

Transcript Prepared by Clerk of the Legislature Transcribers Office
Health and Human Services Committee February 25, 2026
Rough Draft

HARDIN: Welcome! We're going to get going. Today's a little bit different, everyone. We're going to start with some gubernatorial appointments. Three of four of those are over our telephone system, so you're going to hear the voices coming in from above you. One of those folks is here with us today. So, we're going to conduct a bit of an interview with each of those folks, so that's just kind of a little bit of a different procedure. Then, we'll launch into our bills with LB777. So, let me kind of describe how things work here today. Thanks for joining us. I'm Brian Hardin from District 48. I'm-- I serve as chair of this committee. The committee will take up the bills in the order posted. The 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 tables at-- the little rooms off to the side here is where they really are. Please print clearly, fill it out completely, move to the front row to be ready to testify when your bill comes up. When it's your turn to come forward, give the testifier sheet to the page. If you do not wish to testify but would like to indicate your position on a bill, there are also yellow sign-in sheets back on the table for each bill. 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'll finish with a closing statement by the introducer, if they wish to give one. We'll be using a three-minute light system for all testifiers. When you begin your testimony, the light on the table will be green. When the yellow light comes on, you have one minute remaining, and the red light indicates your time is finished. Questions from the committee may follow, which do not count against your time. Also, committee members may come and go during the hearing. This has nothing to do with the importance of the bills being heard; it's just part of the process, as senators may have other bills to introduce in other committees. A few final items to facilitate today's hearing. If you have handouts or copies of your testimony, please bring up at least 12 copies and give those 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

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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. 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'm going to have the committee members with us today introduce themselves, starting with Senator Riepe.

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

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

G. MEYER: Good afternoon. I'm Glen Meyer. I represent District 17: Dakota, Thurston, Wayne, and the southern part of Dixon County.

QUICK: Dan Quick, District 35: Grand Island.

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

HARDIN: Also assisting the committee today, to my left is our research analyst, Bryson Bartels. To my far left is our committee clerk, Barb Dorn. And our pages for today are--

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

DEMET GEDIK: Hi. My name is Demet Gedik. I also go to UNL, and I study political science.

HARDIN: Today's agenda is posted outside the hearing room. And with that, we're going to begin today with the gubernatorial appointment of Dr. Kate Hesser. Kate, are you able to hear me OK?

STEVE RAMOS: It'll ring here in a minute.

HARDIN: OK. Let's all listen for the ring, shall we? This is Steve, everyone. Steve Ramos. We couldn't get anything done without him around here. That's a good sign.

KATE HESSER: Hello?

HARDIN: Dr. Hesser?

KATE HESSER: Yes.

HARDIN: Hi, this is Senator Brian Hardin. How are you?

KATE HESSER: Very good. How are you doing?

HARDIN: Well, I'm fine. I'm sitting here with, oh, 75 of my best friends, and we were wondering if you have a few minutes to talk about the Nebraska Rural Health Advisory Commission.

KATE HESSER: Sure.

HARDIN: Wonderful. Are you ready to do this, this gubernatorial appointment process here?

KATE HESSER: Yep.

HARDIN: Awesome. Can you hear me OK?

KATE HESSER: I can.

HARDIN: And we can hear you as well. And with that, would you be willing to tell us about yourself? Tell us what you are thinking. What entered your mind to say, you know what, you need to do this? Educate us.

KATE HESSER: Sure. So, I-- this is actually my fourth term on the Rural Health Advisory Commission. I was on it for a term-- [INAUDIBLE] my third term. I was on it as a term during medical school as a [INAUDIBLE], and then this is my second term since I've been a family physician. Do you guys want any of my background, or?

HARDIN: Yes, please.

KATE HESSER: OK. So, I am a family physician in Crete. I have been here for 16-and-a-half years. I grew up in Fairbury, Nebraska. I did undergrad at Chadron State College, used the RHOP program, and then I got my medical degree from the University of Nebraska Medical Center in Omaha and then completed my family medicine [INAUDIBLE] training track, Grand Island. And then, was an-- hired to Crete, and that's where I've been ever since. My husband [INAUDIBLE] also a family physician in Crete, and we have three boys, one of whom is senior and accepted into the RHOP medicine program at Chadron State College this fall. So, we have a lot of interest in rural medicine. My husband and I grew up in rural Nebraska. We've lived there most of our lives, and obviously, we want to continue [INAUDIBLE] of healthcare.

HARDIN: And so, you've been serving on this advisory commission since about what year?

KATE HESSER: So, I was a [INAUDIBLE] as a resident in med school, and [INAUDIBLE] 2006 to 2009. And then I was off of the commission for quite some time. Then this is now my second term on the [INAUDIBLE] so 2003 to '23.

