*Indicates written testimony submitted prior to the public hearing in accordance with the Legislature's guidelines on ADA testimony
Rough Draft

HARDIN: Welcome to the Health and Human Services Committee. I'm Senator Brian Hardin, District 48. And I serve as chair of the committee. The committee will take up the bills in the order posted. We're actually going to start with appointments today. But 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 one of these little rooms off to either side. Be sure to print clearly and fill it out completely. Please move to the front row to be ready to testify when that bill comes up. And 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 on that 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 microphone. Tell us your name, and spell your first and last name to ensure we get an accurate record. We'll begin each bill hearing today with the introducer's opening statement, followed by proponents of the bill, then opponents, and finally anyone speaking in the neutral capacity. We will finish with a closing statement by the introducer if they wish to give one. We'll be using a three-minute light system for all testifiers. When you begin your testimony, the light on the table will be green. When the yellow light comes on, you have one minute remaining. And the red light means we're about to eject you through the top of The Sower in the building. No, that's not true. But it does mean we're going to ask you to try to finish it up quickly. Committee members will come and go during the hearing. That's got nothing to do with the importance of the bills being heard. It's just the process of this building and how it works. We're introducing bills in other committees. A few final items to facilitate today's hearing. If you have handouts or copies of your testimony, please bring up at least a dozen 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 the hearing. 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 [SIC]. Written position letters will be included in the official hearing record, but only those testifying in person before the committee will be included on the committee statement. You may submit a position comment for the record or testify in person, not both. I will now have the committee members introduce themselves, starting with Senator Riepe.

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

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.

HARDIN: And joining us today is our legal counsel, John Duggar, as well as our committee clerk, Barb Dorn. And-- ladies, would you introduce yourselves?

SYDNEY COCHRAN: Hello. I'm Sydney. And I'm a sophomore studying history at UNL.

DEMET GEDIK: Hi. My name's Demet Gedik. I'm also a student at UNL. And I study political science.

HARDIN: We're going to start today with a Zoom call. Listen overhead. So we have Linda Mentink for the Commission for the Blind and Visually Impaired. Can you hear us, Linda?

LINDA MENTINK: Yes, I can, sir.

HARDIN: Wonderful.

LINDA MENTINK: Can you hear me?

HARDIN: We look forward to hearing from you. Take it away.

LINDA MENTINK: OK. I'll give it back when I'm done. Good afternoon, everyone. My name is Linda Mentink. I am from Columbus. I am a reappointee to the Board of Commissioners for the Nebraska Commission

for the Blind and Visually Impaired. I've served on this board for the past four years. I've really enjoyed it. I'm originally from Wisconsin and moved here in 2004 to teach music, and work with Bible Baptist Church Choir. So I teach music at the Christian school there part time, and very involved in, in the ministry there, also in other blindness organizations. My desire for being reappointed to the committee has a little bit to do with the fact that I enjoyed it a lot and a little bit also to do with the fact that, in Wisconsin, the vocational services are deplorable. And I didn't get good service in Wisconsin, and other blind people still don't get great service in Wisconsin. And I heard about the Nebraska Commission for the Blind and saw people interacting with each other, traveling around well, doing what they need to do. Found out a little bit more about it and-- that it's one of the top commissions in the United States of America. And I really wanted to be a part of making life better for blind people. So that is my desire to continue as a commissioner.

HARDIN: Very good. Can you tell us a little bit about your passion for this continued opportunity?

LINDA MENTINK: Well, I think it's important that, that blind people get the training they need so that they can be in-- independent as a blind person, just like I am. I mean, there are things we need to depend on others for as we, as we all do, whether we're blind or sighted. But I've just been really encouraged by the work the commission is doing, and I want to help to facilitate that and, and do what I can to lead the commission and, and to be a, a support to the commission and to Carlos Servan as executive director.

HARDIN: Very good. Questions from the committee? I'm seeing none. We appreciate you calling in. And I'm just curious, can you-- you, you can hear us OK, right? Because in years past, believe it or not, we've struggled with this technological piece and we've had to use smoke signals.

LINDA MENTINK: That wouldn't work for a totally blind person.

HARDIN: That's correct.

LINDA MENTINK: No, I-- I'm using a, a Braille tablet. It's called a BrailleNote Touch.

HARDIN: Yes.

LINDA MENTINK: And it-- it's an Android system. And so--

HARDIN: It's working.

LINDA MENTINK: --I, I have the Zoom app on it. And so--

HARDIN: Awesome.

LINDA MENTINK: --we're good.

HARDIN: Well, thank you so much. We appreciate you being with us today.

LINDA MENTINK: Thank you.

HARDIN: Wonderful. Thank you. This concludes our appointment hearing for Linda Mentink. Now we're going to have Cheryl Livingston. And Cheryl's right here.

CHERYL LIVINGSTON: Yes.

HARDIN: No more fancy technology sh-- for this one. Thank you for joining us.

CHERYL LIVINGSTON: You're welcome. Thank you for having me.

HARDIN: Thanks so much. Tell us about your-- tell us about your world.

CHERYL LIVINGSTON: Well, I am-- like Linda, I am a reappointee to the Nebraska Commission for the Blind and Visually Impaired. I am myself what they call a low-vision person, which means I have some usable vision but my eyesight isn't good enough, say, to drive a car. I do reprint. I-- I'm kind of in a unique position of having been an employee of the Commission for the Blind. Also, I just want to say that I'm a native Nebraskan. I was born and raised in Fremont and lived in Omaha for a while and then moved to Lincoln. So I've lived here now for a number of years. I-- I'm, I'm in the unique position of-- for-- at one time having been a client of the commission. Of course, back then it was the Nebraska Services for the Visually Impaired, and it was a state agency under state government. I was a

client back in the '70s and then later a, a client again in the '90s when I went to finish my college degree. And this was, again, before the agency became an independent commission. I am also the designee of the National Federation of the Blind of Nebraska, which is a consumer organization of blind people that's organized on a national level. We have an affiliate here in Nebraska. And the board of directors of the Nebraska affiliate agreed to have me represent the federation on the commission board. And I would also like to say that I enjoy being a commissioner. You know, having been a client at one time, having been an employee at one time, I retired from the commission for-- in 9-- in 2020 after 21 years of work with the commission directly as an employee. I was not a counselor, but I was a member of the support staff. And that was an important part of-- you know, being a part of the commission too. So now I get to see the commission from a little bit different perspective from the point of being able to look at it, look at the work that they're doing, you know. The, the more-- the board supervises Carlos Servan, who is the executive director. And I, I, like Linda, believe the commission is doing very good work. And the, the clients seem to be pretty pleased with the work they're doing and, and the counselors seem to be pretty pleased too, so.

HARDIN: Very good. And so, in, in total, you've been involved either working with or serving in this capacity for how long?

CHERYL LIVINGSTON: Probably in one way or another since the 1970s.

HARDIN: OK. That's wonderful. Questions for-- yes, Senator Meyer.

G. MEYER: Thank you, Chairman Hardin. Thank you for coming today. As part of the, the Commission for the Blind and Visually Impaired, you're advising, making suggestions, trying to improve the delivery of services and that type of thing. Do you interact with, with the Governor's Office? Do you interact with the Legislature and, and-- just-- could you describe a little bit of, of what your interaction is? Perhaps you just did, but.

CHERYL LIVINGSTON: Well, yes. We-- for instance, last week, there was a hearing that was held on possible state-- budget cuts to state agencies, and Carlos Servan and I came-- in fact, it was in this very room-- last week and testified opposing the 5% budget cuts that are being suggested by the Governor. So board of commissioners, you know,

we can, we can come and, and talk to senators, be involved in, in legislative issues. You know, we can visit with Carlos about issues that concern the commission. We also can reach out to the commission staff and ask how they're doing with their jobs and their services and so on. In fact, right now, the board is in the process of trying to work up a survey that we can send to the commission staff to find out how they feel about their jobs, how they're doing, what kinds of things they might need. And then we'll use that information from that survey to determine if changes need to be made or, or-- you know, to help Carlos with his job of directing the, the commission.

G. MEYER: Well, thank you. Given, given your perspective of having benefited services from the commission and now oversight with the commission, I appreciate your service. Thank you for coming in today.

CHERYL LIVINGSTON: Thank you.

HARDIN: Can, can you maybe share with us given the fact that-- you've, you've been, you've been at this for a while. How do we need to change?

CHERYL LIVINGSTON: Well, I think, I think that, right now, the commission is doing a good job of providing services. And I think the employees seem to be pretty, you know, pretty happy with their jobs. I guess one of the things that I would, I would like to see is, is maybe the counselors receiving a little bit higher salaries because I think the work that they do is, is very important. And I understand that they're being paid a little bit less than what the-- you know, what counselors in voc rehab are, so I think that, that-- if they could receive an increase in salary, I think would be great for them.

HARDIN: OK. Thank you. Any other questions? Seeing none. We appreciate you being here.

CHERYL LIVINGSTON: Thank you.

HARDIN: Thank you. This concludes our appointment hearing for Cheryl Livingston. Next, we're back to the Zoom world, Dr. Jeremiah Rethwich [SIC]. Can you hear me, sir?

JEREMIAH RETHWISCH: Yep. I can hear you just fine. Can you hear me?

HARDIN: Wonderful. We can hear you also. Thanks for being with us. Would you be willing to tell us a little bit about your world?

JEREMIAH RETHWISCH: Yeah, sure. So I've been a, a practicing chiropractor for just over 20 years. Grew up in Wayne, Nebraska originally. Went to Wayne State College and then onto chiropractic school up in Minnesota. Moved back here in '04. Been practicing ever since. I now practice in a multispecialty clinic with chiropractors, physical therapists, and massage therapists. And I've served on our state associations, the, the Nebraska Chiropractic Physicians Association Board of Directors for several terms. I've been on several of their committees: the Legislative Committee, PAC Committee, Scope of Practice Committee. Have done a, a term with the Board of Chiropractic a few years back. And now Board of Health. So practicing full time and, and help out with the association and, and boards like this when I can.

HARDIN: Very good. Tell us a little bit about what you anticipate a-- as-- participating as a Board of Health member.

JEREMIAH RETHWISCH: Well, we've had two meetings so far. And, and, and so far, I-- you know, we haven't had a whole lot going on. Nothing, nothing interesting, that's for sure. So I'm just kind of-- just kind of, you know, newly getting into this and, you know, don't really have any expectations. Just, just here to serve and help out.

HARDIN: Well, we on the Health and Human Services Committee will see if we can spice that up for you with some 407 processes sometime soon, so. Any questions from the committee? If you cannot--

JEREMIAH RETHWISCH: Nope? No, thanks.

HARDIN: If you cannot see us, they're all snickering, so. They, they like those 407 process experiences. But we really appreciate your willingness to serve in this capacity. We desperately need the Board of Health because-- well, other than Dr. Ben Hansen, who sits on this particular committee, the rest of us did stay in a Holiday Inn Express last night. So we, we need you, we need the technical review committees, and we need that process to, to work well. So we thank you for being with us.

JEREMIAH RETHWISCH: Yep. Thank you. Glad to help.

HARDIN: This concludes our hearing for the appointment for Dr. Jeremiah Rethwich. Next up, Dr. Jaime Dodge. Thank you for being with us.

JAIME DODGE: Thank you, Senator Hardin, committee members. Jaime Dodge. I practice full time here in private practice in Lincoln, Nebraska. I've done so not only in Lincoln but other parts of Nebraska for a little over 20 years. Have served on the Board of Health since 2022-- was my first appointment, so I'm a reappointee. And served in one of the allopathic physician in these slots on that, on that board that Dr. Rethwisch just spoke about. Originally from Custer County, Callaway. Married with five children, all of which are still here in Lincoln. And I've enjoyed the time on the board. As you well know, it's a multidisciplinary body. We represent al-- almost every medical, chiropractic, physical therapy, mental health, multispecialties across the state bo-- across the state. With laypeople as well. And look forward to continuing to serve. Would appreciate the opportunity.

HARDIN: Thank you. Questions? How do you perceive-- I, I, I think one of the challenges I look at just in general-- and I think, oh, boy, this is going to be coming to the Board of Health-- is just the technological challenges that are coming our way in, in medicine in general. We're all using that catchphrase of AI and so on and so forth and-- anyway, do you have thoughts? You've been around doing this for four years, and is it beginning to pick up in tempo in terms of some of these things that might make your own eyes cross and whatnot? Can you just kind of speak to the technological challenges of being a part of a board of health in any state right now? But what's that look like, feel like?

JAIME DODGE: Yeah. That's a great question, Senator. I think the-- technology and innovation often, a-- as you well know, outpace legislation and regulation. And I think a body like the Board of Health plays an important role in staying ahead of that from a standpoint of keeping Nebraskans, I would say, safe, informed, a-- as the technology advances a-- and, you know, people like, say, physicians or hospital systems or health care, seek to utilize that-- and, and maybe necessarily so-- but just making sure we use that to

the benefit of the citizens versus maybe to the benefit of, you know, a, a-- just the technology itself. So it, it is--

HARDIN: Can I ask an inside baseball question? What happens when somebody-- let's say a scope of practice oriented bill or something does come along and it's involving a new technology that some of you've probably heard of-- maybe you've used it, but it's not quite common yet-- how does the Board of Health go about the process of going, we need to figure out what this is? What does that look like for you all?

JAIME DODGE: Yeah. And again, as, as an advisory board, what's great about it i-- you have the perspectives of all the different practitioners on the board, this-- the, the, the laypeople, and the experience over years. We're, we're all-- I would say all, but almost all of us are 20-plus years into, into our professional careers, which gives that perspective to, to take a new technology and say, you know, this could be good. It could be very good. Oftentimes, advances are if, if used the right way, so. You know, our-- the processes by which we discuss and then review and then advise-- gonna say, for example, the, the Legislature or the chief medical officer-- are set up just in that way to, to allow for that advancement, to allow for that innovation, but to also perhaps give some words of caution or, or, or advice to where maybe we should implement it a different way or at a different time.

HARDIN: Very well. Not seeing any other questions. Appreciate you being here.

JAIME DODGE: Yeah. Thank you.

HARDIN: Thank you. This concludes our appointment hearing for Dr. Jaime Dodge. And so now we are going to turn to LB1091. And Senator Bostar. Welcome.

BOSTAR: Thank you. And good afternoon, Chairman Hardin, members of the Health and Human Services Committee. For the record, my name is Eliot Bostar. That's E-l-i-o-t B-o-s-t-a-r. Representing Legislative District 29. I'm here today to introduce LB1091, legislation that reflects the ongoing collaborative work between providers, policymakers, and the Nebraska Department of Health and Human Services

to ensure that Nebraska's most medically complex, long-term care clients receive consistent, high-quality services. This bill is about refining our system so it meets the needs of the most vulnerable and most care-intensive Nebraskans. LB1091 makes a simple change to exclude skilled nursing facilities and nursing facilities' services for long-term care clients with special needs from enrollment in the Medicaid managed care program. Instead, skilled nursing facility care and nursing facility services provided to a long-term care client with special needs shall be administered and reimbursed through fee-for-service Medicaid or another non-risk-based delivery system authorized under the state or federal law and not through Medicaid managed care. This legislation works to preserve budget neutrality while providing clear statutory direction that ensures specialized long-term care services for individuals with complex needs are administered in a manner that prioritizes stability and continuity. By clarifying expectations in statute, the Legislature can support the Department of Health and Human Services in implementing a service delivery model that works better for clients, providers, and the state of Nebraska. Of the nearly 300,000 individuals currently enrolled in Heritage Health-- the state's managed care system-- this legislation impacts fewer than 150 Medicaid beneficiaries. LB1091 is not designed to upend the state's managed care systems but instead recognizes the specific challenges that caring for this high needs population creates and shifts this small group back under a fee-for-service payment system. This change creates consistency in our system for long-term care clients and their families, as the remainder of the state's long-term care supports and services are currently funded and managed through a fee-for-service model. Importantly, LB1091 recognizes the Department of Health and Human Services has been willing and engaged partner in conversations about how best to serve this population. Legislation offers a framework for continued collaboration, one that respects the department's operational expertise while giving providers and families confidence that services for their medically fragile loved ones will remain stable and appropriately structured. My office and the proponents of the bill have worked closely with leadership of the Department of Health and Human Services and the Governor's Office to craft AM2194-- which I have distributed-- which eliminates the fiscal note and any concerns from the department regarding their ability to continue deploying various utilization management policies that are outlined in the current regulations for special needs

long-term care facilities. This is simple legislation meant to deliver the best and most tailored quality of care for the most vulnerable special needs long-term care clients in our state. The clarifying amendment rectifies concerns of Department of Health and Human Services and maintains fiscal neutrality for state coffers. I'd urge your support for LB1091. I thank you for your time and consideration. Be happy to answer any initial questions you may have.

HARDIN: Thank you. Senator Fredrickson.

FREDRICKSON: Thank you, Chair. Thank you, Senator Bostar, for being here and bringing this bill. So I'm, I'm just kind of reading over this quickly. So the-- essentially, this would be almost like it a-- it'd be a carve-out for Medic-- managed care for these organizations. Is that--

BOSTAR: Yeah. I, I think you'll, you'll have some of the folks behind me probably argue about the technicality of the-- whether it's a carve-out. I, I think functionally that's accurate. I think that there's-- there's the opinion that they were sort of inappropriately carved in--

FREDRICKSON: Understood.

BOSTAR: --for this group.

FREDRICKSON: Understood.

BOSTAR: We're fixing that.

FREDRICKSON: And is the concern that if they were to be in network with managed care that-- can you, like, share a bit more about why this is, I guess-- why, why, why is this needed, right, work with-- yeah.

BOSTAR: Yeah. Absolutely.

FREDRICKSON: And I can ask someone behind you too [INAUDIBLE], but.

