blood drawing.

**RIEPE:** What's your name, [INAUDIBLE]?

**CHERYL WILLIS:** I retired in 2013 from my actual RN work as a nurse practitioner. So you wouldn't want me to draw your blood now.

**RIEPE:** OK, thank you. Thank you, Chairman.

**FREDRICKSON:** Thank you, Senator Riepe. Any other questions? Senator Quick.

**QUICK:** Thank you, Vice Chairman. So first I want to thank you for your work as a nurse and--

**CHERYL WILLIS:** Thank you.

**QUICK:** My wife is a nurse. She retired, she was labor delivery for 44 years, so she works very part-time now still as a nurse but in-- at the drug and alcohol addiction facility in Grand Island, so. But I just want to thank you for your work and--

**CHERYL WILLIS:** Thank you.

**QUICK:** --for being here.

**CHERYL WILLIS:** Much appreciated. Nurses, I feel, are very vital, and healthcare CHWs are very much needed, especially in our rural areas.

**QUICK:** Yeah. Where do you actually live at then?

**CHERYL WILLIS:** I live in Omaha, Nebraska.

**QUICK:** OK. Yeah. All right, thank you.

**CHERYL WILLIS:** You're welcome.

**FREDRICKSON:** Other questions? Seeing none, thank you for being here.

**CHERYL WILLIS:** Thank you.

**FREDRICKSON:** Next proponent. Welcome.

**SUSAN BOCKRATH:** Thank you very much. Good afternoon, Vice Chair Fredrickson, and hello, Senator Hardin. My name is Susan Bockrath, I am-- spelled S-u-s-a-n B-o-c-k-r-a-t-h, I'm the executive director of the Nebraska Association of Local Health Directors. And I'm here because our organization of all local health departments in the state supports this bill strongly, and we're very grateful to Senator Hardin for introducing it. As you've heard, CHWs are active members of community-based teams in local health departments. Their work looks, looks different depending on local needs and priorities, and the expertise that the community health workers have. I have additional examples of their work, but I'm going to just jump down and talk about the business case and an example in Nebraska of why we think community health workers are really a, an under-realized potential in our state. In 2023, CHWs' efforts in a statewide pilot project between local health departments and UnitedHealth Care Community Plan helped improve high blood pressure among hypertensive Medicaid members. UHC estimated that this work may have helped avoid over $717,000 in health care costs, creating a clear win for patients, providers, and payers. LB19-- LB912 helps position Nebraskans to replicate programs and results like this and like the other that Director Newmyer was referencing. This bill is aligned with years of strategic, collaborative work that has included the Division of Public Health, local health departments, Medicaid and long-term care, health systems, community partners, and community health workers themselves. Nebraska already has accessible, homegrown training options aligned with national standards known as the C3 core competencies. UNMC is one that was just mentioned by the previous testifier, Creighton, and we also have developed a community health worker training. So we are as a state ready to go with providing that foundational training for community health workers and, and what we are seeking today is that endorsement. In 2024, DHHS determined that enabling legislation is needed to formally endorse CHW trainings. And LB912 provides them that authority. It's nothing more than that. It supports CHWs in clearly defined non-clinical roles that complement licensed professionals and

often work alongside licensed professionals. They're again part of teams generally. By establishing a CHW training endorsement framework, LB912 builds confidence among employers and payers that community health workers have a foundational level of training and are ready to do the work, and helps unlock sustainable funding opportunities beyond short-term grants and pilot projects. For these reasons, on behalf of local health departments across the state, I respectfully urge the committee to advance this bill. And I'd also like to just say that we would be here supporting this bill even if it wasn't for the rural health training program. Community health workers are part of local health department and partners' workforce currently. We've long wanted to develop this workforce more, and this is one, one of the elements that necessary to continue to grow this, this resource across our state. And I can answer any questions.

**FREDRICKSON:** Thank you. Questions from the committee? Senator Riepe.

**RIEPE:** Thank you, Chairman Quick [SIC]. I see that you're here in Nebraska Association of Local Health Directors. Does that mean health departments?

**SUSAN BOCKRATH:** Yes.

**RIEPE:** Oh, OK. Thank you, Chairman.

**FREDRICKSON:** Other questions? Senator Quick.

**QUICK:** Yeah, thank you, Vice Chairman. So, like, as far as the training goes, would that be more online training through these programs or would like-- or would it be in-person trainings or--

**SUSAN BOCKRATH:** I think that the, the beauty of doing a competency-based model is that we can provide trainings in different ways. So, community health workers are often, you know, what you call lay people, and they might be coming to this work for, for a variety of reasons with a variety of different passions, as Jessica mentioned. And so, it's important that we-- I think it's important as a state that we provide different ways for people to get that training. Our training is-- that we developed, we've had a HRSA grant several years ago-- we developed a training that is entirely online and it's supported by a, a community of practice where community health workers from different health departments can connect online as well. We facilitate that. And that was designed basically to allow whenever if

a health department has an ability to bring community work, community health worker onto their team, they can start the training right away. They can-- they don't have to wait. Creighton and UNMC's is more of a traditional kind of education model where they're, they're made part of cohorts, and I'm probably, I don't want to say too much about them because I don't know all the details, but they, they run from a certain time to a certain time and then they do another cohort. So and there's-- I think UNMC has a little bit more of mix online in person. I think Creighton's, if I remember right, is more in person, focused on being in person. So I think the nice thing is that Nebraska already has solid options for these trainings that are available, that are kind of set up to meet people where they're, where they're at. And this, this bill would allow for additional, additional trainings that are maybe are available now that I'm not aware of, or that become available could also be endorsed. But tying into those national competencies to make sure that that foundational skill set is, is developed, I think, is what we really want to allow DHHS to be able to do, so that we-- all of us can be feel secure that all these different trainings are, are meeting the mark.