HARDIN: OK. Very well. Since you've been around this system for a while, would you mind sharing with us what you see looking forward? What are some challenges that are coming up that require your talents?

KATE HESSER: I would say the biggest challenge with-- most people would agree-- is getting and retaining providers in rural Nebraska. I've seen this first-hand in Crete. We have, like, a [INAUDIBLE] get one provider added [INAUDIBLE], and it's very difficult to do [INAUDIBLE] people to rural Nebraska, and it's very difficult to keep them in rural Nebraska. So, incentivizing [INAUDIBLE] huge push for the [INAUDIBLE] through our loan repayment program, and so I feel like that's very important, as well as attracting more family physicians. We have a, a lot of people that [INAUDIBLE] go to be retired over the next 15 years, and [INAUDIBLE] be able to replace [INAUDIBLE].

HARDIN: Very well. Thank you. Questions from the committee?
Senator Riepe.

RIEPE: Thank you. Thank you for being with us, Doctor. Merv Riepe here, just so that-- you can't-- we're not on voice or, or on--

KATE HESSER: Sure.

RIEPE: --on visual. Your credentials here that I have in front of me, you, you talked about medical degree. You-- are you a dentist or a physician?

KATE HESSER: So, I am a physician.

RIEPE: You're a physician.

KATE HESSER: Correct.

RIEPE: OK, our documentation, unless I'm looking at the wrong page, it say D.D.S.

HARDIN: I think that, that might be-- I think that might the next one.

RIEPE: Oh.

KATE HESSER: [INAUDIBLE].

RIEPE: I was getting to the top of the list here.

KATE HESSER: Yeah, yeah.

RIEPE: OK, well I have a question then as a dentist. One of my primary concerns is that we have a very long waiting list to get an appointment with a dentist in the western part of the state. I've heard the number 3,000, that are of all ages. Do you have any idea as to how we might approach that?

KATE HESSER: So, I think you want to direct questions to the next person that's [INAUDIBLE], Dr. Kate Kusek. She is a dentist.

HARDIN: Yeah.

KATE HESSER: I am a physician.

HARDIN: So, Dr., Dr. Hesser is a family physician.

RIEPE: I don't know how I got this.

HARDIN: And so-- but we can copy that same question. In general, we have this strange thing. It's a phenomenon. We call it the medical desert. I'm from as far west as you can get, Dr. Hesser, before you fall off into the flat-earth world known as Wyoming. And so, I'm from the Scottsbluff area.

KATE HESSER: Mm-hmm.

And so, the trick question that we ask many is, how do we cool down that medical desert? How do we go about attracting kind of what you were mentioning before, in terms of repopulating some of the decimated numbers we have, particularly since COVID and largely because of COVID, from the professional ranks, frankly? Whether it's doctors or dentists or nurse practitioners or PAs or EMTs. How do we go about repopulating those folks for what we need?

KATE HESSER: I think they're going to have luck if people come from a rural area to get them to go back to a rural area. So obviously, I mentioned the RHOP program, which is the Rural Health Opportunities Program. That's done through our state college system. And [INAUDIBLE], and that's to attract young rural high schoolers into a program where they will then go on to professional school and hopefully return to their rural, you know, [INAUDIBLE]. That, that program is great. [INAUDIBLE] they are trying to expand it. I think it-- when I did it, there was only three people in the medicine portion, and now it's up to five or six, depending on where you go. So, I think expanding those types of programs is very, very important, and that we get incentives to these kids who want to come back to their hometowns or nearby [INAUDIBLE]. The other thing [INAUDIBLE] is it comes down to money a lot [INAUDIBLE]. People are coming out of medical school, dental school, with a lot of debt, and somebody's able to provide them some loan repayment toward that debt, they're going to be more likely to look at those communities, whereas in Lincoln, they're probably not going to get as much reimbursement if they sign on to Lincoln. So, I think that that's a huge driver to get people out to rural environments for at least the length of their loan repayment. Then once they're there, they fall in love with the community and they stay there.

HARDIN: Other questions? Senator Meyer.

G. MEYER: Thank you, Chair Hardin. Welcome, Dr. Hesser. It's, it's a pleasure to have you here today. I struggle a little bit with hearing aids. They're supposed to help. They sometimes do. You are a Pierce, Nebraska native. Did I hear that correctly?

KATE HESSER: No, I am from Fairbury, Nebraska.

G. MEYER: Obviously, I didn't hear that very well. Thank you. Question number one down. So, may I, may I ask where you, where you practice now?

KATE HESSER: Yes, I am in Crete, Nebraska right now.

G. MEYER: Where--

HANSEN: Crete.