BOSTAR: Right. I mean, the folks behind me are-- they're the ones living with it--

FREDRICKSON: Yep.

BOSTAR: --the, the system and programming day-to-day who will do a much more compelling job with this than, than I'm about to. So, you know, note that, please. But essentially, this population is just not served particularly well with how managed care systems work. They are extraordinarily high needs patients, clients, individuals who, when faced with continuity challenges with their care or delays in programming with their care, face extraordinary complications, and complications that frankly cost us a lot of money. Because for this group of people, when, for example, there's a challenge with admission to a qualifying facility under this framework, they're ending up in acute care settings. They're ending up in hospitals, which actually costs the state more money. I mean, these are-- this is a Medicaid population. So by introducing the levels of processes that MCOs have for, for-- again, for this small group of people, it ends up creating more problems and more costs.

FREDRICKSON: Understood. Thank you.

HARDIN: Any other questions or all-- have we all been persuaded by Senator Bostar to wait for others to speak to us first? So-- looks like you persuaded them. Will you stick around?

BOSTAR: I won't miss it.

HARDIN: Great. Proponents, LB1091. Welcome.

NASH MAHUPETE: Thank you. Good afternoon, Chair. And good afternoon, members of the Health and Human Services Committee. My name is Nash Mahupete, N-a-s-h M-a-h-u-p-e-t-e. And I proudly serve as president and CEO of QLI. I'm here today in strong support of LB1091. In 1989, this Legislature did something no other state has successfully replicated: the Unicameral gave their approval for QLI to be built in Nebraska in partnership with DHHS and Nebraska Medicaid. That decision would forever change the lives of thousands of Nebraskans for the better. QLI was created to serve a very specific and complex population-- like Senator Bostar was saying-- individuals with brain injuries-- traumatic brain injuries, spinal cord injuries, and other catastrophic conditions. From the beginning, we were designed as a solution for Nebraskans whose needs did not fit traditional systems.

In 2017, with the implementation of Heritage Health, QLI's rehabilitation campus was swept into the managed care system as a function of la-- licensure classification. The regulations governing this special needs population did not change. The clinical needs did not change. But the care management reimbursement changed, and not for the better. Since that time, our experience has made it clear that MCOs are not the appropriate vehicle for administering long-term care services for individuals with specialized needs. Prior to Heritage Health in 2017, approximately 20% of the individuals we served were Nebraska Medicaid members. Today, that number has decreased and fallen to less than 5%. This decline is certainly not due to the reduced need. As hospital data shows, admission for traumatic brain injuries and spinal cord injuries has steadily increased in recent years. The reduction reflects increased denials of admission to QLI and denials by MCOs of continued, necessary care. Over the last four years, MCOs have functioned just like commercial health group ca-- insurance carriers. While that model may function in short-term, acute care settings, it does not provide the stability required for medically complex individuals who re-- who require long-term rehabilitation and support. When the most appropriate level of care is provided, long-term outcomes improve and we know long-term cost decrease. The right care at the right time is not only clinically responsible. It is fiscally responsible. QLI for many years has boasted outcomes that are unrivaled. 90% of the people that we serve at QLI go home. They leave better. And yet we have seen a huge reduction in Nebraskans on Medicaid served. That's a travesty. LB1091 offers a targeted refinement. It does not dismantle managed care. It affects at most 150 individuals. If you're doing the math, that's 0.005% of the people on, on, on, on-- enrolled in-- on-- in Heritage Health. It returns this narrow, highly specialized population to a fee-for-service structure that already exists in Med-- within Medicaid. Because the administrative framework and personnel already exist in DHHS, our goal today is to restore a system: one that works for a very specific population of medically complex Nebraskans, one that works for Nebraska Medicaid, and one that works for providers like QLI. I'll wrap up. This bill strengthens alignment between Legislature, DHHS, and providers, and it ensures that individuals with specialized needs are served in the most appropriate and fiscally responsible manner. I implore you, committee, to support LB1091. I'm happy to answer any questions.

HARDIN: Paint a picture for us of some of the technologies that are employed there and some of the outcomes that can happen as a result of the technologies that are employed that help 90% of the people to go home better than they came in.

NASH MAHUPETE: I'll paint a picture of the technologies, but I'll also say it's the people that work at QLI who make these outcomes happen. I work with--

HARDIN: The technologies don't run themselves.

NASH MAHUPETE: Yeah, exactly. 450 amazing individuals whose heart is in the mission of delivering life-changing rehabilitation and care-protecting did-- dignity and this commitment to excellence. The technology that we have over there is second to none. We have people coming from all over the United States. 48 states are sending people to Omaha, Nebraska-- small, little Omaha, Nebraska-- because they know that we have world-class technology that is being deployed in, in sometimes trial phases that we're utilizing within QLI. You have machines such as a Rise&Walk, which can help somebody get up and work on some of the, the, the gait patterns that they need to get so that they make improvements. When I look at QLI and the things that we're doing, we're there to do just two basic things. One of them is this piece of neuroplasticity. We're there to teach and reteach individuals how to get back to life, and technology is a huge partner in that. The other thing that we do is, I always say, is we deal hope. People have hope when it comes to life after injuries. And so the technologies we have over there are second to none. I'm very proud of the committee that we have. They've all visited QLI, and so I know that there's commitments with this committee in terms of the stakeholders of people that are out there being served. So thank you.

HARDIN: Questions? Senator Quick.

QUICK: Yeah. Thank you, Chairman. So-- I know I had the opportunity to visit your facility in, in Omaha. And you have a variety of age-- people fro-- all different ages, right, and different-- whether it's a workplace injury or maybe a car accident or things like that. Could you talk a little bit more about some of the--

NASH MAHUPETE: From an admissions aspect, you're talking about people who are sometimes maybe as young as 14 and-- younger adults. Sometimes you'll have-- we don't cut off at a certain age, but then you have to be able to participate in this program. You have farmers who might be in their 70s or 80s but they're quite sprightly. And so you have everything in between there, but our average age is about 40, in the-- in their 40s. And so you're talking about people who have had catastrophic brain injuries and-- probably the place that they would go if they didn't-- if they don't come to QLI is probably a skilled nursing facility, which is for-- designed for people at the end of their life. These are people with a lot more life to live. And you'll hear one of the te-- testifiers today. We have people going back to work and coming off of Medicaid. And so that is a huge savings. And so anyone who would come in opposition of this I think is a little bit maybe delusional as to why we're over here saying this is the right vehicle for us to move back to this fee-for-service. So it is imperative, yes, that we continue to serve the young Nebraskans who are getting injured appropriately.

QUICK: Yeah. And, and then along with it, I think you've-- when I was there-- you might have family members there too because, as they're going through their process, you might've had family members have to work with them as well to help them acclimate back, right?

NASH MAHUPETE: We are working-- thank you very much, Senator Quick. We're working not only with the person who's injured. We have a family housing pro-- as part of our program, where that loved one is also part of the process. There's a healing that needs to happen not only with the person that's injured but their network and people around them. And so sometimes we're getting people from far west in Nebraska coming out to, to, to Omaha and staying over there for the duration of their, of their loved one-- not just so that they learn how to help that person get back home but also they go through the healing. This injury does not just impact one person. It-- inj-- it, it impacts sometimes a whole network of individuals-- friends, family, children of, of, of, of, of those people that we're serving. So it is imperative that they're part of their program. So yes, great observation on that.

QUICK: Yeah. Yeah. Thank you.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair Hardin. Nice to see you again. I too had an opportunity to tour the facility, and it was very impressive. You say you're getting referrals from almost all the states in, in the United States and perhaps, perhaps other countries-- I don't know about that, but.

NASH MAHUPETE: That's right.

G. MEYER: What sets you apart? Why do people come here? Why aren't other states and other communities emulating what you're doing? Or are you working with other areas to set up something very similar to QLI?

NASH MAHUPETE: Well, the secret sauce is our people, first of all. And-- it was an honor to host you on our campus, by the way. When people are sending the, the-- their injured loved ones or even workers from other states-- first of all, they know that they're going to get bang for their buck. Other states are saying, it's better for us to not serve them within Nebraska-- and this is including Medicaid-- and go to-- to, to-- not to serve them in their states and go to Nebraska. And they have mechanisms that they've said, we'll make an exemption and then you can get back en-- enrolled into this managed care. And one of the things that I talked about was this piece of-- you have individuals who are coming-- and 90% of the people we're serving-- our outcomes are out the roof. 90% of the people that we serve go home. That is a big deal. Because this means that there are less people in nursing homes, there's less people in hospital beds, which costs more. There's less people going back to rehospitalization because they haven't gotten the right treatment. And there are people who are living with purpose on purpose. And so that's a piece of why people are sending individuals to, to, to QLI. We've had some discharges to South Africa, to Bulgaria, Sofia. And we might be getting an-- another admin that we'll be taking, hopefully, to Japan at some point, so. We're a pride of Omaha and Nebraska. Proud to be in the state.

G. MEYER: If I may, we-- you, you talk about the skilled nursing facilities, maybe an alternative, if not at your facility, cost-wise, how, how, how do you stack up? And-- I hope that's not a uncomfortable question, but that's certainly always a consideration. But very

cost-effective compared to a skilled nursing facility or, or alternative to coming to your facility?

NASH MAHUPETE: Very cost-effective if you're looking at being fiscally responsible. When you have somebody that comes or goes to just straight a traditional nursing home, you're going to talk about meds for depression. You're going to talk about pressure ulcers. You're going to talk about-- you know. So this is something that-- as all of us are taxpayers of this great state, we have to make the right fiscally responsible actions. And again, I said 5%-- less than 5% of people [INAUDIBLE] Nebraska are coming to QLI. That means, somewhere along the line, they've gone hospitals, they're sitting in, in nursing homes, and are probably going back and forth in the hospital. The Hospital Association probably wrote a letter of support, and there'll be some evidence probably there to show that it is a better investment for our state-- not just the kind, nice thing to do, but a great investment for our state to get people to QLI when they need to be. And we are-- we have always proven and shown that we're great stewards of funding. When we say we serve who we serve-- we, we don't say we serve the, the, the resident and the client that we have. We say we serve QLI, the mission. And the QLI mission serves the client, the family, funding sources. So that would mean Nebraska Medicaid, our community at large, and each other as team members. So that's what every single person that comes to QLI and works over there understands. We're not just myopic and just looking at this one thing. It's a matter of, let's look at a whole picture. We are taxpayers as well.

G. MEYER: We always think about return on investment, and it sounds like that certainly is also a consideration. And it looks like we're getting a very good return on our investment, so. Thank you.

NASH MAHUPETE: Thank you very much, Senator Meyer.

HARDIN: Senator Ballard.

BALLARD: Thank you, Chair. Good to see you again, Nash. Can you help paint a picture of the last ten years in this space? You said 2017 was kind of the, the change of-- you've seen a decline in Medicaid members into your facility.

NASH MAHUPETE: Yes, sir.

BALLARD: Is-- so is that just based on reimbursement rate or is that just from your admission standpoint? Can you ki-- kind of paint a little bit broader, broader picture on that point?

NASH MAHUPETE: Up until about 2016, about 20% to 25% of the people that we're serving on our campus, on our rehabilitation campus, were on Nebraska Medicaid. In comes Heritage Health, and we have seen a decrease in those numbers because of a, a-- pretty much denial for, for acceptance to come to QLI. And so where are those people going? And then we've had situations where people have been admitted to QLI and then quickly they cut the funding. And so-- we are in it for the long haul. We have had people-- for example, last year, in total, $1.6 million that we went un-- unfunded, not just from Medicaid but because we're always going to do the right thing. When we bring in somebody into our-- onto our campus, we're saying we will make sure that we have gone all the way to make sure that you get home and, and, and back to what we consider the fair amount of work that we put into people. So $1.6 million unfunded. And so we've seen that decrease. And also less than 5% now has been Nebraska Medicaid because they will deny before you even get there. And if you get there, it's a huge risk because we've gone through something called a state fair hearing, which is travesty at best, and you have to pay 70-something thousand dollars and-- or upwards of that. That is something that we would have to go through to then get appro-- approval for, for those individuals to then get the payment back. And so it's a huge risk. We-- now we're looking at our partners and, and the people in-- of the state of Nebraska as a risk. That's not how we should be administering Medicaid. People are not a risk, and so-- that's how they-- that's how it has become. And that is unfair to the people of Nebraska. And anyone who tells you otherwise, that this should not happen, is probably somebody who is maybe hoodwinking and wanting to make a selfish act to-- that does not put the investment in the people of Nebraska.

BALLARD: OK. Thank you.

NASH MAHUPETE: Thank you for your question, Senator Ballard.

HARDIN: Other questions? Seeing none. Thank you.

NASH MAHUPETE: Thank you, committee.

HARDIN: Proponents, LB1091. Welcome

BRENT SHANHOLTZ: Good afternoon. Thank you for the opportunity to speak to you today regarding LB1091. I'm Brent Shanholtz, B-r-e-n-t S-h-a-n-h-o-l-t-z. I'm the chief financial officer for Ambassador Health, a family-owned health care organization that has served Nebraskans for over 50 years. Ambassador Health provides special needs care to some of the most medically complex patients in the region-- specifically, ventilator-dependent patients and pediatric patients with ventilator, tracheostomy, and medically complex care needs. Ambassador admits these complex patients directly from the hospital with a focus on efficiently shortening the higher cost, acute care stay, and achieving quality patient outcomes. The current Nebraska special needs model gives Ambassador Health a unique perspective on the functioning of managed care organizations. I'm a CFO, so I'm going to start with some numbers. Over the last seven years, our special needs programs have averaged about 94 admissions per year, 88 discharges per year, and cared for an average of 52 Medicaid patients per day. Only 7% of those Medicaid patients' days were covered by MCOs. About 57% of those Medicaid admissions, however, to our programs were covered MCOs. Compare that to the time of discharge, only 21% of patients are still covered by MCOs. The censa da-- census data indicates that the Nebraska Medicaid Department is managing the majority of the length of stay and is involved in the majority of the discharges from the Ambassador's special needs programs. The impact of the days managed by the MCOs is small compared to the overall footprint, and the Nebraska Medicaid Department is handling and will continue to manage the vast majority of the special needs clients. These trends support the budget neutrality of LB1091, as the patient days managed by the MCOs are minimal and the streamlined process with the Medicaid Department keeps the dollars within the special needs programs and avoids the unnecessary administrative MCO cost. Additionally, there's a well-established rate-setting process for Nebraska's special needs providers. It's driven by annual cost reports and patient utilization. The existing structures with the existing number of beds for providers is not going to be changing. Thus, the calculation method for the per-day cost and the daily reimbursement rates will be unchanged. The model will continue to provide direct cost visibility, alignment with legislative appropriations, and stable

provider participation in care access, along with flexibility and timely adjustments for changing needs for this medically complex population. Nebraska Medicaid already has efficient processes for navigating patient eligibility for case management and for level of care determinations. And please do not assume that denials and case management directives can only be administered by the MCOs. The Nebraska Medicaid Department has no problem saying no and, and denying care when appropriate. And the Medicaid Department, they evaluate care needs and placement options, and they do so with clear and efficient processes for quality patient outcomes. MCO utilization and special needs drives duplicative and redundant administrative processes. Preserving coverage for special needs nursing facilities protects care access, supports hospital discharge efficiency, and ensures continuity of care for Nebraska's most medically fragile. Happy to answer any questions.

HARDIN: Thank you. Questions? Senator Quick.

QUICK: Yeah. Yeah. Thank you, Chairman. So on the-- so the MCOs when it comes-- do they determine a number of days they feel would be appropriate for that patient if they're-- or how does that work? Can you explain some of that?

BRENT SHANHOLTZ: I'll, I'll do my best. And it's not always consistent, but there will generally be a, a determination of days or an authorization for a certain time frame to be updated and reviewed and then redetermined. So that could be anywhere from 1 or 2 days, or that could be 14 days. In some instances, that could be a month. Generally, it's shorter compared to longer for that authorization. And I would add to that, you're providing all the information, say, from the hospital, from the practitioners, from, from all the folks involved in the care management at the time of admission. Each time you're reviewing that authorization or updating that authorization, you're pulling all that information together again and resubmitting that information again each time to go through an authorization process, you know, a week or two later.

QUICK: OK. Because I know, like-- so my mom was in a skilled care unit, which is completely different from what you're doing, but-- so she was-- they said she could have 90 days. And then at that end of that 90 days and-- she would have to go to a nursing home or do

something else, which I don't think was, you know-- anyway. So do you face some of that too, where you get a certain number of days-- I guess you're trying to explain that-- you are, and then you have to go through that process again of reapplying if that person hasn't finished the rehabilitation to try to up a number of days and-- is there any point where you get to where you know someone needs more rehabilitation to get to where they need to be to be able to go back home but there's-- you can't get them to approve that process?

BRENT SHANHOLTZ: In, in a word, yes. I-- not applying just to Medicaid but to that insurance coverage process in general. And oftentimes with the MCOs, yes, you, you may run into a process where a determination has been made, a denial has been issued for continued care, and perhaps you dispute that as a provider. Perhaps the patient or the patient's family disputes that. May choose to follow the insurance company's determination. You may choose to appeal that. All of those-- all those determinations take time, energy, and, and financial resources to follow those processes.

QUICK: OK. Because you would also have work comp claims too, right? I mean--

BRENT SHANHOLTZ: Yeah.

QUICK: --someone who's hurt on the-- on a job and-- that would be probably some of the same process then, right?

BRENT SHANHOLTZ: Yes.

QUICK: You-- OK.

BRENT SHANHOLTZ: And special needs care sees a lot of work comp related activities and-- yes, that's-- I-- again, not directly affiliated with, with a managed care organization for Medicaid, but, but definitely a relatable process.

QUICK: OK. All right. Thank you.