**QUICK:** OK. And then I know you mentioned that there was the UNMC and Creighton, but like community colleges, would they--

**SUSAN BOCKRATH:** Actually, I do think that Northeast Community College also has a community health worker training. That was developed several years ago, and I, I was under the impression that it might have been on a hiatus. I don't know if this might provide some-- given that we are likely to see more people hired in this role with the rural health transformation program, I don't know if that would be something that they would, they would re-- restart. And I might, again, they may have been doing it all along. I just, I knew there was a time where I was hearing a lot about it and then I didn't hear as much, so I thought maybe it was on a hiatus.

**QUICK:** OK, and then I know from the previous testifier, I'm guessing you're never going to turn down even retired nurses or retired help.

**SUSAN BOCKRATH:** Gosh no, no. I think that, and I think that-- I mean, community health workers can be hard to explain because they do not, they-- the, the thing that makes them special is that they have the connection in the community. And so if that can-- and it could be, you know, could be someone who drove a truck, it could someone who was a

nurse, it be someone with a lot of different-- it could be someone who was a, a, a computer scientist. If, if they have that kind of connection in the community and might be able to-- and a passion for the work, and might able to sort of extend and support the healthcare system, I think that there are a lot of people who can, who can take on these roles.

**QUICK:** And I'm guessing they may not be able to go beyond their license, you know, beyond their certificate.

**SUSAN BOCKRATH:** Absolutely not. No, no, absolutely not. There's, there's supervision around that, and so, yes, that is, that is-- there's, there's a lane. And that's one of the reasons why you do want to have an endorsed training, so that that's one of the things I think that can be hard to, if you were to just go into it without the right kind of training, to be able to identify when it is you were potentially stepping outside of your lane.

**QUICK:** OK. Thank you.

**SUSAN BOCKRATH:** Mm-hmm.

**FREDRICKSON:** Senator Riepe.

**RIEPE:** Chairman, thank you. I'm on another committee, and in that committee, happens to be Banking and Insurance Committee, we're very concerned with fraud, for particularly elderly people.

**SUSAN BOCKRATH:** Uh-huh.

**RIEPE:** And so that you bring someone in here who's had some level of training, but you're, you're opening a potential here, and my question gets to be is would these community health workers have to be bonded? Are they going to have to have insurance for neglect and, and oversights and, you know, things that they're guilty of that someone falls down the stairs because of them? These are the, the dark legal sides of things that they have to have protection. And just to turn somebody loose in their house.

**SUSAN BOCKRATH:** So community health workers would be employees of local health departments, and so they would fall under that, the insurance of those local health departments. We're-- community health workers are not necessarily-- or not necessarily, they are not just

sort of pointed in a direction and said go out and knock on a door. So and I don't know the ins and outs of my members' sort of insurance policies, but I do know that all-- most of them have had community health workers working for them for, for, for quite some time. They do do-- and like home visitors as well. They have a lot of experience with helping people, helping their employees manage that kind of interaction in people's, people's homes. And also being, you know, not only for the safety of the people who they are visiting with, but for their own safety.

**RIEPE:** I had a late wife that we had help at home for 17 years and we had some theft over the years. And obviously in 17 years, you go through a number of people. But we had so not major theft, but we had theft, credit card theft, appliance theft. Things that you wouldn't think the people would take, but they do. Some of these were-- came highly recommended. So you can't be there all the time to watch them. That's-- it's a problem, or a potential serious problem.

**SUSAN BOCKRATH:** I'm sorry that you had that experience. Yeah.

**RIEPE:** It's part of, it's part of life.

**SUSAN BOCKRATH:** Part of life. Yeah.

**RIEPE:** And they didn't steal the car, so I'm OK.

**FREDRICKSON:** Senator Quick.

**QUICK:** Yeah. So just off of that, do you have to do background checks for people who are employed or--

**SUSAN BOCKRATH:** Yes, as, as employees, our health departments all do background checks on their employees, yes.

**QUICK:** OK. Thank you.

**FREDRICKSON:** Other questions? Seeing none, thank you for being here.

**SUSAN BOCKRATH:** Thank you.

**FREDRICKSON:** Next proponent. Moving on to opponents. Anyone here to testify in the neutral capacity? Seeing none, we did have some online

comments. We had 11 proponents, 0 opponents, and 2 in the mutual capacity. And with that, Senator Hardin, you're welcome to close.

**HARDIN:** I look at the community health workers and, to give you some kind of a, I guess, a roadmap, in the world of big companies, it's common for big companies to have in your HR department an EAP, an employee assistance program. Because there's a basic, well, it's wonderful that I have these benefits available to me, and I really don't know how to use them. I have all of these things that I could use. How does it work? How do I navigate it? And so the employee assistance program within an HR department in a big company will often have a person who directs traffic, who basically is an information booth and says, OK, it's great that you have this thing, this thing, and this thing, these things that you can do. Tell me what's going on for you. And that employee can basically say, well, here's what I need. OK, let's help direct you to this directory or to these people and help get them going because it's just difficult to navigate health systems, even if you have great, amazing stuff available. What we have in the community health worker world kind of works like that EAP, in my opinion. They're coming alongside and saying, OK, there's these resources. They're out there, they're available. But in the margin of life is yes, but how? How do you do that? And so one of the things they do is, for example, provide some friendly accountability. Have you taken your medicine today, or this week, or this month, whenever they may be connecting with them. And so it's really to free up a lot of that busy work. I've always said let decisions be made and problems be solved at the lowest possible level. Don't I, Michael? And so it's, it's that kind of thing that allows the medical professionals to operate at their peak more of the time, so that they're not dealing with a lot of administration and, and other kinds of things that are non-clinical that can be taken care of at a different level. And that's a lot of what this program is about.

**FREDRICKSON:** Thank you, Senator Hardin. Any questions from the committee? Seeing none, thank you. That will end our test-- or our hearing for LB912.

**HARDIN:** Next up will be LB860. And you don't look like Senator Bostar at all.

**NATHAN JANULEWICZ:** I do not. Senator Bostar regrets that he's not able to be here this afternoon.

**HARDIN:** OK.

**NATHAN JANULEWICZ:** You have me.

**HARDIN:** Well, our shuffling that we do here in the room is done. We are snappy dancers and we're ready for you to take it away.

