HARDIN: Welcome to the Health and Human Services Committee. I'm Senator Brian Hardin, District 48, and I serve as chair of the committee. Do you know where District 48 is? You go as far as you can until you fall off in Wyoming. That's where we are, right there. 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 entry rooms over here. 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 at the same table. These sheets will be included as an exhibit in the official hearing record. When you come up to testify, please speak clearly into the mic. Tell us your name, spell your first and last name to ensure we get an accurate record. We'll begin each hearing today with the introducer's opening statement, followed by proponents of the bill, then opponents, and finally, 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 3-minute light system for all testifiers. When you start your testimony, the light on the table will be green. It turns to yellow when you have one minute remaining, and red means stop. Questions from the committee may follow, which do not count against your time. Also, committee members may come and go during the hearing. It has nothing to do with the importance of the bills being heard. It's just part of the process, as senators are doing the same thing in other rooms around the Capitol building. 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 similar items will not be accepted as exhibits for the record. Props, charts, and 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. 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 a.m. the day of the hearing. The only acceptable method of submission is via the Legislature's website at legislature.nebraska.gov. Print and 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. I'm Merv Riepe. I represent District 12, which is Millard, Omaha, and the fine little town of Ralston.

FREDRICKSON: Good afternoon. I'm John Fredrickson. I represent District 20, which is in central west Omaha.

G. MEYER: I'm 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 research analyst, Bryson Bartels. To my far left is our committee clerk, Barb Dorn. And our pages for today are--

SYDNEY COCHRAN: Hello. My name is Sydney, and I'm a second-year history student at UNL.

DEMET GEDIK: Hi. My name is Demet. I'm a senior at UNL, and I study political science.

HARDIN: Thank you. And we're going to get rolling with LB942, and Senator Riepe. Welcome.

RIEPE: It's a big chair. OK.

HARDIN: OK.

RIEPE: You're ready for me to take off?

HARDIN: Yes, please.

RIEPE: OK. Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. For the record, my name is Merv Riepe, and it's M-e-r-v R-i-e-p-e. I represent, as I stated earlier, District 12, which is Omaha, Millard, and the fine little town of Ralston. I am here today to introduce LB942. LB942 was brought forward by the

Nebraska Hospital Association to address ongoing issues with how emergency and inpatient hospital services are reimbursed under Medicaid, particularly when clinical judgment is overridden by retrospective administrative decisions. At its core, this bill addresses downcoding. Downcoding occurs when care that has, that has been or was provided and documented at one level of intensity is later reclassified to a lower level of payment. For, for hospitals, this often means that an emergency department visit or an inpatient admission is reimbursed as something less than what was clinically required, even though staffing, testing, monitoring, and treatment were already delivered. Hospitals report that this most frequently affects very common presentations: infectious diseases, respiratory conditions, muscular skeletal injuries, gastrointestinal complaints, behavioral health crises, and short inpatient stays. These are among the most frequent and resource-intense encounters hospitals manage every day. When large numbers of these cases are downcoded, the financial impo-- impact is not theoretical, it is cumulative and significant. For example, a Medicaid patient may present to the emergency department with chest pain, shortness of breath, and abnormal vital signs. Based on these symptoms, a prudent layperson would reasonably seek emergency care for a cardiac event, and the hospital initiates cardiac monitoring, imaging, laboratory testing, and physician evaluation. If the patient is ultimately diagnosed with a nonlife-threatening condition and discharged, that final diagnosis may later be used to classify the visit as a nonemergency, resulting in reduced reimbursement, even though the hospital was required to fully evaluate and stabilize the patient, based on how the patient originally presented. LB942 addresses this issue in 2 primary ways. First, it reinforces the prudent layperson standard for emergency services. The bill makes clear that Medicaid and managed care organizations must determine whether an emergency exists based on the patient's presenting symptoms at the time care was sought, not on the final diagnosis after evaluation and treatment. It also prohibits the use of a diagnostic-based analog, analog rhythm or list to respectively label care as nonemergent and reduce payment. Second, LB942 clarifies inpatient reimbursement standards, including how the "two midnight rule" is applied. The "two midnight rule" is a federal payment standard that generally classifies a hospital stay as inpatient if the admitting physician reasonably expects the patient to require care spanning at least two midnights. If that expectation is not met, the stay may instead be paid as outpatient or observation even if the patient was formerly admitted and received inpatient-level care. LB942 affirms that inpatient status should be based on a

physician's admission order and clinical judgment at the time of the admission using medical factors such as severity of symptoms, comorbidities, current medical needs, and risk of adverse events. The bill allows patients reimbursement when a two midnight stay is reasonably expected. Accounts for unforeseen circumstances like transfer or death, and preserves physicians' discretion to admit patients as inpatients when medically appropriate, even if the time threshold is not ultimately met. Importantly, this bill does not eliminate overnight mandated higher rates or prevent utilization review. What it does is ensures that hospitals are reimbursed consistently with the care they are medically required to provide based on the real-time clinical judgment rather than hindsight. LB942 is about alignment between patients present-- patients' presentation, physician decision-making, and reimbursement policy, so that hospitals might continue to provide timely emergency and inpatient care to Medicaid patients across the fine state of Nebraska. Thank you, Chairman Hardin.

HARDIN: Thank you.

RIEPE: Oh, thank you. Oh, I have a little more.

HARDIN: Oh, OK. Please.

RIEPE: I would be happy to answer your questions to the best of my--

HARDIN: We felt cheated up to that moment. Please keep going.

RIEPE: You don't take a breath up here or you get caught-- to my ability, and if I can't-- and this is the key line here-- a representative from the Hospital Association will be here to speak after me-- someone that knows a lot more about it than I do. Thank you very much.

HARDIN: Very good. Questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Senator Riepe, for being here, for your bill. I'm just kind of reading over this a little bit, so I just want to make sure I understand this clearly. I'm, I'm interpreting this as to say that there are situations where a person might seek emergency medical intervention. At the time, may be clinically assessed as an emergency situation but upon discharge diagnosis is maybe downgraded or shifted because their status has changed which is preferable I would imagine, from a clinical perspective. And so, insurance is only reimbursing at a lower rate.

They're, they're, they're sticking the patient with the fact that they saw an emergency, or-- can you help me understand that a bit more?

RIEPE: Well, it's like you go into an emergency room or the hospital and it's a false alarm. And so all of a sudden, it is not the insurance companies in this situation. It's Medicaid, and so it's the payment from the managed care organizations that's the issue at hand here. But, you know, the hospital under the EMTALA law is required to evaluate a patient that comes into the hospital. You don't, you don't have a choice. You can't have someone that presents and then say, well, I don't know. Let's wait an hour or 2 hours and see how you do. You got to evaluate them. But if it's then not later determined to be an emergency, they say, well, you should have had a, you know, a magic wand and figured out that it wasn't an emergency, but you can't. It's, it's professional judgment. But you-- in my opinion, you still need to get paid because you did spend time, money, letter, expertise, and everything else. And so, it's just, in my opinion, it's a matter of-- well, you came in to buy something, you got in there, you tried it on, everything else, you wore it out, and then you didn't like it. So it's just a matter of fairness.

FREDRICKSON: OK. And then, one more question on that, as well.

RIEPE: Yes, sir.

FREDRICKSON: You're-- I, I would, I would consider you a fiscal hawk. I'm looking at the fiscal note here. It's a little bit of a doozy. I'm kind of curious to hear your thoughts on that.

RIEPE: Well, I am a fiscal hawk, but I also understand that you-- when it comes down to patient care, you have to, you know, do the right thing first. And you can't, you know, you-- sometimes in life in general, you may not be able to afford something, but financially you do it, and you will have to figure it out later, so that's kind of where I'm at. But you're right, I'm generally kind of, a fiscal hawk is a nice description for a cheapskate.

HARDIN: Would we call this compassionate conservatism? Is that what we would call this?

RIEPE: That's what I'd call it.

HARDIN: OK. Very good. Help me out because I think you and I also kind of share this notion that well, we have a lot of laws that are probably not necessary in the state of Nebraska. What's keeping MCOs

and hospitals from negotiating this, and playing marbles or something, to try and sort this out, instead of having to get a law to sort this out?

RIEPE: Well, I think with the situation, is the hospitals don't have a lot of impact on the negotiation with the managed care organization. It's done through the state. So it's the state and the managed care organizations doing that negotiation. Much-- at times, I'm sure at the chagrin of the hospitals, rural or urban, any of them, they're, they're simply-- most of the people in here aren't old enough to remember when-- when I was a kid, we had a game we called "Crack the Whip." And, and some people will remember that, where you would grab hold of hands in a large lot-- lawn, and you'd swing, and the one on the end was the one that got hurt. That's where the hospitals end up being. They're the last line, if you will-- it may be a better phrase is, they're the last on the line of defense. Under EMTALA law, they have no choice. They have to take these patients. But then, to have to take them-- and they serve a, a, a great screening thing. This patient cannot just go home, unknowing whether they do or, or do not have something serious going on. And so then the care is rendered, but then they say, well, you should have known. Well, if you should've known, you wouldn't have done it to begin with. So I think, in that way, I know the phrase common sense is used, maybe overly so, but it is kind of get down to a what's a reasonable-- what would you do in that case? You have to take care of the patient.

HARDIN: OK.

RIEPE: But you-- if you spend a lot of money, time, and resources, you should get paid.

HARDIN: Senator Quick.

QUICK: Yeah. Thank you, Chairman. And I know-- my, my-- I'm going to-- how I'm going to phrase this is so it's comparable, but it's not similar. So you have Medicaid, and then we have the private insurance industry. And I know, even from our side, you know, employer-based insurance, we had an insurance company one time refusing every claim for everybody. And so, the hospitals also face some of that. I don't know if they face that through the MCOs, but we were facing that just with-- within our own insurance company, just trying to, you know, get care for ourselves, you know being able to go to the doctor. And so, so one of the things out of that, that we-- we ended up getting a different insurance company because it just wasn't going to work for

any of us. And plus the fact, they were able to negotiate, really sit down and negotiate what that pay would be for-- you know, what your co-pays would be, you know, they negotiated with the hospitals, the clinics, and all of that. So I do think that that process would be good for-- if they were to negotiate that. But I see your point, that they're not-- they're kind of like at the end of the weapon. They're-- they don't have that opportunity. So one of my questions would be, do they have any ability to-- say they downgrade that code. Is there a process that they can say this isn't right?

RIEPE: I'm sure there is an appeal process, but I don't know how complicated it is. One of the things that's compared to that with the hospital business, often with farming, is that they're, they're not price setters, they're price takers. And so, through the managed care organization or even through the insurance, or through the corn you have to sell, you take what the market is and you have little control over it. If it's a-- for some reason, you've got to get the-- I use-- going back and forth here. If you have to get corn out of the crib because you need space, you may not be at the peak of the market when you want to sell that. And same with the hospitals here. They just-- they're not in a good situation to say, well, you know, we'd like to use this defibrillator on you, but that's an extra $25, and we're not sure we're going to get paid. And so-- you can't let that dictate how you give care, and you can let it dictate, you know, under the Hippocra-- Hippocratic Oath, you know. And this is the mission of any of the hospitals I've ever worked with is you didn't have an understanding of what their economic worth was, you know? If they had a need, you had to take care of it. That was, that was part of your-- and we always said that, that was part of your tax exempt status, too, that you were required to do that. And, of course, I worked for the-- Children's, and then the Catholic nuns. And, you know, they were very much, if you think I'm a fiscal conservative, work for Catholic nuns for a while. You know what I'm talking about. So, but nobody cut corners when it came down to patient care, and I believe that's true of all hospitals.

QUICK: Yeah, yeah.

RIEPE: Not all. I maybe should qualify that, but the good ones, the charitable ones, the compassionate, conservative kinds of, of caregivers.

QUICK: And I, you know, just going off of that, we all kind of talked about the Medicaid reimbursement rates. They're low already. And now,

if you're taking more of those away from a hospital that could really-- and they're providing that care.

RIEPE: Yes. And at the same time, we're seeing growth in Medicaid.

QUICK: Yes.

RIEPE: So we're seeing-- that payer mix gets poorer and poorer as, as we go along. And that-- it's basically pronounced, I think, in rural Nebraska, where there's a fairly high percentage of Medicaid patients for-- just given the price of in-- insurance-- healthcare insurance premiums today.

QUICK: Thank you.

HARDIN: Other questions? Will you stick around?

RIEPE: Yes, sir.

HARDIN: Awesome. Proponents, LB942. Welcome.

MARK HOWERTER: Thank you. So my name is Mark Howerter. I am-- that's M-a-r-k H-o-w-e-r-t-e-r. I'm a physician. I've got about 37 years of emergency medicine physician. I've been an ED director for 20 years. I'm chief medical officer of our hospital for the last 3 years. And I would like to thank Senator Hardin for-- and the committee for the opportunity to testimony, and, and a special thanks to Dr. Riepe for bringing forth the-- this legislation. So I will tell you that this is a, this is a downcoding exercise. This is what we're seeing. And insurance companies don't do this. This is a Medicaid-only thing. And so by downcoding-- I mean, there's-- in the emergency department, there's usually 5, well, 6, if you include critical care, but 5 major codes. And so, they'll take you from a high-level code down to a lower-level code based on diagnosis, based on discharge diagnosis. Has nothing to do with how much resource you put into it or, or what the acuity of the case was. And you know, in looking at cases that we, we, we evaluate, and I, I've found in just doing an audit in our hospital, there's really, of, of the common cases, 3, 3 major themes: abdominal pain, chest pain, fevers in kids. All of those have the potential to be very high-risk cases. When we, when we, you know, get a patient in, we-- they don't have a diagnosis stamped on their forehead. We don't know what it is. It could be anything. They're walking off the street and, and unfortunately the practice of medicine is such that you may have an inclination that, you know, this is kind of a-- probably a minor issue and then you get the testing, and it's not infrequent

you're surprised. So it's important we follow the algorithms, it's important we work these patients up, and we get to the finish line. And I've, you know, the, the kinds of diagnoses they would downcode would be like constipation, indigestion, irritable bowel syndrome. But I've seen each of those things where, you know, that was kind of my hunch, and it ended up being a small bowel obstruction, ended up being appendicitis, ended being an ischemic bowel, lack of circulation that required surgery, a surgical abdominal problem. Cartilage-- you know, for chest pain, cartilage strain, strain of the cartilages that hook the, the, the, the ribs to the breastbone, esophagitis or heartburn, viral pleurisy, which is just a minor inflammation of the lining of the lung that hurts like the devil, strained rib mu-- so I've seen each of these things where I thought this is the diagnosis, did the workup, and found out, oh no, this is an acute coronary syndrome. So you know, unfortunately, people-- patients don't read the textbooks. They aren't presenting with classic symptoms, frequently. And so, it's incumbent on-- upon us to do the workups and, and find out-- to get to the finish line, as I say, and find what the diagnosis is. Well, so we do the, we do the full workup, which could include labs, X-rays, CAT scans at times, if we're looking for blood clots, observation, sometimes 3-5 hours of observation, medications. And once we're reasonably sure that this is not an, an emergency, then good for the patient, and we let them go home, but we'll code the appropriate diagnosis. And you know, coding is based on, on how much intensity you put into the patient. That's how coding works. If you put a lot of intensity, you do a lot of tests, do a lot of medi-- give a lot of medications, prescribe medications, it's a higher intensity case. If you say, hey, this is nothing, you, you may go home, it's a lower-level case, a lower coding case.

HARDIN: If I can ask, how do you-- and keep it in small words. Look what you're dealing with here. How do you determine if there is an emergency medical condition? I mean, educate us.

MARK HOWERTER: Yeah. That's a wonderful question. And, and that's language right out of the EMTALA law. Right. So it's incumbent upon us to find out. We do a medical screening exam to determine whether there's an emergency medical condition. So what that means is you have to do whatever's within your resources to determine that you don't have that. So that means a physical exam after a careful history and then appropriate lab testing, maybe appropriate radiology testing, maybe EKGs, maybe, you know, there could be a variety of other tests that you have to do until you are reasonably certain that an emergency medical condition doesn't exist. All very resource-intensive. So

that's-- that is a great question. And once we get to the point where we are reasonably certain there's not an emergency medical condition, then our EMTALA obligation has, has been satisfied. But, but we have to get to that point and the courts have been pretty clear that you have to do whatever's within your power, whether 3 a.m. or 3 p.m., and with using the resources available to you, to get to that point to be reasonably satisfied that you're not there.

HARDIN: OK. Senator Meyer.

G. MEYER: Thank you, Chair Hardin. We probably have 2 classifications coming to the emergency room: those being brought by first responders and then the walk-ins. Is there some way to delineate, to, to evaluate those differently, or are you held to the same standard?

MARK HOWERTER: Yeah. Well, here's my experience. That is fraught with disaster. What I find when we do chart reviews, when we do process improvement programs, what we see is you're just as likely to have a bad thing happen to you if you walk in as if you take an ambulance, especially in the state of Nebraska. We have a lot of really tough people, and we have a lot of stubborn people who say, I'm not calling an ambulance. I'm just going in with my heart attack. I'm just going in with my stroke. I had a, I had a 90-year-old guy drive in, drive in with his right broken hip. So he's operating his, his gas pedal and his brake pedal with a broken hip, he fell off the back of his pickup, drug himself into the pickup, drove in. Like why in the world wouldn't you call-- you know, he had a cell phone. Why wouldn't you call 911? So I'd like to say you could differentiate the two and say, OK, if they come in this way, it's lower acuity, if they came in this way, it's higher acuity. I've also had people with upper respiratory symptoms show up in an ambulance. So it, it just-- you, you can't use that as a very good barometer, necessarily.

G. MEYER: In the probability, if it's an emergency call, they probably don't have any ability to not take you to the emergency room, from a liability standpoint, and a--

MARK HOWERTER: They--

G. MEYER: And a commitment they must-- they're probably required to.

MARK HOWERTER: Once they are, once they are called, unless the patient refuses, they are required to transport. Yes.

G. MEYER: Thank you.

HARDIN: Senator Ballard.

BALLARD: Thank you, Chair. Thank you for being here, Doctor. And I'm sure Columbus Community Hospital would never do this, but what is prohibiting a hospital from not including everyone into additional emergency testing? If, if you just-- if we, if we pass this law, and you can't get downgraded, so why wouldn't hospitals just say, everyone gets additional [INAUDIBLE]?

MARK HOWERTER: No. The, the-- so the leap of faith is that we, we work patients up and code them appropriately. Frankly, we're too busy to try to do everything to everybody. It doesn't make sense. I mean, if I have a-- if I have an easy case, somebody that really probably should have been in the clinic, or in the emergency department-- or I'm sorry, in an urgent care setting, I'm not going to spend a lot of time-- you know, an ankle sprain. How much time am I going to spend on an ankle sprain? I'm not going to spend a lot-- I've got a chest pain. I've got a shortness of breath. I've got somebody with low blood pressure. I've got somebody with high blood sugar. I've got enough things going on that why would I want to do nth degree workup on that, so I'm not going to. I don't know of an emergency doctor that would. They see that as kind of, OK, this is a breather, and that's going to get coded appropriately. I mean, that's going to be coded accordingly. So, you know, I did a quick exam on that ankle. Maybe I got an X-ray, maybe I didn't, maybe I didn't need to. They walked on it. It doesn't look like it needs it. They're not going to get much. But a chest pain? A chest pain has to be worked up. It's just, it's just foolish and irresponsible not to.

BALLARD: OK. Thank you. Appreciate it.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair. Hypothetically, let's say I wake up on a Saturday morning and I think I might be having a stroke. I go into the clinic or I go into the emergency room. Difference in care? CT scan, MRI, as far as with the emergency room? Perhaps a CT scan but no MRI in the clinic?

MARK HOWERTER: Well, the, the current standards are--

G. MEYER: This is hypothetical.

MARK HOWERTER: Hypothetical, but the current standards are even if you came into your clinic, at least in my world, that clinic is going to

be calling me in the emergency department very fast, saying I've got somebody that I think has a stroke and we know that you are a stroke center and have a stroke protocol and we really want them in your hands, because I don't have the medication to give them. The, the mandate, the mandate really is that everybody that presents with stroke-like symptoms gets an immediate CAT scan and I mean, that's a very time sensitive thing. We do that immediately. Every family doctor out there also knows that, and they don't-- that, that's in their-- it's just like, OK, you're, you're in the right church, wrong pew. We need to get you to the emergency department, where you are-- where, where they can take care of you and give you the appropriate treatment.

G. MEYER: Thank you.

HARDIN: Thank you.

MARK HOWERTER: Yeah.

HARDIN: We appreciate it.

MARK HOWERTER: OK. Thank you.

HARDIN: Proponents, LB942. Welcome.