HARDIN: You were mentioning-- the length of stay is largely determined by insurance contracts, perhaps more than the reality of the needs of the fragile person. Is that correct to say?

BRENT SHANHOLTZ: It, it-- yes, depending on the, the eligibility and the coverage of the, of the beneficiary, yes.

HARDIN: Do you have a sense in terms of, of those who come to Ambassador about how many of those go home or are, shall we say, in a much better place so that they go back to a skilled nursing center? And do you have a percentage idea of how many are, are helped by the time that they spend with you?

BRENT SHANHOLTZ: Sure. You know, the, the goal with every patient that, that we're providing care for is to get to the-- get, get rehabilitated, get stabilized, education wi-- with family and caregivers at home and, and move to a lower level of care or move to home if at all possible. Our pediatric population we focus on very closely in terms of having respiratory therapy, education, and training to get that patient home. It can be very intimidating as a parent to understand that, now I have tracheostomy cares that I need to perform and suctioning that I need to do in the home. And if you don't have that education and that training and that safe transition home, you're going to be in a position where you're at risk of readmission. And then you're back to the hospital setting, an emergency room visit at a high cost. And then you're probably back to a, a care provider like Ambassador or, or a-- another special needs provider to work that process again. And that is creating, you know, additional cost to the program. That's wha-- that's what we're all trying to avoid, so. To answer your question, yes, the goal is always to transition a patient home. Not all special needs patients are going to be able to make a full transition home. A, a ventilator dependency, the need for, for special-- specialized equipment and things of that nature are going to be in that case. But I mentioned in my opening remarks we admitted 94 patients, we discharged 88 patients on average over the last seven years. Most of our patients are, are getting to that lower level of care and, and eventually getting back home.

HARDIN: Very good. Senator Quick.

QUICK: Yeah. Thank you, Chairman. Do you also have to work with people to try it with-- so when they do go back home-- and let's just say they-- like, for an A-- A&D waiver or something like that, do you help them learn how to do that process so that-- because a lot of people really don't understand how to, how to do that type of wor-- you know.

BRENT SHANHOLTZ: I really appreciate that question. We, we have a, a very involved social services and support team that helps navigate all of those benefits, including the MCO processes and protocols and insurance, but also your eligibility, your determinations, your, your, your waivers for the-- for, for home- and community-based services. And, and navigating that Medicaid eligibility and those six-month resources-- oftentimes, you're going to have patients that, that require guardianship or, or additional support that we have to line up as well. If you have a, a pediatric patient whose family isn't available or able to support that level of care, that falls to the special needs providers like Ambassador Health to oversee all the aspects of the care.

QUICK: All right. Thank you.

HARDIN: Very good. Seeing no other questions. Thank you for being here.

BRENT SHANHOLTZ: Thank you.

HARDIN: Proponents, LB1091. Welcome.

CHRIS LEE: Thank you. Good afternoon. My name is Chris Lee, C-h-r-i-s L-e-e. COO of Madonna Rehabilitation Hospitals. And thank you for this opportunity to testify in support of LB1091 on behalf of Madonna. In addition to our four hospital level facilities, we also operate a nursing facility, St. Jane de Chantal, which houses Madonna's special needs program. St. Jane operates beds dedicated to providing care to Nebraska Medicaid beneficiaries who meet the definition of long-term care clients with special needs. In our case, these individuals fall into two categories: ventilator-dependent clients and other special needs clients that require complex medical care that exceeds the nursing facility level of care. In the last 12 years, we've saved Medicaid $43 million by returning clients to the community or lesser levels of care and by reducing costly complications like ventilator-associated pneumonia to levels far below national benchmarks. And we've included a report in your materials that details those outcomes and the methodology that we used for those estimates. Unfortunately, access to the program has declined since 2017 when it began to be administered by MCOs. Since 2016, when we served a census of 36 clients, we've seen volume steadily drop to the all-time low of

just 15 in this current year. This 58% decrease equals 7,500 client days annually. However, we do not believe that that represents a decreased need in the state but increasingly restricted access. It's likely these days have shifted to higher cost care such as acute care. And acute care hospitals tell us that they struggle to discharge patients who fit special needs criteria. When patients become stuck in hospital beds, it inflates the cost of care to Medicaid. Internally, we see access issues. A resident I'll call John-- who's a real person-- suffers from a brain injury, is unable to control all four limbs, is completely dependent, is unable to swallow, so takes nutrition through a stomach tube, has chronic respiratory failure, and a permanent trach to breathe. John requires medical management from a Madonna physician and frequent respiratory therapy interventions to manage multiple issues, including a chronic drug-resistant infection and blockages of his airway. John was not approved for special needs. So we moved John adjacent to our special needs unit to provide the higher level of medical resources that are available there. We do so at our expense because it's the right thing to do. And if we didn't, who would? But when appropriate clients are denied access, it puts them at risk and threatens the long-term sustainability of special needs services provided at Madonna, Ambassador Health, and QLI. Madonna believes this small, unique cohort is not best managed by MCOs, which are better suited to population health management. We urge the committee to advance LB1091, which would return the management of this important but niche program to DHHS. Thank you for your consideration. And I'll be happy to take any questions you might have.

HARDIN: Thank you. Questions? Senator Quick.

QUICK: Yeah. Yeah. Thank you, Chairman. So I know you talked a little bit about-- so what happens to some of the people that-- I-- you know, you're, you're taking care of them at your own expense for some of them, so what happens with the person that doesn't get that help? Where do they go? I mean--

CHRIS LEE: Well, I can tell you from our own experience. As I said, we operate four hospital-level facilities. And we discharge between 2,700 and 3,000 patients a year, and several hundred of those are Medicaid patients. And when we're unable to discharge a patient with Medicaid out of our hospital bed to our special needs unit that needs that type of care, we send out referrals to practically every nursing facility

across the state of Nebraska. And what we often find is absolutely no one will accept that patient into their nursing fils-- facility because they're not able to. This is a highly specialized program for a tiny number of people that are very complex to care for. And we've had people stay in our hospital beds for months because we're not able to get them into a special needs program and no nursing facility will take them. We've had people stay in our-- in a licensed hospital bed for as long as a year because there's just no placement for them. John that I mentioned in, in my talk is someone like that, that if we didn't care for him, I don't think there would be any other nursing facility that would be able to take him in the state.

QUICK: And then on that too, you-- you know, you talked about maybe the number of people that you're actually seeing a reduction in number-- where are those people ending up? Are they-- because nursing homes probably aren't taking them either, right?

CHRIS LEE: I think that's right. And anecdotally, we hear from some of our partners in acute care that make referrals to us that they are sometimes really struggling to manage patients, you know. I know-- I was talking to Bryan Health executives recently who said that at times they're having to, you know, have patients in their halls because they have no beds to get patients out of the ER up into their acute care hospital. And part of that throughput problem is the fact that there are patients just like this that there's nowhere for them to go.

QUICK: All right. Thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. Do you find that the nursing homes that are unable or unwilling to take your patients-- is that based on the payer mix, the compensation as pro-- private versus Medicaid? I mean, many of them I-- I'm quite sure have a limited number of Medicaid they can take to keep their lights on.

CHRIS LEE: Thank you for the question, Senator. I, I would say that it's primarily based upon capability. So within our nursing facility-- St. Jane that I mentioned-- we have two different areas. We have one area that's a little bit more like a traditional nursing facility, and then we have the special needs program. And within our nursing

facility, we don't have the medical capabilities on that side of things concentrated enough to provide really excellent care. And so that's why I said even though that we couldn't get John into this program, we moved him over right next to it so that we have the concentration of medical resources, the physician visits that are there, if not daily-- often daily-- even multiple times a week-- the heavy rotation of respiratory therapists. And a much higher nursing mix as well-- higher on the RN side or the professional side and a higher nurse-to-resident ratio than we would have in a nursing-- a typical nursing facility setup. So it's really about capabilities and resources-- of course, which translates into cost as well.

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

HARDIN: Earlier with the QLI folks, they were talking about the ratio of the professionals that are working with this population. I'm assuming that yours looks similar to that. Is that about the same? It sounds like they were not quite four to one in terms of that mix. Is yours similar to that?

CHRIS LEE: Ours is a little bit different in that most of the folks that we get home we're doing through our hospital-- our rehabilitation hospitals and our specialty hospitals. And this program for us is really focused on those folks that-- and there's always, always going to be a few that are less likely to be able to get home. So they're mostly ventilator dependent. Now, we are able to get a few every year with that extended time over in special needs home. And that's a big cost savings for the state. But the majority of those folks will be on a ventilator long term. And so our ratios are a little bit lower. They're, they're more like six to one, right in that neighborhood.

HARDIN: I see. Very well. Seeing no other questions. Thank you for being here.

CHRIS LEE: Thank you.

HARDIN: Appreciate it. LB1091, proponents. Welcome.

MARIA LIGHTHALL: Good afternoon, Chair and members of the Health and Human Services Committee. My name is Maria Lighthall, M-a-r-i-a L-i-g-h-t-h-a-l-l. And I'm here in support of LB1091. In July of 2014,

Erik, my husband and father of three, fell down the stairs in our home. He was rushed to Nebraska Medicine with life-threatening injuries and underwent immediate surgery on his brain. He survived, but he required intensive care for over a month. The official diagnosis was a severe traumatic brain injury. And I had no idea this would-- how this would eventually impact our lives. The-- in the ICU, Erik had several major setbacks: seizures and more bleeding on the brain that required additional surgery. He had a feeding tube as well as a trach to help him breathe. With one misstep, Erik went from being a successful attorney, an entrepreneur, and loving husband and father to being 100% dependent on others for his safety and care. To watch my husband in this state broke my heart. I felt helpless and hopeless. After the ICU, Erik spent five months at Madonna Rehabilitation Hospital receiving excellent care and treatment. After he became well enough, we had to start planning for the next move. Home was not an option. We were equipped-- we were not equipped to handle his complex needs. And a traditional skilled nursing facility was not appropriate. These places are designed to care for people in the last chapter of their lives. Erik was only 43 years old, had so much life to live and more recovery was needed. We were given QLI as an option, and we jumped at the chance. We knew QLI was a national leader in brain and spinal cord injury. And we're incredibly grateful for the opportunity. He began his rehabilitation journey at QLI in December of 2014. His therapists worked collaboratively and tirelessly to accelerate his recovery. He relearned to eat, speak, and eventually took his first steps again. The progress was slow but steady, and every day brought a new milestone. After more than a year of intense therapy, Erik regained in-- independence and no longer relied on others for his basic needs. He was making a comeback. While Erik was able to do much more for himself, he still needed a level of attention that I could not provide at home. Thankfully, QLI had the perfect solution. Erik moved into QLI's summit-- a residential setting for younger people with injuries like Erik's. There he was able to continue his rehab recovery. He thrived there and eventually progressed to a lower level of care, the QLI Lead Assisted Living Apartments, where he has been since August of 2018. In his apartment, Erik is part of a community and receives the right amount of support to live a full life. I cannot fathom where Erik or our family would be if he didn't receive the intense, specialized treatment, care, and therapy he needed so desperately. If Erik had gone to a nursing home during a time when he

still had promise and potential, the impact would have been tragic. I'm not sure he'd even be alive today, let alone thriving in life. This bill offers more than the right level of care or even therapy. It offers hope. It provides so many Nebraskans with a fighting chance to rebuild our-- their lives, reconnect with loved ones, and lead fulfilling lives on their own terms. It's a chance they deserve. I urge you to support LB1091 as if it were your own loved one, because one day you just may need it. Thank you. I can answer any questions you have.

HARDIN: Thank you. Seeing no questions. We appreciate you being here.

MARIA LIGHTHALL: Thank you.

HARDIN: LB1091. Those in support. Welcome.

AARON MASON: Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Aaron Mason, A-a-r-o-n M-a-s-o-n. I'm here today as a proponent of LB1091. In December of 20-- 2022, I was driving in Garland, Nebraska, a small town by Seward. And I rolled my pickup truck on a gravel road. I was left with a C6/C7 spinal cord injury. I was rushed to Bryan West Hospital. After that, they performed emergency surgery on me, and that's when I knew that, you know, I had basically, you know, a really life-altering event kind of-- once I woke up about three or four days later. Before that, I'd had a good job of coaching. I coached college baseball. I worked construction before that. Just some things I really like, like to do. But after I discharged from the hospital, I-- I spent two months in the hospital. Then I went to Madonna in Lincoln. There I began getting PT and OT in there. And after three months there, I was able to start the rehabilitation program at QLI in Omaha in March of 2023. I learned how many skills I could learn, like, [INAUDIBLE] my own the physical strength, learning how to, you know, slideboard, sit up on my own. Just things to be a lot more independent. My staying at QLI was-- funded and authorized through two different Nebraska managed care organizations. They were only granted-- me for two months. I simply wasn't ready to move on, though. I was recommended to move into my parents' house in Bellevue since they were nearby, but their house wasn't accepta-- wasn't wheelchair accessible at all, nor were they trained to take care of me as a spinal cord patient. So luckily-- QLI was so grateful to me, and they funded me to stay and enrolled me in a

scholarship program. And I was able to stay there a lot longer. And I learned how to drive. I started coaching high school baseball out-- while I was there. And most importantly, I discharged to an apartment back here in Omaha, where I can live independently. LB1091 will ensure people that living with catastrophic injuries like mine have access to the right level of care when they need it most and a shot at living the life that they deserve. Thank you.

HARDIN: You've be-- been on quite a journey.

AARON MASON: Yeah.

HARDIN: And you are a Coach Mason.

AARON MASON: Yes.

HARDIN: Any other questions? So contrast where you are right now. You have the independence of your own vehicle, you're coaching baseball, you're involved in-- you have your own place. That's a very different world than where you probably thought you would end up when you arrived at Bryan West.

AARON MASON: Yeah. I was-- a lot of thoughts.

HARDIN: A lot of thoughts.

AARON MASON: I'm very thankful to be where I'm at today because I definitely didn't think any of this was possible, though.

HARDIN: Well, we appreciate you being here.

AARON MASON: Yeah. Thank you guys.

HARDIN: Thank you. LB1091 proponents. Any more proponents? LB1091. Opponents. Welcome, Mr. Bell.

ROBERT M. BELL: Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Robert M. Bell. Last name is spelled-- or, name is 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 Na-- Nebraska Association of Medicaid Health Plans, whose members include the three current managed care

organizations providing Medicaid coverage services under a contract with the Department of Health and Human Services: Molina Health Care, Nebraska Total Care, and UnitedHealthcare of the Midlands. The association is appearing today in respectful opposition to LB1091. I certainly appreciate Senator Bostar and the proponents' focus on protecting individuals with complex, long-- long-term care needs. I think you've heard some very powerful stories today. Fundamentally, the association must be opposed to any carve-outs to managed care. LB1091 removes skilled nursing and nursing facility services for individuals with special needs from Medicaid managed care and returns them back into a fee-for-service model while managed care organizations, MCOs, would still provide the wraparound services. Separating the core specialty care services from the managed care system compromises the integrated care coordination model essential for the positive member services outcomes. Managed care is affected because it integrates physical health, behavioral health, pharmacy, and specialty services under an accountable structure. Members with the most complex needs benefit when their one carrier organization is responsible for coordinating the full continuum of care. Carving out key services divides accountability, complicates communication, and increases the gaps in care, especially during transitions between care settings today. Managed care organizations handle care coordination, utilization, oversight, claims processing, and provider support. Carving out services requires the state to recreate parallel administrative infrastructure while still coordinating across systems, leading to administrative cost increases to the state Medicare program. We do want to be clear that-- or, the MCOs want to be clear they are committed to collaboration with the providers to develop a consistent authorization tool and other standards that streamline processes to reduce administrative burden without compromising integrated cor-- care coordination. For these reasons, the Nebraska Association of Medicaid Health Plans respectfully opposes the passage of LB1091. I appreciate the opportunity to provide this perspective. Thank you.

HARDIN: Thank you. Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here. So I guess I'm trying to understand your testimony and kind of comparing that to some of what we've heard have been some of the challenges from the facilities that are actually providing these services wi-- that

MCOs have caused. And so I'm just kind of ha-- it, it seems like the two are in conflict with one another.

ROBERT M. BELL: They are. That's probably why they're proponents. I mean, I mean-- not to be-- we're, we're oppo-- we're opposed to being cut out of the business that, that we perform, right? And that's just kind of a fundamental thing that the association must, must do-- and our, our three MCOs. So we understand that there-- the concerns about managed care in general. There always are. No matter what type of insurance or insurance type of products that there are when-- there is pushback between the managed care aspects of that and health care providers. And so when we see legislation that comes in that, that carves out, you know, the business model that we-- that has been created for us then, you know, fundamentally, we have to come in and oppose.

FREDRICKSON: Yeah. I, I, I understand that. I mean, it just sounds like objectively the MCOs have not been successful in this context.

ROBERT M. BELL: I-- you know, I think we would disagree with that. I, I think the providers that you heard from would, would make that argument. It's a very difficult job. They have a very difficult job. You know, we have responsibilities under our contract with the state to do the things necessary to provide care for our members and to manage that population appropriately within the resources that are allocated, so. You know, I think, I think you heard from the proponents that they want us out of this business, so. And, you know, we want to stay in it.

FREDRICKSON: Thank you.

ROBERT M. BELL: You're welcome.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair Hardin. Good to see you again, Mr. Bell.

ROBERT M. BELL: Yep. No problem.

G. MEYER: You're opposed to being cut out in this particular instance. And yet it would seem that, in many instances, care is terminated before maximum outcome is achieved. Savings over outcomes?

ROBERT M. BELL: No. I, I, I mean-- I have to push back on that. I-- we believe in outcomes as well. You know, it's-- there's a balance in that, of course, right? But the care of the patient comes first.