**NATHAN JANULEWICZ:** All right, good afternoon, Chairman Hardin and members of the Health and Human Services Committee. For the record, my name is Nathan Janulewicz, that's N-a-t-h-a-n J-a-n-u-l-e-w-i-c-z, and I'm the legislative aide for Senator Eliot Bostar. I'm here today to introduce LB860, a bill to establish a coordinated behavioral health program for children and young adults under the age of 21 with complex behavioral health needs. These are youth who experience frequent behavioral health crises resulting in repeated emergency room visits, hospitalizations, residential placements, and disruptions in care. Many are simultaneously involved in multiple systems, including behavioral health, child welfare, developmental disability services, and juvenile justice. Because responsibility is spread across systems, care is often uncoordinated, leaving families and young adults navigating service on their own. When services are fragmented, families are left to act as care coordinators themselves, parents and caregivers are forced to navigate a maze of providers, eligibility rules, and disconnected plans, often during moments of crisis. The outcome is predictable: delays in care, miscommunication between systems, and preventable escalation to higher, more restrictive levels of care. In some cases, families simply burn out, and youth end up in a welfare or justice system. Over the last several years, Nebraska has taken steps to better understand how to serve these youth more effectively, including work initiated by DHHS and conversations with providers, families, and stakeholders across the state. LB860 was introduced to address this coordination challenge by directing the Department of Health and Human Services to establish a program specifically focused on youth under 21 years of age with the goal of supporting families in the community and preventing unnecessary institutionalization or out-of-home placement. Since this bill was introduced the department has met with involved third-party partners and indicated that the concepts envisioned in LB860 can be implemented administratively without the need for additional statutory direction.

Given this assurance I would respectfully suggest the committee allow DHHS to proceed with this work and continue to carefully monitor its progress and outcomes. I appreciate the committee's time and consideration. Thank you.

**HARDIN:** Thank you. Appreciate you being here today.

**HARDIN:** Proponents, LB860.

**LIZ LYONS:** Good afternoon.

**HARDIN:** Welcome.

**LIZ LYONS:** Chairman Hardin, members of the HHS committee, I'm Liz Lyons, L-i-z L-y-o-n-s. I'm here on behalf of my client, Magellan, who regrettably could not be here today. As Nate gracefully illustrated, our client has had really thoughtful conversations with the department. We are always looking to pursue a partnership in any realm, in any way that we can work towards better organized care for certain populations. This all was generated from RFI from Children and Family Services years and years and years ago. So naturally there was excitement that perhaps there would be an avenue to partner with the state. So we wanted to continue to have that conversation and concept, and very lucky to have that direct access to the director of behavioral health who's behind me and will be able to testify. But we will defer to the department on the best pathway moving forward on to navigate care for this population of kids.

**HARDIN:** Very well. Thank you. Would you like to have questions or would you like to punt?

**LIZ LYONS:** It's up to you, sir. It's Friday. I thought Friday, no questions.

**HARDIN:** That sounds like a good thing to have. So wonderful, thank you. Proponents, LB860. Welcome.

**SARA HOYLE:** Good afternoon, Chair Hardin and members of the Health and Human Services Committee. My name is Sara Hoyle, S-a-r-a H-o-y-l-e, I serve as director of human services for the city of Lincoln and Lancaster County. I am here to testify in support of LB860 on behalf of Lancaster County. In my department, we encounter children with complex behavioral health needs who are often involved with multiple

systems, including health care, education, child welfare, juvenile justice, and disability services. Too often these systems operate in silos, leaving families to navigate fragmented and confusing pathways to care on their own. This increases the risk of crisis, institutionalization, and out-of-home placement, outcomes that are both costly and harmful to long-term well-being. By focusing on youth with complex multi-system needs and prioritizing care coordination and community-based services, LB860 promotes earlier intervention before behavioral health challenges result in arrest, detention, or deeper system involvement. Services such as crisis mobile response and stabilization, intensive home-based treatment, and coordinated psychiatric care are resources needed to divert youth from detention and into appropriate treatment. Additionally, the Legislature's emphasis on care coordination through behavioral health region strength-- strengthens local representation while maintaining statewide consistency. Lancaster County and Region 5 Systems recently partnered to establish a youth and family crisis and resource center known as SquareOne that will operate 24 hours a day, 7 days a week for families in crisis. While this is an important step forward, behavioral health capacity to serve families remains limited. For example, our own region's professional partner program currently serves 187 families, with more than 20 additional families on the waiting list for service. Finally, the authority granted to pursue federal approvals positions Nebraska to maximize federal funding and ensure long-term sustainability. This approach coupled with protecting access to services by avoiding increased administrative requirements and cost-shifts to providers through proposed service definition changes will help ensure children and families can receive the services they need. For these reasons, I respectfully urge the committee to advance this legislation. I would be happy to answer any questions.

**HARDIN:** Thank you. Questions? Senator Riepe.

**RIEPE:** Thank you, Chairman. Are you familiar with the new approximately $200 million Children's Nebraska mental health program?

**SARA HOYLE:** Vaguely, not enough to testify on it.

**RIEPE:** I'm just, you know, my piece is more of a statement. There's a lot of mental health. I can't help but think that Lincoln doesn't have a mental health programs either through the state or private-wise. I

also get concerned quite frankly with a Magellan provider coming in and being potentially having all the potential of being another St. Francis. And so I'm very paranoid about that. I just think we have to do an extremely in-depth inventory of everything that we have. We have so many, in my opinion, so many disorganized mental health providers throughout this state that it's just frustrating to me. I think it's a lot of money that goes to waste, but that's my conservative nature. I'm sorry for the lecture, but--

**SARA HOYLE:** No. And Senator, I agree with you, and I think that this bill speaks to--

**RIEPE:** You don't have to.

**SARA HOYLE:** No, I do. I do, though, and agree with you because, unfortunately, in my office, we oversee juvenile justice for the city and the county. And I can't tell you how many families are in my office who are not getting behavioral health services. And I think that-- and they don't know how to access it. And when they're able to access it, then they're on a waiting list. So your family is experiencing a behavioral health crisis, but you can't get into somebody for 20 days. So and, and that's not a system that works. And I can tell you that firsthand from our families. And you're right, there needs to be more coordination. And I think that that's what this bill is speaking to. Something needs to change to help our families.