DAVID GRIFFITHS: Thank you. Good afternoon, Chair Hardin and members of the Health and Human Services Committee. My name is David Griffiths, D-a-v-i-d G-r-i-f-f-i-t-h-s, and I serve as Chief Financial Officer for Bryan Medical Center. I've worked in healthcare finance for a majority of my career, starting in my hometown of Scottsbluff, and now in Lincoln for the last 10 years. I'm here today on behalf of Bryan Health, our dedicated caregivers, and the patients who come from all of Nebraska's 93 counties who rely on our care, in support of LB942. LB942 prohibits denials or reductions in reimbursement based on file diagnosis, discharge codes, or algorithmic tools that retroactively classify visits as non-emergent, as well as incorporates the two-midnight rule currently in place for Medicare for the Medicaid population. As CFO, I witnessed the financial and operational consequences of retrospective downgrades of emergency department care, decisions made not on what our clinicians, clinicians saw at the bedside, but a diagnosis code on an insurance claim. LB942 corrects this by requiring Medicaid and managed care organizations to determine whether a service was emergency based solely on the patient's presenting symptoms at the time they sought care, as perceived by a

prudent layperson. Today we face denials and reduced reimbursement when a patient's final diagnosis is labeled non-emergent even when their symptoms, chest pain, dizziness, bleeding, shortness of breath warranted emergency evaluation as perceived by the patient. We cannot negotiate around state code. In the past year, nearly 5,000 emergency department claims were downgraded or denied through these retrospective processes, resulting in more than 650,000 reduced reimbursement at Bryan Medical Center for care that was rendered. These aren't minor adjustments. These are real dollars withdrawn from hospitals that must remain open 24-7, fully staffed, fully equipped, and ready for every Nebraskan who needs us without notice. This erosion of reimbursement threatens the stability of emergency care in rural and community hospitals where margins are already razor thin. The practice of allowing MCO emergency room downcoding has been in place since 2020, and the code has been applied inconsistently and inequitably across hospitals over this time. Upon inquiring with colleagues across the state, very few have been impacted by the application of this code to the magnitude that we have, indicating the prohibition of this practice will have a much smaller fiscal impact to this date than is being proposed in the fiscal note. The state does not require, nor did it direct the MCOs to down code emergency visits. Instead, they have opportunistically sought to exploit this opportunity. Critically, this bill does not expand benefits or drive unnecessary utilization. Rather, it ensures that our payment system reflects clin-- clinical reality. When a patient believes they may be having a heart attack or complication of pregnancy, they make the judgment call to come to the emergency department. The care we provide should not be devalued by their insurance company, based off a judgment made by a third party that never once laid eyes on the patient. As CFO, I am accountable for the stewardship of our resources. I am equally accountable for ensuring that financial rules do not undermine clinical judgment or jeopardize access to care. LB942 restores alignment between federal EMTALA obligations and clinical practice and Medicaid reimbursement. Thank you to Senator Riepe for bringing this important legislation forward. I urge the committee to advance LB942. Thank you for your time, and I'm happy to answer any questions.

HARDIN: I could tell you were extra robust by the way you came up here, and then you said you were from Scottsbluff--

DAVID GRIFFITHS: Yes. Yeah.

HARDIN: --so, I appreciate that part. $650,000 just at Bryan. Do you happen to know what the wider number might be, statewide?

DAVID GRIFFITHS: I don't know how to estimate that. It seems to have been inconsistently applied. Bryan Medical Center does, in total, like 106,000 emergency visits in a year, so we're one of the larger EDs in the state. So I would think our impact would be one of the larger ones in the state and would be significantly lower in rural areas, even though they have a higher Medicaid population.

HARDIN: Different subject. Is the federal "two midnight rule" permissive at all, or I guess my question is if it's mandatory, shouldn't, shouldn't this be happening already? I guess it's back to that-- it seems like a lot of this ought to be sorted out in the mix. You know what I mean? But--

DAVID GRIFFITHS: Yeah, Medicare only requires it for their population--

HARDIN: Medicare does.

DAVID GRIFFITHS: So it's not even required for managed Medicare at this point in time. That's-- has to be, like you said, negotiations between the hospital and the insurance companies. Why that doesn't work well is it's one-on-one, so we could negotiate for Bryan, but that doesn't help the rural ones, or--

HARDIN: OK.

DAVID GRIFFITHS: So it's-- if a larger fix is possible, it helps a larger audience, and Bryan has more negotiating power than a-- Regional West, for example.

HARDIN: Sure. Other questions? In your experience, how long does it take an MCO claim to get processed for ER?

DAVID GRIFFITHS: Well, that varies. I would say our average Medicaid is probably about 45 days to 60 days.

HARDIN: OK. How does that compare to good ol' Medicare?

DAVID GRIFFITHS: Medicare's pretty quick. They have a 14-day bill hold, and then they process. So we generally get our reimbursement from Medicare within a month, if it's-- unless there's some special circumstances there.

HARDIN: Oh, I would love to ask you which MCO does the best job. I'll ask you offline. How would that be? Any other questions? Seeing none, thank you.

DAVID GRIFFITHS: OK. Thank you. Appreciate the time.

HARDIN: Next proponent, LB942. Welcome.

TIFFANY JOEKEL: Thank you. Good afternoon, Chairman Hardin, members of the HHS Committee. My name is Tiffany Joekel, T-i-f-f-a-n-y J-o-e-k-e-l, and I'm representing Nebraska Medicine today in support of LB942. I'll focus my comments on Section 4 of the bill, limited to the application of the Two-Midnight rule to the Medicaid population. So as it has been established, the Two-Midnight rule is used in Medicare and has been in place in 2013-- since 2013. It was implemented as a benchmark at that time to reduce improper billing, improve clarity for hospitals, and to ensure consistent reimbursement policy. The rule essentially says that a hospital inpatient admission is reasonable and medically necessary if the admitting provider expects that the patient will require hospital care that spans at least two midnights. As an example, if a provider treats a patient and expects the patient will be able to leave the hospital the following day, an inpatient admission likely isn't medically necessary under this rule, and the patient would be classified under observation status, which provides a lower level of reimbursement. But if the provider treats the patient on a Monday and believes the patient will require continued inpatient-level care at least until Wednesday, an in-patient mission-- or an in-patient classification is appropriate under the Two-Midnight rule. How the process works in our hospital, essentially, any sort of admission undergoes 3 levels of clinical review. So for example if a patient presents to the emergency department, the ED physician believes it's unsafe for them to leave, to leave, they will admit them. At that time, then another physician, an admitting physician, reviews the case and evaluates whether inpatient or observation status is appropriate. And then, within 24 hours of that review, there's another utilization management nurse specialist who reviews the case to determine whether inpatient or observation status is appropriate. So despite these multiple levels of clinical review, we're still experiencing instances where a patient has received inpatient care based upon the recommendation of physicians. But Nebraska Medicine is retroactively being reimbursed by the Medicaid managed care organization for observation status, which again, is a significantly lower level of reimbursement. LB942 seeks to address this unfair retroactive determination by insurance companies

that such inpatient care wasn't necessary, but it's after that care has already been provided and the insurance company has all the information that the bedside provider didn't yet have when they were making the determinations. I'd like to make a quick comment about the fiscal note, which is that as I read it, and particularly the department's fiscal note, there is no mention of the Two-Midnight rule in the driving factors in the cost. I think that tells me, at least, that hospitals are mostly doing this right. What it doesn't reflect is the time and energy and resources spent to make sure we're getting it right-- so appeals, peer-to-peer reviews, and the amount of time we have to spend to make sure that we are reimbursed for the inpatient care that was already provided. I'm happy to answer any questions

HARDIN: Thank you. Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here, and for your testimony. I don't know if you know this off the top of your head, but like a ballpark of, you know, what's a dollar amount that Nebraska Medicine might lose out on, for lack of a better word, based on this downcoding.

TIFFANY JOEKEL: Yeah. I, I asked our RevCycle folks who couldn't be with you today-- sorry, they're the experts, you get me instead, but they said it's about, on average, about a $5,000 difference in reimbursement.

FREDRICKSON: Per, per patient.

TIFFANY JOEKEL: Yes. Per case. Yep. So, you know, it's not insignificant. The cases that are being downgraded for us are short stays. They're, on average, 3.5 days at Nebraska Medicine and 2.7 days at Bellevue Medical Center, our 2 inpatient hospitals. But that adds up over a significant number of patients, and we are one of the largest Medicaid providers in the state. So, we're, we're losing about $5,000 a case on each of those cases, again, for care that was already provided. It's, it's significant.

FREDRICKSON: And that might fluctuate month-to-month, but what would that be, on average, a month?

TIFFANY JOEKEL: I, I don't know. I don't, I don't want to speculate, but I can follow up.

FREDRICKSON: That'll do. Thank you.

HARDIN: Other questions? So you kind of touched on this, but it struck my curiosity. So I'm an ER patient. I come in and a-- an ER doc makes a judgment. Two midnights, not two midnights. As the previous testifier was saying, a regiment of tests is performed. Best judgment, a judgment call is made. Is there a way of getting a hold of any statistics that you're aware of, either for Nebraska Medicine or others, to get an idea of how good are, are ER docs at judging? Did, did they get it right? Did they not get it right? I mean, as you said, we tend to get it right more than we get it wrong.

TIFFANY JOEKEL: Right.

HARDIN: Something to that effect.

TIFFANY JOEKEL: Yeah.

HARDIN: And so, anyway, I was just wondering if there's any available statistics that we could land our hands on to go, what does this really look like?

TIFFANY JOEKEL: I don't have that at my fingertips. What I would say, it's one thing I want to clarify. So it's not just the ED physician, it's two docs making that determination, right? You have the ED doc determining that they need to stay, it's safer for them to stay. And then you have another attending physician, in our case, reviewing the case and also saying yes, the course of care will require this longer stay. I think what the fiscal note tells me is that we must be getting it right a lot of the time, because much of that fiscal impact, in fact, as best I could tell, none of it was attributed to applying this Two-Midnight rule. It must be working because Medicare's doing it, right? And that is the great bulk of our patients. So I don't have a specific statistic for you, but it must be working out most of the time.

HARDIN: OK. Other questions? Thank you.

TIFFANY JOEKEL: Sure.

HARDIN: Appreciate it. Other proponents, LB942. Proponents. Opponents, LB942. Hello, Director.

DREW GONSHOROWSKI: Hello, again.

HARDIN: Welcome.

DREW GONSHOROWSKI: Good afternoon, Chairman Hardin and members of the, of the Health and Human Services Committee. My name is Drew Gonshorowski, D-r-e-w G-o-n-s-h-o-r-o-w-s-k-i, and I am the Director of the Division of Medicaid and Long-Term Care in the Department of Health and Human Services. I am here to testify in opposition to LB942. First, the bill is inconsistent with 42 CFR 438.114 and CFR 489.24, which together establish clear and distinct federal standards governing, governing emergency department obligations and Medicaid payment requirements. While hospitals are required to provide medical screening and stabilization under federal law, Medicaid payment obligations are narrower and limited to services furnished for a clinically diagnosed emergency medical condition. This bill improperly combines these separate standards and would compel the department to pay for services beyond what federal Medicaid law requires. In fact, this bill would require the department to pay for services never rendered. The bill would require the department to adjud-- adjudicate and pay claims based on the patient's initial presentation rather than the final clinical diagnosis. This approach is incompatible with generally accepted billing practices, utilization review, and program integrity frameworks, all of which re-- re-- rely on documented medical findings and not the hypothetical to determine coverage and payment. Requiring payment based on presenting symptoms without regard to diagnostic outcomes significantly increases the risk of improper payments, undermines post-service review, and weakens the department's ability to meet federal audit and oversight expectations. This proposed process would remove any incentive from hospital systems to actively manage their patients to the most appropriate level of care and would produce the absurd, absurd result of paying for hypothetical diagnosis. Third, the bill alters the definitions of hospital observation stays and inpatient admissions, areas governed by long-standing industry standards and federal guidance. Redefining these terms in statute would introduce confusion for providers, disrupt existing billing and reimbursement practices, and lead to inconsistent application across the provider community, community. These changes further heighten the risk of payment errors in federal compliance findings. Finally, the bill exceeds federal limitations on emergency medical service for aliens by requiring payment for services that, that may not meet the federal definition of an emergency medical condition. Federal law strictly limits EMSA coverage for treatment necessary to address the true emergency medical conditions for individuals without citizenship or qualified immigration status. Expanding coverage beyond these boundaries would place Nebraska Medicaid out of compliance with federal eligibility and payment

requirements and expose the state to significant fiscal and legal risk. The department strongly opposes the proposition that Medicaid should increase payments on a nonclinical basis and introduce payment integrity and federal financial participation risks into our program. We respectfully request that the committee not advance the bill to General File. Thank you for your time. I'd be happy to answer any questions on this bill.

HARDIN: So you're saying they're not the same, Medicare and Medicaid, and they're not supposed to be the same.

DREW GONSHOROWSKI: Yeah, Medicare and Medicaid tend to operate very differently. I'm, I'm not a Medicare expert, but, but I do know a little bit about Medicare, and, and, and we can follow up with this. But my understanding on the, the two-night stay, at least-- and I haven't read it for years at this point, but I'm, I'm fairly certain that that came out of some OIG findings around sort of improper payment in this space, and happy to follow up with that.

HARDIN: OK. All right. Questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here and for your, your testimony. So I, I, I'm wondering if you can maybe elaborate a little bit more. I'm, I'm a bit confused. You, you said that, that this would compel the department for pay-- to pay for services that were never rendered. Can you help me understand that more?

DREW GONSHOROWSKI: So, so ultimately, I think that this kind of gets to the, the crux of, I think, our, our-- one of our main concerns around this legislation is that you, you have someone show up for a specific diagnosis. There's a-- there-- whether or not they act on this incentive without having that active conversation between the MCOs and the provider around what is medically necessary, open space to create incentives for, you know, providing services across the board. There isn't that sort of adjudication occurring, and that can result in services just not being rendered, services being billed that aren't rendered.

FREDRICKSON: So-- right. But I guess, kind of hypothetically, I'm thinking someone does show up to the emergency room. Chest pains, right? Maybe believes, truly believes that it, it could be a heart attack, right. I mean, I would imagine like from a services rendered,

rendered perspective, the hospital is going to, in fact, be conducting a thorough assessment to ensure an accurate diagnosis.

DREW GONSHOROWSKI: Yeah, and I think in that case, that would be fair, fair characterization. Yeah.

FREDRICKSON: OK. My other question is you said that the proposed process would remove any incentive for hospital systems to actively manage their patients. How, how would that be true?

DREW GONSHOROWSKI: So, so in-- I think, ultimately, a lot of-- this, this bill kind of comes down to this discussion of emergent versus nonemergent emergency room usage. And our hope is, right, is the incentive should be that when, when someone comes in-- you could use a frequent flyer as an example-- that there is an incentive to figure out where their appropriate level of care is, whether that's coordination within the hospital. If it's only on presenting diagnosis right, the hospital does what they do. They receive someone at their worst. They, they ensure that they are safe, they work through that process, and, and then they, they send them along. Right? The-- that incentive disappears where it's-- when you have that opportunity to say, OK, this person has been in 10 times, and perhaps we have an opportunity to pass them to the outpatient side for, for some sort of screening, even though understanding that they're presenting a diagnosis that, that would look something like chest pain or, you know, a, a behavioral health incident. We, we want to ensure that that conversation still happens and happens clearly, with the payers and also the providers, around what is medically necessary for that individual.

FREDRICKSON: OK. And are you under the impression that that is not currently happening in our hospitals?

DREW GONSHOROWSKI: I-- our, our view is that, that this, that this legislation removes that incentive from the conversation.

FREDRICKSON: And would, would-- and would like-- would the clinical well-being of the patient not be enough of an incentive? I'm, I'm just thinking through when I've, when I've been in hospitals or ERs, I mean, I don't get the sense that the attending physician is wanting patients to stay there forever. I mean, [INAUDIBLE].

DREW GONSHOROWSKI: No. And I, and I would agree with that, too. And we're, we're-- Medicaid and the Division is fully committed to

ensuring that this-- that, that our members live long lives. Right. And this is not just a conversation about one emergency room visit. It's about figuring out the best path for them to live this fulfilling life. That doesn't always look like coming into the emergency room, receiving what, my opinion, in our, in our hospitals, is unparalleled care. Right? But that doesn't mean that that's the only piece of the conversation on how they are coming back into our community and being rehabilitated. That, that all fits within this, and it shouldn't just be this conversation around, you know, sort of-- I'm trying to think of the best way to say this. Sorry. It is really around this medical necessity conversation, but also where the incentive lies, to ensure that this, this patient has the best care, in the appropriate setting.

FREDRICKSON: OK. Thank you.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair. Thank you for coming in, Dr. Gonshorowski. Can you tell me what the federal limitations are in emergency medical services for aliens?

DREW GONSHOROWSKI: Right. So, so--

G. MEYER: I mean, as compared to--

DREW GONSHOROWSKI: Yeah. Yeah. So, so in, in Medicaid programs for undocumented individuals, Medicaid can only provide for emergency services, and that's a very clear definition in, in Medicaid federal statute. The issue here is that we believe-- the Division believes that, that this legislation would expand that definition beyond what federal, federal statute says is permissible to provide for undocumented individuals. The specific tie here is that there is a specific provision within HR 1 that discusses around Medicaid's role with this, with this population, and in terms of the Medicaid population, we, we effectively put our financial-- federal financial participation at risk if we are funding beyond emergency medical services.

G. MEYER: The, the probability of a medical institution receiving any compensation for medical treatments without Medicaid for an undocumented individual, they probably aren't going to get reimbursed in any fashion, in all probability?

DREW GONSHOROWSKI: Yeah, I, I, I would assume that that's, that's a safe assumption. And it is a difficult tension, right-- is because

EMTALA requires services to be rendered when someone comes in the door, but those services have to be very clearly within the, the federal statutes on the provision of emergency services.

G. MEYER: Thank you.

DREW GONSHOROWSKI: Yeah.

HARDIN: Medical billing is squishy. And so different MCOs, and so on and so forth, and my experience with it having I guess worked in the insurance industry for many years, I look at it and say getting a hold of nuclear codes is easier than figuring out medical billing across America. It's complex. Within that context, here's my question. If someone-- if, if I come into the emergency room, and I'm on a plan that's an MCO-oriented plan, and I get Care A. And I come in, and I am on some major medical plan, and I also get Care A package. Same-same. Is there a difference in how those pay? I know there is, but my question is, is it also different if I come in with each of those, and it turns out that I didn't have a really serious issue? Let's say I had a strange pain down my arm and I thought that maybe it was a stroke or something. Turns out, I need to take an antacid because the digestive system doesn't play fair in the human body. And so, uh-oh, the doctors thought, legitimately so, and they took extra care to make sure that I wasn't having a stroke or a heart attack or something like that. Thankfully, it turned out that wasn't the case. Are we essentially talking about picking up capitated care, of sorts, within the MCO place, or we're, we're kind of paying a set price that's a high price, no matter how the final diagnosis turns out? Did your father me-- follow me through any of that maze?

DREW GONSHOROWSKI: Yeah. I'm following you. I, I think that the-- I think-- I haven't thought about it in that context, but it, but it would be almost a-- sort of a expected cost. Yeah.

HARDIN: Capitated care basically says we're going to pay X, whether we see you or not, and this is an extreme of that, but basically says, we're going to pay you X, no matter how the outcome happens. No matter what the outcome is, you get paid X.

DREW GONSHOROWSKI: And, and ultimately, that's why we're here, right, is because--

HARDIN: OK.

DREW GONSHOROWSKI: --providers aren't necessarily in agreement with this conversation around medical necessity, right, about how we're-- how, how our MCOs are paying. Right.

HARDIN: It's, it's medical billing. And I guess just pointing out the fact that medical billing is difficult stuff. It really is. Other questions? Thank you. Any others in opposition, LB942. Mr. Bell.

ROBERT M. BELL: Hello, again. 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 is spelled B-e-l-l. I'm the executive director and registered lobbyist for the Nebraska Association of Medicaid Health Plans, which I'm going to refer to as the Association, whose members include the 3 current managed care organizations providing Medicare coverage services under a contract with the Department of Health and Human Services: Molina Healthcare, Nebraska Total Care, and UnitedHealthcare of the Midlands. I don't like testifying against Senator Riepe's bills normally, so this is, I think, the first time this year. I know. He's looking at me. So-- but the Association is appearing today in respectful opposition to LB 942. The payment reduction methodology for emergency room services that are at point in this bill are currently promulgated in the Nebraska Administrative Code, which is under Title 471 NAC 10-007.01N(i)-- long enough citation for you-- related to Medicaid covered services for nonemergent services delivered in emergency rooms. The regulation states: when the facility or the department determines services are nonemergent, the room fee for nonemergent services provided in an emergency room will be disallowed to 50% of what would otherwise be allowed. All other Nebraska Medicaid allotable charges incurred in this type of visit will be paid accordance to 40-- 471 NAC 10. So right now, under current law, MCOs are just merely following the law as, as state-- is stated in the rules and regulations. Of course, here in the Legislature, there's a hierarchy of norms here. You can certainly pass a statute requiring MCOs to do something different. However, I also understand that just prior to the session that some of the hospital systems and some of MCOs have been in initial discussions on some of the nuance of, probably, very likely, the coding issues. And I would certainly be hopeful that those discussions will continue after this hearing today, would probably include the Department of Health and Human Services. So the Association of Medicaid Health Plans respectfully opposes the passage of LB942. I appreciate the opportunity to testify. Thank you.