G. MEYER: Crete. OK. All right. Is that considered a health care desert?

KATE HESSER: So currently, Saline County is not eligible for a loan repayment program because we are [INAUDIBLE] to Lincoln. That being said, we continue to practice obstetrical care in Crete. We have nearly a hundred deliveries every year. To attract [INAUDIBLE] physicians with obstetrical training is incredibly difficult. We would not be able to give up that part of our hospital practice because we have a large immigrant population, and they do not have transportation a lot of [INAUDIBLE] to get to Lincoln. So, this is something we have to maintain for the foreseeable future, and get partners the correct training is there's [INAUDIBLE].

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

HARDIN: Very well. Any other questions? Dr. Hesser, we can't see any other questions, and so we really appreciate your time today.

KATE HESSER: Great, thank you.

HARDIN: Thanks so much.

KATE HESSER: Bye.

HARDIN: This concludes our gubernatorial appointment hearing for Dr. Kate Hesser. We're going to move on to the next one, which will also be an online experience with Dr. Katherine Kusek. She is a dentist. And are you pulling her up on your handy-dandy telephone there, Steve? Wonderful. Folks, should we tell her that she's won a new car or something when we call? That might be fun. It's technology. Really, it's good. These poor folks have to disclose [INAUDIBLE] to us here. Hello, Dr. Kusek? Can you hear me?

KATHERINE KUSEK: I can.

HARDIN: How are you?

KATHERINE KUSEK: I'm well.

HARDIN: Great. I'm sitting here with 75 of my finest friends, and we're in the Capitol in Lincoln. Do you have a few minutes for a gubernatorial appointment discussion about being on the Nebraska Rural Health Advisory Commission?

KATHERINE KUSEK: Of course. I do.

HARDIN: We're so relieved that that's your answer. And so, we're going to dive in. Would you mind just kind of giving us the big picture of who you are? This is a reappointment for you, but maybe give us some of your background,--

KATHERINE KUSEK: Sure.

HARDIN: --some of what you've learned having served in this role before, what you're looking forward to, and just kind give us an overall picture of what this looks like for you.

KATHERINE KUSEK: Yeah. My name is Dr. Katherine Kusek. I'm a general dentist in a private practice in Albion, Nebraska. I graduated from the Creighton School of Dentistry in 2011. I did a residency in New Mexico after that. I have been on the RHAC for a couple of years now, and I've really enjoyed the collaboration between different health care-- from-- between all the different spokes of health care. I've, I've really enjoyed the collaborative nature.

HARDIN: Very good. Unpack that for me a little bit. What is that like, when you're talking about that collaboration? What other

kinds of doctors do you work with, and, and how does that-- how does that feel, and how does that work?

KATHERINE KUSEK: Oh, on the, on the rural health commission?

HARDIN: Yes.

KATHERINE KUSEK: Yes, so there are physicians, and then me as a dentist, and there are mental health providers and a few hospital administrators. And it's one of the-- because I work in a private practice rather than in a hospital setting, it's the one of the, the opportunities that I get to get some insight into health care as a whole in the state of Nebraska. And I also-- working and living in a rural community, I feel very strongly that having health care providers out here in the rural area is really important. And so, I appreciate the ability to contribute to the state's efforts to make that, I don't know, more, more available to the individuals of rural Nebraska. That's not super eloquent. I did not write this down before I started.

HARDIN: What kind of things are you concerned about leaning into the future, as you serve on this commission?

KATHERINE KUSEK: Can you maybe give me a little bit more clarity on what you're-- on what you're asking there? I mean, that's a little bit--

HARDIN: As you serve-- as you serve on the commission, is there anything that goes through your mind at 2:37 a.m., and you go, uh-oh, we're going to have to deal with blank, when it comes to rural health. And whether it's particularly in the area of dentistry or any other areas, is there anything that gives you concern about rural health in Nebraska?

KATHERINE KUSEK: Yeah. Rural health in Nebraska, my-- one of my main concerns is just how far people have to drive to access care. And secondary, or, in addition to that, I am pretty concerned about wait times for patients who [INAUDIBLE] get in to see dentists out here, even for, even for patients with insurance. For example, my practice, I cannot take new patients right now. We are absolutely full. And I know that there are many other practices, private practices, some of them take Medicaid, some of them don't. There are a lot of-- it, it can take a long time just to find somewhere to go to create a dental

home. And so, the, the-- there's one room out here for more providers, but finding and incentivizing providers to be out here-- I think once people get out here and have lived out here for a couple of years, you realize how wonderful it is. But sometimes, that initial hurdle can be a challenge, and I think that the rural health commission has a real-- a really important role to play in that, just with getting some of those younger providers, that initial incentive to, to get out here and experience how wonderful it is to have a life and a practice in this area, because all of their training has been happening in cities, and so the life that they're used to is city life, and it, it does take a couple of years to kind of adapt your life to the, the wonderful but also different life that is rural Nebraska.