G. MEYER: I, I-- I'm, I'm sure of that. I, I-- I'm not accusing you of being a cold, heartless individual. That's not my--

ROBERT M. BELL: That's OK. I've been accused of a lot of things in my, in my day, Senator Meyer.

G. MEYER: But, but it, but it appears that if we continue care and we get the best possible outcome for those folks that need our care, it's much more cost-effective to extend that care for a, a period of time, return to a home setting instead of a clinical setting, a, a, a nursing home, if you will. Isn't that much more cost-effective? And wouldn't that be more cost-effective for the MCOs also?

ROBERT M. BELL: It, it would be, yes. So-- and I, I believe that's our goal.

G. MEYER: Seems to be the goal, but it doesn't appear to always be the outcome. In fact, it, it does not appear to be the attainable outcome that, that generally happens. Just from the testimony shared in-- this, this particular day and in previous days also, so. Once again, I don't believe you're a cold, heartless individual. And so I, I-- but I appreciate your perspective. Thank you.

ROBERT M. BELL: Yeah.

HARDIN: Senator Ballard.

BALLARD: Thank you, Mr. Chairman. Thank you for being here. It's good to see you again. I, I appreciate the consistency. I do. But can you-- and we had a conversation a couple weeks ago about cost savings. And I'm still trying to wrap my head around the cost savings of MCOs of not being carved out. I understand in our previous mandates, cost savings-- or, there's a cost on premiums for mandates. I understand that. But I-- just help me understand what cost savings are there for MCOs, for taxpayers by opposing carve-outs.

ROBERT M. BELL: What cost savings are there for taxpayers?

BALLARD: Or MCOs. Cost savings. I'm just trying to figure out-- I'm trying to wrap my head around-- help me understand.

ROBERT M. BELL: Well, if, if we're able to manage care across a spectrum of care, we believe we can do that more efficiently than the state of Nebraska, right? That's the whole point of the state of Nebraska contracting with private entities to provide these services. We're, we're good at it. We're skilled at it. I mean, of course you heard testimony that says in this small population we are not. That-- we, we bring expertise of the private sector to a governmental program. You know, I, I think we hear a lot about, you know, government should be run like a business. Well, this is a-- an aspect of that, right? And that-- that expertise saves taxpayers dollars at the end of the day. So-- by managing the care and saying no and giving pushback sometimes. And provide-- perhaps providing different perspectives on the type of care, the level of care, those kinds of things, where there could be beneficial outcomes for the patient as well as savings for the taxpayer, so.

BALLARD: OK. I appreciate it.

ROBERT M. BELL: You're welcome.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair. Given the fact that we're looking at a carve-out-- my word perhaps, not, not your word, but--

ROBERT M. BELL: No, I think I said carve-out. Yeah.

G. MEYER: [INAUDIBLE]. Yeah. And I'm sure that's probably got negative connotations, which I don't sub-- subscribe to.

ROBERT M. BELL: Sure.

G. MEYER: We're talking about a population of about 150 out of 300,000. Materially, does that affect you that much? If, if we're looking at, at the types of outcomes, the, the very positive things that are coming from QLI and, and some of these other, other facilities, why do you bother? Why-- I, I, I mean, we, we-- we've got the-- we've got the evidence that this is by far a-- from an outcome

standpoint, very positive. Don't you have a big enough piece of the pie?

ROBERT M. BELL: Great question. Do we have a big enough piece of the pie? If you give away one piece of the pie, will they come for the next piece of pie next? You know, it, it-- not to make a analogy, but it's a slippery slope, right? If, if we don't throw up some opposition to this carve-out, when the next carve-out comes-- and I'm sure you're never going to hear from a provider that is, is asking for a carve-out from our programs that, you know, the MCOs do a great job and we receive, you know, all the funding that we're asking for and we never get pushback and things like that. There's, there's some friction in there, and that friction is intentional. If, if, if we don't come in on this carve-out and we show up on the next one, you know, are we, are we then principled? I mean, if, if, if we oppose all of the carve-outs, you know, then I think we have a little bit more consistency. And we don't know what's going to come next. We don't know, when I'm sitting here next year, what, what carve-outs I-- that, that may be before the Legislature that we may have to oppose, so.

G. MEYER: I think, I think that's very valid. And I appreciate that very much. One aspect that I, that I think is important is, if we've got a, a section, if we got a part of the service providers excelling at what they do, isn't that incentive for the MCOs to do better?

ROBERT M. BELL: If they're doing well, should we do better? I, I think we all benefit if we all do the best that we can.

G. MEYER: You know, and, and I think that, that follows through in some of the other things we deal with here in the Legislature. If you've got a problem with school choice-- I'll throw that out there just [INAUDIBLE] controversial--

ROBERT M. BELL: Sure.

G. MEYER: --two controversial things-- raise your game. Make it so people don't need to leave.

ROBERT M. BELL: Yeah.

G. MEYER: I, I-- just a thought.

ROBERT M. BELL: Sure. Sure. Should-- can we do a better job, is I think what you're, what you're telling me. I don't, I don't necessarily hear a question in there, but will pass that back along to the, to the MCOs.

G. MEYER: I'll throw a question. What do you think?

ROBERT M. BELL: I think I'll put-- I think I'll pass that along to the MCOs.

G. MEYER: All right.

ROBERT M. BELL: How about that, Senator Meyer?

G. MEYER: Thank you, Mr. Bell. I appreciate it

HARDIN: Seeing no other questions. Thank you.

ROBERT M. BELL: You're welcome.

HARDIN: Those in opposition, LB1091. Those in the neutral, LB1091. Those named Senator Bostar, LB1091. Online, we had 17 proponents, 0 opponents, 0 in the neutral. Welcome back.

BOSTAR: Thank you, Chair Hardin, members of the committee. So just to summarize, we have legislation to better serve the needs of a maximum of 150 individuals out of 300,000 individuals on Medicaid. And a lot of-- a lot of folks, many of-- several of-- who you heard from today have worked very hard on this and worked with the, with the Governor's Office, with the department to get to where we are now. And with that amendment, there's no fiscal impact, no concerns about any of it. And so we've-- I think what you have before you is really something that, that represents a win for the whole system and, most importantly, a win for the individuals that we all are to some degree entrusted with caring for as members of our society. All right. I'll talk a little bit about the opposition, but I-- you know-- I-- I'll, I'll, I'll say this on the, on the front end of that. I appreciate Mr. Bell-- I appreciate his honesty with the committee. So what you heard from them is they don't want to lose the business, so to speak. There was some discussion about wraparound services and continuity, but the reality is that, within the long-term care framework-- basically, everything else is already fee-for-service. So this is better aligning a level of

continuity for these individuals. There's opposition from the MCOs because the MCOs want to make money. That's it. It's really pretty simple. And, and I appreciate Senator Meyer's question about, really, how much money are we talking about when we talk about 150 people out of 300,000 people. And you're right. It-- it's inconsequential. They're not going to notice the difference in money. And Mr. Bell was honest about that. He said it's because it's about the next thing. It's about the next time someone wants to carve out a population out of MCO coverage. That's the threat. It's not the 150 people and the dollars that they'll lose from that. And they will lose those dollars. But they don't really care about those dollars. It's the next one. And maybe the one after that. Because it's just about the money. The argument today from the opposition wasn't about the care at the end. It was about the money. It was about, we're worried about you all taking more of our money away if we let you take this money away. That's it. That's what it is to them. And that's really unfortunate. And, and I think that we certainly owe these individuals a lot more than that. And, and so I would, I would ask the committee to, to treat this legislation favorably. I think it's very important. I think that, over the last several years, the, the population of individuals from our communities who are-- who tragically find themselves in a position to require the services of, of the people who are working at the providers that you heard from today, we, we owe them something. And we owe them better than what they're getting right now. And so with that, I'd be happy to answer any final questions.

HARDIN: And those questions are? Senator Meyer.

G. MEYER: Thank you, Chair. Thank you, Senator Bostar. I appreciate what Mr. Bell was saying. If I was in his shoes, I'd be doing exactly the same thing that, that, that he is doing.

BOSTAR: If I was paid by the MCOs to represent them, I'd have to come up with something too.

G. MEYER: It's, it's his job. And, and I ha-- I have a great deal of respect for the job he does. And I think he's got a-- I think he's got a valid point. OK. What's, what's the next situation that we have to face? Would you agree that we need to evaluate each opportunity or each issue that's presented to us on its own merit and, and certainly

take that into consideration when we're perhaps faced with this? Again, in all fairness to Mr. Bell.

BOSTAR: Of course. Look, i-- if I thought what we really needed to be doing is removing everybody from the MCOs, the bill would say, let's remove everybody from the MCOs. But it doesn't, right? It-- it's very narrow. It's very targeted. And I think that the next bill that comes before this committee-- assuming that there is going to be one at some point in time-- that, that examines the question of carving out a population from, from MCO coverage to fee-for-service, I, I, I would hope and I, I believe that this committee will evaluate it on its merits and not use this hearing or the thought of a hearing after it to consider whether or not it makes sense to do.

G. MEYER: Thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. You're a smart guy. You've had to dig into this to understand it. And it's been about ten years-- I was here when managed care first came in. A-- my question gets to be, as an oversight group, have we done anything to take a step back and say, this is where we need to be going into the future? Because we were not very successful as an agency, a bureaucracy of running DHHS. That's why we went to managed care, thinking we would get more. Do you-- I-- I'm just-- I'm not holding you to anything. I'm just-- and maybe-- I'm just interested if you have some reflective thoughts after going through this.

BOSTAR: I, I think from-- again, it, it-- from the amount of examination that I've done on this, I would say that my impression today is that it seems to work well in some sen-- settings and it seems to fail in others. And, and I think without question it's failing for these individuals that we're talking about under LB1091. So-- LB1901. So that's sort of my-- I would need a lot of time to, to fully answer your question about is this a-- do I think overall this should be done by the department or, or MCOs?

RIEPE: Or some other model even. I don't know.

BOSTAR: Or some other model.

RIEPE: I don't know.

BOSTAR: I think I, I-- look, to be honest, I think that's a question we should always be asking. Because we shouldn't just settle for whatever we're doing and assume that we're doing it the best way we can. So I, I, I genuinely appreciate the question, and I think it deserves real contemplation by everyone here.

RIEPE: My concern as well is that managed care in and of itself is growing rather quickly and has since we expanded Medicaid.

BOSTAR: Well--

RIEPE: You know, at some point in time, how big is it?

BOSTAR: Right.

RIEPE: I, I don't know. But thank you very much.

BOSTAR: Thank you.

RIEPE: I appreciate your hard work. Thank you, Chairman.

HARDIN: Seeing no other questions, we appreciate it.

BOSTAR: Thank you.

HARDIN: Thank you. This concludes LB1091. We'll be transitioning the room over to Senator Rountree and LB737 in just a couple minutes. Senator Rountree, I think we are dangerously close to being ready.

ROUNTREE: You're supposed to be ready. OK.

HARDIN: We are ready when you are ready.

ROUNTREE: [INAUDIBLE] last hearing. Good afternoon, Chair Hardin and members of the Health and Human Services Committee. My name is Victor Rountree, V-i-c-t-o-r R-o-u-n-t-r-e-e. And I represent District 3, which is made up of Bellevue and Papillion. Today, I'm here to introduce LB737, which would require a joint hearing of the HHS Committee and Urban Affairs Committee once a year to review progress on the Olmstand-- Olmstead Plan for the state. Over the interim, the Urban Affairs committee heard my LR86, which centered on the state of

affordable, accessible housing in Nebraska. In that hearing, we learned about the lack of available housing units for individuals with disabilities. Members of the Olmstead Advisory Committee testified to the deep need for integrated housing that is available for members of the disability community. As a member of the Urban Affairs Committee and a senator in my first year, I had not heard of the Olmstead Plan and the landmark Supreme Court decision that requires integration for the disabled community. As I have continued to discuss accessible housing with advocates in the housing space, there have been others who are deeply involved in the housing development arena who are unaware of the Olmstead Plan and what that means for so many Nebraskans. With that in mind and in a consin-- consultation with disability advocates, I have introduced LB737. This bill requires that, once a year, the HHS Committee and the Urban Affairs Committee will hold a joint hearing to assess the progress of the Olmstead Plan and submit a report to the Clerk of the Legislature. In my time so far as a senator, it has become clear to me that we do our best work when we communicate and collaborate. There are aspects of accessibility that this committee understands deeply and there are aspects of affordable housing and the need for additional housing that the Urban Affairs Committee understands. I think that by collaborating and being intentional in our approach, we can deliver results for those in need in our state. I have prioritized LB839, which requires additional reporting from municipalities on the current stock of affordable, accessible housing in their cities. I would like to be able to include this bill as a piece of an accessible housing package aimed at assessing the lack of housing and working towards addressing issues-- those issues. There are some amazing testifiers behind me who can speak to the history of the Olmstead decision, the implementation of the Olmstead Plan, and the realities of disabled Nebraskans. With that, I would be happy to take any question that you may have, but I'll let you know upfront that I may defer those to those who I really know have the answers. Thank you so much.

HARDIN: Thank you. Any questions? Senator Riepe.

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

ROUNTREE: Thank you, sir.

RIEPE: Do you have a breakdown in terms of the, the demand on a rural and urban basis or--

ROUNTREE: I think that should be following me.

RIEPE: OK.

ROUNTREE: OK.

RIEPE: OK. Do you have any thoughts about if someone on the rural side might be able to qualify under this new windfall that we have, $218.5 million? Do you think they could qualify under that?

ROUNTREE: They possibly could.

RIEPE: OK. We'll wi-- we'll see how that--

ROUNTREE: We'll see what we--

RIEPE: We don't even know exactly how that's going to unfold yet.

ROUNTREE: OK.

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

HARDIN: Thank you. Senator Quick.

QUICK: Yeah. Thank you, Chairman. And I remember-- and I think you had a bill in Urban Affairs too on, like, when we're building some of these new complexes and utilizing-- making sure there was ADA accessibility to some of those, right?

ROUNTREE: Yes, sir.

QUICK: OK. Yeah. And I don't know if you wanted to talk a little bit about that, but I-- I know we had that bill, but I-- you pro-- you know more about your bill than I do.

ROUNTREE: Well, we dealt with assessment dwelling units, accessible-- and that was ensuring that-- first was to get a count of how much accessible housing that we have here in Nebraska. So that was my priority bill, making sure we could track that. And then-- our testifiers will come back and they'll talk about the need more so. We

had another bill that dealt with-- and-- the-- for new dwelling units like fiveplexes, sixplexes, that-- X amount of that would be built as accessible, you know, from the start to qualify for some of our state funds that are authorized. And then we had one final bill that dealt with housing, and that one-- as I recall, that one-- we dealt with assessory dwelling units. Not accessible, assessory dwelling units. So we'll get some opportunity there. That would provide more housing as well. So looking back, getting a count of how much housing we have available, looking at putting implementations in place that, when we build new housing-- and those are multifamily units and so forth, not just individual units. We recognize-- back to what Senator Riepe was asking-- was that if we have some of the units built out in some of our western areas, it really is going to require something for someone to go out and be able to make a profit as they go to build but also ensure that we have the assessable dwellings that are out there, so.

HARDIN: OK.

QUICK: Thank you.

HARDIN: Very well. Will you be with us at the end?

ROUNTREE: I will be with you because this is very important, so I will [INAUDIBLE] this.

HARDIN: Thanks.

ROUNTREE: Thank you so much.

HARDIN: We're ready for proponents of LB737. Proponents. Welcome.

KATHY HOELL: Thank you. First of all, I would like to request reasonable accommodation under the ADA for these lights to be turned off. And because of my speech patterns, I may need a little more time, but I will make it as reasonable as possible.

HARDIN: If she hits those lights, I'll tell her to stop forthwith. How's that?

KATHY HOELL: That works.

HARDIN: Awesome. Take it away.

KATHY HOELL: OK. First of all, good afternoon, TNR Committee. My name is Kathy Hoell, K-a-t-h-y H-o-e-l-l. And I am currently one of the co-chairs of the Olmstead community, which is a stakeholder, and Departmental Advisory Committee that reviews the Nebraska Olmstea-- Olmstead Plan. The Olmstead decision is referring to a 1999 ruling by the United States Supreme Court in the case of Olmstead v. L.C. The court determined that, under the ADA, individuals with disabilities have a right to live in the community rather than institutions if appropriate services can be provided. This decision about whether a-- somebody that lives in the community is a-- not just the individual. It's made by their entire team, their doctors, wha-- their, their family, that they can get the support and services they need in the hearing. But it's-- emphasizes not-- staying away from unnecessary institutionalization of people with disabilities, which constitutes discrimination and that public entities such as the state of Nebraska or any city must provide the most integrated setting. The rule-- this ruling has had profound impact on disability rights in the United States, prompting states to develop plans and take steps to ensure that people with disabilities receive the care and support in their community and promote greater independence and inclusion. Currently, the way the plan is, is now, the Legislature and the Governor receive an update every three years. I can't look at the lights. Excuse me.

HARDIN: Would you just turn the light off? That'd be great. Thanks.

KATHY HOELL: They receive a report every five year-- every three years, and this is not adequate. It makes it impossible to make any substantive changes that will allow people with disabilities to leave in the-- live in the most integrated setting. By passing LB737, the Legislature will have an annual review and be able to decide if legislation is needed to make this happen. Three years just is way too long. An example of this is that the housing workgroup has been able to get any data on the status of accessible housing in Nebraska. Last year, we approached Senator Rountree with a legislative resolution to examine the housing situation in Nebraska. After the public hearing on LR86, there was a number of bills that have been introduced this session for how it-- as Senator Rountree had mentioned, and hopefully they will all pass. But for the housing group, these bills were extremely important because they gave us the data we neede-- that we need to determine what is the state of housing in Nebraska. And without good data, we can't know where we're going. We don't know what

to-- what needs fixing. I mean-- I was at the hearings on these bills, and nobody had a problem with the basic premise of these bills. The people with disabilities need acces-- accessible housing. There were little pro-- little tweaks that had to be made on how far the lookback was and how much housing was built. But-- and it, it ended up being 5 years versus 15 years. I mean, these, these are things that are easy to live with, but we still need that data. We can't move forward without it. I am asking the committee to move LB737 forward. And I'd be delighted to answer any questions for you.