HARDIN: Thank you. Questions? Thank you.

ROBERT M. BELL: You're welcome. Have a good afternoon.

HARDIN: Others in opposition, LB942. Those in the neutral, LB942. Senator Riepe, will you come back? Welcome.

RIEPE: You ready for me to go ahead?

HARDIN: Why, sure.

RIEPE: Thank you, Chairman Hardin. I, I want to express my appreciation to you and to the committee, and also to everyone here who-- today, who's for-- here, whatever reason, and also, particularly, a thank you to those who have testified on either side of this particular topic. I think, by its very nature, a managed care organization is supposed to be a managed care organization. So it would seem that they should be the ones who are managing the patient, whether they do or don't go into the emergency department. Now, I understand that that's not a reasonable approach because they wouldn't know necessarily where it's at, but I also find it very unreasonable to think that someone can walk in, receive a service, and then expect to be able to negotiate it on the way out the door. This does not happen with commercial insurance. It does not happen with Medicare. It only happens with Medicaid, and I may assume that it only happens in, in Nebraska Medicaid, best I know. It just seems that it's an unfair advantage that hospitals have to take patients under the EMTALA law, and as a social, moral obligation, and then that they can then be denied unilaterally by a managed care organization as to what they will or won't get paid for, either in the total dollar amount or by the procedures that they may think. So we have to ask the question, you know, who's the, who's the attending here? Is it the physician who has to make those decisions on the spot, or is it the managed care organization, sitting back someplace in Lincoln or Omaha, that's trying to make those decisions-- on-site decisions, maybe at 1:00 in the morning? So, the fiscal note's a challenge, but it is also something that, as the state of Nebraska, we signed up for. We signed up-- we expanded Medicaid at the will of the people. And so, when you take on an obligation, you're responsible for that obligation.

HARDIN: Questions? So you're thinking we're the only ones that handle it this way around the state-- or around the country?

RIEPE: I'm thinking that-- I'm sorry?

HARDIN: Are, are we the only state that handles MCOs within this category this way, around that?

RIEPE: I do not know for sure on that.

HARDIN: OK.

RIEPE: My guess is probably not, because these managed care organizations are nationwide, so that--

HARDIN: OK.

RIEPE: It would be illogical to think that they would only have it here in this state, and have probably been successful in introducing this unilateral action in other states that they practice in, in part to, you know, be a-- they have to make a profit. I don't deny them that.

HARDIN: OK. Very good. Questions? Thank you.

RIEPE: Thank you. Thank you very much.

HARDIN: Oh. I will also say we do have 6 proponents online, zero opponents, and zero in the neutral.

FREDRICKSON: That will bring us to our next bill, which is LB911. Does LB911 have an e clause? [INAUDIBLE] what 911 is.

HARDIN: That's a great question.

FREDRICKSON: All right, Chair Hardin, you're welcome to open.

HARDIN: Thank you, Vice Chair Fredrickson, and good afternoon, fellow senators of the Health and Human Services Committee. I'm Senator Brian Hardin. For the record, that's B-r-i-a-n H-a-r-d-i-n, and I represent the Banner, Kimball, and Scotts Bluff Counties of the 48th Legislative District in western Nebraska. Last year, I became aware of concerning issues relating to Medicaid reimbursement for ABA and the safety of the individuals receiving this therapy. This committee had an interim hearing over this issue, and I wanted to further address additional issues relating to ABA. That's why I am before you this afternoon to introduce LB911. LB911 is a public health and patient safety bill that addresses how applied behavior analysis services are delivered, supervised, and regulated in Nebraska. In the absence of clear statutory guidance, Nebraska has seen inconsistent supervision

practices, regulatory confusion, and even accountability-- and uneven accountability in the delivery of intensive behavioral health services. It focuses on 3 core areas: clinical supervision standards, Medicaid oversight for intensive services, and clarity around child care licensing requirements for therapeutic settings. Applied behavioral analysis, or ABA, is a medically necessary and evidence-based therapy that serves many Nebraska children with autism and other developmental disabilities. For families, these services can be life-changing. For the state, they represent a significant investment of public resources. Like other Medicaid-funded therapies delivered at scale, ABA warrants clear statutory guardrails. LB911 starts from a simple principle: when services are medically necessary and publicly funded, we have a responsibility to ensure they are delivered safely, effectively, and with appropriate accountability. First, LB911 strengthens supervision requirements for licensed behavior analysts. Under current law, there's very little statutory guidance around how clinical supervision must occur, even for programs delivering a high volume of services. This bill establishes clear expectations that supervising clinicians maintain a meaningful physical presence in Nebraska and remain actively engaged in the treatment being delivered under their license. LB 911 limits remote-only clinical supervision for high-intensity programs providing more than 15 hours of direct services per client per week. It also requires regular, documented, in-person observations of treatment implementation and staff performance. These provisions build on the minimum supervision and professional accountability standards established by the Behavior Analyst Certification Board, while appropriately addressing areas that the BACB leaves to state regulation, particularly in the context of intensive, publicly-funded services. The intent here is not to eliminate telehealth or modern supervision tools. Rather, it's to ensure that high-intensity, hands-on clinical services receive hands-on clinical oversight. This bill does not dictate staffing ratios or clinical models. It establishes minimum accountability standards. When something goes wrong, Nebraska families should know that a licensed professional with boots on the ground is accountable. Second, LB911 provides DHHS with targeted tools to ensure continuing medical necessity for intensive ABA services paid for through Medicaid. ABA services can involve a significant number of weekly treatment hours, and in some cases, continue for years. LB911 directs the department to establish clinical review protocols for services that exceed 20 hours per week or continue beyond 12 consecutive months without documented functional progress. This provision is not about denying care. It's about making

sure that care remains individualized, goal-oriented, and responsive to a child's development over time. Medicine is not static, and treatment plans should not be either. These reviews are intended to guide future treatment planning, not to retroactively deny services already delivered. Periodic review ensures that services are still meeting clinical needs and that public funds are being used responsibly. This is consistent with how Medicaid already treats many other long-term or intensive services. ABA should be no different. Third, LB911 brings much needed clarity to the intersection of clinical therapy and childcare licensing. In recent years, ABA providers across Nebraska have faced uncertainty about whether they are required to obtain childcare licenses simply because they serve minors in a clinical setting. This confusion has created regulatory overlap, inconsistent enforcement, and unnecessary barriers to care. LB911 draws a clear and commonsense distinction. Facilities that provide medically necessary ABA therapy without offering custodial care, recreational programming, meals, or naps would not be licensed as childcare centers solely because of the age of the clients they serve. At the same time, the bill makes clear that if a facility goes beyond clinical treatment and provides nontherapeutic supervision, extended daycare, or recreational programming, childcare licensing requirements do apply. The Department of Health and Human Services is also directed to adopt rules addressing dual licensing or waivers for programs that operate extended or wraparound services. This approach protects children, supports families, provides clarity for providers, and reduced duplicative regulation. In closing, LB911 is about patient safety, professional accountability, regulatory clarity, and responsible stewardship of public dollars. It does not eliminate services, lower standards, or limit access to care. Instead, it ensures that Nebraska statutes reflect how these services are actually delivered and how they should be overseen. Most importantly, it ensures that Nebraska families can trust that intensive services delivered to their children meet consistent and enforceable standards. I appreciate the committee's time and consideration, and I look forward to the testimony today. Happy to try to answer any questions.

FREDRICKSON: Thank you, Chair Hardin. Any questions from the committee? Seeing none. Will you be around to close? Yes, you'll stay. All right. We'll now be taking proponents for LB911. Any proponents? OK. We'll be moving on to opponents for LB911. Welcome.

JEANINE AMARO: Hi. Jeanine Amaro, J-e-a-n-i-n-e A-m-a-r-o. Good afternoon, and thank you for all you do for your constituents across Nebraska. I am a parent of 2 children with autism, and one with

severe, nonverbal autism. I come to you before-- before you, not only as a parent, but as someone deeply concerned about how this bill will affect children with complex needs and families across Nebraska, especially those in our rural communities. I understand the need to regulate the ABA companies that have taken advantage of the system. I want to see regulations on the companies that come here and see our children, my children, as dollar signs. But I fear the way LB911 is being proposed is going to cause more hurt to the autism families than it will help. As a parent, I have seen firsthand the challenges that children with severe autism face every day. Access to specialized therapies, consistent care, and individual supports are not just helpful, they are essential. This bill threatens to limit and restrict services that my child and so many others depend on to thrive. They are not optional services. They are lifelines for us. They help my child to learn to live in a-- learn to live in and navigate a world that is not kind to him. Any reduction in supports could mean the difference between progress and aggression. Families in rural areas already struggle with limited access to qualified providers and resources. For many, the nearest specialist may be hours away. This bill would exacerbate those challenges, making it harder for the children in rural Nebraska to receive the care they need. Without adequate services, families might be forced to make heartbreaking decisions-- whether to stay in their communities or move elsewhere, in search for help for their children. I do believe there's a way to rewrite the bill, to propose that those outside of a certain area or radius of a major metropolitan area would be allowed telehealth services for their children. Although I support oversight of how many hours should be allotted for clients, I do not believe that we should be spending taxpayer dollars having DHS review services that are provided by private insurance companies. There's already audits and reviews set up for these, but to have blanket authority to review any cases over 20 hours per week seems excessive. I'm also concerned about the potential HIPAA violations with DHS reviewing those that they are not paying for. There is another line in this bill that is concerning to me, as a mom. The bill states that cases would be reviewed if the child goes 12 months without documented functional progress to ensure medical necessity. My fear is that we don't have a definition of what medical-- of what functional progress means. So I fear that if my child does not make enough progress that they would take away services. There are times that he regresses, and I hear that he may no longer be worth it to the plans to pay for his care. I want to be clear that we support accountability and oversight. We want the children protected, but we-- these goals must be achieved without

sacrificing access to medically necessary services. So I respectfully ask the committee to slow down, listen to families and providers, and ensure that any legislation strengthens rather than weakens Nebraska autism care systems. Please do not pass a bill that could unintentionally limit opportunities for children who already face, face enormous challenges.

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

RIEPE: Thank you, Chairman. Thank you very much for being here. My question gets to be as, as a concern, I think in Omaha there's a group that's called Radical Minds, and there are some other, quote-unquote, for-profits. You know, I still have pains from the St. Francis, trying to think that we can end up hiring someone outside. I also have a concern that at the same time when we do that, we don't necessarily cut down on any staff within DHHS. My question to you is, have you had some experience in working with these agencies and providing services? Part of the reason I bring it is that I have a family in my district that has, and so, I'm trying to learn more, so I can help them, too.

JEANINE AMARO: Yes, so both my children have received ABA services. We've been at a few agencies with my youngest, three different ones in fact. Two of the locally run ones I will say are very good. My concern is more with the private equities and those agencies that are prescribing 30 to 40 hours, across the board. I think there's ways to regulate some of those, and make sure that we are providing medically necessary services.

RIEPE: OK. Do you use telehealth, as well?

JEANINE AMARO: For my kid?

RIEPE: Yeah.

JEANINE AMARO: No.

RIEPE: OK. Do you know of people in your sphere of influence that do, or is that--

JEANINE AMARO: I am not--

RIEPE: Is, is it, is it a growing or, or lessening?

JEANINE AMARO: I'm not a huge fan of it. I don't think that's, for my child, it would be the best. But I'm also in Omaha, where I have access to services right around every corner. We don't see BCBAs going out to rural communities. There's no way that you would be able to pay a BCBA salary and have them go out to rural Nebraska, so they'll be left--

RIEPE: [INAUDIBLE]. After you've seen one case, you've seen one case. And so-- OK. Thank you, Chairman.

FREDRICKSON: Thank you, Senator Riepe. Other questions? Senator Meyer.

G. MEYER: Thank you, Vice Chair. If this bill passes, how does that affect you personally, your day, your day with your autistic children?

JEANINE AMARO: I foresee a lot of ABA companies possibly leaving Nebraska, which would then be a fight for ABA services with what's left. So wait lists would be longer, providers-- there wouldn't be as many options, so you're kind of stuck with who you have. We're very lucky that we have amazing providers. Some that do have services from telehealth providers, that's all they have the option to right now. I don't think immediately my family will be affected. It will eventually, because as the services leave the state, it will have a-- an effect over everybody. Chaos ensues in my house. It is, with a level 3 nonverbal child, any changes in services, when we haven't had enough services, when we had to transition services from one agency to another, we've had a lot of aggres-- regressions. He can get very aggressive, not towards others, thank goodness, but he can get aggressive towards himself. He will headbang, he bites himself, he-- very dysregulated. So we see a lot of self-harm. So if there is a disruption in his care, that tends to be what we see.

G. MEYER: OK. Thank you.

FREDRICKSON: Other questions from the committee? Senator Quick.

QUICK: Yeah. Thank you. And I know you talked a little bit about, you know, so that right now, there are services in Omaha and maybe Lincoln, for providers. But in rural Nebraska, we're already seeing a reduction in services in my area. And although I see that telehealth could be OK, but I know my son was a RBT, and he had to work one-on-one with that child, and how important that was. And so, with already seeing a reduction in services for rural Nebraska, what, what would you see as-- how, how can we fix that?

JEANINE AMARO: I wish there were more BCBAs that would be willing to go to rural Nebraska. I, I think there still needs to be, we still need to allow telehealth for the supervision of BCBAs in rural Nebraska. The RBTs will be there. They will be-- which are the registered behavior technicians, the ones that work one-on-one with the kids. I, I would like to see the committee work with some providers, see what's realistic, go a little slower, and say what can we set in place that would allow them to go out maybe once a month, instead of putting a set time on, you know, do they need 8 hours, which isn't realistic. Because you can't bill 8 hours a day, you can only bill 6, so that would be a 2-day thing for one child, and we can't send a BCBA out to do that. Right? So if you work with some of the providers here and say what can we do to make it make sense, financially? What can we do to make it make sense with oversight, then I think there's going to be other solutions.

QUICK: OK. And I know it was brought up, too, about the-- you know, there could be regression, and you, and you go backwards. And so, I look at all-- other types of help. I mean, you look at cancer. Someone could have, you know-- they could be in remission, and the next thing you know, the cancer is back. So, you know, for me, it's about providing that type of care for these kids. They can regress and go backwards, and now we're going to say that they're, they're not going to reimburse for that. So, I guess I have some issues with that, so making sure that these children can still receive those services.

JEANINE AMARO: Right. And regression is part of autism. It happens.

QUICK: Yeah. Thank you.

FREDRICKSON: Other questions from the committee? Seeing none, thank you for being here.

JEANINE AMARO: Thank you.

FREDRICKSON: Next opponent for LB911. Welcome.

DESIREE DAWSON: Thank you. Thank you for having me. So thank you, Chairman, for the opportunity to speak and for the members of the committee. My name is Dr. Desiree Dawson. I'm speaking on behalf of the Nebraska Association for Behavior Analysis, or NEABA's Public Policy Committee. I want to thank Senator Hardin for initiating--

FREDRICKSON: Can you spell your name? I'm sorry to--

DESIREE DAWSON: Yes.

FREDRICKSON: Spell your name, please.

DESIREE DAWSON: De-s-i-r-e-e D-a-w-s-o-n.

FREDRICKSON: Thank you.

DESIREE DAWSON: I want to first thank Senator Hardin for initiating these conversations around ABA. We agree that appropriate regulation is important. However, we don't believe that LB911 is the appropriate avenue to address these concerns. I was directly involved in the drafting of Nebraska's current practice act for behavior analysts. That process included consultation with national organizations such as our Certification Board, the professional organization, the Council for Autism Service Providers, and others to ensure that consumer protection was worded appropriately in that initial draft. I would like to say that NEABA, nor any of the other organizations mentioned, were consulted on the content of this bill. As written, NEABA's Public Policy Committee opposes LB911 and urges the Legislature to maintain alignment with exist-- the existing practice act. This bill would significantly limit access to ABA services, especially in rural Nebraska. Section 2 requires a physical presence in the state, which directly conflicts with the Nebraska Telehealth Act. A growing body of peer-reviewed research shows that ethically-delivered telehealth ABA services can be just as effective as in-person for a subset of the population that receives services. To limit this would be denying services to people who otherwise would not have access. Section 3 introduces unclear and conflicting supervision requirements. It misrepresents the BACB standards and it codifies supervision ratios into statute, which freezes practice in time and prevents evidence-- evidence-based care from evolving with the science. Section 6 would require the department to conduct extensive clinical reviews, increasing the state's cost. And if this is not something that is currently happening, the state organization is happy to provide a medical necessity review and work with the MCOs on how to determine appropriate medical necessity. And while we support this legislation for the childcare service distinction, we believe that there are alternatives that can be explored, such as facility licensure. Overall, this bill attempts to amend the Behavior Analysis Practice Act and it undermines the efforts that NEABA, CASP, APBA, and the BACB, and others who worked on the current practice act that was worded and designed for consumer protection. Thank you for your time, and I'm happy to answer any questions.

FREDRICKSON: Thank you for your testimony. Are there any questions from the committee? I have one. Do you have any data or awareness on what percentage of ABA services are provided via telehealth in Nebraska.

DESIREE DAWSON: I don't have that off the top of my head. I believe CASP has been looking into that. What makes that difficult is that providers located within a 50-mile radius of the border, through Medicaid, are considered in-state providers, so that is really tough, with Omaha and Council Bluffs being right there, to determine what's happening across state borders. Additionally, a child out in western Nebraska might receive services supervised by a BCBA in Denver, who is actually closer in location to them than somebody in Omaha.

FREDRICKSON: Got it. Got it. Thank you. Senator Meyer.

G. MEYER: Thank you, Vice Chair. Is there anything salvageable in this bill, in your opinion?

DESIREE DAWSON: I do think that there's some wording with the childcare that does need to be addressed. Just right now, the way the statute is worded, ABA facilities, there is some confusion on whether or not there needs to be childcare also in place for a, a, a medical necessity service that's being provided. In my opinion, no. But NEA BA did have a bill drafted to introduce, but that was before the introduction of LB911, so we do have wording and verbiage that we would love to consult with, to salvage that piece of this bill.

G. MEYER: So there would be an opportunity with an amendment to improve this bill. That would be something you--

DESIREE DAWSON: For the childcare piece, yes. I believe.

G. MEYER: OK. Thank you.

FREDRICKSON: Senator Quick.

QUICK: Thank you, Vice Chairman. So like with the telehealth side, is there, like, studies that show like a certain level or on the spectrum, that telehealth is actually successful or-- versus, you know, where they need one-on-one care?

DESIREE DAWSON: Yes. That is a great question. That research is currently rolling out. It really took off during COVID. Because when that-- when the pandemic hit, most in-person services stopped. And the

only way that they could be-- continue to receive services was through a technician going to the client and the supervisor remote supervising in. So with that massive change, there was a lot more research that has been done with this. I know off the top of my head that there is telehealth research training caregivers to do specific assessments with the kid, and the BCBA is guiding the parent on how to do that. There are several skills-based protocols that parents and technicians have been trained to implement through high-quality supervision that are effective. I don't have information about the profile child that best benefits from those services, though.

QUICK: OK. Then just one other question. I know-- and you kind of touch on a little bit, but-- so if DHHS is going to review these and then decide, you know, whether to provide services, not provide service, how is that going to affect the care?

DESIREE DAWSON: I do think-- I, I also do take issue with the blanket prescriptions of 30 to 40 hours a week. There-- not every child needs that level of, of care, but there are children who do. And I worry that the limitations posed in this bill would impact those more profoundly impacted by autism the most. What NEABA would love to help with is creating a medical necessity rubric or guide to provide the MCOs and educate on what to look for in those treatment plans to determine what is medically necessary for that child, or are they being prescribed too many hours, based on the skill sets being determined in their assessments.

QUICK: Thank you.

FREDRICKSON: Other questions from the committee? Seeing none, thank you for being here.

DESIREE DAWSON: Thank you.

FREDRICKSON: Next opponent to LB911. Welcome.