HARDIN: If I moved to somewhere near Albion, how long would it take me to be able to get in to see you?

KATHERINE KUSEK: To see me?

HARDIN: Yes.

KATHERINE KUSEK: For me, probably the other side of never. Our practice has been closed to new patients for a number of years.

HARDIN: About the time I get my third set of teeth, is what you're telling me. OK. Well, that, that does paint the picture for us. Other questions? Senator Riepe?

RIEPE: Thank you, Chairman. I did have a question. It appears that you grew-- or went to high school in Albion.

KATHERINE KUSEK: I did.

RIEPE: Did you have a difficult time after becoming a dentist as being still viewed the high school young woman? Or were they readily accepting to-- of you?

KATHERINE KUSEK: As far as moving back to my hometown?

RIEPE: Yes.

KATHERINE KUSEK: You know, I was apprehensive about that when I first moved back, and it was so much easier than I anticipated it being. Really, the overwhelming response that I got from

people was "we are so happy you're here," and there was really very little pushback. [INAUDIBLE] maybe it's because I was a good student in high school. I was, I was a good student. I didn't get into a lot of trouble. But I, but I really-- there was very little pushback, and I thought that it would be difficult to treat my friends and neighbors, but really, it makes me feel just very accountable for the quality of my work, which I feel like is an important trait to, to foster in any healthcare profession. And people have been very good about not overstepping boundaries as far as-- you know, I think sometimes people worry, you know, is everybody going to be calling me on the weekend? People only call me when it truly is an emergency. People are so respectful. I've been, I've been-- it's really been-- zero of my fears when moving back have, have come to fruition.

RIEPE: Good, good. The question I have, too, is on the board that you currently serve on,--

KATHERINE KUSEK: Yeah.

RIEPE: --the rural health board, does the discussion of the long waiting list that you've described even for Medicaid patients--

KATHERINE KUSEK: Oh, it's terrible.

RIEPE: --as you've discussed, discussed. I've, I've heard the number of 3,000, but that seems awfully large. Is that-- is there any chance that that's correct? 3,000 [INAUDIBLE]--

KATHERINE KUSEK: Unfortunately, it is correct.

RIEPE: It is?

KATHERINE KUSEK: Yeah.

RIEPE: Do you have an answer?

KATHERINE KUSEK: Wait times are literally years to get into some of the UNMC programs, but it's, it's-- the only word for it is unconscionable.

RIEPE: Thank you. That's a concern of mine as well. Thank you very much.

KATHERINE KUSEK: It is.

RIEPE: And thanks for being on our call.

KATHERINE KUSEK: Sure. Of course. My pleasure.

RIEPE: Thank you, Chairman.

HARDIN: Any other questions? Seeing none, we thank you so much for your time.

KATHERINE KUSEK: Of course.

HARDIN: This concludes our appointment hearing for Dr. Katherine Kusek for Rural Health Advisory Commission. Another one that will be also over the system here is Myra Stoney. And is she being cued up, Steve?

STEVE RAMOS: Yeah.

HARDIN: Let me know when she's ready to go. Hello, Myra?

MYRA STONEY: Yeah!

HARDIN: Hi, Myra, This is Senator Brian Hardin. How are you?

MYRA STONEY: I'm doing well. How are you?

HARDIN: Well, I'm fine. I'm sitting in Room 1510 in the State Capitol in Lincoln, Nebraska. Have you ever been to that place?

MYRA STONEY: I don't know if I've been to Room 1510, but I have been to the Capitol.

HARDIN: [INAUDIBLE] special, and it's full of 75 of your closest friends who are listening in as we speak, and so--

MYRA STONEY: Awesome.

HARDIN: --thanks so much for your seeking to be reappointed to the Nebraska Rural Health Advisory Commission. I see on your information here that Senator Dave Murman is your senator, is that correct?

MYRA STONEY: That is correct.

HARDIN: Is he a good senator?

MYRA STONEY: I have talked to him, and he seems very easy to talk to, and I think overall he's been doing a great job.

HARDIN: Well, good, because if he wasn't, the seven of us sitting here listening to you, we're going to give him a very hard time. And so--

MYRA STONEY: Trust me, I would give him a hard time also, so. I'm not shy.

HARDIN: OK, wonderful. Great. Well, we would like you to give us an overview of you. This is a reappointment, so kind of tell us about your history, if you don't mind, as well as your experience already on the commission and what you're looking forward to in the future.