HARDIN: Thank you. Appreciate you being here. Questions? Seeing none. Thank you so much, Ms. Hoell.

KATHY HOELL: OK. Thank you.

HARDIN: Proponents, LB737. Welcome.

JONI THOMAS: Thank you. I'm going to get a little taller for a minute here. OK. Thank you, Chairperson Hardin. I appreciate this opportunity and to members of the committee. My name is Joni Thomas, J-o-n-i T-h-o-m-a-s. And as a member of the Olmstead Advisory Committee and the chairperson of the community supports workgroup under the Olmstead Plan, I strongly support LB737 because Nebraska needs meaningful oversight of our Olmstead obligations and our progress toward true community integration. Nebraska has already committed to the principles of Olmstead. We que-- the question before us today is not whether we agree with community integration but how we ensure that our systems actually deliver it. Because I support the bill, I also want to make sure it works as intended. That-- today, I want to focus on several key areas-- not a lot, I promise-- that will determine whether the-- this legislation becomes a powerful accountability tool or simply a procedural exercise. First, stronger reporting requirements are essential. Without measurement-- measurable outcomes and transparent data, there is a risk that agencies control the narrative of-- instead of demonstrating real progress toward Olmstead compliance. Oversight must include clear benchmarks and accountability. Second, people with disabilities and lived experience must be central to the process. Oversight cannot be simply-- sorry. Oversight cannot rely solely on providers, state officials, medical systems, but meaningful inclusion of lived experience ensures that evaluation reflects real outcomes and-- rather than assumptions.

Third, we must be clear that Olmstead is not only about institutional transitions. True community integration means real access-- access to employment opportunities, reliable transportation, accessible, affordable housing, acc-- accessible entertainment and recreation. All of the things-- the ability to live, work, love, learn in the community of their choice, like every Nebraskan wants and is entitled to. As you consider implementation, I acour-- encourage this committee to-- and the other committee that Senator Rountree was talking about-- that you measure what measurable outcomes define successful Olmstead progress. Are current policies increasing or decreasing the risk of institutionalization? How are waiver limits evaluated against Olmstead obligation? And how are the people with disabilities meaningful involved with-- in the decision-making? I do that kind of stuff all the time. LB737 has the potential to create real accountability. With strong reporting, clear definitions, and disability-led participation, Nebraska can move beyond compliance toward true community integration. Thank you for your time and consideration. And I'm happy to answer any questions.

HARDIN: Thank you, Ms. Thomas. On a scale of 0 to 10-- 10 being high, 0 being, well, low-- how does Nebraska rate in terms of the job it's doing in this area right now?

JONI THOMAS: In community integration?

HARDIN: Yes, ma'am.

JONI THOMAS: I think it depends on where you live, what type of disability you have, and the supports that you need. I have lived in the community all my life. I, you know, have been able to work, have been able to have my own house. I drive. So for me, community integration has worked well. 100-- 90%. For other people who are especially in rural areas, who don't have available providers or don't have available supports for this behavioral health or personal care, I don't think we do as good a job. I would say 50% at best. As far as people being able to get around in this state, it's better than it was. But, you know, Olmstead has a transportation workgroup as well, and they're doing some great work. And I think that it has potential.

HARDIN: OK. Thank you. Senator Meyer.

G. MEYER: Thank you, Chair Hardin. Thank you for coming today. Are we making progress? Are we better than we were ten years ago, five years ago? Are, are we moving-- I-- we're not moving at these-- hare's pace. I suppose we're moving at the, the tortoise's pace, but are we making progress?

JONI THOMAS: We are making progress. I'm a little nervous about the future, but I've had a disability since I was two and a half. And so when I went to school, we had segregated school for people who had physical disabilities. That's not the case now. So, you know, we've definitely made progress. There's still things that need to be improved, you know, but at least we have people like this committee that will listen and senators like Senator Rountree that bring our struggles to you. And, you know, I think if we work together, we can continue to make it better.

G. MEYER: ADA accommodations, things of that nature, vast improvement. We've come a long way-- are, are-- as, as part of what your recommendations are, that's to improve accessibility-- I would, I would assume that's the case.

JONI THOMAS: The ADA, as you know, was passed 35 and a half years ago. There are some places that don't do a great job at knowing that that law was passed. I think there's still a lot of-- some minor things that could be better if we had stronger-- you know, there's somebody that signs off on new buildings and parking lots and all of those types of things as to whether or not they meet ADA. And I'm not sure that always happens from-- as I traveled around. Not just Nebraska, but traveled around the country.

G. MEYER: I sense that you're more than capable and willing of pointing out the deficiencies on a fairly immediate basis as you encounter them, so I, I appreciate your testimony today. Thank you.

JONI THOMAS: Thank you. I have been known to help someone understand.

G. MEYER: Just shocked. Just totally shocked.

HARDIN: Senator Quick.

QUICK: Yeah. Thank you, Chairman. So I know-- you know, some of this has addressed some of the housing concerns or needs. And I know with

some of the, the-- you know, say like in Grand Island, we built some middle income housing, rural workforce housing developments and just making sure that those are also ADA-- or at least a certain percentage, right, that is accessible for people with disabilities to gain-- to be able to, to have those type of-- a place to live. So I know we're looking at trying to gather the numbers, right? So is that the big thing? I mean, just making sure rural Nebraska as well as-- you, you talked about maybe Lincoln and Omaha. There might be more acce-- you have more access to maybe some of those type housing units. But in rural Nebraska, we're not building them, right?

JONI THOMAS: It, it doesn't seem to be as available the farther west you go. It's a-- quick story. I took a job in 2009 in Grand Island. And I had just built a house in 2007. And unfortunately, I built it at the time that you couldn't sell it after you built it. But I was go-- so I was commuting to Grand Island. And I tried to find housing in Grand Island. And the only way I could have moved and been able to find accessible housing was if I built it. And-- so I did work on a project when I was out there with their housing and a veterans group. It's been a long time, but I think it-- they were building veterans lot housing for a particular group. And we did, you know, advocate that it was accessible. But, yeah. It-- I know it was rough when I left there in 2017.

QUICK: Yeah. Thank you.

JONI THOMAS: Yeah.

HARDIN: Seeing no other questions. Thank you.

JONI THOMAS: You're welcome.

HARDIN: We appreciate it. Proponents, LB737. Welcome.

BETH LIBRA: Thank you. Good afternoon, and thank you for your patience in this long day. My name is Beth Libra, B-e-t-h L-i-b-r-i [SIC]. I am the current chair of the Nebraska Council on Developmental Disabilities, testifying in support of LB737. The Nebraska Council on Developmental Disabilities is fe-- a federally mandated, independent council composed of individuals with developmental disabilities, family members, providers, agency representatives. While appointed by

the Governor and administratively is supported by DHHS, the council operates independently, and our comments today do not necessarily reflect on the views of the Governor's administration or the department. The council has been instrumental in Nebraska's Olmstead Plan's efforts, beginning when LB800 did not advance in 2018. The council allocated $127,000 of federal funds con-- contracted with the Technical Assistance Collaboration to develop Nebraska's first formal Olmstead Plan. In 2019, we supported LB570 to strengthen the state's efforts towards the comprehensive cross-disability strategy framework. Our executive director serves on the Olmstead Planning Advisory Committee and has constantly advocated for measurable benchmarks, accountability, implementation steps, and meaningful data transparency. A robust Olmstead Plan is not just symbolic. It operates as a blueprint to ensure that individuals with disabilities can live, work, and learn in the most integrated setting appropriate to-- consistent with ADA and the Supreme Court's desis-- decision on Olmstead v. L.C. Currently, Nebraska's statute requires periodic reporting of the Olmstead Plan every three years. However, there is no statutory requirement for an annual review or structured public engagement. Integration is not a one-time compliance exercise. It requires continuous evaluation, cross-system coordination, and a responsiveness to emerge in barriers such as workplace sort-- shortages, hous-- housing cap-- capacity limitations, and service gaps. LB737 strengch-- strengthens the oversight in a practical way, requiring an annual joint hearing between the Health and Human Services Committee and Urban Affairs. The bill creates predictable, structured reviews of a process of housing, employment, education, transportation, and community supports-- the core pir-- pillars of community integration. Importantly, LB737 does not create any new eligibility categories-- sorry, my eye is watering-- categories mandated in funding appropriation. It strengthens the accountability and legislation partnership. The budget constraints cannot justify failures of upholding civil rights, funding implementation, and effective Olmstead protections of individuals' rights in the community and inclusion, also provided the state's de-- state with defensible positions against claims of noncompliance. As a chair of the Developmental Disability Councils, I believe structured transparency, consistency, oversight strengthens our system, protects our civil rights, and supports sustainability outcome-- and quality outcomes. For this reason, I ask the committee to advance LB737. In your

packets, I made a fact sheet about Olmstead just because it's been a while. I also have a PowerPoint of what the role the Developmental Disability Council took in helping develop the Olmstead. I welcome any of your questions. And I thank you for your consideration.

HARDIN: I've not had a chance to go through the, the packet yet.

BETH LIBRA: Mm-hmm.

HARDIN: Are there states who are doing this particularly well? We always like to try and find a paradigm somewhere.

BETH LIBRA: Minnesota is doing a really good job. And also, I know Oregon and Colorado are doing a decent job at, at implementing their Olmstead Plan.

HARDIN: I see.

BETH LIBRA: I think Nebraska has the unique makeup of Nebraska. I live in Wayne County, so my kids were fortunate enough to go to school in Norfolk. I was a half a mile in on the Norfolk School District, so it made a huge difference than going to a smaller school like Winside or Pierce. And I co-- my previous job, I covered all the way out to Cherry County. And so what I would see in Keya Paha County or Brown County was very different than what I saw in Madison County. It, it-- I think that structurally is why we need a plan like this, where we're coming together and looking from county to county. Because what's working well in Omaha and Lincoln or Kearney or Grand Island may not be working in Keya Paha or Brown or Wayne County or Pierce County or Cedar County, for that matter.

HARDIN: Or Banner County.

BETH LIBRA: Huh?

HARDIN: Or Banner County.

BETH LIBRA: There you go. Well, those are the ones I, I trot around in a lot.

HARDIN: Well, that's helpful. Any other questions? Appreciate you being here. Thank you.

BETH LIBRA: Thank you so much.

HARDIN: Proponents, LB737. Welcome.

DIANNE DeLAIR: Good afternoon. Excuse me. Little bit of a cold, so bear with me. Good afternoon, Chairperson Hardin and members of the Health and Human Services Committee. My name is Dianne DeLair, D-i-a-n-n-a D-e-L-a-i-r. I am the Legal Services Director for Disability Rights Nebraska. We are a private, nonprofit organization, and our sole mission is to advocate and promote the rights of Nebraskans with disabilities all across our state. I want to thank Senator Rountree for introducing LB737, as it recognizes the importance for legislative oversight and collaboration of our state's compliance with the Americans with Disabilities Act and the U.S. Supreme Court decision in Olmstead v. L.C. As you know, in 1999, the U.S. Supreme Court issued its landmark decision in Olmstead v. L.C, stating public entities must administer services in-- to individuals with disabilities in the most integrated setting appropriate to their needs. It ruled that unnecessary institutionalization of persons with disabilities is discrimination under Title II of the Americans with Disabilities Act. It requires states to eliminate unnecessary segregation of persons with disabilities in its practices and policies. Before Olmstead and the ADA, people with disabilities lived in institutions, the [INAUDIBLE] Developmental Center, Lincoln Regional Center. They were kept from mainscre-- mainstream schools. And their experiences of typical life were very restricted, sometimes nonexistent. The U.S. Supreme Court's decision at Olmstead tells us that unjustified segregation-- that separation of people from everyday community around them-- is a violation of the ADA. Because changes to state systems take time, the U.S. Supreme Court ruled that if a state created a plan that shows the steps they are taking to reduce institutionalization, they could rely on their plan as a defense to violations under the ADA and Olmstead. These plans are about how states will implement changes to the system so that people with disabilities have access to the services and supports they need in the community rather than having to be confined to an institution or facility. The Health and Human Services Committee and the Urban Affairs Committee is uniquely positioned to handle the oversight and implementation of Olmstead. We heard testimony about the need for accessible and affordable housing all across our state. Well, this committee oversees the work of the Nebraska health and human services

systems, the Medicaid waivers that help thousands of people stay healthy and living their life outside of institutions and in their home. When we're talking about Olmstead, we're talking about a systems change. And so when we're talking about living in the most integrated setting is-- how is our state doing with the way they administer their programs, their services? Are they doing it in a way that assists people to live in the community or does it create additional gaps and barriers? There was a question that I would like to just answer, you know, how are we doing here in Nebraska? You know, I could talk about that for hours, but what I did include in your packet is a letter of finding from the U.S. Department of Justice that was issued to our state in 2024. And in the area of mental health and community integration, we're failing. They found violations of the ADA, Title II, and Olmstead.

HARDIN: Kind of to that point, Ms. DeLair-- I, I guess I would ask the next question. So it's possible for us to have a joint hearing. And then what? Any time any of us brings a, a bill like any of these today, I think what any senator needs to ask is, OK. We're gonna bring this bill and then it's gonna become a law. And then what? What-- what's the existential outcome, right, of what goes on next? So what are you seeing in these other states? There were a few others that were mentioned from Minnesota to Colorado to O-- to Oregon. What are you seeing? And more to the point, what's out there that works? What, what-- and then what, is my, I guess, my question.

DIANNE DeLAIR: Yeah. So when we're talking about systems change, this is going to take time. It involves not only health and human services but other state agencies-- education, transportation was mentioned. It's really different across the board in many states. Minnesota is one state. New York also has a cabinet-level position for their Olmstead work and commitment. Now, as far as moving forward-- you know, I don't know how many folks have heard of Olmstead or Olmstead planning or even that we had legislation introduced in 2016 that established it. And so when we have the type of turnover that we do with our, our legislators, you know, it is incumbent on all of us to be educated about these issues. We spend a lot of time as advocates talking to senators and providing that educational piece. And I think that the more engagement and collaboration that you have with the state-- you know, you're a key piece of moving this forward.

HARDIN: So as far as you-- as far as you know, other states have adopted at least this annual step that Senator Rountree's talking about here?

DIANNE DeLAIR: No, I-- a lot of states will start with their Olmstead Plans after they've been sued. And-- so, you know, that's going to look different in-- from state to state. I don't know if they have annual types of reviews. But there, there are components where the Legislature is involved, and it's recommended that that be a key piece because this is a statewide issue. And, you know, there may be at times legislation that needs to be passed so that we are in compliance. And the area of behavioral health in our state is where we are most vulnerable. We have some serious work to do in this area. And I have included that letter of finding which outlines the investigation that was conducted and also the recommendations that were advised that the state should take so that we are within compliance with federal law.

HARDIN: Other questions? Seeing none. Thank you.

DIANNE DeLAIR: Thank you.

HARDIN: Proponents, LB737.

***MARY ANGUS:** I am a person with a disability and a former member of the Olmsteadt Steering Committee, Advisory Council, and housing subcommittee. I am very much a proponent of LB737. I believe it is vital to the rights of people with disabilities, especially in light of the proposed Aged and Disability Waiver. That waiver is detrimental to many with disabilities. Many will be forced to be institutionalized, including to nursing homes. That is in violation of the Olmsteadt decision of the Supreme Court and Title II of the Americans with Disabilities Act. That remains in effect nationally [https://www.ada.gov/resources/olmstead-employment-qa/]. Previously, advocates have been told that lack of funding is not an adequate excuse for such a violation. Nebraska has been charged with violations several times and have come to settlement agreements. For instance, the Beatrice State Development Center lost it's Medicaid accreditation in 2008. That meant that all costs were paid by the general fund instead an approximately 40 BSDC/60 Medicaid reimbursement rate. The oversight of that settlement agreement took until 2015. Consider the

cost to Nebraska's budget. The current legislation required the Senators to get Olmstead reports of progress every 3 years. Annual updates would provide the Senators with information needed to determine how the Legislature could resolve problems in a more timely manner.

HARDIN: Opponents, LB737. Those in the neutral. Senator Rountree. While he is coming, let me read to you. We have a-- Health and Human Services Committee received written ADA testimony from Mary Angus, Mary Angus of Omaha in support of LB737. This testimony will be included in the official hearing transcript and the testifier included on any committee statement that is published. The testimony has also been provided to all members of the committee. Additionally. There were 8 proponents, 0 opponents, and 1 in the neutral for LB737. Senator Rountree.