**RIEPE:** Didn't we have Magellan here before? I mean, I've been on this committee for 8 years. I remember having a state contract with Magellan.

**SARA HOYLE:** Yes.

**RIEPE:** And a friend of mine, John Wheeling [PHONETIC], was the director of it.

**SARA HOYLE:** Yeah, and I don't know how Magellan fits into this. I'm here solely to speak about the need for services.

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

**HARDIN:** Other questions? Seeing none. Thank you.

**SARA HOYLE:** Thank you.

**HARDIN:** Proponents, LB860. Welcome.

**MARSHALL BIVEN:** Thank you. It's nice to be here. What a pleasure to be on a Friday, seeing all of you guys. My name is Marshall Biven, M-a-r-s-h-a-l-l, and last name, B-i-v-e-n. I'm not representing anyone, I mean any organization, in an official capacity today. I am a medical student at Creighton University. I'm born and raised here in Omaha, Nebraska. And not only have I been somebody that has used services, behavioral health services, here in the state, but I'm also somebody that is looking to become a psychiatric prac-- practitioner in the future. Hopefully I'll be able to do some child and adolescent psychiatric services when I become a physician in a few years. So I came here today because when I read this bill, I think there was two things that struck me. That it's both comprehensive and cohesive. And so what do I mean by that? Comprehensive being that, you know, I've worked in many different situations so far. I've worked doing psychiatric interviews with people that are suffering from alcohol use disorders. I've worked with children, some suffering from pretty severe behavioral health issues. And now more recently I've been working with people that are unhoused in downtown Omaha. And what I've noticed is that all of these different people need very different types of care at very different points of their life, and I think one thing that this bill does very well is it outlines very many of these different types of care. Whether it be outpatient services, whether be inpatient, whether it be residential, I think it does a very good job of outlining specifically what types of care are going to be needed. And I think, as you brought up, Senator, there is an issue of coordination. And, I think one of the parts of this that I appreciated was the cohesiveness, that they're, the department is going to have a program specifically for getting these services into the hands and into the families that need this. And beyond that, I think this is an attractive thing for future physicians. We want to see that the health care systems that we're entering into are well-organized and are not going to be leaving the children that we are treating suffering after they leave our clinics. Beyond that, I also think that this is an investment for the future, and so I understand that any type of program is going to take monetary investment to get up and running. Where I think that is an invest for the future is there's plenty of research that outlines that being able to-- not addressing mental health concerns and behavioral health concerns is something that not

only is going to propagate into further heavy use of emergency rooms and more severe psychiatric services, but we're also going to be, you know, people that are not going to be able to be productive members of society, whether economically or in their families, in their communities. And they're going to using these services at a higher rate later on. And not just psychiatric services, but also we're talking about, imagine people that are using substances. It's going to affect their liver, so they need liver transplants. They're going need psych-- psychiatric medications, antipsychotics and they're going to be further encountering the criminal justice system. And so I think this is an investment, it's preventing a lot of that further monetary investment that we're going have as a state, whether it be Medicaid or Medicare.

**HARDIN:** Mr. Biven, I have you in the red. So if you can conclude some thoughts.

**MARSHALL BIVEN:** Of course. Yes. So I, I, I support this bill as a part of it being comprehensive and cohesive, and I think it's a good financial investment for the future. Thank you.

**HARDIN:** Thank you. Questions? Seeing none, we appreciate you.

**MARSHALL BIVEN:** Yeah, thank you.

**HARDIN:** Proponents, LB860. Good afternoon.

**EDISON McDONALD:** Good afternoon, hello. My name is Edison McDonald, E-d-i-s-o-n M-c-D-o-n-a-l-d, and I'm here today on my own behalf in support of LB860. I want to thank Senator Bostar for introducing such an important bill, and would encourage the committee to move it forward. In October, 2013, I was sitting on my couch studying for the LSAT when I received a call from my mother. Couldn't clearly understand what she was trying to say. And finally I was able to parse out that my little sister Trinity had died of suicide. She was a smart, young, talented Nebraskan, a cheerleader, a musician, an artist in the Arts and Humanities program just down the road from us here. All of her friends remembered her for her large tackling hugs that would knock you over. It was a tragedy, but it was far from the only one. We saw the complexities of that system. I've attended far too many funerals for friends that I've lost. People like my family who had access to good health insurance, knew people to talk to, how to

navigate complex systems. I've also seen and helped families of those who don't have those benefits. The systems of supports weren't really there. But it's not just my family and friends. Yeah, suicide is the second-leading killer of young people in Nebraska, and behavioral health needs continue to grow. So a large part of my career and off-time has been focused on helping those in need. We've made a lot of progress on a number of fronts, but there are still a number things that I think hold true. Chronic long-term underinvestment has been problematic, along with complex, and as Senator Riepe pointed out, disjointed programs have been highly problematic. And pretty much west of Lincoln is, I would say, really feels like a desert for most families in terms of access to services. As someone who's experienced Nebraska's system or lack thereof, both in a personal and professional aspect, I think there are a lot of opportunities. I think this is a huge one with a really tremendous ROI that I'm really disappointed we haven't moved on before, and I think just makes a lot of sense. A couple of things I'd like to tag on of just potential things to consider within this. I think we really need to look at better connecting our funding system within behavioral health and better leveraging 1915(c) waivers which Nebraska does for its DDAD system but hasn't really tapped to-- into on behavioral health. In particular, I know that in 2028, I believe it is, there's a significant amount of new CMS funds that could be available for this, but we're still waiting on the, the guidance as that rolls out from CMS. With that, I would just encourage you, please consider this. I know it's gonna be a hard year with anything with a fiscal impact whatsoever but, you know, I sat down to pay my property taxes this year for the farm, and I thought, how much extra would I pay for that tackling hug? How much extra would I pay so that no one else had to deal with that? And it's a lot more than this costs. So thank you.