MYRA STONEY: Sure. So, I am a native of South Dakota. I always try to lead with that because I get the twang in once in a while. I graduated from University of South Dakota in Vermillion with a health services administration degree. I have lived in Nebraska for just under 30 years. I live in the McCook area with my husband, and I've worked in health care since I've been probably a junior in high school, with the exception of a few years in medical manufacturing, which is still medical, but it's not the same. I've done nursing home administration, I've other jobs in nursing homes. I ran two rural health clinics for the hospital out here in McCook for a couple years. I've done hospital billing. And the last 21 years, I've been fortunate enough for the most time, fortunate most of the time, to be the health director at Southwest Nebraska Public Health. Now, having said that, I'm not going to say anything about COVID, but it did take a few years of my life, it felt like, and I did get some gray hairs out of that. I really did enjoy my last serving on the Rural Health Advisory Committee. I think I-- I'm representing the rural consumer on the board, and I think I do a good job in representing the people we serve because I can see their struggles in trying to pay for insurance, I see their struggles in trying to find providers, getting transportation. I see their struggles in trying to find a dentist that accepts Medicaid. You know, all kinds of different things that I've seen while I've been on the board. It's things I see in my day-to-day line of business as well, and I'm going to pause a minute

because I'm really good at talking, but I think you might have questions for me.

HARDIN: Well, I really appreciate what you're sharing with us. Senator Fredrickson has a question for you.

MYRA STONEY: Sure.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here, and for your willingness to, to serve. I, I-- one thing that you said to me that sort of struck out-- stuck out was you, you'd mentioned kind of your connection with the community and certainly kind of seeing firsthand a bit of how folks are impacted. You, you mentioned that there have been some struggles with Medicaid. What, what kind of struggles have you been noticing?

MYRA STONEY: Well, the struggles I hear from providers. For example, some of our dentists in our area have-- they struggle with having to do the paperwork for three agencies. And I know at least the dentist that I work with for our board, and he is no longer accepting Medicaid patients because of the reimbursements. Now, switching to Medicaid with our local medical providers, I've been trying to encourage our local medical providers to accept Every Woman Matters so that we can get some women presenting screens, mammograms and pap smears, things like that. And there again, what I've heard from them is it's the paperwork and the reimbursement.

FREDRICKSON: OK. So, so, so would you say kind of primary concerns-- I just want to make sure I'm understanding it right-- is, is, is-- one, it seems like it's kind of the administrative burden, but the-- but then--

MYRA STONEY: Yes.

FREDRICKSON: --the other side is, is the reimbursement rate. The-- it-- and I'm-- my assumption is, just to-- is it-- they feel it's too low?

MYRA STONEY: Yes, low reimbursement, high administration.

FREDRICKSON: Got it. Thank you.

MYRA STONEY: You're welcome.

HARDIN: Other questions? Senator Riepe.

RIEPE: Thank you, Chairman. There's been a lot of talk recently about hospitals, some of the critical-access hospitals moving more to be emergency single observation beds. I think there was a story in the Omaha World-Herald, at least, that said that five additional critical-access hospitals outside the urban centers may be at risk due to financial pieces. Does your advisory council talk about that? And do they have a response or some concern-- or the level of concern, or-- can you help me with that?

MYRA STONEY: I can't remember specific conversations around that topic. When Marty Fattig was still on our rural health advisory committee, he would talk about some of the impact with the critical hospitals, critical access hospitals, and how fragile some of that system is. Roger Wells, who's the PA on that board, also would address some of those concerns with us. I do know, in our area of southwest Nebraska, our health department serves nine counties and we have six hospitals in that region, and I know-- I think all of them but one are critical-access hospitals and struggling to make ends meet, some of them, or most of them, so. I would say it-- it's definitely-- the reimbursement is definitely risky right now, for the hospitals.

RIEPE: OK. We could probably talk on more about the One Big Beautiful Bill, and whether it's that beautiful or not, but. Thank you very much for being with us. Chairman--

MYRA STONEY: Yes, thank you.

HARDIN: Other questions? Seeing none. We really appreciate your time. Thank you--

MYRA STONEY: Thank you for having me.

HARDIN: Absolutely. Thank you so much. This concludes our appointment discussion with Myra Stoney and, and the Nebraska Rural Health Advisory Commission. Next up, here in the room, April Dexter. Hi.

APRIL DEXTER: Hi.

HARDIN: Thank you for joining us today.

APRIL DEXTER: Thank you.

HARDIN: Tell us about you, and, and why on earth would you want to do this? Is this a reappointment or an appointment?

APRIL DEXTER: A reappointment.

HARDIN: A reappointment.