ROUNTREE: All right. Thank you so much, Chairman Hardin and to our committee. And thank you to all of our wonderful testifiers that came and testified today. I think it makes sense, you know, if we come together in this reporting collaboration with this committee and with our Urban Affairs Committee on which I sit as well. We have a really strong study this summer really drawing attention to the needs in our disability community. This is a start for us. I know that reporting requirements said three years, but this-- getting us to starting out with every year collaboratively will let us know where we stand as far as what resources we have in the states and where we do have those gaps. You asked what will happen once we get that information and come together and present it, we are here. We are legislators at this time. So we can pass legislation that's going to build and fill those gaps. At the end of the day, it makes it much easier for us to take care of the needs of all of our constituents here in Nebraska. And I had a hearing over in the Urban Affairs Committee, and we talked about housing and LB840. We went back and we made an amendment on that particular bill for new housing that is being built or new structures that are being built. 10% would be disability housing for physical disabilities. And then 4% would be for visually impaired type disabilities and that. But one of the questions that was asked during the hearing from the committee was, why can't we just build a whole disabled community and put everybody there in the community, as Ms. Hoell [INAUDIBLE] let us know. It's about integration. It's about not being in an institution. It's about, as we age, being able to age in

our homes. So many times, we're going to need to make adjustments in the home. I know I plan to age in mine. And with the VA, if I can't get up my stairs, then I want to have them come in and modify my home if it means an elevator over in the corner to get up and down the stairs or the lift chair. But I plan to age in my home. And that keeps our people integrated in the community. Think it meets the need of what the Olmstead is asking of us, so that every individual has an opportunity-- I don't know about you when you come into the state of Nebraska from coming out, but I always see that sign, and it says what? Nebraska, the good life. So it allows all of us to continue to participate and live that good life. So with that, I would ask the committee to advance this bill, LB737, out of the committee. Let's get it on to the floor for debate and pass it. General File, Select, Final Reading. And then we can implement this. We have so many resources available, knowledge [INAUDIBLE] in Nebraska. Is that red light for me? OK. Thank you. But, but let's pull it all together and we can do the best we can for our members in Nebraska. With that, sir, thank you.

HARDIN: Questions? Senator Riepe.

RIEPE: Thank you. Thank you for being here. My question would be, is- do you have a priority commitment?

ROUNTREE: Yes, I do have a priority commitment committee bill for housing here. And that priority-- I think it was LB839. And that one is our reporting.

RIEPE: OK.

HARDIN: OK.

RIEPE: Thank you.

HARDIN: Seeing no other questions. Thank you.

ROUNTREE: Thank you so much.

HARDIN: This concludes LB737. We'll transition the room. And we will move to Senator Hansen and LB1012.

HANSEN: It's unusual not having a full room behind me on a bill, which is probably O-- which is probably OK.

HARDIN: Well.

G. MEYER: Let's put the word out.

HARDIN: Yes.

HANSEN: Yeah.

G. MEYER: Senator Hansen's testifying.

HANSEN: And I'm, and I'm glad my friend Senator Rountree used the right slogan-- state slogan instead of the other one for his bill. So that was good.

HARDIN: I think we are ready--

HANSEN: All right.

HARDIN: --when you are ready.

HANSEN: Yes. All right. Thank you, Chairman Hardin and members of the Health and Human Services Committee. My name is Ben Hansen. That's B-e-n H-a-n-s-e-n. And I represent Legislative District 16, covering Burt, Cuming, Washington, and parts of Stanton Counties. I am here to open on LB1012, which updates Nebraska's medical lien statute to include physical therapists among the health care providers who may file a medical lien for most-- for post-injury care. Currently, physicians, nurses, chiropractors, hospitals, and EMS providers are included in the statute. A medical lien is a legal claim filed by a hea-- filed by a health care provider against a patient's personal injury settlement or lawsuit proceeds. It provides repayment for medical treatment received after an accident, allowing patients to defer paying bills until they receive compensation while also getting rehabilitative treatment critical to their recovery. Of course, there is no guarantee of a settlement and payment, but the health care provider's able to be assured that, if there is one, there will-- they will be reimbursed for services at the customary rate as long as they are willing to wait for payment to ensure that care is not delayed. This bill does not apply to workers' compensation cases, and a lien

filed by an attorney takes precedence over a medical lien. LB1012 is straightforward legislation that enables physical therapists to get pa-- patients care promptly with a reasonable expectation of payment. So with that, thank you. And I'm available for any questions.

HARDIN: Thank you. Are there any questions? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you, Senator Hansen. My-- this is no stump the band question, it's-- why is it limited to physical therapists? Is it-- is-- are occupational therapist-- which is kind of a comparison to physical therap-- are they covered?

HANSEN: No. Occupational therapists or athletic trainers are not covered. I think it's maybe because-- and I'm sure people behind me could probably explain more-- that they deal a lot more with probably personal injury cases, not workers' complications, which I don't-- which I don't think apply to this.

RIEPE: But they might want to put a lien against an attorney.

HANSEN: Well, that's a tale for a different story that I'm not going to touch.

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

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair This is primarily focused on private pay, certainly Medicare, Medicaid, insurance carriers. Is, is, is-- this is primarily private pay?

HANSEN: Yes, this should not apply to-- I believe not Medicare or Medicaid. I'm trying to think of all my PI, workmen's comp stuff. But no, it should not. It's all insurance based.

G. MEYER: OK. Thank you.

HARDIN: Will you stick around?

HANSEN: Yes.

HARDIN: Wonderful.

HANSEN: I have to because I got the next one.

HARDIN: OK. That's helpful. LB1012, proponents. Welcome.

NICK WEBER: Thank you. Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Nick Weber, spelled N-i-c-k W-e-b-e-r. I've been practicing as a physical therapist in Nebraska for ten years. And I currently serve as the president for the Nebraska Chapter of the American Physical Therapy Association. I'm here today in support of LB1012. Physical therapy is a licensed health care profession in Nebraska, regulated by the state, and recognized as an essential component of injury recovery. Physical therapists evaluate, diagnose movement-related conditions, and provide medically necessary treatment that helps patients return to work, sport, and daily life. Yet despite this role, physical therapists are excluded from Nebraska's medical lien statute. This is not because physical therapy is new or unproven, rather it is simply because the words "physical therapist" are missing from the law. We have seen this situation before. In 2000, a court ruling determined that chiropractors were not protected under Nebraska's lien statute because their profession was not explicitly lissed-- listed. The Legislature later corrected that oversight, and today LB1012 asked for that same straightforward update for physical therapists. This bill does not expand the law. It does not change settlement structures. It simply adds one provider type. From a patient perspective, this matters. In injury cases-- whether motor vehicle accident, workplace incidents, slips and falls, recreational activities-- patients often need prompt rehabilitative care. The lien framework allows patients to seek treatment from the provider of their choice without being forced to delay care due to upfront financial concerns. Excluding physical therapists limits that choice and can fragment recovery by steering patients away from evidence-based rehabilitation. This current omission makes Nebraska an outlier compared to other states where physical therapists are explicitly included as health care providers eligible to assert liens for injury-related treatments-- meaning they can secure payment out of a settlement similar to what physicians, hospitals, and other licensed providers can do. Equally important, physical therapists are already embedded throughout Nebraska's multidisciplinary injury care teams and routinely coordinate with physicians, attorneys, and insurers. LB1012 simply aligns statute with real-wor-- real-world practice. So at its core, this bill is about

fairness, consistency, and patient access. Physical therapists provide medically necessary care. Physical therapists are licensed professionals. Physical therapists should be treated the same as other health care providers under existing law. LB1012 accomplishes that with a narrow, targeted change. On behalf of Nebraska's physical therapists and patients we serve, I respectfully ask for your support. Thank you for your time. And I'd be happy to field any questions.

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

RIEPE: Thank you, Chairman. My question would be this is-- this has become more of a current issue because, at one time, physical therapists weren't as predominant out in the community, if you will, in a business mode. They were more institutional. In physical therapy, we just-- what Senator Hansen just talked about, occupational therapists but-- respiratory therapists-- most of those don't go into private businesses on their own. Is that what precipitates this and possibly the reason that was excluded?

NICK WEBER: I think it's really two parts. OK? So I think the first is, like you mentioned, I think physical therapy as an evidence-based provider of care is becoming more and more prevalent. And so more and more individuals are seeking out our care for these type of injuries that we're speaking about. I think on the other side of it is just the reimbursement challenges across the health care community and the fact that, you know, why we didn't do this in '08 when the chiropractors did. It maybe just wasn't as a big of an issue for us then as it is now. And when you think about, you know-- the average patient comes to PT for maybe 12 visits. OK? And so if, if a PT's getting, say, $100 a visit-- just estimate, OK-- we might be talking about $1,200. Before, maybe that particular private practice in a small rural area was more willing to take on that risk and, and, and hope they got paid. Now, in our current environment, we just can't take that risk. And so that's why this is really becoming more important right now. It's just that security [INAUDIBLE].

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

FREDRICKSON: Senator Meyer.

G. MEYER: Thank you, Vice Chair. I have a knee replaced. I go to my local hospital that has a rehab department. I don't have insurance. How's that generally handled under that circumstance? It-- do, do I have to pay a portion upfront? Is there an estimate on what it's gonna cost, how many, how many appointments it's going to take?

NICK WEBER: Most systems have a out-of-network rate for patients, which they can, they can choose to take on at that location or a different one. What-- speaking more specifically kind of to rural private practices, they would have, like, a cash pay option typically for you to, to choose from.

G. MEYER: Set up a payment option.

NICK WEBER: Exactly. Yes.

G. MEYER: Do you find people-- since physical therapy hurts sometimes-- I've had two knees replaced. I've had a shoulder-- seven AAGRs in my left shoulder, and-- but I was aggressive in my physical therapy because-- yeah, hurt-- hurts, but it get-- you get better quicker. Do you find that people, given the fact that it's uncomfortable having physical therapy, that they forego that and then have more problems from lack of physical therapy down the road?

NICK WEBER: It-- it's definitely a approach that requires active participation, right? And so that's not for everybody. Some people prefer passive treatments over the more active ones. And so-- for sure, that steers people away from our particular profession at times. That's of-- obviously a personal choice. And something that we, we try to-- to your point, those that are active and work hard tend to get better outcomes. So that's kind of on us for educating the public on that opportunity.

G. MEYER: This is probably totally unfair of me, but do you enjoy making people cry?

NICK WEBER: I mean, there's no doubt that someone has taken my PT designation and flipped it to personal torture or something of that nature before. For sure. I get that joke a lot.

G. MEYER: As long as you enjoy your work.

NICK WEBER: It's-- yeah. It's, it's still rewarding. Absolutely.

G. MEYER: Totally unfair of me. I apologize.

NICK WEBER: It's OK.

FREDRICKSON: Other questions? I've got a couple. Thanks for being here. Thanks for taking the time to testify. It's good to see you again. So what would the process be if this were passed into law? How would the physical therapists, like, recover on the payment, like, the injured party-- from the injured party? What would that process look like?

NICK WEBER: So-- yeah. So they-- essentially, they submit the, the medical lien, correct? Right. And then they essentially just what-- they provide the care. So then that gives them the security of, like, if a settlement is reached, I'm going to get paid from that settlement. Right? So first and foremost, it allow-- it gives them confidence that, hey, I can initiate the care right now when the patient needs it rather than wait for the settlement. Because who knows how long that takes, right? So that's put in place. And then typically that person would have a, a legal representative that, once the settlement is finalized, then that individual takes their percentage out of whatever that agreement was and then distributes the rest of the money onto the providers that, that participated in the care.

FREDRICKSON: OK.

NICK WEBER: Yeah.

FREDRICKSON: And, and who pays the legal fees in these situations?

NICK WEBER: The patient, but typically I would say it's, it's built into the settlement.

FREDRICKSON: OK.

NICK WEBER: Yeah.

FREDRICKSON: Thank you.

NICK WEBER: Mm-hmm.

FREDRICKSON: Senator Riepe.

RIEPE: Thank you, Chairman. Would you put a lien on for a $15 bill?

NICK WEBER: I don't specifically own a private practice, so I can't speak to that. I think-- I don't want to try to speak for private practice owners, but I think it comes down to just--

RIEPE: I'm just curious how, how low they would go in-- I-- I'm curious.

NICK WEBER: Yeah. I mea-- I mean, no treatment initially-- initiating a treatment session, nothing is going to be that low.

RIEPE: You probably don't have a treatment that costs $15.

NICK WEBER: I-- not that comes to mind, no.

RIEPE: OK. Thank you.

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

NICK WEBER: Thank you.

FREDRICKSON: Next proponent.

BRIAN BRUNKEN: Good afternoon, everybody. Chairman Hardin, members of the Health and Human Services Committee. My name is Brian Brunken. That's B-r-i-a-n B-r-u-n-k-e-n. I am the chairperson for the-- of the Practice Management Committee for the Nebraska Chapter of the American Physical Therapy Association. I also serve as a clinic manager for GO Physical Therapy in Omaha. We're an outpatient physical therapy practice with clinics spanning Nebraska from Kearney to the west and Omaha to the east. Every day, our therapists provide medically necessary care to Nebraskans recovering from injuries, helping them return to work, family life, and full participation in their communities. LB1012 would allow licensed physical therapists to collect payment for their services provided to patients who are treated under a medical lien related to an injury, as Nick already stated. Currently, as Doc-- Senator Hansen, Dr. Hansen let you know,

physicians, nurses, chiropractors, hospitals, and emerge-- emergency medical providers are explicitly included in its statute already. They're eligible to receive their usual and customary fees from a judgment or settlement. Physical therapists, despite delivering essential rehabilitative care, are not. This exclusion creates real challenges for both clinics and patients. Liability cases often take months or even years to resolve. During that time, physical therapists continue providing care in good faith, knowing payment is uncertain. Once settlements finally occur, PTs are frequently not reimbursed by attorneys or patients, leaving clinics responsible for pursuing payment long after services were delivered. This places a significant administrative and financial burden on physical therapy practices, especially small and independent clinics. It also creates confusion and stress for patients. Many assume that, once their case settles, all medical bills have been paid. Unfortunately, that is not always true, and patients are sometimes surprised to learn that they still owe for physical therapy services-- care that was essential to their recovery. LB1012 would help prevent these situations by ensuring physical therapists are treated equitably alongside other health care providers in mean-related cases. Importantly, this bill does not create any additional cost or tax burden for Nebraska taxpayers. It simply modernizes existing statute to reflect today's health care delivery model and recognizes physical therapists as integral members of the injury care team. Passing LB1012 supports patient clarity, provider fairness, and a long-term sustainability of physical therapy services across our state, especially in rural and underserved communities. I respectfully urge you to support LB1012 and thank you for your time and consideration. I welcome any questions.

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

G. MEYER: Do you find that people forego physical therapy? And, and, and it can be based on the discomfort of it, but the cost where it-- where they-- they really should go for physical therapy but they find the cost prohibitive. And, and, and once again, I'm, I'm not judgmental on what the charges are and that type of thing. But given the economics we're dealing with, people would forego that rather than some other perhaps things they feel are more necessary?

BRIAN BRUNKEN: Well, certainly they forego because of cost. And as the years have gone by-- I've been doing this for 29 years and I own my own practice for 18. I joined up with Grand Island Physical Therapy two and a half years ago. And-- so I can talk from a smaller practice and a bigger practice, but patients are very in tune with what it costs for out of pocket, and they want to know after the first visit or maybe two or three visits. And they do call us physical terrorists, by the way, as well. But I've seen-- I, I, I asked our billing department before presenting today. You know, is this a rampant thing where we're not getting paid in these medical lien situations? It's not, you know, overreaching, but it's still very frustrating, especially if you think about somebody I saw three or four years ago and I finally get a settlement and then the attorney doesn't pay us or the patient doesn't pay us, and then do you take them to small claims court or do you send them to collections and get 50 cents on the dollar? We're just asking for our, you know, services rendered and getting paid for those.

G. MEYER: Do you sense, given, given the economics we're dealing with, that people aren't going for their normal medical, medical care as well as physical therapy? Are you seeing somewhat of a decline in people seeking services and, and could correlate that with even just seeking any, any type of medical care?

BRIAN BRUNKEN: Certainly. I know-- I could talk for hours like-- previous bill on this. But we know-- most of us have private pay insurance. Most of us get our physical taken care of each year. But then care beyond that because maybe they have a $4,000 deductible, a $7,500 out-of-pocket max or even higher, they will forego the next thing, the next thing. I'm, I'm a licensed physical therapist, but we see people stop after two or three visits. And you talked about your total knee. And I agree with Nick, 10 to 12 visits kind of shows about the average for something like that. Maybe a little more if there is some more scar tissue due to your genetics. But I, I have patients that they get their first bill-- and we're pretty active on trying to collect on each session-- and they just cease at that point.

G. MEYER: Once people have their deductible met, you see them coming-- responding much easier.

BRIAN BRUNKEN: Certainly.

G. MEYER: I think that's human nature.

BRIAN BRUNKEN: We're busier toward the end of the year, always, 100% of the time. I don't know if Senator Hansen can speak to this, but once the out-of-pocket max or their surgery's been met, well, I'll, I'll-- maybe I'll get my other knee done this year and-- then physical therapy's covered, but. Nick mentioned that physical therapy visit maybe is around $100. And if you, again, have that high deductible plan, you-- you're paying for all that physical therapy yourself, you know.

G. MEYER: Thank you.

BRIAN BRUNKEN: You're welcome.

FREDRICKSON: Other questions? Seeing none. Thank you for your testimony.

BRIAN BRUNKEN: Thank you.

FREDRICKSON: Next proponent for LB1012. Seeing none. We will move on to opponents for LB1012. Seeing none. Anyone to testify in the neutral capacity for LB1012? Seeing none. Senator Hansen, while you come up, there were online comments. We had 13 proponents, 0 opponents, and 0 in the neutral capacity.

HANSEN: Thank you, Vice Chair. Senator Meyer, if physical therapists or chiropractors ever make anybody cry, it's usually almost always out of happiness.

G. MEYER: I appreciate that. Thank you.

HANSEN: Actually, I have a sign in my, my office has-- says we make knotty people cry, with k-n-o-t-t-y, so. All right. Well, you, you heard it. It's a pretty simple bill. Hoping to move it through pretty quick. I don't know if anybody has any questions to ask me, I'll do my best to answer them.

FREDRICKSON: Any questions of committee? Senator Hansen, where did you get that sign?

HANSEN: I made it.

FREDRICKSON: Oh. Thank you. Other questions? All right. Seeing none. Thank you so much.

HANSEN: Thanks.

FREDRICKSON: That will conclude our hearing for LB1012. And we will move on to LB1233, which is also Senator Hansen.