**HARDIN:** Thank you. Questions? Appreciate you sharing it.

**EDISON McDONALD:** Yep.

**HARDIN:** Proponents, LB860. Opponents, LB860.

**THOMAS JANOUSEK:** Good afternoon.

**HARDIN:** Good afternoon.

**THOMAS JANOUSEK:** I know the game on this has changed a little bit. I'm gonna read through my testimony, then I'm happy to answer any questions.

**HARDIN:** All right, thank you.

**THOMAS JANOUSEK:** And educate a little further.

**HARDIN:** Yes.

**THOMAS JANOUSEK:** All right. Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Dr. Thomas Janousek, T-h-o-m-a-s J-a-n-o-u-s-e-k, and I am the director of the Division of Behavioral Health in the Department of Health and Human Services. I am here to testify in opposition to LB860. DHHS already offers many of the services listed in LB860 to individuals under 21 years of age. Services are administered through their appropriate division, allowing the best-suited providers to customize programming based on the appropriate level of care for the person. LB860 assumes these services can be conglomerated across multiple divisions with similar clinical and financial eligibility requirements. This is not the case. The Division of Behavioral Health, Division of Medicaid and Long-Term Care, and the Division of Developmental Disabilities serve separate populations with unique needs. Consolidating the operation of services provided by multiple divisions into a single program would be unnecessarily complex, costly, and may not meet each person's individualized needs. Additionally, the bill creates several complications related to care coordination. The bill requires care coordination to be offered through both the behavioral health regions and managed care organizations. LB860, as written, implies that the behavioral health regions would be responsible for care coordinating Medicaid-funded youth services in conjunction with the MCOs, and potentially the developmental disability service coordinators. It is not clear who is responsible for which group of individuals. This is further complicated by care coordination being provided already through certified community behavioral health clinics. In a hypothetical situation under this bill, an individual could potentially have four care coordinators leading to confusion and extra unnecessary hardship for anyone rendering or receiving services through the program. In summary, and I want to emphasize this, while DHHS is in favor of supporting the behavioral health needs of individuals under age of 21

and the overall premise of this bill, DHHS respectfully opposes LB860 because the language lacks clarity, is redundant to existing programming, and would potentially create more issues than it aims to solve. We respectfully request that the committee not advance the bill to General File. Thank you for your time, and I would be happy to answer any questions on this bill.

**HARDIN:** Thank you. Appreciate that. Questions? Senator Riepe.

**RIEPE:** Thank you, Chairman. We had the opportunity, we didn't get a big chance to talk at the lunch the other day.

**THOMAS JANOUSEK:** Yes.

**RIEPE:** And I think that at least I overheard some of the conversation. You have some other plans, and I don't know whether this is where you want to talk about those or not, but it's not as if you're over there sitting behind your desk without any future plans.

**THOMAS JANOUSEK:** Correct. I can just talk a little bit. We already have this program that's offered through our regions, which is the Professional Partner Program. And this is a high-fidelity RAP program that aims to do exactly this, which is get youths that are at risk for institutionalization, get them routed into appropriate outpatient levels of care and, you know, kind of give them anything that they need to succeed. So the program essentially already exists. We also have a number of the services that are in this bill that are offered-- able to be offered a little bit more individually in a more customized fashion so we can coordinate that care. This is truly just something where the language of the bill, to commit to something like this might create more issues with the implementation of a more fluid and operationalized program rather than us having an opposition to the concept, so.

**HARDIN:** This creates more challenges than it solves?

**THOMAS JANOUSEK:** Essentially, yes.

**HARDIN:** OK, other questions? Senator Riepe.

**RIEPE:** Thank you. Is it also an issue with going with an outside group, as opposed to the mix sometimes can be healthy and sometimes it can be unhealthy?

**THOMAS JANOUSEK:** Yes, I would agree with that. As the language is written, it seems that it would be an outside group in addition to the behavioral health regions, which could create that kind of confusion that I referenced in my testimony, essentially indicating that there would be too many hands in the cookie jar, so to speak, in terms of trying to care the-- coordinate the care for the individual.

**RIEPE:** Also, what about the kids that are covered by Medicaid? They should be under the managed care organizations. So this, this brings a new player into their camp, which they would have to accept, I think.

**THOMAS JANOUSEK:** Yeah, I, I can't comment on specifics with Medicaid, but I do know that they offer care coordination already existing through the MCOs.

**RIEPE:** So we have the potential of having two people on the same nickel.

**THOMAS JANOUSEK:** Yeah, that would be correct.

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

**HARDIN:** Senator Meyer.

**G. MEYER:** Thank you, Chair Hardin. And so just looking at it from my perspective, it would appear that combining these departments and managing combined or disparate budgets and who has the responsibility for what it simply looks like it's an unworkable structure, both financially and probably operationally, would that be your assessment?