APRIL DEXTER: Correct.

HARDIN: Tell us about your world.

APRIL DEXTER: Yep. Hi, I'm April Dexter. I live on a ranch near Amelia, Nebraska, outside of Chambers. I'm a family nurse practitioner. So, I work full-time in Atkinson, Nebraska at the critical-access hospital and rural health clinic, and then about every other weekend, I use my nursing license and I work as an RN at the nursing home in Burwell.

HARDIN: Very well.

APRIL DEXTER: So, I'm requesting reappointment because I think that it's important to have people on this commission that actually work in the trenches, so-to-speak, that actually work in rural health care, that know firsthand the, you know-- what's going well and what's not going so well.

HARDIN: And you grew up where?

APRIL DEXTER: I grew up in Ericson, Nebraska.

HARDIN: OK.

APRIL DEXTER: Do you know where that is?

HARDIN: I don't, but I know where Amelia is.

APRIL DEXTER: You do?

HARDIN: Yep.

APRIL DEXTER: OK. Ericson has a population of 92.

HARDIN: OK.

APRIL DEXTER: It's by Burwell, Ord, that direction.

HARDIN: Very well. Very good. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. Could you share with me your-- at the Burwell hospital, what's the percentage of Medicaid patients?

APRIL DEXTER: So, I work at the Atkinson hospital. I work in the Burwell nursing home.

RIEPE: Yes, but at the nursing home, what--

APRIL DEXTER: At the nursing home, over half.

RIEPE: Over half?

APRIL DEXTER: Mm-hmm.

RIEPE: OK. I heard one recently, it was 85 percent.

APRIL DEXTER: Mm-hmm.

RIEPE: That's, that's alarming.

APRIL DEXTER: Mm-hmm.

RIEPE: OK. Thank you, Chairman.

HARDIN: We've asked kind of the same thematic question, and-- as we look at the rural world. Have you noticed we're missing some folks that would be nice to have? And so, how do we as a state fill that-- those gaps? Do we not fill those gaps, and we just have to learn to be content with finding new ways? Do we be innovative now? What do we do with this medical desert?

APRIL DEXTER: Yeah. I echo what, what my other commission members have said as well. However, I'll add to that, as far as nursing. Yes, we're-- we need providers. We-- providers don't come to rural Nebraska unless you grew up there, or unless you married somebody from there, from-- generally speaking. So, I feel like you already have programs in place, we just have to sustain them. You know, the rural health opportunity program, the RHOP, you know, is, is there. Which is a great program, which lands providers in rural Nebraska. I feel like once

providers get to rural Nebraska, they learn to love it. You know? There's not a lot that attracts people there, there's not a lot to do, you know? But once they start living the rural life, they generally stay there. And if you look at our-- like, the Rural Health Advisory Commission annual report that they send out, there's a lot of good data there that shows the student loan reimbursement program, repayment program. You know, when people are-- receive those-- I was actually a recipient of the student loan repayment program years ago. And, you know, once you're there, for me, it was a three-year obligation as a nurse practitioner; for the physicians, it's a five-year obligation. Well, by the time you-- when you graduate, you go to rural Nebraska, you receive those, you know, some of those student loan reimbursements in that five-year period, many times, they've married, they've started a family, their kids are going to school there, and they stay there. So, I think the programs that you have are there, we just have to sustain them. We have to have the funding to keep them going. They're working.

HARDIN: Very well. Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here, and for your willingness to serve and for your work in your community as well. So, you mentioned the, the RHOP program, the rural health opportunity program. So, what are the-- the, the questions I've always had with this, and I, I need to dig into this a bit-- little bit more, but I've always wondered about sort of like a-- almost like a residency requirement with these, right? So, you know, a lot of things like federal loan forgiveness programs, for example, you have to commit to X amount of years in certain types of settings, and my understanding is that one of the barriers we have to that is that when students initially accept these opportunities, they're, they're, they're 18, and the age of majority is 19, so you can't necessarily sign over--

APRIL DEXTER: Right.

FREDRICKSON: --at that age. But I'm, I'm just curious-- that was a very long-winded way of asking, do you find that the majority of RHOP recipients that you're aware of actually end up practicing in the rural parts of the state? Or do you find that you still experience brain drain with, with, with those folks as well?

APRIL DEXTER: I do think there's probably a number of RHOP students that end up changing their mind, you know, just like any high school kid that's going to college. How many times do we change our-- you know, they change their majors, kind of thing. That's definitely a risk.

FREDRICKSON: Sure, sure.

APRIL DEXTER: Sure. But I know of several physicians and PAs that I've worked with that were part of the RHOP program, and then they're back working in, in our local areas, yes.