HANSEN: OK. Good afternoon, Chair Hardin and members of the Health and Human Services Committee. My name i-- again is Senator Ben Hansen. That's B-e-n H-a-n-s-e-n. Representing Legislative District 16. I offer for your consideration today LB1233, a bill that would establish the Developmental Disabilities Provider Excessive Training and Cost Reduction Act. LB1233 works to prohibit the Department of Health and Human Services from imposing unnecessary costly training requirements on employees of developmi-- developmental disability providers and to ensure that they are focused solely on guaranteeing the health, safety, and welfare of the individuals served. The bill also makes it clear that the department must offer providers the option of meeting requirements with more economical in-house training options so long as the in-house training meets all safety requirements. Let me start by giving some context. In the developmental disabilities provider space, the Department of Health and Human Services, following federal requirements, establishes rules and regulations that govern the standards expected of providers licensed to serve this population. Because of the close nature of interactions between the employees and individuals they serve, federal regulations and the Nebraska Administrative Code include requirements for, quote, approved emergency safety intervention techniques. In these training requirements, safety is a priority for all involved. In Nebraska, DD providers have been complying with these training requirements in various ways. Before, there were options. One approach towards completing the training that some providers used included in-house training programs for their employees. These training-- trainings encompassed all the requirements of federal and state law. Others who did not have internal curriculum would pay for the training from providers who met all requirements. Even after demonstrating the effectness-- effectiveness of these in-house options and other contract programs, the department issued a provider bulletin on February 5, 2025-- 2024 with notice to providers. I have handed all of you a copy of that bulletin for you to review. Under the terms of the

bulletin, the department modified Nebraska Administrative Code and determined, and I quote, the Division of Developmental Disabilities had de-- has determined that the Mandt system is the only system that will be accepted for use with ESI-- that's emergency safety interventions. The Mandt system is a private training program offered by a single company. Under this bulletin, providers are now left with no choice but to purchase training for each of their employees from one provider, creating a monopoly. As you will hear today, this has resulted in remarkable, unexpected costs. This is why I have brought LB1233. The bill simply asks the question of whether we as the Legislature and state think it is good policy to allow the department to unilaterally mandate the use of one comp-- one private company to complete training requirements when there are less costly and, more importantly, safe alternatives. Training re-- requirements are not a bad thing. In fact, I believe-- and the providers who will testify in support of this bill today believe-- that it is critical to their ability to appropriately provide services. There is no space for unsatisfactory training that could cause there to be a risk for the health or safety of the person served through these services or for the employees during this important work. But the department's limitations on options have caused some issues. I, along with many of you, am a person who believes that go-- that government regulation gone too far can have unintended consequences and lead to unnecessary costs that have large impacts. That's the story you'll hear today. There are a few providers here to testify that can talk in more detail about the implications of this change. Please do not hesitate to ask them any questions you have. With that, I appreciate your time and ask you to support LB1233. And on a side note, I have been in communication with the department, and we are trying to work out some of the kinks of this bill to see if we can kind of come to some resolution and move this bill forward. So, you know, I'm sure you'll hear from borth the-- from both sides and then get a better idea where we're trying to find some reconciliation here. So with that, I'm happy to answer any questions you might have, or I will defer to those following me. Thank you, Chair.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you again for being here. You mentioned-- it sounded like-- or imply that it's a higher price than what we're currently doing--

HANSEN: Yeah. I-- before, they did have less costly options to provide this training, whether it's in-house or some other way. And so now they're pretty much stuck with one company doing the training.

RIEPE: Which obviously can impact cost.

HANSEN: Yes.

RIEPE: Do we have a cost?

HANSEN: I'm sure the people following me will give that.

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

HARDIN: Senator Quick.

QUICK: Yeah. Yeah. Thank you, Chairman. So, you know, when they're-- when they make these changes, is that-- like, do they communicate with-- or maybe that's some-- a question for them too, but are they communicating with the, the providers to make sure that this is something that's going to work within their, you know, budgets?

HANSEN: Yeah. You probably want-- I'm sure it's-- varies in all aspects from who they're communicating with and when. So with this particular instance, I'm unsure on how soon this-- they communicate it versus how soon [INAUDIBLE] implementing.

QUICK: OK. All right. All right. Thank you.

HARDIN: Very good.

HANSEN: All right.

HARDIN: Will you be here at the end?

HANSEN: Yes, sir.

HARDIN: Wonderful. Proponents, LB1233. I see them flashing signs across the room. Welcome.

ALANA SCHRIVER: Good afternoon, late afternoon, Chairman Hardin, members of the HHS Committee. My chair is broken. My name is Alana Schriver, A-l-a-n-a S-c-h-r-i-v-e-r. And I'm the executive director of

the Nebraska Association of Service Providers, which is the state membership association for the home- and community-based providers serving individuals with intellectual and developmental disabilities on the 1915(c) Medicaid waivers. So thank you for the opportunity to speak on behalf of the disability community. Thank you to Senator Hansen for introducing this bill. At its core, LB1233 is about accountability, flexibility, and common sense. It ensures that training requirements are appropriate, competitively priced, and compliant with federal law. Let me be clear: no one in this field opposes training. Providers of developmental disability services are deeply committed to high-quality, person-centered supports. Staff must be trained to recognize and report abuse and neglect, understand person-centered values, implement behavior supports appropriately, and use de-escalation techniques effectively. These are baseline expectations, and they are entirely consistent with the federal requirements and guidance from the Centers for Medicare and Medicaid Services. However, there's a critical distinction between requiring effective training and mandating a single, specific curriculum. Mandt, or any single crisis intervention curriculum, is not a federal mandate. CMS does not require uniformity across all providers. CMS cares about outcomes, that whatever training is used is effective and that staff are competent. The shift to a single state-mandated curriculum is a state administrative decision, not a CMS directive. Moreover, CMS technical guidance cautions states against including qualification requirements that are unrelated to quality and effectiveness. The guidance specifically discourages imposing standards that do not demonstrably improve the quality of services. If a provider already has a training program that effectively prevents abuse, teaches safe and appropriate emergency interventions, and ensures staff competency, forcing that provider to abandon it and purchase a different program does not inherently enhance safety. It simply increases costs. It is also important to note that CMS does not expect staff-- every staff member to be certified in physically restraining techniques unless their role specifically requires it. Overly broad mandates that require all staff regardless of job function to undergo intensive, high-cost certification programs go beyond what federal oversight requires. These costs are not abstract. DD providers operate on tar-- tight margins, largely funded by provider rates that have not kept pace with inflation or workforce pressures. Every additional unnecessary training cost diverts

resources away from direct supports, wages, recruitment, retention, and innovation in care delivery. LB20-- LB1233 does not eliminate training requirements. It does not lower standards. It does not compromise safety. It does restore alignment between state policy and federal intent. We all share the same goal: protecting vulnerable individuals and ensuring high-quality services. This bill advances that goal by emphasizing effectiveness over exclusivity, competency over branding, and accountability over bureaucracy. For these reasons, I respectfully urge the committee to advance LB1233. I also-- one of my colleagues was unable to come-- he's sick-- so I did submit his written testimony with his dollar amounts for your review as well.

HARDIN: Thank you. Questions? Senator Meyer.

G. MEYER: Thank you, Chair. Whether it's the Mandt system or any other system, are they essentially the same type of training?

ALANA SCHRIVER: Not necessarily, no. Mandt, for example, about 20% of that curriculum is physical restraint. As a parent of a child with developmental disabilities, I don't love that. My son in his ISP, in his individual safety plan, does not require physical restraint. I don't want his staff thinking that that's an appropriate response. I would prefer other de-escalation techniques that other curriculum focus more on.

G. MEYER: Would, would this be similar training to-- I know like in nursing homes, things of that nature, properly handling people that are unstable on their feet, even bed transfer, does this include lifts and things of that nature? Is that--

ALANA SCHRIVER: Em-- emergency safety intervention is specifically more for high-risk behaviors. So it wouldn't necessarily-- if you have an elderly person in custodial care who isn't prone to challenging behaviors, they would not have--

G. MEYER: Training's not transferable, essentially, as far as--

ALANA SCHRIVER: Yeah. Not everyone with a developmental disability in our services has emergency safety intervention as a requirement of this-- like, if you're a staff person working with someone, unless they have those in their emergency safety intervention, is part of

their individual support plan, this training didn't previously happen. So now providers are having to pay to train all of their staff even if that staff doesn't work with an individual who needs ESI training--

G. MEYER: OK.

ALANA SCHRIVER: --according to their plan.

G. MEYER: Thank you.

HARDIN: Senator Quick.

QUICK: Yeah. Thank you, Chairman. And so-- you know-- of course, you-- maybe heard my question to Senator Hansen about, were there conversations before they wanted you to switch to this type of training?

ALANA SCHRIVER: I-- not with me directly or with anyone I know personally, but I think-- if I'm not mistaken-- and Director Green can correct me if I'm wrong-- I think what they did is look at what curriculum a lot of providers were already using. And a lot of providers do use Mandt. But it is also the most costly one, so our larger providers were not using Mandt because they have more staff. So for example, APACE supports the most individuals in Nebraska. Last year, they operated on a $650,000 operating loss, and about $625,000 of that was switching to Mandt to meet this requirement.

QUICK: OK. And can you talk a little bit about-- so you-- there's federal requirements that come down, right, and then what-- you really ha-- you know, as long as you're within those federal requirements, that should be what the standard should be, right? Or--

ALANA SCHRIVER: Right. And in our state statute, it actually implies there's multiple options. It just says you have to work with a state-- one of the state-approved curriculum. And so this provider bulletin that came out is a little bit in conflict with state statute that implies you have a choice of curricula. And then the provider bulletin then says, nope, you actually don't. And provider bulletins are not technically enforceable since they're not statute.

QUICK: OK. All right. Thank you.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair Hardin. I was thinking about another opportunity in dealing with-- handling situations. Law enforcement-- sometimes we're dealing with emergency protective custody, things of that nature, that could-- and also involve disabilities and, and, and-- there could be some col-- you know, correlation there. Is this something that law enforcement, Ma-- the Mandt training or something similar to that-- is this something that would benefit law enforcement?

ALANA SCHRIVER: They might. I know schools use Mandt. Mandt's not bad training. It's good training for what it is. It's just the most expensive version. It's hard to negotiate prices. But it's, it's not a bad training program, and it is helpful for those participants who do need those de-escalation techniques.

G. MEYER: Thank you.

HARDIN: Senator Quick.

QUICK: Yeah. Yeah. Thank you, Chairman. So-- and-- of course, I worked with you last year. I had the bill for working on the guidance documents and how the-- how they're used. So really-- in some of this process, what we thought would be better is if there was a, a meeting to-- well, a-- or a regulatory process that we would go through to change those type of processes.

ALANA SCHRIVER: Or if the state wants to enact a mandate for one provider-- like, for example, our case management software is a mandated-- everyone has to use Thera, but then the state pays for that because it takes away your negotiation ability. So if the state wants to use Mandt, OK, let's use Mandt, but pay for it then. Otherwise, allow people to negotiate their cost.

QUICK: OK. All right. Thank you.

HARDIN: Seeing no other questions.

ALANA SCHRIVER: Thank you.

HARDIN: Thank you. Proponents, LB1233. Welcome.

JUSTIN SOLOMON: Thank you. Good afternoon, Chairman Hardin. I am Justin Solomon. That's J-u-s-t-i-n S-o-l-o-m-o-n. And I serve as the chief operating officer and chief financial officer of Integrated Life Choices. We're a statewide provider of developmental disability services. And I'm testifying today to urge you to support LB1233. Alana and I are kind of pulling double duty due to some colleagues that got ill, so I'm happy-- my testimony mainly focuses on the financial components. But in the interest of full disclosure, we are one of the providers that had an in-house curriculum. And we're happy to-- and I'm happy to answer any questions you have about the nuances between training systems and how different providers navigate that space. So at its core, this is a bill about fiscal responsibility, reducing red tape, and allowing businesses to deploy our resources effectively to best serve our fellow Nebraskans. As a provider of home- and community-based services, our mission is simple: we want to help individuals with intellectual and developmental disabilities live meaningful and fulfilling lives. And to do that, we need to be very judicious with every dollar available that we spend to ensure as many dollars as possible and as many resources as possible are directed towards staff wages, employee safety, and quality programming. Currently, however, these rigid state mandates that LB1233 addresses forced us to spend hundreds of thousands of dollars on specific, out-of-state corporate training vendors rather than support for the people that rely on us for services. LB1233 cuts red tape and allows us to reinvest those funds where they belong: here in Nebraska serving people with developmental disabilities. We recently conducted an accounting of the costs associated with this single vendor training Mandt mandate, and the numbers show a significant waste of resources that could be better spent. A breakdown of these costs are included in my testimony at the very back, so you can follow along if you'd like. And at ILC alone, the total cost to comply with this mandate is over $306,000. And that's a biannual cost. The annual cost is north of $150,000 a year. This is more than a quarter million dollar mandate that is not driven by safety needs-- because we have successfully used federally compliant, state-approved training curriculum for 20 years. The cost is entirely due to a lack of flexibility. And instead of going to frontline wages, these funds are absorbed by administrative overhead and vendor fees and the costs associated with a monopoly. The mandate of LB1233 will solve those broke-- and our costs are, again, broken down as such. The first cost that we have, $82,000 or so a

year, is our employee cla-- additional employee classroom time that we have to account for over what our curriculum was costing before. And this is time, again, where people are ex-- expected to sit in classrooms that-- really, we assessed wasn't needed and time that they could instead be using serving people with disabilities. The second category has a cost of about $127,000 annually. And when-- this is from when staff are polled to do that additional training, what we have to backfill with because, of course, if someone's training-- we provide 24/7, 365 services. Someone has to come fill that gap. And oftentimes, that's done with overtime. So-- as a compounding cost. The third cost for the in-person training salary is-- the third cost component is the in-person training salaries. That's about $36,000 a year. And these are to maintain our cadre of training-- certified training prof-- providers and to deliver the specific proprietary curriculum. The fourth component and the fifth ca-- component are the costs associated with training our trainers-- which is over $50,000 a year, or near that-- again, before our trainers can teach a single class, they have to undergo a rigorous and expensive certification process. And as a statewide provider, very few of those classes are, are offered west of Lincoln. So we provide services in Scottsbluff, along I-80, you know, and Valentine, other place--

HARDIN: If I can encourage you to kind of wrap it up, Mr. Solomon.

JUSTIN SOLOMON: The last cost component is the tokenization, and this is an increasing cost and kind of shows the monopoly power. Mandt added a cost annually of $10 a trainer that you, you now have to pay. That didn't happen beforehand. The costs are going up year after year. Of course, we have no ability to negotiate. So-- again, happy to answer any questions you have about the cost components or the training curriculum and the differences.

HARDIN: Thank you. Questions? Senator Quick.

QUICK: Yeah. Thank you, Chairman. So like-- I, I think it was brought up that there's a difference, like-- and what type of training you might need for different providers.

JUSTIN SOLOMON: Yeah.

QUICK: Can you talk about that? I mean--

JUSTIN SOLOMON: Yeah. So-- here's a good example. So we have qui-- a big presence in Norfolk and Wayne. Alana mentioned certain people have in their individual safety plans and a-- the permission to use an emergency safety intervention or a hold-- a physical hold to prevent an unsafe situation. No one in our-- in that operation in Norfolk and Wayne has that in their programs. Right? We're not allowed to engage in ESI if they are having an em-- an, an emergency. We ha-- still had to train a hundred staff on this curriculum even though they would not ever-- they can't use it. If we-- if, if a staff were to engage in some sort of physical hold with a single one of those person, we're, we're calling adult protective services. Right? So they literally can't utilize the training, but we're still required to provide it. And so what this bill would allow us to do is use our professional discretion to know when a staff needs to be trained to actually engage in an, in an emergency safety intervention and train those people accordingly. It would also allow us to-- what we did, because we didn't like any of the, the actual holds themselves, the physical interventions themselves, is we put together our own curriculum. A lot of the, the fundamentals of the curriculum aren't owned by any specific provider. Right? The crisis cycle is not trademarked or copywritten by anybody. The-- Maslow's hierarchy of needs, all of those components are just pop-- are, are largely part of every curriculum in this space. And it's-- they're not owned by anybody, so we were able to package those along with our own proprietary curriculum and train our employees on it. And we were able to do that across three states. And this is the only state where we had any issue. So I think that speaks to just the, the, the, the lack of flexibility that the current mandates give providers.

QUICK: All right. Thank you.

HARDIN: Other questions? Seeing none. Thank you.

JUSTIN SOLOMON: Thank you.

HARDIN: Proponents, LB1233. Opponents, LB1233. Good afternoon. Welcome.

TONY GREEN: Good afternoon, Chairman Hardin, members of the Health and Human Services Committee. My name is Tony Green. This chair is broken. T-o-n-y G-r-e-e-n. And I am the director for the Division of

Developmental Disabilities of the Department of Health and Human Services. And I'm here to testify in opposition of LB1233. The department has a statutory and ethical responsibility to ensure the health, safety, and rights of individuals who receive services through our Medicaid home- and community-based waivers. A core component of this responsibility is the ability to establish and implement training requirements that reflect current evidence-based practices, response to emergency risk, and align with federal expectations for participant protections. LB1233 would significantly constrain this authority by imposing rigid and unclear limitations on how required trainings are selected, approved, and delivered. It also presents substantial implementation challenge. Section 4 of the bill limits the division's ability to establish training requirements by relying on vague and imprecise language that would be difficult to operationalize. Section 4(a) restricts training to employees whose job duties, quote, may reasonably require the use of restraints. This standard is undefined and subjective, creating uncertainty for providers, employees, and the department. In addition, the provision focuses narrowly on physical restraints and fails to account for the full range of de-escalation, crisis prevention, and behavioral support practices that are essential to avoiding the use of restraints altogether. Effective training must address early intervention strategies, situational assessment, and nonphysical techniques that protect both participants and staff. Section 4(b) further requires the division to allow in-house trainings, creating a presumption that such trainings must be approved regardless of their content or alignment with best practices. While providers do play an important role in workforce development, allowing in-house trainings may not reflect nationally recognized, evidence-based standards and increases the risk of improper and inconsistent restraint use. This approach also expands potential liability for the department, providers, and employees if participants are harmed as a result of inadequate or inappropriate training. Finally, LB1233 would create confusion and inconsistency for participants, providers, employees, and service coordinators. Varying training approaches across providers would require stakeholders to understand and apply different techniques and standards, complicating service delivery, oversight, and monitoring. This inconsistency ultimately risks participants to undermine the division's ability to ensure uniform safeguards statewide. Additionally, having multiple curriculums actually increases a provider's cost, as the staff often

move from one provider to another and then have to be retrained in whatever model that provider uses. We respectfully request that the committee not advance this bill as written to the General File. And I'd be happy to answer any questions you have.