**THOMAS JANOUSEK:** As written, yes. Yeah, just by nature of the language in the bill.

**G. MEYER:** OK, thank you.

**HARDIN:** Other questions? Seeing none, thank you.

**THOMAS JANOUSEK:** Thank you for your time today.

**HARDIN:** Propo-- I'm sorry, opponents, LB860. Welcome.

**ROBERT M. BELL:** Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Robert M. Bell, spelled R-o-b-e-r-t, middle initial M, last name spelled B-e-l-l. I am serving as the executive director and registered lobbyist for the Nebraska Association of Medicare Health Plans, whose members include the three current managed care organizations providing Medicaid coverage under a contract with the Department of Health and Human Services, Molina Healthcare, Nebraska Total Care, and United Healthcare of the Midlands. The association is appearing today in respectful opposition to LB860 as drafted. My experience as a lobbyist these past few years and working with Senator Bostar for the past six sessions in the Banking, Commerce, and Insurance Committee informs me of the level of vision and commitment he has to health care and improving the lives of Nebraskans. But I think as you've already heard, there's some issues with LB860. The Association of Managed Care Organizations provide care coordination for Medicare youth 20 and younger. This new program as drafted, and if adopted, would involve behavioral health regions and require the regions to provide the coordination of care, which would be a departure from the current system for the Medicaid youth in, in need of behavioral health services, and leading to questions of the roles of the MCOs in the managed care program in the delivery of these important services to the youth addressed in the bill. And, as Senator Riepe mentioned, perhaps in the inclusion. I know the language is permissive of a new MCO specifically for this population. As the department, Senator Bostar, the committee and other parties look at having further discussions on the correct manner to deliver behavioral health services to this population of youth, the association stands ready to provide assistance in those discussions. And so we respectfully oppose the passage of LB860 in its current form. I appreciate the opportunity to testify. Thank you.

**HARDIN:** Questions? Senator Meyer.

**G. MEYER:** Thank you, Chair. Is there some way to fix this, so it works?

**ROBERT M. BELL:** Oh, great question. I'm not sure, to be honest with you. But I think that starts with discussions with the parties, with the, with the Department of Behavioral Health, Medicaid, MCOs,

Magellan, behavioral health regions, things like that. I mean, the first thing you gotta do is talk, right, so?

**G. MEYER:** And just briefly, is there any reason why we should fix it so it works?

**ROBERT M. BELL:** Should we fix behavioral health--

**G. MEYER:** The bill, as Senator Hardin mentioned.

**ROBERT M. BELL:** Oh, well, I, I think I heard-- what I heard--

**G. MEYER:** Are we trying, are we trying to fix a problem-- solve a problem that doesn't exist, I guess?

**ROBERT M. BELL:** I, I don't know. I don't know that I--

**G. MEYER:** [INAUDIBLE] better than I do.

**ROBERT M. BELL:** Yeah, no, I, I understand your question, Senator Meyer. I, I don't know that there's a reason to pass a bill right now. I think perhaps things can be done administratively, if there's a path forward.

**G. MEYER:** OK, thank you.

**ROBERT M. BELL:** You're welcome.

**HARDIN:** Other questions? Seeing none, thank you.

**ROBERT M. BELL:** Have a good afternoon and a good weekend. Thank you.

**HARDIN:** LB860, those in opposition. LB860, those in the neutral. And this concludes LB860. Thank you. Next up. Oh yes, online we have 3 proponents, 0 opponents, 1 in the neutral. Senator Quick, how are you?

**QUICK:** All right, I'm good. I'm back again, right?

**HARDIN:** We have LB722, take it away.

**QUICK:** All right. Thank you, Chairman Hardin and members of the Health and Human Services Committee. My name is Dan Quick, D-a-n Q-u-i-c-k, and I represent District 35, and I'm here today to introduce LB722. LB722, which is a cleanup-- which is cleanup legislation we passed

last year, which was LB454. LB454 was, was designated as a Speaker priority bill and had two provisions. One, updating procedural requirements for, for regional behavioral health authorities to secure mental health care prov-- health care services. And number 2, clarifying the definition of individuals who have access to funding for housing needs. After the passage of LB454, however, it became apparent that we needed additional language to, to-- in the statute to accomplish the goal of ensuring that individuals with, with substance abuse disorders, not just mental health illness, can assess housing assistance funds. Currently, the Behavioral Health Services Fund provides housing-related assistance and landlord risk mitigation payments for individuals with serious mental health illnesses. LB722 amends Section 71-812 to allow the use of these funds to support individuals with substance abuse disorder, not just those with serious mental health issues. It also adds a definition of sub-- substance use disorder by referencing Section 71-430 and clarifies that serious mental health illness does not include standalone diagnosis of substance use disorder, DSM, V codes, or developmental disability, developmental disability unless concurrent with mental health illness. This more accurately reflects the population of, of individuals who are in need of these funds. In developing this bill, we've been-- we've engaged with key stakeholders, including mental health providers and the Division of Behavioral Health. There will be testifiers after me who will speak further on the details, details of these issues. LB722 is an important cleanup to legislation we passed last year that will ensure access to Nebraska's behavioral health system. With that, I respectly-- respectfully urge the committee to advance LB722, and I'm happy to answer any questions you may have.

**HARDIN:** Any questions? Senator Riepe.

**RIEPE:** Thank you, Chairman. Thank you, Senator. I'm always interested when we're talking about a new program, is what are we leaving behind? What are we giving up to get that new program? Is it a new name? Is it a-- because, you know, just to keep piling on and adding on to programs ends up in adding on and piling on of additional personnel, which means additional expenses up and down the line.

**QUICK:** Well, you know, last year when we-- when I brought this bill, we were looking at, you it's a pilot program, so we were to add substance abuse to mental health. And so, but over the summer, when the money-- when the dollars were gonna be distributed, they said we

can't give it for substance abuse because it's not worded right from the bill we passed last year. So we're just trying to fix that, that issue that we definitely overlooked last year when we were, were putting the legislation together.

**RIEPE:** I'm sorry, how long is the pilot program?

**QUICK:** Someone behind me might have to answer to that, but I, I know that it goes to, to the, like the regions, so they're the ones that I believe kind of administer those-- those dollars run through them for the housing program.

**RIEPE:** OK.

So right now--

**RIEPE:** So we don't know how long the pilot project is going to be, or does it sunset?

**QUICK:** They might be able to answer that question. I'm not, I don't-- I know last year, we talked about it. But, you know, I'm getting old, so my memory is kind of short.