ANDREW PRINE: Chairperson, members of the Legislature, thank you for giving me the opportunity to speak here. I'm Dr. Andrew Prine. That's A-n-d-r-e-w P-r-i-n-e. I'm a licensed behavior analyst practicing in Nebraska. I'm here representing Powerback Pediatrics. I'm a lifelong Nebraskan. I got all my degrees through Nebraska University, and I provide medically necessary and appropriate services to children and families across the state, including through telehealth when it's clinically appropriate. My agency provides services to children in

rural Nebraska, including, to name a few, Wood River, Dodge, Grand Island, Fairbury, Kearney, Hastings, Utica, Harvard, Ravenna, in addition to Omaha and Lincoln. I appreciate the intent behind LB911, particularly its focus on oversight, quality, appropriate utilization of services, and, and I share the same goals. I, I strive to ensure the best possible quality of care for our Nebraska families. However, I'm here to express opposition to LB911 as it's currently written. First, I'd like to express some curr-- concern that LB911 creates regulatory conflict and duplication. DHHS already holds the authority to investigate complaints, review practices, enforce medical necessity through util-- and utilization management, and assigning that overlapping investigatory and disciplinary authority to the Advisory Board of Behavior Analysts could introduce confusion, and weakens the clarity of that regulatory framework. I'm also concerned about the bill's supervision and telehealth provisions, especially. Nebraska already has clinically-grounded telehealth policies in place through DHHS that require justification, safeguards, ethical compliance, and access to in-person care when clinically indicated. So LB911 replaces that, you know, flexible, evidence-based approach with these rigid thresholds that are not tied to individual clinical needs or outcomes. So to illustrate this impact, one of my own current clients lives over 2 hours from my current-- where I live, right? Telehealth-supported supervision has allowed that child to receive medically necessary care under my supervision that would not be available locally to her. Under LB911 as written, that model would likely become nonviable, not because of clinical concerns, but because of statutory limits, and I would no longer be able to provide services to that client and oversee that learner's progress. So in summary, LB911 attempts to address real concerns, but in doing so, risks restricting access to care and creating regulatory conflict. So I respectfully urge the Legislature to pause, substantially revise or withdraw this bill, and engage the stakeholders to develop a more workable approach. Thank you.

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

QUICK: Yeah. Thank you, Vice Chair. So for services like out in-- or-- Grand-- I'm from Grand Island, so Grand Island, Wood River, in that area, you don't have a facility out there-- I'm-- I believe, or do you--

ANDREW PRINE: No. We provide in-home care.

QUICK: In-home care.

ANDREW PRINE: Yes.

QUICK: So you send someone out from either Lincoln or Omaha?

ANDREW PRINE: Well, our current RBTs that serve those areas live in those areas. So the RBT has to be in-person. I provide oversight to the case via telehealth, and occasional in-person, when I can make it out there.

QUICK: OK. And so, do you have a wait list, then, for-- or-- because, you know, for me-- you know, I've been talking with one certain facility. And I know they had a-- and they're not able to take on the Medicaid patients anymore. And they had an actual facility, where kids could come in to their, to their facility. But I wasn't aware of any others-- you know, providers in the area, so. And maybe there are and I just-- I'm not aware of them, but.

ANDREW PRINE: They're limited.

QUICK: Yeah.

ANDREW PRINE: Yeah.

QUICK: Yeah. So-- and, and I know one of the places that I, I was talking to someone with, they had a waitlist--

ANDREW PRINE: Yeah.

QUICK: --for-- because they could only take on a certain number of, of, of children.

ANDREW PRINE: Yeah. Our bottleneck is always with the RBTs, because we do hire RBTs to be in-person, providing those direct-care services on that, on that daily basis. So in that, in that regard, we don't have a waitlist. We can offer, you know, remote parent trainings or-- and, and consultation services right away to our kids, once their treatment plan is approved by Medicaid.

QUICK: OK. And, and, you know, I've talked about this before, when my son was an RBT in Omaha, but he went directly into the school and worked with a child right in the school system. And I'm guessing that doesn't really happen out in rural Nebraska, that they're able to go right into a school.

ANDREW PRINE: Not as much, no. The schools aren't as welcoming, all these, like, outside providers. So sometimes, it's building that relationship, and sometimes, they just receive guidance from their administration not to allow outside providers in.

QUICK: So what do you see happening with a child-- I'm sorry for all the questions-- but, but a child who is receiving services and now they become school-aged. Do the parents, you know-- I suppose, depending on where they're at on their-- what they're-- where they're at personally, can they go into the school system? How does that work?

ANDREW PRINE: That's going to be such a case-by-case basis kind of issue. You know, some kids might, might benefit from some school-based services if they can be provided. Sometimes, you know, they're able to develop the appropriate schools in that early intervention phase of their life that they can generalize and, and be successful in those least-restrictive environments, but that's not always the case. Some, some children require years and years of, of ABA therapy, like intensive one-to-one therapy, in order to be successful. So it's really difficult to, to generalize an outcome based on anything like that.

QUICK: All right. Thank you.

FREDRICKSON: Thank you, Senator Quick. Senator Riepe.

RIEPE: Thank you, Chairman. And thank you for being here. I guess my first question out of the shoot is, what is your doctorate in?

ANDREW PRINE: Education.

RIEPE: Education. OK. And that came from what school?

ANDREW PRINE: UNO.

RIEPE: UNO? OK. OK, so do you have a clinical background at all?

ANDREW PRINE: I have a clinical background in school psychology and behavior analysis.

RIEPE: OK. I was in pediatric administration for 15 yea-- I've never heard of your organization. But then, I was in Omaha.

ANDREW PRINE: We're, we're small potatoes.

RIEPE: Pardon?

ANDREW PRINE: We're small potatoes.

RIEPE: OK.

ANDREW PRINE: We're relatively new. We've been in Nebraska for about 2 years.

RIEPE: What does a licensed behavioral analyst do?

ANDREW PRINE: So a behavior analyst--

RIEPE: Or are you in management?

ANDREW PRINE: I'm, I'm in both. I, I, I am a clinical director, so I oversee all of our BCBA team in a consultative role and a supervisory capacity, but I also carry a small caseload. So I'm, I'm involved in the direct care of, of some of our clients.

RIEPE: My other question would be, is do you contract with the state or, or do you strictly take care of state patients, or do you take care of private patients, as well?

ANDREW PRINE: We have some private insurances that we--

RIEPE: OK. And so, are you a freestanding, for-profit?

ANDREW PRINE: Yeah.

RIEPE: OK, so you report to your board, do you? Or where-- you, you don't have a board?

ANDREW PRINE: Yeah. We have a leadership team that oversees all of our analytics.

RIEPE: OK. How many-- just to educate me, how many employees-- how many do you have in Powerback Pediatrics?

ANDREW PRINE: Nationwide, or just in Nebraska?

RIEPE: No. It, it is a national company?

ANDREW PRINE: Mm-hmm. Yeah, we're national.

RIEPE: Where are you based out of?

ANDREW PRINE: So our leadership team in ABA is based out of Michigan. We're part of a larger health organization that also provides OT, PT, and speech services, and they're based out of New York.

RIEPE: OK. I'm trying to figure out a little bit how outside org-- organization-- we have so many in-- in-state ones. I'm just figuring out how do you fit into the whole equation in, in terms of-- for lack of a better term-- in terms of competing to be a provider in some of these-- but how long have you been here?

ANDREW PRINE: I've lived in Omaha my entire life.

RIEPE: How long has the company been here?

ANDREW PRINE: About 2 or 3 years. I can't remember the exact--

RIEPE: About 2 or 3?

ANDREW PRINE: Yeah. I can't remember the exact date we started services in Nebraska, but.

RIEPE: OK. That's all I have for right now, Chairman. I may want to come back. Thank you.

FREDRICKSON: All right. Thank you, Senator Riepe. Other questions from the committee? I have one. You, you had mentioned that there-- you do utilize some telehealth. I know that's been a question that's come up a few times, and it's obviously relevant in the proposed legislation. So when you provide telehealth-- so I want to make sure I understood this correctly. You said that there's, there's an RBT that's in-person with the patient.

ANDREW PRINE: Yes.

FREDRICKSON: So the telehealth is from a supervi-- supervisory perspective.

ANDREW PRINE: Supervisory, yeah.

FREDRICKSON: So the patient's not receiving ABA via telehealth?

ANDREW PRINE: No. They're receiving in-person ABA through the RBT. I'm overseeing the case, so I provide protocol modification and direction to the RBT via telehealth.

FREDRICKSON: Understood. Is ABA itself ever provided strictly via telehealth?

ANDREW PRINE: Can you say that again?

FREDRICKSON: Is ABA itself ever provided via telehealth or is it just the supervision part?

ANDREW PRINE: I don't know of very many cases where, like, the direct care, the one-to-one care is provided via telehealth, but I, I don't want to speak that broadly.

FREDRICKSON: OK, so--

ANDREW PRINE: Typically, in my experience, it's, it's the supervision that is typically provided via telehealth. The BCBA role, the master's level clinician utilizes the telehealth.

FREDRICKSON: Then there's an RBT-- in-person clinician.

ANDREW PRINE: And the RBT is a-- they just have to have a, a, a high school diploma and a training.

FREDRICKSON: Got it. OK. Thank you. Other questions? Seeing none, thank you for being here.

ANDREW PRINE: Thank you.

FREDRICKSON: Next opponent for LB911. Welcome.

SHELBY WAGNER: Thank you.

FREDRICKSON: Go ahead.

SHELBY WAGNER: Good afternoon. My name is Shelby Wagner, S-h-e-l-b-y W-a-g-n-e-r. I've been a practicing board-certified behavior analyst in Nebraska for the last 7 years. While I appreciate the Legislature's intent to ensure quality, oversight, and protection for individuals receiving behavior analytic services, I'm here today in opposition to LB911 as currently written, due to significant concerns about both the process by which it was developed and the practical impact it will have on children and families across our state. First, I'm concerned that the relevant stakeholders were not meaningfully consulted in creation of this bill. Professional organizations such as NEABA, the BACB, the national body responsible for credentialing and ethical

standards in our field, were not involved. These organizations represent the very professionals who will be regulated under this bill and have extensive expertise in supervision, service delivery, and consumer protection. Without their input, the bill risks being misaligned with established professional standards and creating unintended consequences. Second, LB911 imposes rigid in-person supervision and physical presence requirements, including mandatory in-person observations per client each month. While oversight is essential, these requirements fail to account for Nebraska's geographic realities and workforce shortages. For many providers, particularly those serving high-need or rural families, these mandates will reduce capacity and delay services without clear evidence that they improve clinical outcomes. Third, the bill places significant restrictions on remote supervision. Even though remote supervision is supported by national standards when used appropriately and ethically, removing this flexibility will increase costs, limit provider participation, and ultimately reduce access to care for families who already face long waitlists. Finally, I want to share a brief example from my own practice related to the childcare regulation provisions of this bill. I oversee 2 clinics in Omaha that provide medically necessary behavior analytic therapy to children. These services are prescribed, individualized, and delivered under clinical supervision. They are not custodial care. Families do not enroll their children with us for childcare. They seek treatment. Under LB911, clinics like mine could be required to meet childcare licensing standards that were not designed for therapeutic settings. This creates confusion and additional administrative burden, and in some cases could force clinics to reduce services or close-- not because care is unsafe, but because the regulation does not fit the service being provided. Disruptions may lead to concerns with consistency, continuity of treatment for these children that already have a small, time-constrained window of therapeutic effect-- effectiveness. In closing, while I support thoughtful evidence-based regulation that promotes high-quality care, this bill in its current form will reduce access to medically necessary treatment for Nebraska's children and was developed without adequate input from the professionals it seeks to regulate and stakeholders it affects. For these reasons, I respectfully ask this committee to advance a no vote on LB911, and to engage with NEABA, the BACB, and practicing behavior analysts in the state to develop legislation that truly protects families without restricting access to care. Thank you for your time. I can answer any questions.

FREDRICKSON: Thank you for your testimony. Questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. I'm trying to educate myself here a little bit. On our previous testifier, he stated that he was a licensed behavioral analyst, and you say in yours that you're a board certified. Tell me the difference.

SHELBY WAGNER: We're both. So the-- I think-- I don't speak for Andrew, but I think we're both both. So in order to be a licensed behavior analyst in the state of Nebraska, we do require our certification from the BACB. So the BACB is a national certifying board that we get our credential through, and then with that, we can also be licensed in the state of Nebraska.

RIEPE: So are you licensed in the state of Nebraska?

SHELBY WAGNER: I am.

RIEPE: You just didn't state it.

SHELBY WAGNER: I did not.

RIEPE: OK. OK. Thank you, Chairman.

FREDRICKSON: You're welcome. Senator Quick.

QUICK: Yeah. Thank you, Vice Chairman. So like, do you serve any areas of rural Nebraska, or just mainly Omaha?

SHELBY WAGNER: Right now, I am just in Omaha, but I have previously served clients in Columbus.

QUICK: OK. And then, I know-- so out in rural Nebraska, I've heard of the waitlists, and do you face any of that in, in Omaha, as well, like, only be able to serve a certain number of kids?

SHELBY WAGNER: We do. Both of my clinics currently have waitlists, again, due to some of that workforce shortages. And with that telehealth piece of things, BCBAs are able to see more clients because it kind of expands where we can see clients at.

QUICK: Do you-- how long would your waitlist be? Because I know the one I heard about, like in my area, would be up to 6 months.

SHELBY WAGNER: It could be. It kind of depends. Right now, similar to like what Andrew said, RBTs and BCBAs, there's a shortage, and so that is what is holding us back from being able to take on more kids right now.

QUICK: OK. And then, he did talk about the training. And I know my son went through training, too. But what is the required number-- I mean, is there a required number of hours, or is that set by, by you or by the state?

SHELBY WAGNER: For RBTs, or--

QUICK: Yeah.

SHELBY WAGNER: So RBTs are also given their credential through the BACB. That requires at least 40 hours of training for that certification.

QUICK: OK. All right. Thank you.

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

SHELBY WAGNER: Thank you.

FREDRICKSON: Next opponent to LB911. Welcome.

THEMIS GOMES: Hi. Thank you. Good afternoon. My name is Themis Gomes, T-h-e-m-i-s G-o-m-e-s, and I am the chief executive officer of Behaven Kids. We are a Nebraska-based provider of applied behavioral analysis, ABA, and pediatric mental health services, as well. We serve children with autism and other developmental and behavioral needs, focused exclusively in Nebraska, and we've existed here for over 20 years. I appreciate the opportunity to testify regarding LB911 today. I want to begin by stating that providers like Behaven Kids support strong oversweat-- or oversight, quality standards, and child safety. Our organization is licensed as a childcare provider and the licensure has meaningfully supported our ability to deliver individualized high-quality care. It has strengthened safety standards, ratios, and environmental oversight while, while still allowing clinical teams the flexibility needed to meet each child's unique needs. Importantly, our model reflects true individualized care. The children we serve receive, on average, 18 to 22 hours of services per week, based on clinical need and not a one-size-fits-all or full-day program structure. Childcare licensing has allowed us to responsibly support these individualized schedules while maintaining safe-- safety and

compliance. This demonstrates how thoughtful regulation can work well when aligned with how services are actually delivered. However, as currently written, LB911 raises serious concerns about access to care, workforce sustainability, and continuity of services to families. First, access to care in Nebraska is already fragile. Families across the state, especially in rural communities, face long waitlists and limited provider availability. Policies that restrict how qualified clinicians deliver services, including limitations on telehealth or rigid structural requirements, risk further reducing access for children who already have few options. Telehealth has been a critical and clinically appropriate tool for parent guidance, clinical oversight, and continuity of care. Restricting its use does not inherently improve quality, but it does increase delays and disruptions. Second, LB911 adds regulatory burden during a period of significant system instability. Over the past year, providers have faced multiple regulatory changes alongside substantial Medicaid rate reductions, including cut-- cuts implemented approximately 6 months ago. Many organizations are still adjusting staffing models, wages, and service delivery, simply to maintain viability. Adding new requirements without clear coordination, alignment, or transition time creates operational risks, not just for providers, but for the children and families who depend on consistent services. Third, workforce impacts must be carefully considered. Nebraska already struggles to recruit and retain qualified clinicians. Increased compliance complexity without clear evidence of improved outcome risks accelerating burnout and discouraging providers from serving Medicaid populations or practicing in the state.

FREDRICKSON: And you're in the red, so if you can finish up your thoughts.

THEMIS GOMES: Yeah. Finally, families bear the real consequences of these decisions. For families that are navigating autism and complex behavioral needs, consistency matters. So we-- I hope that, you know, we can-- I, I respectfully urge the committee to pause, substantially revise, or reconsider LB911 as currently written. Providers and families were not meaningfully consulted in its drafting, and the bill would benefit greatly from collaboration with those delivering and receiving care across Nebraska. We're eager to engage in that dialogue and help shape policy that protects children without sacrificing access, individualized care, or system stability. Thank you for your time.

FREDRICKSON: All right. Thank you. Any questions in the committee? Senator Riepe.

RIEPE: Thank you, Chairman. You spent quite a bit of time talking about your professional organization and the ethics and qualities of it. In the last year, 2024, how many disciplinary actions did you have to take against members, and what's the total count of your members?

THEMIS GOMES: Members, as in the children that we serve?

RIEPE: Your organization you were talking about. Is that an organization or not an organization?

THEMIS GOMES: Behaven, Behaven Kids is a behavioral and mental health provider, so we provide ADA services.

RIEPE: Within that provider group. How many people are in it?

THEMIS GOMES: We have 100 employees.

RIEPE: How many were disciplined in last-- one year-- last year?

THEMIS GOMES: Discipline for what, specifically?

RIEPE: Well, you know, for bad practices. I mean, it's pretty common that-- why would you, why would you discipline someone if it wasn't for failed performance? That's what I'm looking for. I'm not looking for their personality. I'm looking for if they failed to perform.

THEMIS GOMES: If the clinicians failed to perform?

RIEPE: Did you-- nevermind. Did-- thank you, Chairman.

FREDRICKSON: Thank you, Senator Riepe. Any other questions from the committee? Seeing none, thank you for being here.

SHELBY WAGNER: Thank you.

FREDRICKSON: Next opponent. Welcome.

CARLEY STARLING: Thank you. Chairman Hardin and members of the Health and Human Services Committee, my name is Dr. Carley Starling, C-a-r-l-e-y S-t-a-r-l-i-n-g. I'm a licensed psychologist and small business owner in Hastings. I work with complex children and families since 2010. I am also a mother to a daughter with severe mental illness, and I care deeply about the children and families we serve

because I live the reality of what it means to fight for care, navigate systems, and hold hope while doing hard things. I wasn't going to do that. Today, I am here on behalf of Nebraska Association of Behavioral Health Organizations in strong opposition to LB911. I want to acknowledge the admirable intent of this bill: better oversight and stronger safeguards. I share that goal. But the reality is that LB911's supervision and childcare provisions will reduce access to medically necessary ABA and constrict ABA further across Nebraska, especially in rural communities. To understand what's at stake, let me tell you about Buddy. Sorry. They may be in the room. Buddy is a non-- was nonspeaking when he started with us. He had aggressive and unsafe behaviors and could not tolerate basic medical exams. When he began having seizures, his neurologist believed that an EEG would require sedation. Through ABA, our team built trust, reduced fear, and taught Buddy the skills to tolerate the 3-day procedure safely. Buddy completed that 3-day EEG without sedation. That is what ABA can do when it is accessible and properly supervised. Let's talk numbers. OK. First, supervision. LB911 assumes that supervision workforce-- it assumes that Nebraska has a workforce that isn't there. According to the Behavior Analyst Certification Board, there are 375 BCBAs living in Nebraska. DHHS reports 339 of those are concentrated in the Omaha and Lincoln metro areas. That leaves 36, 36 BCBAs for the remaining 80 counties, and that's before you subtract those working in schools, hospitals, academia, or administrative roles. And families are feeling this right now. When I checked the Medicaid provider directory this week and again this morning, only one ABA clinic west of Lincoln was listed as in-network with 2 of the 3 MCO plans, and the third plan listed none. Here's the practical reality. Nebraska Medicaid requires a supervising clinician to be involved for at least 10% of a child's ABA hours, and they should. At 15 hours a week, that's 1.5 hours of BCBA supervision per child per week. A BCBA with 25 supervision hours weekly can supervise about 16 or 17 kids.

FREDRICKSON: And you're in the red, so I'm gonna ask you to wrap up.

CARLEY STARLING: Across the 80 counties outside of Omaha and Lincoln, even under generous assumptions, that capacity is for about 600 children in the entire greater Nebraska. Affect-- and with Nebraska-- or with autism affecting about 1 in 31 children, Nebraska has roughly 15,600 children with autism.

FREDRICKSON: So thank you, and I saw you passed out your written testimony--

CARLEY STARLING: Yes.

FREDRICKSON: --which we can certainly review, and I'll see if there's any questions from the committee. Are there questions from the committee? Senator Quick.

QUICK: And I've come to visit your facility and I've seen the good work that you do, and we've had some conversations. You know, and you've already kind of alluded to how this is going to affect specific-- specifically, rural Nebraska.

CARLEY STARLING: Yes.

QUICK: So can you go into a little more detail about what's happening in rural Nebraska, to be able to provide these services?

CARLEY STARLING: We don't have all the services that we-- or we don't have all of the providers that we need in rural Nebraska. We already know that. We do everything we can to try to bring providers in. We've been trying to hire a full-time, on-site BCBA now, for 2 years, 2 full years. And I pay above-average salaries, I provide full-time benefits-- or full benefits, above and beyond what we have to. I provide paying for licensure, supervision, we are a clinic of a team, and we try-- do everything we can to bring more providers in so that more kids can be seen. Unfortunately, with the rate cuts that we took in the last 6 months, we can no longer see Medicaid kids because I can't pay providers enough to keep them. And in rural Nebraska, that's, that's our reality.