HARDIN: Thank you. Questions? Senator Fredrickson.

FREDRICKSON: Thank you, [INAUDIBLE]. Thank you, Director Green. Good to see you. Thank you for being here. So kind-- I, I listened to your testimony. I was kind of reviewing this and certainly kind of appreciate what-- the things you, you were outlining. I'm also kind of hearing what some of the providers had said and, and kind of the challenges that they're facing. And I know Senator Hansen mentioned in the opening that there's-- might be some conversations between the department going on. Is this something that-- do-- I guess what I'm trying to-- I guess my question is, do you, do you sort of see what the providers are saying as well some of, like, the maybe unintended consequences that some of these things have brought up and-- I guess how do we sort of walk that line, right--

TONY GREEN: Yeah.

FREDRICKSON: --or-- yeah.

TONY GREEN: No, it's a good-- it's a good question. And I think, you know, where we've had conversations recently about what this perhaps could look like through an amendment that we would certainly take a, a, a, a look at and see what the position might be. If there is angst in the single provider model-- which we still believe was the, the right choice, right? This-- so you understand what this training is. While it is, is heavily focused on de-escalation and, and communicating with folks with developmental disabilities so that they don't get in very difficult and challenging situations-- often using physical aggression-- the ultimate use at the end of this training is, how do you physically restrain somebody? And allowing multiple systems to be in place to say, well, if you work for us, we say restrain a client this way. And if you work for us, we say restrain a client this way. So that was our position on why we chose one model, so that all staff across the state who work with folks with developmental disabilities are trained in one way to communicate effectively with folks, de-escalate them, and then, ultimately, if you have to get to

that level of physical intervention, it's gonna look the same across the state regardless of who you work for or what provider you pick. But more specifically, Senator Fredrickson, if there-- if that in and of itself would be-- you know, if there is a second national model that we might want to adopt-- because there are many, right? When we did the initial review of all the curriculums, I think we reviewed somewhere around 10 or 12 curriculums across the country that are, are considered evidence-based practices or nationally recognized and widely used in this profession and many other professions that work on, on workplace violence or de-escalation techniques. And so that might be an area that we could look at. I think a sticking point for us will be allowing a provider to have a homegrown model that they just themselves feel that this is the best way to restrain a client. I don't know that that's a position we would want to be in, and it seems to be a slippery slope to do that. I would also follow up and say that the, the assumption that, that a, a curriculum had been in place and approved by the department is a very loose approval. Prior to this, this work starting, where we started to really look at what safety models were being implemented by providers across the state, the approval process is you submitted an entire policy and procedure manual to the department as part of your certification process. And in that, one of the requirements is you had to have policies and procedures in these specific areas, one of which was emergency safety interventions. And so by virtue us-- of us approving your policy, because you identified a safety intervention, that, that was the approval. It wasn't really going in and looking at, is that an effective model or not? It was just, you had identified a model and it met the requirement of the regulation to have a policy. So we began this work in 2023, working with all of the providers across the state in what their curriculums were. As you've heard our analysis of that, we felt this was the model that had the best approach to, to working with folks. It-- because it does have such a hemp-- hea-- hea-- heavy focus on the front end of communication, relationship building, and working to de-escalate folks, and, and 20%, as Alana would say, on, on the physical intervention. Over 80% of the providers when the decision was made were already using and paying for Mandt.

FREDRICKSON: Thank you.

TONY GREEN: You're welcome.

HARDIN: Is there a potential cost savings where we don't get sued as much if we di-- do it one way?

TONY GREEN: Well, I mean, I think-- you know, we, we still believe that a, a single model acc-- you know, we're trying to streamline all of our, our direct care workforce training. Right? And so this is one area that, that we feel very strongly that it-- if, if, if you're going to physically intervene with folks, that should generally look the same across the state, and especially for staff that go from provider to provider, right, who have to be trained in my model as an agency because I have an in-house model. Now I go to another agency, I have to now be retrained because they use Mandt. Or this one would use another. Part of this has, has escalated just in the significant growth in the number of providers. We've had a 47% increase in agency providers in this state. And as of the end of January, we're sitting at 175 providers. And so allowing, the way the bill is written today, for me to approve a provider to have their own homegrown-- although probably not realistic, I could be requested to review 175 homegrown models.

HARDIN: A previous testifier was saying that they had a number of employees who really didn't work in that space and yet were required to go through the Mandt system. Is there any kind of an a la carte way of going through the Mandt system and saying, well, these are people who, by job definition, are not someone who would ever have to use the restraint?

TONY GREEN: Yeah. I-- I'd be happy to take a look at that. I, I believe-- and I, I, I don't want to misspeak, so-- but direct care, obviously, I think is probably today a requirement. And perhaps the argument is there are some folks working direct care who may not work with somebody today who has a program or an issue that would indicate a need for emergency safety. But remember, these are, these are techniques that if-- they're, they're unexpected. They're emergencies, right? So let's-- nobody has a history of, of running into traffic but all of a sudden you're out someday in the community and they do, we would expect those staff to intervene and physically assist that person back to safety. And we would want them trained to all do that the same way.

HARDIN: Other questions?

TONY GREEN: So I think we do require all direct care today to do it, but I do not believe that there is expectations today that HR staff or bookkeepers or finance folks are required to do the Mandt. But if you are in a position that works with clients-- and why part of that becomes necessary, as you know, with a significant direct care workforce shortage, these staff are often being placed unexpectedly with clients they don't traditionally work with to cover shifts. And so as you're trying to manage-- maybe the client I normally work with does not require that physical intervention, but tomorrow I might be assigned to a home where they're short-staffed, and now I need to know that. And so I think we do widely say direct care should have it so that you can intervene in an emergency situation, and knowing that direct care staff do often flow from setting to setting.

HARDIN: Thank you. Other questions? Senator Quick.

QUICK: Yeah. Thank you, Chairman. So when you first decided to, to go to this specific type of training-- I mean, were there problems that were coming up and that's the reason you went to it? Or was it just something that you thought that the whole state should do?

TONY GREEN: Yeah. I think-- I don't know that I would say problems other than, you know, so-- you know, you-- we've been asked of wha-- were the rising incidents of abuse, neglect? We've always had them. We've always had people who have been injured in physical restraints. We're, we're running right now about 120 times a month. These emergency safety interventions are being physically where folks are intervening. The concerning part, Senator Quick, was when we went out to really start digging in to see what are these curriculums and what are the training models that providers are using. And some of them in, in a homegrown or a hybrid model had techniques in, in self-defense that would mirror karate or jitsu. And that was very concerning to us. I would not classify that as widespread, so I don't want to portray that all providers were doing that. But that started to, to ring alarm bells for us of, we need to go look at all of the providers. And so we went provider by provider across the state to look at what curriculum did they have, what were they using. And again, 80% were already using Mandt. And our desire to go to a single system, that seemed to be the most logical because the expense was already being incurred by the largest number of our providers with that model.

QUICK: And my other question would be-- so with the expense of it to, to some of them who haven't had it before, the Mandt training-- I mean, if the re-- state's requiring everybody to use that model, isn't there some way you can negotiate that cost down because you're using one provider rather than-- you know, it's almost like an unfunded mandate. So you're passing down a cost to the providers who are already struggling to provide those services for people, so.

TONY GREEN: Yeah. So I, I think there, there would be opportunities for the state to do that on behalf of the providers. I believe we did that when Mandt initi-- because when we first launched the decision to go with Mandt, there was not a per-student fee that Mandt was charging. That $10 you heard about, that wasn't in place when we adopted Mandt. That came after. And I believe we had contacted Mandt who waived that for one year for Nebraska providers. Additionally-- again, this was a long lead in to this decision. We started the analysis of their curriculums in 2023. We launched the provider bulletin in February of 2024, giving them a 17-month runway before implementation. Implementation wasn't until July 1 of '25. So today, all the providers are already on Mandt. So we would be undoing something that all the providers are actually compliant with today. We also offered-- at the time, when we made this decision, we had ARPA funding available to us. And so the cost that you heard for trainers, we paid for that for all of the providers that did not have Mandt trainers on staff already. In addition, if you were using Mandt and you wanted additional trainers, we paid for those as well. And so we, we did expend our ARPA funding to pay for one-time trainers for all the providers to get this up and running.

QUICK: All right. Thank you.

HARDIN: Other questions? Seeing none. Thank you.

TONY GREEN: Thank you.

HARDIN: Opposition, LB1280-- LB1233. Those in the neutral. Senator Hansen.

HANSEN: I was just about ready to have the best closing of my political career and then Senator Fredrickson steps out, so. I'm going to hold off now. All right. Thank you, members of the HHS Committee. I

appreciate the department coming in here and discussing some of their concerns with us. And I really do think there can be a path forward, some kind of resolution. I think we just need to find it, and I'm willing to work with them and both parties involved and-- whether that involves opening up-- like they said, there are multiple nationally accredited models out there that maybe we can open up some of those so at least they have some kind choice, some negotiating ability, maybe, with some of these entities. Maybe there could be some pathway forward for some sort of state reimbursement if we're going to mandate a single source. So I think, I think there's some, there's some things there. And I do see their need-- they do want probably some consistency and hopefully decreasing instances of res-- restraint use. And I can see where this does get-- why it can get costly for people. You know, you, you have a lot of these people who are in contact with these individuals-- you know, multiple individuals who might be in contact with people they may, they may need to restrain at some point. And so they have to train quite a few people. Whether it's the people ha-- with direct care with these individuals or whether it's the person in the front desk answering the phone. I mean, they, they all have to be trained in this to some extent because at some-- in some way they may need to use that. I don't think they're going to be using Kung Fu, like, like they said. I don't think they're being trained that way. I think there-- it's much more specific than that. And so I'm going to continue to work with them. I'd like to come to a resolution here so we can move this forward this year and see if we can help out these providers. As, as you heard, it can be very costly. They're saying $650,000 deficit, and over $600,000 of that was just in this training alone, so. Might do whatever we can to help these DD providers, so. With that, I will answer any questions the best that I can.

HARDIN: Questions? Senator Quick.

QUICK: Yeah. Thank you, Chairman. And I don't know if you would know this-- and I probably should've ask the providers this, but I'm going to guess that most of the people that they have in their facilities or they're taking care of are either on some type of a Social Se-- Social Security disability, SSI, or probably Medicaid. There's probably-- I don't know how many would be on private pay. Probably not that many. So I know the, you know, the reimbursement for those is pretty low. So

it's not like they're a lot of money, but I don't know if you have this--

HANSEN: Yeah. That, that would be a good question for them to get more specifics about that.

QUICK: OK. All right. Thank you.

HARDIN: Seeing no other questions. Thank you.

HANSEN: Thank you.

HARDIN: Online, we had 8 proponents, 0 opponents, and 0 in the neutral. As Senator Ballard is coming, just as a preliminary advertisement to the committee here, we will be execing after LB1057. Senator Ballard.

BALLARD: Good afternoon. Chairman Hardin and members of the Health and Human Services Committee. My name is Beau Ballard. For the record, that is B-e-a-u B-a-l-l-a-r-d. And I represent District 21, northwest Lincoln, northern Lancaster County. And I'm here today to introduce LB1057. LB1057 is a straightforward bill that simplifies an unnecessary administrative burden. Currently, all developmental disability providers are required to obtain and matain-- obtain and maintain a certification status with the Division of Public Health at DHHS to be operation. Today, if one of those DD providers wants to expand their support to a persons-- to a persons on the aged and di-- disabled waiver, a separate and additional license with public health is required to deliver a specific service on the waiver called adult day service. DD providers that serve individuals through, through the waivers under the Developmental Disability Service Act are already exempt from licensure requirement. Some of you, you may recall that, last spring, we had a constituent outreach to several of us on the committee regarding this issue. At that time, bill introduction had already passed, so LB1057 was introduced this year to address those concerns. Those concerns are fixed here, is-- that currently individuals on different waivers must be separated and receive services in different areas of the building, all because the requirement-- required license is being funded by different waiver. We can all agree that participants should be supported in the most integrated and supportive setting possible, not separated based solely

on the waiver funds of their service. LB1057 addresses the inconsistencies by extending the existing licensure es-- exemptions under the De-- Developmental Disability Service Act to the HCBS providers serving aged and disabled waivers and also those holding certifications from public health. I'm happy to answer any questions, but Director Green is behind me to answer very technical questions. With that, I'd be-- I'd be happy, happy to answer any questions.

HARDIN: I think you've sold it. I don't think any of us has a question for you.

BALLARD: It's also almost 5:00, so.

HARDIN: It's almost o-- 5:00. And I just told you all that we're going to stay in exec until midnight, so.

BALLARD: Thank you, sir.

HARDIN: Will you be sticking around?

BALLARD: I'll be here. Appreciate it.

HARDIN: Very good. Proponents, LB1057. Why, welcome back.

TONY GREEN: Good afternoon, Senator Hardin and members of the Health and Human Services Committee. My name is Tony Green, T-o-n-y G-r-e-e-n. And I'm the director for the Division of Developmental Disabilities at the Department of Health and Human Services. Here to testify in support of LB1057. And thank you to Senator Ballard for introducing this bill on behalf of the department. As you've heard, LB1057 proposes a narrow but important clarification in statute by amending the definition of adult day services under the Health Care Facility Licensure Act. Specifically, the bill clarifies that adult day services do not include community-based services provided by entities that are already under-- already certified under the Developmental Disability Services Act or that operate a program of all-inclusive care for the elderly or PACE program. This clarification ensures that these providers are not inappropriately subjected to duplicative health care facility licensure requirements. Developmental disability certified providers already operate within a robust regulatory and oversight framework. These agencies must meet extensive certification standards, are subject to ongoing monitoring and quality

assurance activities, and are held accountable through compliance reviews and corrective action processes. Requiring these same providers to obtain and maintain an additional adult day health license does not meaningfully en-- meaningfully enhance the participant's safety or service quality. Instead, it creates an unnecessary administrative burden, increased cost, and discourages service expansion. Today, if a DD-certified provider wishes to expand their, their care to folks under the aged and disabled waiver, as you heard, the provider has to obtain that separate adult day service license and even though the service is delivered in the same setting by the same staff under similar oversight. This duplicative requirement has led to impractical and counterproductive outcomes, including the need to separate participants within the same building solely based on which waiver funds their services. Such separation runs counter to our shared commitment to person-centered service delivery. LB1057 addresses this inconsistency by extending an existing licensure exemption that already applies to DD waiver providers to those same certified providers when they also serve individuals on the aged and disabled waiver. Importantly, this bill does not reduce oversight or weaken safeguards. Instead, it aligns regulatory requirements with existing certification structures, allowing the providers to offer adult day services at current DD day center sites while maintaining appropriate accountability and protections for participants. We would respectfully request that the committee advance this bill to General File. And I'd be happy to answer any questions you might have.

HARDIN: Questions? It would appear you knocked it out of the park.

TONY GREEN: Perfect. Thank you.

HARDIN: Proponents, LB1057.

ALANA SCHRIVER: Good afternoon again. My name is Alana Schriver, A-l-a-n-a S-c-h-r-i-v-e-r. And I am the executive director of the Nebraska Association of Service Providers, which is the state association for the home- and community-based organizations supporting individuals with intellectual and developmental disabilities on Medicaid waivers. A lot of it is just dittoing what Director Green said, so I will just add a little additional context that there are more individuals on the aged and disabled waiver than on the DD

waivers, yet there are more certified day centers for the DD waiver participants than the aged and disabled. So this would align capacity with need a little bit better, and that means increased access, shorter wait times, and more options for families. And the benefits extend beyond the individuals receiving the services-- family caregivers who rely on day services so they can work, attend school, manage other responsibilities. Expanding access to day services allows these caregivers to enter or remain in the workforce, strengthening Nebraska's economy and reducing financial strain on families. It also makes fiscal sense. The daily rate for services at a day center is less costly than the hourly in-home rate. So if that individual on the aged and disabled waiver could go to a day center, that saves the state money because it's a daily rate instead of paying that caregiver in home on an hourly basis. And like Director Green said, it doesn't reduce standards. It doesn't weaken protections. It simply removes an unnecessary, unnecessary regulatory barrier that "fragsments" services and separates people who should be able to share space and community. So for those reasons, I respectfully urge you to advance LB1057. Happy to answer any questions you might have.

HARDIN: Thank you. Questions? Seeing none. Thank you.

ALANA SCHRIVER: All right. Thank you.

HARDIN: Opponents, LB1057. Opponents, LB1057. Those in the neutral. Senator Ballard is waiving. Wow. Hey. It was a nice-- it was a-- it was a nice change. Well, thank you. This actually concludes our hearings for today. We are going to go into exec. Oh, I'm sorry. Yes, we had 17 proponents, 0 opponents, and 0 in the neutral on that one, so. Well done on the proponents, so.