**RIEPE:** Fair enough. It's Friday. Thank you, Chairman.

**HARDIN:** Thank you. Other questions? Seeing none, will you stick around?

**QUICK:** I will.

**HARDIN:** Proponents, LB722. Welcome back.

**THOMAS JANOUSEK:** Hi again. Ready? OK. Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Dr. Thomas Janousek, T-h-o-m-a-s J-a-n-o-u-s-e-k, and I am the director of the Division of Behavioral Health in the Department of Health and Human Services. I am here today to testify in support of LB722. Last year with the passage of LB454, DHHS expanded the use of behavioral health housing funds to assist individuals with substance use disorders. LB722 similarly aligns the Landlord Risk Mitigation Fund to support individuals with substance use disorders. The Landlord Risk Mitigation Fund is a key component in serving individuals with behavioral health conditions because it funds repairs for damages that

may occur by providing housing to this population. It serves as an incentive to landlords who would like to offer housing, but may be concerned about the potential for physical damages to their rental properties. Aligning the Landlord Risk Mitigation Fund with the Behavioral Health Housing Fund will ensure all landlords offering housing receive equal protections regardless of behavioral health conditions. We respectfully request that the committee advance this bill to General File. Thank you for your time, and I would be happy to answer any questions on this bill.

**HARDIN:** It sounds like you're saying this is a genuine cleanup bill?

**THOMAS JANOUSEK:** Yeah.

**HARDIN:** I've just never seen one before, so.

**THOMAS JANOUSEK:** This is a pretty simp-- excuse me, pretty simple one too.

**HARDIN:** I see, OK. Senator Meyer.

**G. MEYER:** Thank you. Thank you, Dr. Janousek. I'm somewhat familiar with some of the challenges we have in the behavioral health housing situation. We never have enough funding and many probably don't know that along with the housing we end up buying furniture and those types of things to get people started trying to get, get them back on their feet. We're already struggling to find housing. Is part of the problem landowners don't want to rent to us because of the potential problems?

**THOMAS JANOUSEK:** It's certainly a factor. So I mean it's always a challenge to find folks that would want to open up the entirety of an apartment unit to, and have a portion of that go to individuals with mental illness. But this Landlord Risk Mitigation Fund is just kind of one thing that we can try and do to incentivize allowing people to open those units.

**G. MEYER:** I do know frequently we'll have certainly out of Region 4, behavioral health, we can have 30 or 40 people on a waiting list in order to find housing for them. So anything that would facilitate that I think would be very positive thing. So thank, thank you for coming in today for that.

**THOMAS JANOUSEK:** You're certainly welcome.

**HARDIN:** Other questions? Senator Riepe.

**RIEPE:** Thank you, Chairman. My question is this, does DHHS have the authority to redirect funds from the behavioral health housing fund to the substance abuse-- use disorders fund? I mean, that seems-- that kind of pushes in the face of the legislation-- Legislature to say, you know, what do you-- I mean, does DHHS simply want a puddle of money then says, keep your hands off of it, Legislature?

**THOMAS JANOUSEK:** No, as it stands right now, the housing funds are primarily funded by a portion of that documentary stamp tax fund. And this just allows us, we have a portion of that that is used for these risk mitigation costs. So this legislation--

**RIEPE:** Is that by statute or is that by your own administrative decisions?

**THOMAS JANOUSEK:** I believe that's in statute.

**RIEPE:** OK. It's a problem with term limits, is we don't have time to understand all the statutes.

**THOMAS JANOUSEK:** There's just a couple of them, yeah.

**RIEPE:** Yeah, there is a couple. OK, thank you.

**HARDIN:** Other questions? Thank you.

**THOMAS JANOUSEK:** Thank you

**HARDIN:** Proponents, LB722. Welcome.

**PATRICK KREIFELS:** Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Patrick Kreifels, P-a-t-r-i-c-k K-r-e-i-f-e-l-s, and I'm the administrator for Region 5 Systems, behavioral health authority. Today I am here on behalf of the Nebraska Association of Regional Administrators, the Nebraska Association of Behavioral Health Organizations, and Region 5 Systems' governing board. Region 5 is comprised of 16 counties in southeast Nebraska, and I won't go over those. They're in your handout there. The six behavioral health region authorities were established in 1974. Initially, the public policy was established to address mental health

services and expand upon that. Policy was expanded in 1997 to include an emphasis for substance use. And then in 2004, LB1083, the focus was to add an emphasis on transition from institutional care to community-based care and advocate for people with mental health and substance use challenges. The regional behavioral health authorities aid individuals by providing supported housing program, an evidence-based program which affords people an opportunity to achieve or remain in permanent, affordable, community-integrated housing while receiving behavioral health services to support their recovery. This program provides funding by way of a voucher to serve as a bridge to other housing resources through the federal subsidized housing program known as Section 8, or many people transition into independent living and do not use our rental assistance. During the 2025 legislative session, LB454 was introduced by Senator Quick, and I appreciate that very much, Senator, and was signed into law by the Governor. Originally, the housing-related assistance program was created in 2005, and utilizes the documentary stamp tax dollars to provide housing assistance to eligible individuals with serious mental illness. And LB454 extended that to people with substance use. LB722 further clarifies and allows the regions to use the behavioral health services funds for risk mitigation with landlords by paying for extensive damage to their property, to retain a working relationship with that landlord, to retain that property, preserve future housing units, reassure future housing-- or future landlords, and who are willing to take a chance in leasing to people who are unhoused with zero or very low income and present with substance use disorder. There are no requests for additional funds with the introduction of LB722. This change aligns with the original statutes that I discussed above and is also one of the priorities for the Substance Abuse and Mental Health Services Administration. Throughout the fiscal year FY '25, the regions housed 1,017 individuals who met the criteria for our housing. People with serious mental health and substance use challenges do recover, and they do become productive citizens of, of our society. And they deserve that opportunity and chance to recover. I am sincerely grateful to Senator Quick for introducing LB722, and respectfully request that you advance this bill as it supports the wellness and recovery of Nebraskans to build a life worth living. And I'm available to answer any questions.