QUICK: Do you, do you provide any type of telehealth for children, maybe, who live further away that maybe aren't higher needs?

CARLEY STARLING: So we're a multidisciplinary clinic, and so we provide telehealth services for psychotherapy. We also provide telehealth doing parent training, parent coaching on the ABA side. We do parent training. We have done some supervision remotely, yes, yes. And we had a provider that was with us about 50% of the time, and we couldn't get her to move to Nebraska. And so, she just recently resigned because it was too much coming in and out of Nebraska, because my requirement-- not the state's requirement-- my requirement was that they needed to be on the ground more, and they chose to leave instead of staying full-time.

QUICK: OK. And I do know you talked about the wages, too. So I mean, just to pay a competitive wage, I mean to keep someone there, because

it takes special people to actually work with, with kids with autism. And so, you know, I know there are some people that would probably-- maybe would try to work for less, but I mean, you still have to provide for your family. So I mean, I know you're competing with maybe people who would be a CN-- CNA, maybe, or going to some, to some other medical field.

CARLEY STARLING: Right.

QUICK: So I don't know if you want to talk about--

CARLEY STARLING: We provide, we provide 40 hours of our own training on top of the 40 hours that is required by the BACB. And so, we provide extensive training. We also provide 22 hours of training on de-escalation, physical management, and that kind of thing for our staff, because we see clients who have pretty severe, intensive behavior. So they're, they're also given that on top of their, their other salaries. And so, our intent is to grow our RBTs, our techs, and, and help support them, so that they can be senior-level techs. We have some. We're very proud that I had one of my techs that's been working with me for 3 years, she just graduated with her bachelor's degree last week. She wants to get her certification as a BCBA or as a BCABA, an assistant, and we support that, and we're trying to grow that, but we can't do that with bills like this. And we can't do that when we continue to get our rates cut.

QUICK: Thank you.

FREDRICKSON: Other questions? Senator Meyer.

G. MEYER: Thank you, Vice Chair. Thank you for coming in today. With the rate cuts approximately 6 months ago, what was the attrition did you see in out-state Nebraska, with regard to providers?

CARLEY STARLING: What I have seen is that, that the providers that were out there, some of them were not in-network with all the MCOs already. And now, there are fewer in-network than what they were before. Now, I can tell you that when I looked this week at the website, it still shows RBCBA as in-network . And we have not-- we are not taking Medicaid clients anymore, because of the rate cuts.

G. MEYER: What do we need to do to increase providers in out-state Nebraska, which includes everything outside of the, the city limits of Omaha and Lincoln?

CARLEY STARLING: Yes.

G. MEYER: What would you, what would you suggest? Because that's something this committee and certainly this, this body struggles with daily, is how do we provide-- increase our medical delivery providers in our rural communities.

CARLEY STARLING: I would love to come and have that conversation. Senator Fredrickson cut me off at my three minutes, is that what it was, right? As he, as he should, right, and that conversation, sir, is gonna take a whole lot longer than three minutes. I think it has to start with being able to pay a fair wage to, to my staff. Right. We're not here to make a bunch of money, we're here to serve kids. We're here to take care of kids. I'm not from Nebraska, but I came here 8 years ago, to serve kids. And I could have left. If I would have left, my kids wouldn't have had services that are, that are in my building right now. There are no other providers to hand them off to. And so, that's a conversation about rates, it's a conversion about how we treat our families, how we treat our kids, and how we prioritize this in our state.

G. MEYER: Thank you.

CARLEY STARLING: You're welcome.

FREDRICKSON: Other questions in the committee? I had one that--

CARLEY STARLING: Yes, sir.

FREDRICKSON: So in your testimony, you said something that kind of struck me. So one of the requirements we have is for MCOs to have a specific amount of network adequacy for their services. Did I hear you correctly that west of Lincoln, there's only one clinic in the whole state that accepts MCO for ABA?

SHELBY WAGNER: Right now-- so let me clarify my data, so I give you accurate information. I went to the website, the DHHS website, and looked at licensed providers, OK, so licensed behavior analysts and licensed behavior assistant analysts.

FREDRICKSON: OK.

CARLEY STARLING: Sorry, I, I flipped a, an A in there. I can give that to you later, if you want. And the only ones that were listed besides the one that was in my clinic, is in Grand Island. When I spoke with

one of the others, clinics, on-the-ground clinics that is in central Nebraska, they are no longer in-network. And that was at the-- that was not their choice. I will say it that way.

FREDRICKSON: Understood. And prior to the rate cuts that went to effect about 6 months ago, were there higher numbers?

CARLEY STARLING: We were in-network and the other group was also in-network.

FREDRICKSON: OK.

CARLEY STARLING: So two of us, but that's it. That's all that's out there. There are no other clinics.

FREDRICKSON: So would it be safe to say that, in particularly in the rural parts of the state, network adequacy is not there for ABA?

CARLEY STARLING: Absolutely, that would be my assumption.

FREDRICKSON: OK. Thank you. Other questions? Seeing none, thank you. Next opponent to LB911. Welcome.

RYAN JONES: Thank you, committee members, for allowing me the opportunity to speak today. My name is Ryan Jones, R-y-a-n J-o-n-e-s, and I'm the sitting president of the Nebraska Association for Behavior Analysis-- for Applied Behavior Analysis-- excuse me-- NEABA. Despite NEABA having the common goal of creating systems to make sure quality ABA is available at the appropriate dosages as deemed medically necessary, NEABA was not consulted about the contents of LB911. We strongly encourage the committee to oppose LB911 and promote the practice of ABA to remain aligned with the current practice act. This bill attempts to address 3 regulatory jobs at once. First, professional licensure standards. NEABA was the entity that led legislation to require licensing behavior analysts in Nebraska, and we were not consulted on the contents of this bill. Had we been, we could have educated the individuals involved about commonplace errors, such as citing the BACB, a private nongovernmental entity as the standard for oversight. Should the BACB ever change their oversight recommendations, the statute would be outdated. The Legislature cannot control future changes, which we did experience during COVID, when remote supervision was the only way that in-person services could be provided for many families. Second, this bill attempts to address Medicaid utilization control. However, banning remote supervision likely conflicts with federal policy. Medicaid programs explicitly

allow telehealth to provide access for those living in rural areas that otherwise would not receive services. This may also create conflicts with private insurance parity laws, because this bill would apply to all insurance companies in Nebraska, not just Medicaid. On the other hand, enforcing this across all insurance types could be viewed as anti-access and inconsistent with federal healthcare access. The bill also introduces vague clinical review protocols without clear benchmarks, appeal processes, or reference to evidence-based standards. This creates a risk of arbitrary denials of medically necessary services. ABA service needs vary widely based on clinical presentation, and caps set at arbitrary levels restrict care for those most impacted. NEABA has clinical expertise and current research access to help guide medically sound decision-making, and is willing to serve in that role. Third, this bill attempts to address childcare licensing boundaries, which NEABA fully supports and had already drafted a bill to address this prior to the introduction of LB911. NEABA is fully ready and supportive to work with legislators to address the discrepancy in the statute. Attempting to address licensing standards, Medicaid utilization control, and childcare in one bill introduces conflicting information with current statutes, legal vulnerability, and administrative confusion that could cost the state more dollars than it would save. Thank you for your time, and I hope to answer any questions that you may have.

FREDRICKSON: Thank you for your testimony. Any questions from the committee? Seeing none, thank you for being here.

RYAN JONES: Thank you.

FREDRICKSON: Next opponent to LB911. Welcome.

KYLE DAWSON: Thank you. And good afternoon, Mr. Chairman and members of the committee. For the record, my name is Kyle Dawson, K-y-l-e D-a-w-s-o-n, and I am providing testimony today on behalf of the Behavior Analysis-- or Behavior Analysts Licensure Board. So the board appreciates the Legislature's interest in ensuring high-quality services and appropriate oversight of applied behavior analysis. My comments today are limited to two areas that fall within the board's expertise: remote supervision and the potential impact on access to care. First, with respect to remote supervision, the board is concerned that restrictions proposed by LB911 would not improve quality of services and would greatly re-- would likely reduce access to care, particularly in rural areas of Nebraska. There is a substantial body of behavior analytic research demonstrating that

remote supervision and telehealth supported service delivery can be effective when implemented appropriately. These models are widely used across healthcare disciplines and are often essential where in-person supervision is limited by geography or by workplace availability. When the board developed its rules and regulations, concerns related to out-of-state and remote supervision were carefully considered. The resulting regulations require appropriate licensure, accountability, and supervision standards while allowing flexibility for telehealth when clinically appropriate. This balance was intentional and designed to protect consumers while preserving access. The board is concerned that the bill's proposed restrictions would override this framework and create barriers to care without a clear benefit to service delivery. In closing... The board shares the goal of protecting consumers and supporting high-quality care. We respectfully encourage the committee to consider whether the provisions in LB911 related to remote supervision and childcare licensing would meaningfully improve services or whether they would risk limiting access, particularly in rural communities, without achieving the intended outcomes. Thank you for the opportunity to provide this testimony, and I'm happy to answer any questions.

FREDRICKSON: Thank you for your testimony. Any questions from the committee? Seeing none, thank you for being here. Next opponent to LB911. Welcome.

KRISTIN PURINGTON: Thank you. Chair Hardin, members of the committee, I want to thank you very much for your time and allowing me to be here today. My name is Kristin Purington. That's K-r-i-s-t-i-n P-u-r-i-n-g-t-o-n, and I'm a Nebraska property owner and business owner, a board certified behavior analyst, as well as a license-- Nebraska-licensed behavior analyst. I am here today to support careful, evidence-informed regulatory design within applied behavior analysis. I have 22 years of experience in the field. I do provide telehealth as well, and I do provide services to rural communities within that capacity. I want to begin by stating very clearly that I fully support the Legislature's commitment to responsible oversight. Effective regulation protects children, it strengthens public trust, and ensures appropriate stewardship of public resources. Oversight truly is not the concern. Precision is. Nebraska has recently enacted significant reimbursement practice changes within ABA. The full effects on access, workforce stability, provider participation, and network adequacy are not yet measurable. Policymakers benefit most when major system changes are evaluated before additional statutory requirements are introduced. When policy changes outpace the data that

is needed to evaluate them, the risks shift from the system we are trying to improve to the children we are trying to protect. From a governance perspective, layering structural regulation onto an unevaluated system, change increases the likelihood of unintentional disruption, particularly in rural areas where service capacity is already sensitive to workforce supply. The recent audit appropriately highlighted areas requiring attention and where authority already exists within DHHS to investigate, audit, and enforce standards. Statutory duplication may introduce regulatory complexity without strengthening oversight. When operational requirements can be addressed through rulemaking, it preserves, preserves legislative flexibility while allowing subject-matter experts to calibrate that implementation. In complex healthcare systems, regulatory design functions best when it is both transparent and broadly informed, ensuring that policy is guided by comprehensive stakeholder input and grounded outcome data helps to prevent unintended market distortion and protects long-term service stability. ABA, when delivered with fidelity, meaningfully alters developmental trajectories and reduces long-term system costs. Policies that inadvertently compress provider capacity, shift-- risk shifting expenses into more intensive levels of care over time.

FREDRICKSON: And I've got you in the red. So if you can just wrap up your final thoughts.

KRISTIN PURINGTON: Yep, Nebraska has an opportunity to demonstrate what thoughtful government looks like. Not simply responding to concern, but calibrating policy in a way that protects children and preserves access and ensures responsible stewardship of public resources. Careful sequencing is not hesitation. It is how durable systems are built. My goal is not to slow progress but to support regulatory design that Nebraska can stand behind with confidence. Thank you for your time and your commitment to careful policy making.

FREDRICKSON: Thank you for your testimony. Questions from the committee? Seeing none, thank you for being here.

KRISTIN PURINGTON: Thank you.

FREDRICKSON: Next opponent for LB911. Last call for opponents. All right. We'll move on to neutral testimony for LB911. Welcome.

COREY COHRS: Thank you. My, my name is Dr. Corey Cohrs. I was, I was-- C-o-r-e-y, Cohrs, C-o-h-r-s. I wasn't initially planning on testifying

today, which is why I'm choosing to keep my testimony neutral. However, I wanted to clar-- clarify a few things that have been the focus of today's discussion, and also make myself available for questions, given that I was here for the September 5th interim hearing on the sustainability of ABA. What I wanted to draw attention to was simply that there's been a lot of focus on access to care in rural areas and the use of telehealth to provide that. I think one of the things that's worth noting is that although there may be rising empirical evidence to support the use of telehealth effectively, I think that there-- it would be naive to believe that the, the use of telehealth in a university setting that is published is equal to that, especially universally, of that in an applied setting. We all want our kids to have the same access to the same quality of care, but we don't necessarily want them to have access to lower or lesser qualities of care. It-- I-- furthermore, this bill doesn't necessarily ban telehealth for supervision. It simply accepts that if your child is receiving more than 15 hours a week of direct care that you must make in-person visits. I think we could all agree that if a child is receiving 15-- or more than 15 hours a week of direct care, this represents a more complex case, which, in most cases, would warrant-- [INAUDIBLE] on the ground. I think it would be idealistic to take somebody and put them through the 40-hour training, especially if it's done virtually, and then a competency assessment is conducted via telehealth, then expect them to proficiently run a program without having been seen in person. There's a lot of variables that go on, especially in the home or school environment, that do require being in person to be able to model to the RBT how to implement, or how to assess the environment to provide effective care. So those are the-- I think the last point that I'll make, since I'm still in the green, is that I think the Medicaid population and pediatric Medicaid population, when you take the autism diagnosis rate and apply it to that population in rural areas, represents approximately one-third of the potential kids in this state that could be diagnosed with autism and on Medicaid. That means that leaves us with two-thirds of the children in the state that could-- for which telehealth could be used, in many cases, unnecessarily, simply to build oversized caseloads and to supplement that supervision with out-of-state or remote, remote supervision.

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

QUICK: Just have one, and maybe I should ask some of the other providers this, but. So what happens to the child who doesn't receive

any services? I mean, what, what is their-- what, what kind of outcome do they have, or what, what do they have-- what do their families have to look forward to?

COREY COHRS: I, I think that largely depends on the child. I think-- if you're speaking specifically to rural access, I would answer your question with a question, which is what happens-- what's the difference in the outcome between a child that receives 15 hours a week versus 30 hours a week? And I don't think that there is strong empirical evidence to support superior outcomes with 30 hours a week of entirely remote supervision versus 15 hours of entirely remote supervision.

QUICK: All right. All right. Thank you.

FREDRICKSON: Other questions from the committee? I have one, I guess, in, in regards to the telehealth. I appreciate you, you sharing that and I, I'm kind of interested to see as the research comes out, as well. My understanding, from some of the previous testifiers, is that a lot of the telehealth has-- there's an actual physical RBT with the patient themselves, but the telehealth might be sort of the supervision, or might be like family meetings, for example. Do you have any thoughts on that? I mean, it sounds like there's some intervention in-person with the RVT but-- yeah.

COREY COHRS: The RBT then, should always be present. I think that there's a big difference, and I'm going to use an example. There's a big difference between me supervising you remotely and you have a headset and I can instruct you on what to do and I am paying good diligent attention to what you're doing. And I'm simply having a camera on you and not necessarily paying attention and multitasking in the background. The implementation of telehealth can look very differently depending on providers and the motive behind it. So if the motive is to publish a study, I think it's very different than if the motive is simply to generate billable revenue.

FREDRICKSON: Got it. So the idea is, like, when appropriately applied, telehealth can--

COREY COHRS: When appropriately applied, telehealth can be effective. However, I would make the case that in an in-home setting, I think it is still important to have-- if a, if a child is receiving more than 15 hours a week, I think we can agree that that is a-- not a simple case, and it's one that warrants-- it warrants more atten-- it's a--

more complexity warrants more supervision. And I would make the case that being in-person is important, clinically speaking.

FREDRICKSON: All right. Thank you. Other questions? Seeing none. Thank you for being here. Other testifiers in the neutral capacity? Seeing none, we did have some online comments. While Senator Hardin comes up to close, LB911 had zero proponents, 28 opponents, and 3 in the neutral capacity. Chair Hardin.

HARDIN: Thank you. Well, I appreciate everyone coming out today. I think we need to take a look at a little bit of the history of what's gone on, not only this year related to ABA, but we need to take a look at the last few years related to ABA and what kind of brought us to where we are. In 2020, things got spicy in Nebraska. In a nutshell, we saw a more than 2,000% increase in one of the ABA categories. You know what? That wasn't their fault. They didn't make that happen. We did. And it took not just one branch of government, it took all 3 to make that 2,000% increase in 4 years take place. It took the executive branch, and that means the regulatory world not watching or waving red flags. It even took a Supreme Court case in Nebraska. I was part of it, as well. Because in 2023, I voted for a measure that said, hey, let's raise these rates 17% more than what they had been, and these rates in particular were those related to RBT, but also the BCBAs, some of whom are sitting here. They didn't make that happen. Like everyone else, no one from that world gets to come in here and demand to the state, we will be paid thusly. This was a decision made by the people who are supposed to have their hands on the wheel of the ship. So they didn't do anything that we didn't encourage and enable them to accomplish. What we saw with RBTs this summer, for some of you who weren't here, was that literally, over time, those RBT rates-- that's the registered behavioral therapists within autism-- and by the way, let me remind you, I get it. I raised a child on the spectrum. I get it. I understand the empty stare of somebody at the public school who goes, we don't know what to do. I understand what that's like. I understand getting up really early in the morning with a whiteboard and saying, what's the first thing that you do? I sit up. OK, let's write that down. Sit up in bed. What's the second thing you do-- and working out the executive function of functioning in life. And you know what? Over time, we were fortunate. The board got to change, the white board. I get it. Those rates were 2.6 times higher than the national average here in Nebraska. Call it Nebraska nice. I don't think it was nice as much as it was simply being irresponsible, and I participated in that irresponsibility, too. And you know what? Most of the opposition you heard here today-- most of it, not all of it-- most

of it was from the people whose pocket books were affected this year when August 1, those rates went down. And that happened within the regulatory framework. We didn't pass a bill, there was no special session, but we finally woke up and said, wait a minute. By the way, we really can't even take credit for waking up. Do you know why? Because for every $1 we put in from Nebraska, there's about $3.5 that comes in from the feds to take care of what we do in the health sector here, and it was the feds who said, fix these very out-of-scale rates, Nebraska. Do you understand the word clawback? Since we provide most of what you need, fix it. So we didn't even get there on our own and our good cognizance. It was out of fear of getting spanked that we finally stepped up and said, OK, let's do something about this. The BCBAs-- and again, these are people who are far more experienced than the RBTs. By the way, a lot of the RBTs in the state of Nebraska were actually-- those are the registered behavioral therapists. A lot of them were making less than $20 an hour. Not always, but about 40% of the time, that was billing out at $144.44 an hour. There were companies taking about $120 overrouted. And now you don't get to be senators, you're taxpayers. Taxpayers are paying for that, and that's what the feds looked at and said, fix it. And so we did. What it really caused us to do was to look at it and say, we, we have to wake up inside the Legislature, and inside the Department of Health and Human Services, the executive branch, and I would say even the judicial branch. We have to wake up and say, uh-oh, we don't want to be Minnesota. Minnesota nice has been a phrase that's been tossed around in the last few weeks in the news. It does take diligence. I don't want to see kids with autism suffer. This bill was dropped the 9th of January. HHS Office and I was not contacted by most of the group sitting here until 2 days ago. Monday afternoon, an email came in that said we don't like any of it. So it was a little late to do a lot of changes, but it was also not a new subject because we've seen most of these folks before. They were here this summer in an interim hearing. This is not a new subject. It's an ongoing one. And in fact, that's what LB911 is about, is we need to have a framework for beginning to do that. Now, to that end, now that their attention has been gathered and I've reminded you, I am all for saying, let's sit down and let's figure out how we can make some things work because we need them. If you've never had the opportunity to take your 8-year-old out in the snow and get them ready for school and they have their backpack on and they look like Kenny's from South Park, because they're all bundled up and they're standing in 8 inches of snow in their bare feet, you haven't lived in that world. Because that's what it can look like on a good day. We, Nebraska, we need to provide care

for people with autism, and we need to do it in a responsible way. We don't have the luxury of doing it the way we have done it in the past. It's both and. That's why they pay us the big bucks. It's both and. We have to watch and be good stewards and at the same time, we have to provide genuine care. That's what LB911 is a framework for accomplishing. Questions?

FREDRICKSON: Thank you, Chair Hardin. Questions from the committee? Seeing none, thank you. That will wrap our hearing for LB911.

HARDIN: LB724. Senator Quick, you are up. Let's wait for the shuffle to complete. I believe we're ready.

QUICK: All right. All right.

HARDIN: Take it away.