FREDRICKSON: OK. Great.

APRIL DEXTER: And I know-- and then, you know, the other program, the student loan repayment program, which is what the Rural Health Advisory Commission oversees, that's a large part of what we do. I, I can list dozens of people that work in my area and, and all of the surrounding counties that have-- are-- have been participants of that student loan repayment program, which, as you know, that requires community buy-in. And that's one of the reasons I think it works so well,--

FREDRICKSON: Sure.

APRIL DEXTER: --is that yes, there's state funding, but then you have to have a match within your local community in order to get that funding. And so, you have communities that are willing to come up with, with funding to match that, to keep that or get that provider to come. You know? And then, and then, part of that contract, then, is, is staying for-- it depends on what your specialty is. You know, nurse practitioners are three years, physicians are five years. And I think that that program is working really well as well.

FREDRICKSON: OK. Great. Thank you.

APRIL DEXTER: Yeah.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair Hardin. Welcome. I do know where Ericson, Nebraska is.

APRIL DEXTER: Do you?

G. MEYER: Actually, my daughter-- the youngest daughter is a nurse practitioner and was a sole provider three days a week in Burwell until probably about a year or so, and maybe you ran into her on occasion. I know with a small population in our rural communities-- and let's take Burwell as an example. Are we adequately covering Burwell with a nurse practitioner or, or a PA or a doctor two or three days a week? Is there sufficient-- you know, we're trying to-- we're trying to increase the medical availability in our rural communities. How big a community do we need in order to justify putting more resources into these rural communities? I, I, I kind of have an idea of Burwell and, and the, the-- how, how busy they were and things of that nature. Do we need a thousand-person community to generate enough essentially local business to justify a medical facility? Or, or-- from, from your viewpoint, being from Ericson with 92 people, and working in Burwell and-- and I know Atkinson very well also. What, what size of community would support a doctor or a-- and, and a clinic, something along those lines?

APRIL DEXTER: You know, in Atkinson is about a population of 1,200 or 1,300, you know, and we're sustaining a hospital and a, a clinic. There's actually two clinics in Atkinson. I think, I think the question is not necessarily-- or, the answer is not necessarily how many people in-- live in that town per se, but it's the-- how far are they away from anybody else? Another, another thing that I do-- I think, I think providing outreach clinics is important. You know, Valley County in Ord saw a need, and so they didn't think there was enough health care providers in Burwell, so Valley County comes and, and provides care as well. I have-- I had the opportunity over the last two years to run a mobile medical clinic as well, so our hospital received a, a COVID grant, and we bought a 34-foot RV that they renovated and turned into a clinic. And so, my nurse and I take that RV out to rural communities as well. So, we go to Chambers every other week, every other Tuesday, because there's distance to be traveled, and a lot of our elderly population either can't drive the 40 miles for health care, or they don't have anyone to bring them for health care. And so, I think that there are opportunities. It's not only just how many people are in there, but how many people can you serve are being underserved in the surrounding areas, if that makes sense.

G. MEYER: I, I can see where Atkinson, in that particular community-- you know, there, there is a population base there that would support a clinic, evidently two clinics in and a

hospital. Certainly, in the Ericson, you know, you can, you can go to Ord. Actually, my daughter worked out the Ord hospital [INAUDIBLE]--

APRIL DEXTER: Mm-hmm.

G. MEYER: --with an extension over into Burwell. When we get further west, we are so sparse, you know-- should we start thinking about county medical centers rather than in just specific communities? And, and I know some of our counties only have a few hundred residents, some only have 1,000, so it's, it's difficult. But what we find, or what I have found since I've been on HHS, is we are losing providers at a time when we're trying to enhance the number of providers. And when we ask folks that sit in that seat "How do we enhance medical delivery in our rural communities?" Really, we struggle to get any, any type of answer. You're there. You're, you're, you're at the pointy end of the spear. So, you would have a very good perspective to encourage us how we can help you move forward to provide that. So, any insights you could give us as part of the advisory committee, I'd very much appreciate, so.

APRIL DEXTER: Yeah.

G. MEYER: I don't know if there's a question in there or not, but--

APRIL DEXTER: Well--

G. MEYER: But--

APRIL DEXTER: Another opportunity, I think, that we have too, where there are some of these, you know, medical deserts out there and that kind of thing is, is telehealth as well. That's something that, you know, I think is just going to continue to grow, especially in behavioral health. Behavioral health is the one when you're talking about being able to touch, you know, touch more lives and help the maximum amount of people with the smallest amount of healthcare providers. I think behavioral health-- and behavioral health is the one profession that you don't necessarily have to be able to do a hands-on physical exam to be able to help and treat them. And so, that's another opportunity, I think, that's out there.