**HARDIN:** Thank you. Questions? Senator Riepe.

**RIEPE:** Thank you, Chairman. Thank you for being here. Is the totality of your role as the administrator of Region 5 to coordinate 16 counties, or do you actually, you don't actually provide any services, do you?

**PATRICK KREIFELS:** We-- this is one of the services that we do provide and--

**RIEPE:** Substance abuse?

**PATRICK KREIFELS:** Housing.

**RIEPE:** Housing.

**PATRICK KREIFELS:** The rental assistance program.

**RIEPE:** OK.

**PATRICK KREIFELS:** And is provided by all the regions across the state.

**RIEPE:** It all comes back to my concern and frustration, I guess, with what I see as a lack of organization across the state of Nebraska, in particularly mental health.

**PATRICK KREIFELS:** We're very organized and we work closely with providers to see--

**RIEPE:** Not obvious.

**PATRICK KREIFELS:** --to support the provider or the individual, excuse me.

**RIEPE:** Thank you, Chair.

**HARDIN:** Thank you. Other questions? Senator Meyer.

**G. MEYER:** Thank you, Chairman Hardin. Thank you for coming in today. Having been on the board of Region 4, behavioral health, I understand it. Generally care is provided by contracted providers with regard to mental health and substance abuse, for those that, that aren't aware of that. And it's, it's very well managed. And from my personal experience, from the, from the mental health side of it, there's only so much that the Region 4s can do, or Region 5s, or the regions in the state of Nebraska. And one of the questions I always had is we look at

our monthly EPCs we look that our voluntaries and, and we have some repeat clients, some, some people that show up frequently on the list. And my question all the time was what, what is our next step? You know, if we can't provide sufficient oversight and [INAUDIBLE] and care, to go to Senator Riepe's question and concern, what do we need to provide additionally to take care of those folks that, that are more challenged and that we're not meeting their needs? What-- and that goes to the mental health question. What do we to provide additional services? And I know it's going to take money, but what would you suggest?

**PATRICK KREIFELS:** It's a good question, Senator. I appreciate you asking that. And I am one region, one person in the system of care, and I believe that each region has a robust continuum of care and each region has a network of providers. And there's a large continuum. We work closely with the Division of Behavioral Health. Our funds are capitated, and so when the money is out, we have no more funds to continue to offer those services. And we work closely with the division to try to offer a robust community-integrated system. And sometimes individuals have multiple morbidities or complexities that don't adhere or fit into some of the programming, so we have to have specialized programming for those. So I think a focus on more integrated behavioral health services in the community that can address the complex natures of some of the individuals, help them get back into the community, out of the regional center.

**G. MEYER:** Thank you. I appreciate that.

**PATRICK KREIFELS:** Thank you for the question.

**HARDIN:** Senator Riepe.

**RIEPE:** Thank you. I want to pick up on you talked about the coordination of services within that region, but also within each region, there has to be a fairly significant percentage of Medicaid that are under managed care. So it seems to me like those managed care organizations that have accountability for a mental health component as well. Is that correct?

**PATRICK KREIFELS:** Yes, Senator.

**RIEPE:** So you might have some duplication, if you will, between what your regions provide and what the managed care organizations are

contractually required to deliver. I just-- I'm looking to say, are we paying twice?

**PATRICK KREIFELS:** May I respond, Senator?

**RIEPE:** Oh, I wish you would, yeah.

**PATRICK KREIFELS:** Our-- the focus of the regions are, is that public safety net for individuals who fall off of Medicaid. So we are not paying for individuals who are on Medicaid.

**RIEPE:** At least the ones that fall off of that.

**PATRICK KREIFELS:** They, they are not on. Sometimes people have severe persistent mental health conditions that impair their ability to maybe fill out an application for Medicaid or some of them are unable to figure out how to apply, or sometimes there are variables because of their history of rental renting houses or their history of criminal that is difficult for them, so they're not able to get into a house. So it's hard to work with an individual on their recovery if we don't start with the housing component. But in regards to the Medicaid, if their-- if an individual is on Medicaid, the regions do not pay.

**RIEPE:** OK.

**PATRICK KREIFELS:** There's no, there's no duplication there.

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

**HARDIN:** Other questions? Senator Meyer.

**G. MEYER:** Thank you, Chair Hardin. Generally, the process of pay is, would it be fair to say that initially, private pay is explored first and then we move on to other things with regard to paying for those services, anything that's provided by the region? So private pay is looked at first as far with regard to the services our contractors provide for us. Would that be accurate?

**PATRICK KREIFELS:** It is, Senator. And the regions are the last payer last resort, and I know many payers say that, right? But we are-- we have financial eligibility, zero or very low income for individuals, and have to be citizens. And if someone is on Medicaid, then that is billed first. We do audit providers on a annual basis to assess to

ensure that they are assessing if someone is private pay, has commercial insurance, Medicaid, Medicare, that those are all billed before they're billed to us. And if, if there is a, by chance, a small percentage, sometimes it happens, there's a billing error, then that is a payback to the regions, and that does occur.

**G. MEYER:** Thank you.

**HARDIN:** Other questions?

**RIEPE:** No, sir. Thank you. Thank you.

**PATRICK KREIFELS:** Thank you for your time. I do appreciate the questions.

**HARDIN:** Thanks for being here. Proponents, LB722. Opponents, LB722. Those in the neutral. Those who are Senator Quick. Online, we had 5 proponents, 1 opponent, 0 in the neutral.

**QUICK:** Thank you, Chairman and members of the committee. Really this bill is just a simple fix from the, from the bill we had last year. There was a, when we were working with the department and with the regions to try to get the language right, we have evidently missed something. And had to just make sure that we added that substance abuse piece to that, and so that it followed along so that those resources could go out for housing for those. So with that, I'll-- I would hope we could get this out of committee and get it back on the floor so we can fix this.

**HARDIN:** Questions? Thank you.

**QUICK:** All right, thank you.

**HARDIN:** This concludes LB722, and this concludes our hearings for today. Thank you.