QUICK: Well, good afternoon, 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 LB724. I'm introducing LB724 because, to be honest, I'm, I'm frustrated with the, the loss of behavioral health services in my district, specifically ABA services for Medicaid families. We have no other providers for ABA services, and so the loss of these critical services is devastating to families in my district. The children this clinic served were diagnosed on autism-- on the autism spectrum as those in need of ABA services. I have talked with other clinics in my district, but they do not provide the type of service, and especially for children at, at younger ages. So I'm asking, where do these families go? Most don't have the means to travel to Lincoln or Omaha for these services. I want to make it clear that this clinic is staffed with counselors and techs from the area, and is owned by a husband and wife team with ties to Boys Town National Research Hospital in Omaha. They chose to live in rural Nebraska where they knew that there was a dramatic need for services. The reason that this clinic no longer takes families with-- in Medicaid is because of the 50% cut-- ABA rate cut implemented by DHHS this last fall. I know the cut was made because of a dramatic increase in cost, but I also know the providers were willing to negotiate the cost of their services. The providers were willing to work with DHHS to reduce the cost, because they recognized the great need for these services. What we are seeing as, as a result of these cuts are a reduction of the number of providers, especially in rural Nebraska, creating a lack of services for these children. I think that a rate study is in order to give us a better

understanding of the cost compared to the actual services provided. I introduced LB724 to initiate discussions on the right way to determine rates and Medicaid through a cost study which could be implemented directly by the department through a contract with a vendor. In simple terms, a cost study compares the actual cost of providing services with the current rates by service code. The last time the state of Nebraska conducted a cost study was in 2016, and that study was used to set rates in behavioral health systems. That cost study showed the rates did not come close to covering the cost, particularly in rural Nebraska. Behavioral health shortage areas exist, especially in rural Nebraska. And although Lincoln and Omaha have more providers, I believe they struggle to meet the need for, for services in that area. If we want to decrease suicide rates, increase access to behavioral health services for children and adults, we need to understand cost, and use that information to determine behavioral health provider rates. I do not think it is a good policy to slash rates only based on increased costs. Let's be thoughtful in the future as we set policy and rates for services that impact access to-- access to all forms of healthcare for families in Nebraska. There are testifiers behind me that have personal stories and experience of how the rate cuts impacted their lives. Thank you for your time and attention. I'll be happy to answer any questions that I can.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here, Senator Quick. Does the state provide current rate reviews? I remember some place in the back of my head, we-- every once in a while they do that.

QUICK: They might, but I don't know. I can find that out, but I don't know for a fact.

RIEPE: And, and following that was, if yes, did you run them specifically in behavioral health? And, you know, it's critically important, as we all know, to kind of know the population-based size of everything else and the integrity of the study or it's no good. OK. Thank you. Thank you, Chairman.

HARDIN: Other questions? Will you stick around?

QUICK: I will.

HARDIN: Great. Thank you. Proponents, LB724. Welcome.

ANNETTE DUBAS: Thank you. Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Annette Dubas, A-n-n-e-t-t-e D-u-b-a-s, and I am representing the Nebraska Association of Behavioral Health Organizations today in support of LB724, and we thank Senator Quick for introducing this bill that seeks to have a cost study implemented, related to behavioral health services. Historically, Medicaid provider rates were increased in the state budget based upon the negotiated increase for state employees, which was usually 2-3%, to take into the cost of living increases. The Appropriations Committee would then consider additional increases for various providers if requested, and could also decrease, depending on the state's financial status. Because behavioral health services rely heavily on public payers, such as Medicaid, the Division of Behavioral Health, and Probation under the Supreme Court for the bulk of services for Nebraskans, these rate increases were essential. Even though the rate increases were intended to reflect the cost of living, many times they simply were not keeping up with the cost of providing services, let alone building capacity to increase access. We needed to have something that would accurately reflect those costs, so we could present a request for rate increases that wasn't just grabbing a number with no substantiation. When I began my time as executive director with NABHO in 2014, we contracted with Seim Johnson to have a rate study done, which looked at inpatient and outpatient behavioral health rates, both for managed care and fee-for-service, as compared to inflation. And the chart-- the charts were handed out to you today. We used those start charts and worked extensively with the Appropriations Committee and Legislature to begin adjusting behavioral health rates to more accurately reflect the cost of providing care. In 2016, the Division of Behavioral Health conducted a multi-year cost model analysis to actually review the costs associated with providing services. The purpose of the project was to study the current rates and reimbursement of identified mental health or substance use disorder services, understand if rates paid were reasonable given changes in the behavioral health field, and make recommendations for change. You have before you the progress report from 2018 of that work, which goes into detail with the rationale development and financial expenses used. Also, a report from 2016, explaining in detail the various phases. The project identified the benefits to be realized, which includes a standardized framework for a quantitative methodology across services as a part of good budgeting by determining truer costs and determining those unit costs. The numbers we saw in the reports demonstrated services were receiving 7-35% below treatment costs for reimbursement. The World Atlas Report shows the range of per

capita spending on behavioral health was $32 to $345, with Nebraska ranking 32nd at $89.75. Over the course of my tenure with NABHO, we used the cost model and worked with the Appropriation Committee to get rate increases that helped us close the gap. Cost modeling could have really given an accurate picture of ABA rates and what they should have been, and giving you the information that, that really would have been beneficial for, for you. I see my red light is on, so I will conclude, and I thank you for your time and attention, and really encourage you to take a look at that cost modeling. When I was the executive director, my members said they felt that the, the information that was gathered through that cost modeling study was really the most accurate and presented the most accurate reflection of what it actually cost them to provide the services, so I think you'll find it, find it interesting.

HARDIN: Thank you.

ANNETTE DUBAS: Thank you for your time and attention.

HARDIN: Questions? Senator Riepe.

RIEPE: Thank you. And Senator, welcome.

ANNETTE DUBAS: Thank you.

RIEPE: I thought you retired, but--

ANNETTE DUBAS: Well, somebody left the pasture gate open, so I guess I broke away from the herd.

RIEPE: That's good. That's good. You've obviously been very dedicated. Are you down serving as a consultant, kind of?

ANNETTE DUBAS: I am working for NAMI Nebraska, and doing some work with--

RIEPE: Good for you. We need your expertise.

ANNETTE DUBAS: Thank you.

RIEPE: Thank you very much. Thank you, Chairman. That's all I have.

HARDIN: Other questions? Seeing none, thank you. Those in support, LB724. Welcome.

CARLEY STARLING: I don't-- I didn't have anything prepared to give you today, but Senator Quick asked me to speak. So Senator-- or Chairman Hardin and members of the committee, my name is Dr. Carley Starling, C-a-r-l-e-y S-t-a-r-l-i-n-g. I can tell you that as I sat back there, thinking about what I was going to say, trying to mind my manners because I have been told before-- I can say that I sent you a letter back in September about the rate cuts. So you've seen my thoughts come through. I don't need to tell them to you again. The problem that I saw back then, was that we were not comparing apples to oranges-- or we were comparing apples to oranges. I'm sorry. Right. From my research and what I did as I was trying to figure out what was going on and how this was happening, is that it had to do with what's called bundle billing. And so, I went to Dr. Corsi-- went to-- had many meetings with him, good, respectful meetings, and I asked for a cost study. I asked for them to pause what they were doing and do a cost study. Because what we're doing is really expensive. Right? I told you before, I pay my, my staff a fair wage. We're not in it to make a bunch of money. We are in it to take care of kids. This stuff is hard. That's why I got into this business. Sure. There's going to be BCBAs and there's going to be CEOs that are out there, looking to make big bucks off of some of this. Look around, because those CEOs and those people are everywhere, not just in the ABA world. But I think it's really important to remember that we're talking about kids, and we're talking about the rest of their life. And so, we have to stop and think and make decisions using good information and data. And so, I'm here to ask you to please, please, let this go forward, so that we can do a cost analysis and see where that should fall. Because I would really, really, really like to be able to put those kids that I was seeing back on my schedule. Thank you for your consideration.

HARDIN: Thank you. Questions? Senator Meyer.

MEYER: Thank you, Chairman Hardin. I think I got my voice back. I thought I was going to choke there for a minute, so

CARLEY STARLING: I've got the same thing going on. We're good.

MEYER: Yeah. So we were 2.5 times, essentially, the mean, and we were in danger of having what the federal government had paid in the past, claw back.

CARLEY STARLING: Mm-hmm.

MEYER: So I would assume that we were somewhere in the, in the average, right now. Perhaps at the upper end of, of our surrounding states. And so the compensation is what the compensation is. You know, our, our hands are tied, to a certain extent, of, of what the compensation is. And, and so, I'm back to that question. OK, how-- what, what else can we do to enhance the number of providers we have that provide the services, certainly in their rural communities? You know, you-- it appears you've been-- you've tried very, very hard to expand your area. What else can we do? What can we help with? What, what can the Legislature do to help you expand services in our underserved communities?

CARLEY STARLING: I think to this cost study can help look at that, right? Because then we can look at, at, at what the actual cost of doing business is, right, cost of taking care of these kiddos. Because right now, that's what we're talking about, is we're talking about them as kiddos. But I can also tell you that I've worked with them as adults. And if we do not work with these kiddos now, when they're little, when they get bigger, they hit so much harder. I promise you that. Right. And we have that concern as well. Where do they go? What happens? You know, so the whole goal here is that we do have to have good providers and we have to have good intensive behavioral treatment, evidence-based treatment, to help these kids. Because what we want for them is to have a life that is as dignified as it can be, as well as independent. But if we wait until these kids are already struggling to the point of needing to be removed from the home, we're already way too far behind the ball, and then we're playing catch-up. And I can tell you, there's not very many that are as crazy as the wonderful ladies in my clinic that will work with those kids. It's hard work. It's really hard work.

MEYER: I appreciate that. And I think, I think-- I hope you realize we all want to find a way to provide that care for folks. And I guess I'm, I'm kind of reaching, you know, other thing--

CARLEY STARLING: The cost study will help figure that out.

MEYER: Certainly. Certainly.

CARLEY STARLING: Because the-- what happens in other states is that we're able to use codes to bill that we don't get to use in the state of Nebraska. Right. And so, we do a lot of work that we don't get paid for, a lot of work that we don't get paid for. And so, you know, we talk about how much an RBT gets paid, but we don't talk about the

materials that it takes to serve that kid. It doesn't ta-- it doesn't talk about, you know, the snacks that were in the former bill that we use as reinforcement, because that's what it takes to shape behavior. It takes people understanding how this works. It takes making sure you have the right items for all of these kids, right? You have to make sure that you have the, the time and the effort to spend with the families, and know them, and, and there's a lot to it. Running a clinic, hard work. And I've got to fight. I've got to pay somebody to answer the phones for me, and listen to moms and grandmas cry, and then put them on our wait list, right? I've got to pay somebody to, you know, beg insurance companies and Medicaid to pay us. Those kind of things, that would be helpful because that's expensive. I've got to pay people to get the authorizations. I've got to pay people to, you know, do all of these things that are paperwork, that are-- that stack up, that none of us like to do, that we have to do, and that we have always done, and that we didn't get paid for. And so that's where our decision came in, of having, having to say we can't do it anymore, because I could not financially do it in our clinic and continue to provide the benefits to, to the constituents in the 33rd District. Right. Most of them came off Medicaid when they came in and I hired them. They now have full benefits. I had to make choices.

MEYER: Well, I appreciate your efforts and I appreciate you working with us to try to find a solution, so thank you. Thank you.

CARLEY STARLING: I will have a conversation any day about it.

MEYER: Thank you.

HARDIN: Other questions? Seeing none, thank you.

CARLEY STARLING: Thank you.

HARDIN: Proponents, LB724. Welcome.

BETH FRANCIS: This is my first time testifying. I am a grandmother and a mother of autistic kids.

HARDIN: Can I have you give us your name and spell it, please?

BETH FRANCIS: Beth Francis, B-e-t-h F-r-a-n-c-i-s.

HARDIN: Thank you.

BETH FRANCIS: But he is my child. If it wasn't for them, Buddy would not have been able to get his seizures diagnosed. And now, since you guys cut the rates, he no longer gets services at all. I got an email today from a clinic-- is the Lighthouse Clinic. And Lincoln and Omaha have Lighthouse Clinics. And they're starting a clinic in Grand Island with no waitlist. But-- and they take Medicaid except-- or Medicare, except for Nebraska Total Care, and my kids are on Nebraska Total Care. And the waitlist, that would be in Kearney. And either I would have to quit work or my husband would have to quit work for him to go to Kearney for ABA therapy. So then that means one less income, so I may have to go on welfare. I am not asking for assistance with my grandkids. I don't get money back for them, you know, with my grandkids. And if he wouldn't get the ABA therapy, we have a choice. We can either help the kids now or institutionalize them when they're adults. We can either pay now and get productive people, or we can be a society of Nebraska that we're going to institutionalize the kids, and things. And right now, there is no institution in Nebraska that would take a 7-year-old with these problems. I don't want to put him in an institution. I want him to be able to be productive. He could be another Einstein. And you guys-- back when you guys cut the rates, you stated that you would work with the providers. It's simple common sense. OK? They don't want to make a lot of money. You have a service and you have a provider. Why can we not agree on what the outcome is? I mean, it's ridiculous.

HARDIN: So Nebraska Total Care, had they been providing in Grand Island and then something changed, or, or did you change providers?

BETH FRANCIS: Nebraska Total Care is the Medicaid that we have.

HARDIN: OK.

BETH FRANCIS: When Wabi Sabi was the clinic and Boys Town was the clinic that they provided. Well, they ended the contract because they would not negotiate. And so, I've been in with the Spectrum Clinic in Kearney, and they're not sure whether or not they're going to provide the care that my grandson needs, because on their ABA therapy, they do it some after school, some in the mornings, on that. But, you know, it's 50 miles instead of 20. What-- you know, and then we have to take off work. Now, the Lighthouse just started a clinic in--

HARDIN: Grand Island.

BETH FRANCIS: --Grand Island. But you can read the email I got from them this morning. They will not-- they provide all the other Medicaid companies, except for Nebraska Total Care, and it wasn't done by Lighthouse. It was done by Nebraska Total Care on their str-- strategies for network accuracy. They will no longer be taking Nebraska Total Care in any of the Lighthouses. OK. So the Lighthouse people that were there in Kearney and in those areas that were on Medicaid, guess what? They have no place to go. I mean, it's not like Omaha or Lincoln, where you have, you know, centers across, you know--

HARDIN: More options.

BETH FRANCIS: More options. We have no options. None at all.

HARDIN: Yes.

BETH FRANCIS: And that's ridiculous.

HARDIN: Any questions for Mrs. Francis? Seeing none, thank you. We appreciate you sharing with us.

FREDRICKSON: Next proponent for LB724.

KRISTIN PURINGTON: Hi.

FREDRICKSON: Welcome.

KRISTIN PURINGTON: Thank you. My name is Kristin Purington. K-r-i-s-t-i-n, P as in Paul, u-r-i-n-g-t-o-n. I do not have a formal statement prepared. I, I wanted to stay when I heard the subject that was coming up, to speak. As I said previously, I, I am a business owner in Nebraska. I own an ABA clinic. Our clinic that I own was-- I still own, but I no longer have a physical presence, and, and I will state why very clearly. We-- intentionally small, small clinic, knowing that we wanted to provide wrap-around services. We wanted to be able to address what needed to happen in-clinic, what needed to happen in the home, as well as what needed to happen in the community at school. So, intentionally maintained a very small clientele. I moved my business over to another practitioner, who left earlier but was in the room, in-- out of exhaustion, sheer exhaustion. This was also prior to significant rate changes, and I was not, at the time, in-network with Nebraska Medicaid. So I want to state that very clearly, it was not, it was not an effort to make money at all. It was truly an effort to get services out there. As I sit back today and when I looked at the rate changes that were coming in September, I

truly had hesitation of where ABA goes in Nebraska in the future. And I more than understand the need for the change. I truly do. And I do think a rate correction was very much in order. However, when I look at our property taxes currently being fourth in the nation for mid-- Midwest communities, I look at the cost of property insurance, and these are major drivers behind having a physical presence in the state. I honestly could not figure out-- and I have to say my, my hat is off to those practitioners who we've heard today, who are doing their best to absolutely meet all of the standards that are out there for our required services, as well as maintain that physical presence, because it is so incredibly difficult with what rate cuts look like. I would love to see a comprehensive study so that not only we have a good idea of what those rates should look like, but we can collaborate, as providers, to know what pieces can we do better in order to meet the requirements-- and there are tons of requirements for each of our MCOs, but also our private insurers, as well, [INAUDIBLE]-- and really do our due best with these families. I am very much a proponent of quality services, making sure that we have oversight. And I just wanted to really make sure that you understood there are practitioners out there who are doing their due best. It is very hard. And I will stop there, but thank you.

FREDRICKSON: Thank you for your testimony. Are there any questions from the committee? Seeing none, thank you for being here.

KRISTIN PURINGTON: Thank you.

FREDRICKSON: Next proponent for LB724. Seeing none, we'll move on to opponents to LB724. Seeing none, is there anyone here to testify in the neutral capacity to LB724? Seeing none. Senator Quick, you're invited to close. But while you come up, we did have some online comments. We had 4 pro-- 4, 4 proponents, zero opponents, and one in the neutral capacity. Senator Quick.

QUICK: Thank you, Vice Chairman and members of the committee. And you know, there's no really easy answers for all of this, to how to, how to fix it. But I know-- you know, I introduced the rate study to see what we could come up with. You know, maybe we-- you know, because I see they put a pretty fairly large fiscal note on it, so I'm sure it would cost the department quite a bit. But maybe there's another way we can get this rate study done and it doesn't cost so much money. I don't know. But I think you've heard from people, you know, especially in rural Nebraska, we have a, a loss of care for, for ABA services and these are really crucial for not only just rural Nebraska, but also

for our metropolitan areas of, of the state, too. Because it's, it's about the kids and it's about their families. And so, you know, I know-- and I probably wasn't-- I wasn't going to bring this up, but you know, we have bills coming up on education, where we're going to, you know, kick-- you know, have kids suspended from school at younger ages. And some of these kids, maybe they have autism or they have a developmental disability. And so, we've got to be really careful about what we're going to be doing going forward with, with even that kind of legislation. But, you know, I just really hope that we can come up with some type of, of a way that we can address being able to have access to ABA services in rural Nebraska somehow, and whether that's through a rate study or figuring out how we're going to provide more help somewhere through the state level to, to be able to have that. So with that, I'll-- thank you.

FREDRICKSON: Thank you, Senator Quick. Are there any questions from the committee? Seeing none, thank you. That will close our hearing for LB724. And we will move on to LB945, Senator Dorn, who's on his way in here.

DORN: So, I'm looking for my staff.

FREDRICKSON: Oh, OK.

DORN: She has all the paperwork. There she is. Sorry.

FREDRICKSON: No worries.

DORN: We're in Appropriations today, and--

FREDRICKSON: Busy, busy time for you all.

DORN: Well, busy time for all of us.

FREDRICKSON: For all of us, yes.

DORN: Yeah.

MEYER: This probably seems like a relief.

FREDRICKSON: Well, welcome to Health and Human Services, Senator Dorn. You're welcome to open on LB945.

DORN: You bet. Hello, members of the Health and Human Services Committee, Vice Chairman Fredrickson. My name is Myron Dorn, M-y-r-o-n

D-o-r-n, and I represent Legislative District 30 in southeast Nebraska. I'm here today to open on LB945. The bill is to clarify the potential distribution of hospital assessment dollars now flowing into Nebraska. In 2024, the Legislature approved the Hospital Quality Assurance and Assess-- Assessment Act introduced by Senator Jacobson, requiring a Medicaid state plan amendment be filed with CMS to allow for additional hospital assessment tax, which then draws down significant additional dollars from the federal government for hospitals. The plan was approved and last summer, dollar-- dollars-- last summer, dollars began to flow to the state. A portion of the fund in the amount of about $17.5 million each year was kept by the state to pay out of-- to pay out of hospital providers in the Medicaid program, continuing eligibility of children, or the state designated health information exchange. LB945 changes the "or" in that section of law to "and," thereby assuring allocation of dollars to all 3 categories listed in the law. Last legislative session, I introduced LB55, to pay out of hospital providers who served both Medicaid and Medicare patients. Specifically, the intent of the legislation was to utilize these assessment dollars coming back to the state for these purposes: to pay the difference between Medicaid and Medi-- Medicare and Medicaid rates for licensed mental health practitioners after the federal government made the decision that these healthcare professionals could be reimbursed in Medicare after they had been paid Medicaid rates for many years. The rate for those licensed hospital providers was much lower in Medicare than Medicaid, and my bill was to tap $1.5 million in order to keep behavioral health services for our elderly in rural Nebraska. LMPHs [SIC] are those who are master-level behavioral health providers, or the backbone of our behavioral health system. LB55 last year was incorporated in the state budget and was passed-- and passed the Legislature and signed by the Governor. Unfortunately, the Medicaid Division had directed the entirety of the $17.5 million to help cover a part of costs for children's continuous eligibility in Medicaid. The bill before you today gives the flexibility to the Medicaid Division to determine cost between the 3 priorities that were listed in the original LB1087 bill that Senator Jacobson had, rather than just one area. Thank you for your attention to this matter.

FREDRICKSON: Thank you, Senator Dorn. Are there any questions from the committee? Senator Riepe.

RIEPE: Thank you. I need an education. Is the plan here to pay the Medi-- Medicare rate for Medicaid patients on this particular class of treatment? Is, is my understanding, or am I dead wrong?

DORN: They, they are not-- as you see, the rates were much lower in Medicare than Medicaid. And my bill was to put in an additional $1.5 million to help bring those rates both in line. So when they didn't qualify for Medicaid and they were shifted over to Medicare, they had a lot lower rate. So what my bill did was to use part of these assessment funds to help bring that late-- rate back into a similar rate.

RIEPE: Does that create a slippery slope for other services, as well?

DORN: That-- yeah, it, it could, or whatever. Mine was to help those-- part of that assessment, I was going to use those dollars to help pay for part of this to bring them back into a similar rate, so that we were not penalizing certain, certain ones and not the other ones, or whatever, so that we brought them both up to par.

RIEPE: As a long-standing member of the Appropriations Committee, I'm sure you have an inside track on where this money could come from.

DORN: Yes, where it'd come from and where it, where it's gone. Yes.

RIEPE: OK. Thank you for being here. Thank you, Chairman.

FREDRICKSON: Thank you. Senator Riepe. Other questions? Senator Meyer.

MEYER: Yeah. Thank you, Vice Chair. Essentially, it's just staying within that same $17.5 million. It's just making-- or is this addit-- this, this is-- looking at--

DORN: No. This was, this was using-- the bill last year was using that $17.5 million. That's what the proposal is this year again. Realized last year the department determined that, as I had said there earlier, it was "or." And they decided that-- what Director Corsi specifically told me was, when I asked him about it, if they did not use that to fund general funds, which are part of these [INAUDIBLE] things, they would have had to come to the Appropriations Committee to ask for general funds. If myself and about 4 or 5 other senators who used or appropriated these funds, this $17.5 million, if they still stayed with us, they wouldn't-- they, they would have had to come ask for general funds. The way it was, none of us got anything.

MEYER: OK. It's just helping us do the right thing.

DORN: Well.

MEYER: Thank you.

DORN: Yeah.

FREDRICKSON: Other questions from the committee? Seeing none, will you be here to close?

DORN: Yes.

FREDRICKSON: All right. Thank you, Senator Dorn. We will now move on to proponents for LB945.Welcome.

NICKI BEHMER POPP: Hello. Good afternoon, Chair Fred-- Chair Fredrickson, and members of the Health and Human Services Committee. My name is Nicki Behmer Popp, spelled N-i-c-k-i B-e-h-m-e-r P-o-p-p, and I serve as the executive director of the Nebraska Association of Behavioral Health Organizations, representing over 60 community behavioral health providers and hospitals across the state. I am here today in support of LB945. First, I want to thank Senator Doran for bringing this bill forward and for clearly outlining the legislative history behind these dollars. LB945 may appear to be a small statutory change, replacing "or" with "and." But in practice, it is about something much larger, ensuring that the funds the Legislature has identified for specific priorities can actually be used for those priorities. Last session, the Legislature made a policy decision to support out-of-hospital providers through the hospital assessment dollars flowing back into the state. That was not an abstract line item. It was a direct response to a real and immediate challenge facing licensed mental health practitioners, particularly those serving adults in rural Nebraska. When Medicare reimbursement rules changed, LMHPs, master's level clinicians who are the backbone of our behavioral health workforce, were suddenly paid at a significantly lower Medicare rate than the Medicaid rate. That gap created financial instability for providers who are already operating on thin margins. The Legislature acted, funds were identified, Appropriations bill passed, and the Governor signed it. However, when those dollars were directed elsewhere by the department, providers were left in a difficult position. They had relied on legislative action to stabilize services, they had communicated with patients, they had planned staffing, and then anticipated support did not materialize. Importantly, providers did not stop serving these patients. They continued delivering care to older adults and vulnerable populations in good faith because it was the right thing to do for the individuals and families relying on them. They absorbed the financial strain

rather than turning the patients away. But continuing to operate without the expected reimbursement is not a sustainable way to maintain these services, especially in rural communities, where margins are already thin and workforce shortages are acute. This is not about assigning fault. Budget implementation is complex, Medicaid financing is complex. Federal approv-- federal approvals add additional layers. But what LB945 does is give the department and the Legislature the flexibility necessary to carry out the intent behind those appropriations decisions. By changing "or" to "and," the statute ensures that the 3 identified priorities are all permissible uses, rather than functionally elevating one above the other. From a provi-- from a provider perspective, predictability matters. When the Legislature passes a budget and identifies a funding stream, providers reasonably assume that the policy direction will be implemented. When that implementation is uncertain, it creates hesitation in hiring, expanding services, or maintaining programs, especially in rural and underserved communities. And I see my red light is on. So if you have any questions, I'll be happy to answer.

FREDRICKSON: Great. Thank you for your testimony. Are there questions from the committee? Seeing none, thank you for being here. Are there any other proponents to LB945? Seeing none, is there anyone here to testify in opposition to LB945? Welcome back.

DREW GONSHOROWSKI: Thank you. Good afternoon, Senator Fredrickson and members of the Health and Human Services Committee. My name is Drew Gonshorowski, D-r-e-w G-o-n-s-h-o-r-o-w-s-k-i, and I am the director of the Division of Medicaid and Long-Term Care in the Department of Health and Human Services. I am here to testify in opposition to LB945. This bill changes how DHHS may use funds from the Hospital Quality Assurance and Access Act. By changing the word "or" to "and," LB945 requires dollars to be spent on each of the allowable purposes included in the statute, rather than allowing the department to use the funds for any combination of the allowables purposes. As allowed by statute and as noted in the department's fiscal note, the revenues in this fund are fully obligated. By requiring funding of all allowable expenses, existing obligations would be partially defunded, shifting the burden to general funds. Under LB945, any new allowable purposes would further dilute funding toward current obligations, thus increasing the burden on general funds. We respectfully request that the committee not advance the bill to General File. Thank you for your time. I'd be happy to answer any of the questions regarding this bill.

FREDRICKSON: Thank you, Director. Any questions from the committee? I have one. You said, so the-- you said the funds are currently already obligated. Can you shed some light on what they're obligated to, at this point?

DREW GONSHOROWSKI: Yeah. So, $17.5 million, which is, I believe, 3.5% of the, the hospital assessment, which is effectively the, the cap that we can, that we can pay for purposes is all obligated to continuous eligibility for children. And, and that, that actual spend is approximately $21 million, so there is some that the division absorbs in terms of GF. But that-- that's the context here, that there's just-- that, that is the fund. That's all we have allowable there.

FREDRICKSON: OK. Other questions in the committee? Seeing none, thank you. Other opponents for LB945? Seeing none, is there anyone here to testify in the neutral capacity for LB945? Seeing none. Senator Dorn, you're welcome to close. While you come up, we did have-- actually, we had no online comments for LB945.

DORN: Thank you. Thank-- number one, thank you for having the hearing and thank you for listening to some of our explanation and some of Drew's explanation. Last year, when we went through the process, LB55, to get about $1.4 million in funding, several other state senators also had some allocations for that hospital assessment fund. In Drew's defense and in the department's defense, they told us last year, there weren't those funds. They wouldn't-- they were used. We still went ahead and had the bill. We were even approved, and then Governor signed it and everything. And then later, they were right. They had used those funds already, so they weren't there available for anybody else. This year, that's why we brought this bill back, to change that one word in there, so that now, we can also be considered and that maybe they don't use them for their general Fund. So they made up some other deficits that they would have to come to the Appropriation Committee and through the appropriation process to get funded-- or to ask for funding, not to get funded but to ask for funding. The way it was when Senator Jacobson would pass that bill, it did not specifically specify in there that the Legislature had complete control over it. They interpreted it as they did, and that's where those funds went. So. Thank you.

FREDRICKSON: Thank you, Senator Dorn. Are there questions to the committee? Senator Ballard.

BALLARD: Thank you, Vice Chair. Thank you, Senator Dorn. This is going to maybe-- I could follow up with you later. Do you know if the HIE is, is all-- there's a General Fund appropriations, correct, currently?

DORN: For, for--

BALLARD: For the HIE. For the Health Information Exchange. General funds. Do you know what that appropriation is?

DORN: No, I do not. I could not-- if-- we-- well--

BALLARD: OK. I can follow up with you later. That may have been a question for the department, as well.

DORN: In, in-- when the Department for Health and Human Services Agency, we have-- there's multiple, multiple programs. And we had 58 requests for adjustments this year alone, so I don't remember exactly what each of those are.

BALLARD: OK. Because I men-- yeah, because I'm trying to jog my memory of-- I think--

DORN: Yeah.

BALLARD: They, they asked for a substantial increase a few years ago. And so, I'll have to go-- I'll have to-- I'll follow up with you.

DORN: No, they-- you, you were right. I don't know what that was funded at, though. I don't remember that, but they did ask. Yes.

BALLARD: Yeah, it was like an extra $7 million, I believe, or something along those lines. So I will-- I'll follow up with you on the floor.

DORN: OK.

BALLARD: So I appreciate it. Thank you

DORN: That'll be good. We will check that out for you.

FREDRICKSON: Thank you, Senator Ballard. Senator Quick.

QUICK: Yeah, thank you, Vice Chairman. So I don't know if it's how this works, but you know, so if there, if there isn't enough funds, is it what-- is it the case where that money just wouldn't be available

for those programs, or is this-- it has to be appropriated in order for that?

DORN: Last year, the department, even when myself and other senators appropriated part of that $17.5 million, the department did tell us there weren't no funds there. They had specifically used those for other things, so there weren't any funding there. In the bill that Jacobson brought, it did not list specifically that the Legislature will have control over that $17.5 million or that 3.5%. This-- all this does is change some wording so it gives the option now to the Legislature, when we appropriate it, that that would be also appropriate. So that's what it's doing. We understand what the department did. We also understand that there is a budget process to go through and let's all work through that.

QUICK: OK. All right. Thank you.

FREDRICKSON: Other questions? Seeing none, thank you, Senator Dorn.

DORN: Thank you, guys.

FREDRICKSON: Yep. That will close our hearing on LB945. We are moving on to LB812? Is that what it is? LB812? [INAUDIBLE]. Perfect. Moving on to LB812. And Demet, can you move that? Thanks. Hello. Welcome.

NATHAN JANULEWICZ: Hello. How are you? All right. Senator Bostar can't be here this afternoon. He's conflicted out with another hearing. Good afternoon, Vice Chair Fredrickson and members of the Health and Human Services Committee. My name is Nathan Janulewicz, that's N-a-t-h-a-n J-a-n-u-l-e-w-i-c-z. I'm the legislative aide for Senator Eliot Bostar. I'm here today to introduce LB812. Last year, Congress enacted HR 1, which, for the first time, requires work or community engagement requirements for the Medicaid expansion population. These requirements apply to low-income adults ages 19 to 64, and generally require 80 hours of work or qualified activity per month, unless an exemption applies. The question before the states is how to implement these requirements in an effective way. LB812 is designed to implement the federal mandated community engagement requirements through clear, practical guardrails. The bill focuses on ensuring the efficiency, administrative clarity, and predictability for both the state and Nebraska's Medicaid enrollees as the-- as these requirements are put into practice. First, LB812 aligns eligibility requirements with federal law. Federal changes will move Medicaid expansion renewals from an annual cycle to a 6-month cycle, beginning January 1, 2027.

This bill ensures the Department of Health and Human Services conducts re-determinations no more frequently than required under federal law. I offer AM1834 that clarifies the effective date to match the federal timeline. LB812 ensures Nebraska implements community engagement requirements on the federal schedule. Federal law sets January 1, 2027, as the implementation deadline. This bill directs the Department of Health and Human Services to implement no earlier than the required federal law or federal guidance, allowing the state to build systems correctly and avoiding a rush or a turbulent rollout. LB812 also establishes standards for compliance determined in documentation at application or renewal. The department may require no more than one month of compliance with or exemption from the community engagement requirements. This aligns the current departmental planning and avoids unnecessary paperwork barriers. Finally, the legislation requires the Department of Health and Human Services to verify work requirement status at, at the scheduled renewal, currently every 12 months, and moving to every 6 months starting January 1, 2027. LB812 provides clarity around implementation of federal mandated community engagement standards. It ensures Nebraska complies with the federal law without layering on additional administrative complexity that increases costs, overwhelms eligibility systems, and leads to avoidable coverage disruptions. I respectfully urge the committee to advance LB812. And thank you for your time.

HARDIN: Thank you. Appreciate it. Proponents, LB812.

AMY BEHNKE: Good-- oh, I can still say good afternoon. There we go.

HARDIN: That's right.

AMY BEHNKE: Good afternoon, Chairman Hardin, Hardin and members of the committee. My name is Amy Behnke, A-m-y B-e-h-n-k-e, and I'm the CEO at Health Center Association of Nebraska. Our organization supports the work of Nebraska's 7 Federally Qualified Health Centers, most commonly known as community health centers, and the 123,000 patients they serve each year. I'd like to thank Senator Bostar for introducing LB812, which sets reasonable standards for implementing Medicaid changes. Health centers are foundational to the healthcare delivery system in Nebraska and collectively comprise one of the largest primary care systems in the state. Every health center provides integrated medical, dental, and behavioral health services, as well as supportive services like patient education programs, transportation, and assistance with enrolling correctly in and utilizing health insurance coverage, all under one roof. Some of our health centers

also have on-site pharmacy services, and all contract with local pharmacies to provide affordable access to medication. What makes our health centers unique is the commitment to serve everyone in their community, regardless of insurance status or ability to pay. Medicaid is a critical lifeline for our patients. Health center patients are hard-working Nebraskans but many work in occupations that don't offer health insurance. Statewide, 38% of our health and-- of our patients are enrolled in Medicaid, including 66% of the children we serve. In fact, one out of every seven Medicaid enrollees in the state receives their care at a community health center. Medicaid coverage means our patients don't have to choose between buying groceries or going to the doctor, it means they can access specialty services when needed, and it means their children can receive all of their well-child visits. The Medicaid changes included in HR 1 stand to create significant administrative complexities in Medicaid. Based on experiences in states that have already tried work requirements, these complexities will likely lead to eligible individuals losing health insurance coverage, increasing the number of uninsured individuals, and placing additional strain on healthcare providers that are already stretched financially. The vast majority of individuals enrolled in Medicaid are already working or exempt due to medical needs, disability, or caregiver status. The same is true for our health center patients. Those who are able to work do, many working multiple jobs to make ends meet. Collecting paperwork for multiple jobs, fluctuating hours due to the type of work, and the lack of reliable Internet access can all be barriers for providing necessary paperwork to prove work status. Every health center has staff who assist eligible individuals with enrolling in health insurance coverage and experience some of the impacts of this administrative burden. I've listed some of those in the testimony. I'll let you go ahead and read those. I will say we've already seen a significant increase in calls and requests for support since the announcement that Nebraska was going to be the first to implement these changes from HR 1. CMS has indicated that its guidance for implementing work requirements won't be released until this summer, after Nebraska's proposed implementation date. So it leaves several questions about what happens if we have to make changes, if we have to-- if we do something that is inconsistent with current guidance. LB812 allows Nebraska to slow down and take advantage of the full implementation timeline to ensure that our program is set up from the start to reduce burden and reduce the likelihood of loss of coverage. I will stop there.

HARDIN: Thanks.

AMY BEHNKE: Happy to answer any questions.

HARDIN: Sure. Questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here and for your, your testimony. So yeah. I think, I think there's a lot of questions, certainly about HR 1 and sort of the impacts and the actual implementation of some of this, and just kind of curious, you know, based on the fact that the health FQHCs are-- have high Medicaid populations that they, that they serve, have you all been given any insights about the back end or how we're going to be addressing that as a state, or?

AMY BEHNKE: I-- we, we haven't. We've asked the questions. I, I think a lot of that is still being built.

FREDRICKSON: Sure. Sure.

AMY BEHNKE: You know, I think we're kind of building the plane while we're flying it And so, one of the things that I'll say is we think about how we educate our health centers about how to implement this, how we education our outreach and enrollment staff to answer questions for Individuals. We just don't have those answers right now. And so, it's, it's challenging to set individuals up for success. So something like LB812 would give us a little more of a runway. One of the things that's in my testimony that I, I didn't get to is that we have been meeting with Medicaid staff on a regular basis, but because we have such a compressed implementation timeline, it's, it's hard to build a really strong collaborative effort just because things are moving so quickly. So we certainly appreciate that, that we're meeting and that we had that availability. The timeframe just makes it really challenging to make sure that we are setting everything up without potential barriers.

FREDRICKSON: Thank you.

HARDIN: Thank you. Would you kind of help me understand, from your perspective, what are the differences-- are there differences between community engagement and work requirements? I mean, just kind of talk about that world, if you would.

AMY BEHNKE: Yeah. You know, I think community engagement is, is broader because it obviously includes things like attending school, volunteer activities, those types of things, so a, a term of art. I guess that's a bit different than just work requirements.

HARDIN: OK. Very good. And, and maybe that's part of what you had here on the second page, qualifying activities under the ABBBA. Can you talk about qualifying activities? What are they like? What-- thematically?

AMY BEHNKE: Right. So certainly, working 80 hours a week, I think these-- you know, some of the things that are-- the details are still left to be worked out. Somebody who's a full-time student, if you are a caregiver of a family member, if you have a young child, I think if you're pregnant-- there's, there's a significant list of, of qualifying factors.

HARDIN: Wonderful. Any other questions? Senator Riepe.

RIEPE: Yeah, thank you, Chairman. Thank you again for the patience of waiting here all day to be here. Do your providers receive federal funds in addition to the federal funds that are contributed to Medicaid?

AMY BEHNKE: Yep. So in order to be a Federally Qualified Health Center, you meet certain federal requirements. They do all have grant funding that they receive. It makes up anywhere from about 15-17% of their entire revenue stream, and those dollars are specifically meant to help provide for the cost of caring for uninsured individuals who come into the health center.

RIEPE: Do you sense that there's some stability to that, or has everything that's been going on, sort of clawbacks and everything, does that seem pretty stable over the short period of time?

AMY BEHNKE: It has been. I mean, the health center program itself is 60 years old. We just celebrated 60 years of having community health centers in this country. You know, I, I think some of the instability comes around some of the policy changes that have been enacted. What I will say about funding at the federal level is that it has been static for a decade. We haven't seen an increase in funding at the federal level at that time-- at the same time. In Nebraska, for example, our health centers have gone from serving about 68,000 patients to 123,000 patients. So we've seen an increase in the number of patients served, but we've not seen an increase in that federal funding to correspond with the patients.

RIEPE: What percentage of your clientele would be on Medicaid? I assume it's fairly high.

AMY BEHNKE: It is. Yeah. We have about-- we've, we've increased now to about 38% of our patients are Medicaid. A lot of that is due to Medicaid expansion. Prior to expansion, about half of our patients were uninsured. So we've seen a significant decrease.

RIEPE: Do you have the added cost of having have-- having to have interpreters?

AMY BEHNKE: We do.

RIEPE: OK. I assume you have a number of different languages coming in there.

AMY BEHNKE: Yep. So one of the federal requirements is that we provide those kind of wraparound services, so interpreters, transportation, the individuals who assist with outreach and enrollment.

RIEPE: OK. OK. Thank you again--

AMY BEHNKE: You're welcome. You're welcome.

RIEPE: --for being here. Thank you, Chairman.

HARDIN: Senator Quick.

QUICK: Yeah. Thank you, Chairman. So on the federal dollars, is that just like a-- I'm guessing a set amount based on population or people that you serve?

AMY BEHNKE: Right, yep, yep. It's all based on population served, and so it varies obviously from health center to health center across the state. And the payer mix varies from health center to health center, too. And so, some may have a higher rate of uninsured patients than other health centers, and so when you look at those dollar amounts and the, the lack of increase, it makes an even bigger difference in their overall financial stability.

QUICK: I'm, I"m just guessing, but I-- work requirements won't affect those dollars though, right? Or is that--

AMY BEHNKE: Not-- no, not the federal grant dollars that they receive.

QUICK: OK. All right. Thank you.

HARDIN: Any other questions? Seeing none.

AMY BEHNKE: All right. Thank you.

HARDIN: Thanks for making the trip all the way out here.

AMY BEHNKE: Yeah.

HARDIN: I know the, I know the trip. Welcome.

DEBORAH DOKE: Hello. Good afternoon, members of the Health and Human Services Committee. My name is Deborah Doke, D-e-b-o-r-a-h D-o-k-e, and I am the chief development officer at Syracuse Area Health. I am here representing the Nebraska Hospital Association and the Nebraska Rural Health Association. We thank Senator Bostar for introducing this bill, and we appreciate his efforts to align state Medicaid policy with federal law while maintaining access to essential health serv-- healthcare services for our fellow Nebraskans. As Nebraska considers implementation of work and community engagement requirements under HR 1, we strongly encourage the state to utilize the full range of eligibility flexibilities permitted under federal law. While we support the goal of encouraging workforce participation, absolutely, we must be thoughtful about our approach. Hospitals are already facing a crisis of administrative burden and burnout. Every additional reporting layer adds a paper-- paperwork tax to our healthcare system, a cost that ultimately is passed down to Nebraskans. In Nebraska, we like to cut red tape, not add more. Require-- requiring overly frequent re-verification of work status forces hospital staff to spend hours chasing paperwork. To keep our system efficient, we ask that you utilize a one month lookback on work requirements and re-verify compliance and exemption at renewal, not more frequently. Hospitals across Nebraska are committed to serving patients who are actively seeking care for acute illness, chronic disease management, mental health conditions, and recovery from injury. Many of these individuals face unstable employment, caregiving responsibilities, transportation challenges, especially in rural, or episodic health conditions that make compliance with work requirements difficult. When coverage is disrupted, care is delayed, conditions worsen, and patients often reenter the system at a higher cost through emergency departments. My hospital had a patient who is recovering. She was covered by Medicaid and she came in through our ER in distress just this past week. She was in a significant amount of pain and was diagnosed with a bowel obstruction that required immediate hospitalization. We want our patients to ultimately seek medical help when needed, without questioning whether their coverage may have lapsed this month due to an-- to-- due to an administrative issue. LB812 provides an important

opportunity to design a state approach that complies with federal requirements while recognizing the realities faced by individuals who rely on Medicaid for, for access to care. Policies that unintentionally create barriers to coverage ultimately undermine both health outcomes and workforce participation. A person with untreated health conditions may have difficulty maintaining a job. LB812 provides an opportunity to design a Nebraska-specific approach that honors the value of work without drowning our patients and providers in unnecessary red tape. We can protect the stability of our health care system and ensure that Nebraskans spend their time working and not filling out forms. Thank you for your time. And I urge the committee to advance LB812, and I'm happy to answer any questions you might have.

HARDIN: Thank you.

DEBORAH DOKE: Yes.

HARDIN: Questions? Seeing none, thank you.

DEBORAH DOKE: Thank you.

HARDIN: Proponents.

JINA RAGLAND: Chair keeps getting closer.

HARDIN: It does that. Welcome.

JINA RAGLAND: Closer and lower, right? Chair Hardin and members of the Health and Human Services Committee, my name is Jina Ragland, J-i-n-a R-a-g-l-a-n-d, today-- testifying today in support of LB812 on behalf of AARP Nebraska. HR 1 was enacted on July 4, 2025, and establishes clear, national deadlines for states to implement various changes to the-- for the Medicaid expansion population. These federal timelines were designed to give states the time needed to prepare systems, train staff, communicate with beneficiaries, and follow forthcoming CMS guidance accurately and safely. Nebraska has announced plans to implement these requirements on May 1, 2026, a full 8 months earlier than federal law requires. While early implementation is technically allowed, it is not required, not incentivized, and not recommended given the risks involved. States received initial sub-regulatory guidance in December 2025, but a required interim final rule will not be published until June 6, 2026, which will include additional operational details and may introduce new policy considerations. Final administrative expectations for eligibility systems, reporting

exemptions, and verification will not be fully clarified until this rulemaking is complete. Early implementation could cause widespread preventable coverage loss in addition to confusion. In 2025, Nebraska was estimated to have approximately 60,000 individuals under Medicaid expansion el-- eligibility. Approximately 14,000 or 23% are between the ages of 50 to 64, which represents about 36% of Nebraska's total Medicaid population between the ages of 50 and 64. A sig-- significant number of older adults aged 50 to 64 depend on this coverage for critical services, such as cancer screenings, primary care, and behavioral healthcare. Nebraska's accelerated timeline could result in thousands of Nebraskans, 50 and older, losing Medicaid coverage, not because they fail to work, but because of administrative hurdles, reporting errors, or system confusion. These losses disproportionately affect people with chronic conditions, limited Internet access, unstable work schedules, and even caregivers who simply may not be able to comply with rushed or unclear reporting requirements. CMS guidance is still evolving and it is our understanding they're working with our state to assess the state's readiness for early implementation, highlighting just how complex and unfinished the federal guidance still is. Implementing before that guidance is finalized risks misapplication of exemptions, inconsistent enforcement, enforcement, and costly system errors that could harm families and overwhelm DHHS. Finally, it's important to emphasize that there's absolutely no benefit to going early. HR 1 provides no additional funding, no bonuses, and no policy advantage for implementing ahead of schedule. States simply need to comply by the federal deadline that are set forth in HR 1. By using the federal-- full federal timeline, we prioritize accuracy, fairness, and stability, and protect Nebraskans from losing coverage due to administrative failures, rather than true ineligibility. Thank you to Senator Bostar for introducing the legislation. Thank you for the opportunity to comment. We would ask for your support and advance the legislation to the floor, floor. And I'd be happy to answer any questions.

HARDIN: Thank you. Questions? Seeing none, thank you. Proponents, LB812. Welcome.

MATT PROKOP: Good afternoon. Good afternoon, Chairman Har-- Hardin and members of the Health and Human Services Committee. My name is Matt Prokop. That's M-a-t-t P-r-o-k-o-p, and I'm the Director of State Government Affairs for the American Diabetes Association for the Northwest and North Central Region. The ADA is the nation's leading volunteer health organization fighting to bend the curve on the

diabetes epidemic. Founded in 1940, the ADA is comprised of people with diabetes, healthcare professionals, research scientists, and other concerned individuals. The ADA's mission is to prevent, to prevent and cure diabetes and to improve the lives of people affected by diabetes. In Nebraska, 159,200 adults have di-- have diagnosed diabetes. For those living with diabetes and pre-diabetes, Medicaid provides critical access to healthcare, necessary disease management, and medications including insulin and also life-saving technology to help those living with this, with this disease. Nearly one in four adults with diabetes depend on Medicaid for healthcare coverage. The ADA is concerned about the potential loss of critical healthcare coverage for Nebraskans through an expedited process to implement work requirements and eligibility changes to the Nebraska Medicaid program. A thorough examination of the proposed administrative and eligibility requirements is needed to ensure that the changes to the program align and do not add unnecessary red tape to the current Medicaid coverage for Nebraskans. For people with diabetes, access to healthcare coverage is critical to, to successful disease management, effective glucose control, and avoiding hospitalizations and unnecessary and costly complications. Medicaid is not just a safety net, but a lifeline for people with diabetes. We thank Senator Bostar for introducing LB812, and ask the committee to advance this bill to the full floor for, for their consideration, and be happy to answer any questions.

HARDIN: Thank you. Questions? Seeing none--

MATT PROKOP: Thank you.

HARDIN: Thank you. Proponents, LB812. Welcome.

DANA BACON: Good afternoon, Chair and members. My name is Dana Bacon. That's D-a-n-a B-a-c-o-n. I work on behalf of Blood Cancer United, formerly the Leukemia and Lymphoma Society. We're the nation's leading organization that's devoted to fighting blood cancer, finding cures, and improving quality of life for patients and families, here to support LB 812. I'd just like to start by saying that I think the people who've gone before me have made an excellent, broad case, and I support what they've said. What I'd like to add is more of a bit of thought about the cancer experience and what's in front of you. When you get cancer, so many things come along for the ride, and you are facing months, if not years, of frequent treatments, brain fog, often called chemo brain, major expenses. It is so hard for you to focus on what's ahead, nevermind paperwork. And as we've just heard, the

administration's proposal to get this work requirements up and running so fast, there's no incentive for it. You don't get a prize, you don't win a cake. I mean, what you do get though is the opportunity for cancer patients and others to face unintended coverage losses, which would go against what we heard is the administration's goal of helping people live long, healthy lives. That's what we all want in this room. But if you race to get this implemented-- you're leaning toward this big tech idea of moving fast and breaking things, which is great when it's a phone app and you're testing it. But when it comes to people's coverage and the ability to maintain and improve their lives, that's not great at all. I mean, you've heard for years about what happened when Arkansas attempted to roll out their work requirements reporting system. There were about 18,000 people who lost coverage through that program, who weren't by default meant to be the people who would lose their coverage. You're talking people who didn't comply the right way, who intended to get the paperwork in or the phone call in. There are a lot of ways that these things can go sideways. So what I'd really like to encourage you is to remember that they should take the time that the federal government is giving them to make sure this works as well as it can, with all the risks that stand in between patients and the care they need to survive. Thank you.

HARDIN: Thank you. Questions? Seeing none, thank you. Proponents. Welcome.

PEGGY REISHER: Good afternoon. My name is Peggy Reisher. Peggy is P-e-g-g-y, Reisher, R-e-i-s-h-e-r. I'm the executive director for the Brain Injury Association of Nebraska. We're a statewide nonprofit that provides education resources and supports to folks with brain injury. I'm here also to support LB812. Brain injury is not a one-time event. It's oftentimes a chronic condition. It can affect memory, attention, behavior, fatigue, emotional regulation, and the ability just to manage daily tasks. Many individuals with brain injury look fine on the outside but are struggling on the inside. LB812 is important to us because Medicaid work requirements create barriers that disproportionately harm individuals that we serve-- those with brain injury. To qualify for Medicaid today, a lot of our individuals must provide medical documentation verifying disability. Many brain injury survivors-- for many brain injury survivors, this is a challenging process. Under the work requirements, survivors could be forced to repeatedly prove their disability every 6 months just to maintain that essential care. This creates very-- several, you know, real-world problems. First, it being just access to qualified medical professionals is very limited, to no surprise to you, especially in

the rural communities. Secondly, the brain injury itself makes paperwork really hard, and meeting those deadlines often tends very difficult. There's also a, a third financial paradox. Some individuals must pay out of pocket for their medical assessments to require the proof of their disability before they can even qualify for Medicaid. For people already living with limited income, this makes it very, very challenging. Our folks are oftentimes at, at higher risk of losing their Medicaid because-- and being able to participate because of rehabilitation therapies, medications. They often-- and we just feel like this, this, this whole process is really creating, as stated before, a lot of red tape, instead of opportunity. So we stand here-- I sit here today, encouraging you to advance LB812.

HARDIN: Thank you.

PEGGY REISHER: You're welcome.

HARDIN: Questions? Seeing none, thank you. Proponents, LB812.

KELSEY ARENDS: Good afternoon.

HARDIN: Good afternoon.

KELSEY ARENDS: Chair Hardin and members of the Health and Human Services Committee, my name is Kelsey Arends, K-e-l-as-e-y A-r-e-n-d-s, and I'm the senior staff attorney for the Health Care Access Program at Nebraska Appleseed, testifying today in support of LB812 on behalf of Nebraska Appleseed. Because this bill establishes necessary and responsible guidelines for implementing the new, federally-mandated work requirements for the Medicaid expansion category, Nebraska Appleseed supports this bill. First, LB812 establishes a reasonable timeline for implementation of the work requirements. LB812 directs our state to implement these new requirements by the federal deadline, January 1, 2027, but not before. To be clear, implementation by January 1, 2027 will be a massive undertaking and require extremely quick work. In December, Governor Pillen stated his intent to implement work requirements by May 1, 2026. Early implementation would be re-- irresponsible for a number of reasons, including, as you've heard, because the proposed imp-- implementation date is before CMS is due to issue formal guidance. Implementing before our state knows the rules of the road simply does not make sense. Additionally, the early implementation timeline would not leave sufficient time for Nebraska DHHS to make crucial decisions about how work requirements will be adequate-- will be implemented and

adequately communicate them to enrollees and stakeholders. Likely for these reasons, no other state has publicly confirmed an early implementation date. Nebraska should take the time it needs to implement work requirements responsibly by the federal deadline, but not before. The remaining provisions of LB812 simply codify approaches DHHS has already proposed in pending regulations. One such element is that LB812 requires no more than one month of compliance or exemption status for applicants and enrollees. The one month lookback is sufficient to determine eligibility, maximizes efficiency, and minimizes harm to Nebraskans applying for or already enrolled in Medicaid. Again, this approach matches what DHHS has already proposed in pending regulations. Finally, LB812 requires DHHS verifies compliance with work requirements at renewal and not more frequently than once every 6 months, which, as you've heard, will, will be the requirement for the Medicaid expansion category starting January 1, 2027. Nebraska DHHS should only re-verify compliance or exemption at these regularly scheduled renewals and not more frequently in order to maximize administrative efficiency. And again, this approach matches what DHHS has already proposed in draft regulations. I have a few more things in my testimony and in the number of resources I've provided you, especially on the cost of implementing work requirements. Two other states have fully implemented work requirements prior to HR 1, and they've sunk immense administrative costs-- in Georgia, double what they've actually spent on providing healthcare. So there, there's a big price tag associated with implementing work requirements. The other piece I'd flag is it's really important that we have sufficient time to build in transparency. There's a lot of moving pieces. As you've heard from organizations who know Medicaid well, we have lots of questions about how this is all going to work. Imagine for Nebraskans enrolled in Medicaid or seeking Medicaid, how much more confusing this is, and how much more consequential, for folks who are relying on Medicaid for access to healthcare. So I see I'm at the red light. I will stop there, but I'm happy to answer any questions.

HARDIN: Georgia and Arkansas? Was that who it was?

KELSEY ARENDS: Correct.

HARDIN: OK.

KELSEY ARENDS: Correct.

HARDIN: All right. Thank you. Questions? Seeing none, thank you.

KELSEY ARENDS: Thanks.

HARDIN: Thank you for giving us something to read.

KELSEY ARENDS: Plenty. Lots of options.

HARDIN: Proponents, LB812. Opponents, LB812. Welcome back.

DREW GONSHOROWSKI: Is there one more after this?

HARDIN: Oh, we can do, we can do bills all night long. This is HHS. We're, we're not that bankers committee. I serve on that one, too.

DREW GONSHOROWSKI: Well, thank you. Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Drew Gonshorowski, D-r-e-w G-o-n-s-h-o-r-o-w-s-k-i, and I am the director of the Division of Medicaid and Long-Term Care in the Department of Health and Human Services. I am here to testify in opposition to LB812. LB812 provides certain limitations on the department's upcoming implementation of work requirements for the adult expansion group, which is required under federal law. As required under HR 1, individuals eligible for Medicaid under adult expansion must complete 80 hours per month of work, education, volunteering, or participation in a work skills program as a condition of Medicaid eligibility, with some exemptions including-- included for medic-- medically frail individuals and others. The majority of the provisions included in LB812 align with what the department's plans-- with, with the department's plans to implement. Our program is not planning to verify Medicaid eligibility more frequently than required under federal law, neither for the expansion group nor anyone else covered by Medicaid. We will only check compliance with work requirements at these intervals-- or at these renewals. Further, our baseline criteria that beneficiaries subject to work, work requirements must meet only requires them to meet work requirements for at least one month during their renewal period. For example, if we can verify that the beneficiary met work requirements during any of the months since their last renewal, they will be considered as having met them during the entire renewal period. Our opposition to this bill is specific to the provision that would delay our implementation of Medicaid work requirements until January 2027. As Governor Pillen announced in December, Nebraska is preparing to be the first state in the nation to implement the Medicaid work requirements under HR 1. Our program has the opportunity to serve as a model for other state-- for all other states. Additionally, we believe there are many advantages

for our beneficiaries by launching this program sooner rather than later. Work provides people with purpose, and this program will help our beneficiaries become more active members of their communities. Early implementation will ensure Nebraska's Medicaid program is compliant with federal requirements by the January mandate. A later implementation date may put Nebraska at risk. For these reasons, we ask that the committee not advance this bill to General File. Thank you for your time. I'd be happy to answer any questions on this bill.

HARDIN: Thank you. Senator Riepe.

RIEPE: Thank you, Chair. Thank you for being here and patiently waiting. The question I have, I've had some constituents that have contacted me that have maybe renal dialysis and some other things that-- or other kinds of technical and medical procedures that are so time-consuming that they-- will they be able to get waivers? Is that [INAUDIBLE]?

DREW GONSHOROWSKI: Yeah. So, so--

RIEPE: Some ALC-1s?

DREW GONSHOROWSKI: Yeah. That's a, that's a really great question, Senator. On, on this specific issue or, or concern, there is a medical frailty exemption. We are actively working with CMS to help, and, and actually establish what that looks like. So this gets-- as a hospital administrator, you can understand how quickly com-- complex this gets and how, how it needs close policy conversations with, with our federal partners on getting this right, because it is a question of round. I, I can think of the best example is if someone's primary diagnosis is something that would, you know, give them consideration to be medically frail, but they're in for a different sort of inclaiming. Right? So-- and then they're for a different service, and that diagnosis doesn't fall or doesn't actually get represented in the, in the claim. If, if that's the-- if that is the claim that checks whether someone is medically frail, you might have created an administrative issue. So we have to be very considerate of, of those processes as we're, as we're building these out with our federal partners, and, and it is a great opportunity for us to ensure that those are carefully done with the federal partners.

RIEPE: OK. Thank you. Thank you very much.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here. This is-- third time's the charm, I guess--

DREW GONSHOROWSKI: Yeah.

FREDRICKSON: --on the bills today. I have a few questions. So I, I was, I was kind of taking notes to some of the proponents of the legislation, so some questions that have kind of just come up in my mind. Have we, have we yet received any federal guidance on implementation of HR 1 changes like this?

DREW GONSHOROWSKI: So, so it's-- so how, how CMS is operating in terms of-- and this is, this is the situation for all states. I-- we, we sort of have different questions around pieces of the policy of implementation. Because obviously, you want to be able to have the rules in place so that you can build the products and, and, and operate in terms of the systems upgrades. So, so yes, CMS is getting back to us with, with pretty decent regularity. I, I think, I think all of us would want it to be faster, and I think that would be the case for all states. But, but they do-- so I, I can provide sort of examples, just, just questions around something that is in this testimony, whether this question around one month within a renewal period would be permissible interpretation from CMS, and our working assumption is, you know, from them that that would be the case.

FREDRICKSON: OK so some contact with them but no explicit--

DREW GONSHOROWSKI: Yeah.

FREDRICKSON: --guidelines quite yet. Are, are other states implementing this early or are they kind of waiting for the guidance?

DREW GONSHOROWSKI: So, so I, I would say that no state is waiting for the guidance. All states are actively engaged in, in planning implementation. The interim final rule, which is the, the sort of guidance document that comes in June, is a product of that ongoing work with states. So it's, it's not necessarily that a state is going to be surprised by what comes in June, and especially a state that's deeply involved in the process and is active with CMS shouldn't be that surprised.

FREDRICKSON: So are there other states who are implementing this earlier?

DREW GONSHOROWSKI: I'm not aware of any. I'm not aware of any that have specific public dates.

FREDRICKSON: OK.

DREW GONSHOROWSKI: I think--

FREDRICKSON: So as of right now, we're the only state looking to do this early?

DREW GONSHOROWSKI: I would have to--

FREDRICKSON: I don't mean that as-- I, I'm just genuinely curious if there's-- OK.

DREW GONSHOROWSKI: No, no, and I'm, and I'm, I'm trying to think if-- in my conversations, if I've had any specific outreach on early. I, I do believe that at least Montana has state statute that has, has them being implemented-- implementing early. Georgia already has a work requirement, even though their program is very different because it's, it's not necessarily-- they aren't a Medicaid expansion state. So the work requirement in Georgia, effectively someone has to demonstrate compliance to gain coverage in that eligibility category, so it's slightly different. So they already have one. But, but I would say Montana is probably a good example. I don't know the exact date that they would be targeting, but, but I know that they had a legislative activity that moved up their timeline.

FREDRICKSON: OK. And do we-- is it still-- is it-- do we have like, is it around 70,000 in enrollees?

DREW GONSHOROWSKI: Yeah, roughly between-- it, it moves between 60,000 and 70,000.

FREDRICKSON: OK.

DREW GONSHOROWSKI: I, I usually use 70,000.

FREDRICKSON: And does the department have like a, like a communication plan for-- I'm just thinking of those enrollees, for example, when these changes go into place, ensuring they're all aware of what the changes are, what actions are required on their part, what that looks like, how to go about, you know.

DREW GONSHOROWSKI: Yeah. And, and, and I'll say prior, prior to my arrival here, what I had learned about how Nebraska engaged in, in the unwind, so Medicaid redetermination and their ability to really work with the, the, the stakeholders and public partners to ensure that members have a lot of information proactively, I'm hopeful we can emulate a, a sort of model in that space as well. And I'll, and I'll also add, too, that as CMS is coming back with, back with us in terms of guidance, there are specific requirements around noticing, ensuring that we are reaching members by sort of means-- any means necessary. I, I believe outreach already went prior to the, the beginning of, of this year, which was something to ensure that, that we'd be able to, to move on our timeline.

FREDRICKSON: OK. And, and is the plan still to do all of this reauthorization in house with the same staffing levels?

DREW GONSHOROWSKI: Yes. It is.

FREDRICKSON: OK. All right. Thank you.

HARDIN: Other questions? Seeing none, thank you.

DREW GONSHOROWSKI: Thank you.

HARDIN: Opposition, LB812. Those in the neutral, LB812. And we have online, a total of 67 proponents, 4 opponents, zero in the neutral on this bill. And this concludes LB812. It also concludes the hearings for today. Thank you.