G. MEYER: With telehealth, you know, we, we can address medical needs. But the hands-on medical providing is very, very difficult. Do you think we would have an opportunity in our rural communities with our first, first responders, our EMTs, that we could enhance their training to provide for those types of services? Whether it's stitching the wound under the supervision of, of a nurse practitioner, PA-- you know, telehealth, but, but be able to deliver those services, the, the minor medical delivery? Would there be an opportunity to utilize and, and further train our EMTs, our first, our first responders? It, it might be a start in providing some of those services in our very rural communities. But, but-- how would you feel about that?

APRIL DEXTER: I think that nursing-- you know, not just, not just a health care provider-wise, but in the nursing shortage, you know, is, is another huge problem. I mean, fun fact, the hospital of Atkinson on the hospital side employs five full-time RNs. That's it. There's only five of them. Otherwise, they fill the gaps with, you know, with fill-in, with fill-in nurses, agency nurses, that kind of thing, that fill a contract. And so, I know that a lot of places are looking at paramedics. So, from a paramedic standpoint, I think paramedics have enough training that they can help fill that-- fill the gap, as far as from a nursing standpoint. I think you might get into trouble if you're talking about suturing and that kind of thing, keeping it within their scope of practice.

G. MEYER: Oh, God forbid we go outside scope of practice. I, I don't [INAUDIBLE] about that.

APRIL DEXTER: Right? Scope of practice. As long as it's within their scope of practice, I think that maximizing their scope of practice and helping them, helping them work at the highest level of their degree can definitely help with the shortage, yes. However, I also think that a lot of the-- a lot of places, just like you've, you've seen with nurse practitioners like myself, you know, giving them full practice authority allows us to cover the ER by ourself without having to have a physician as a backup always, and, you know, I think that's helped rural Nebraska as well.

G. MEYER: I think the number we hear frequently is we're 5,000 nurses short in the state of Nebraska, and that seems to be continual. And once again, we don't produce enough doctors, we

don't produce enough PAs, we don't produce enough nurse practitioners, and we don't produce enough nurses. And, and I-- yeah, I'm at a loss to why we're not enhancing that. So, I, I appreciate your time.

APRIL DEXTER: Sure.

G. MEYER: I, I belabored you just a little bit too much. But, but thank you for coming today.

APRIL DEXTER: Thank you.

HARDIN: Other questions? Seeing none. We appreciate it. Thank you.

APRIL DEXTER: Thank you.

HARDIN: This concludes our hearing for April Dexter for the Nebraska Rural Health Advisory Commission. With that, we will move on to LB777 and Senator Cavanaugh.

M. CAVANAUGH: Did you not have opponents, proponents for--

HARDIN: Not the, not the-- no.

M. CAVANAUGH: You're supposed to.

HARDIN: We're done.

M. CAVANAUGH: OK. Right? Is that now a rule? OK. Members of the Health and Human Services Committee, my name is Machaela Cavanaugh, M-a-c-h-a-e-l-a C-a-v-a-n-a-u-g-h, representing Legislative District 6, here today to introduce LB777. This bill does two things. First, it requires the Nebraska Medicaid-- that Nebraska Medicaid provide the maximum amount of retroactive cover-- coverage permitted by federal law. Second, it provides a number of key data points for Nebraska DHHS to include in its annual Medicaid report. As we're all familiar, Congress passed a federal budget bill in July 2025, H.R. 1. Included-- it included significant changes to Medicaid and other programs. One significant change under H.R. 1 is a reduction in the amount of retroactive coverage state Medicaid programs can provide for enrollees. Today, applicants for Medicaid may be eligible for up to three months of retroactive coverage. H.R. 1 shortened those periods of retroactive eligibility to just one month for the

Medicaid expansion category, and just two months for every other category of Medicaid eligibility. We now know that our state proposes to cut retroactive eligibility even further. The budget request DHHS submitted in the fall proposed eliminating retroactive eligibility. At their agency hearing in front of Appropriations earlier this month, DHHS made it clear that they intended to eliminate all retroactive coverage for every category of Medicaid, and now, this committee will hold a hearing on DHHS's proposed 1115 waiver to eliminate retroactive coverage later this week. Eliminating retroactive coverage is unwise for many reasons. Retroactive coverage fills critical gaps, especially for individuals and families who have experienced a medical emergency, received pregnancy or newborn care, or entered long-term or nursing home care. The effect of restricting retroactive coverage through H.R. 1 is that families will experience higher health care costs that they, because they have no coverage and very low incomes, cannot pay, and health systems will encounter more uncompensated care that they cannot absorb. If DHHS completely eliminates retroactive coverage for all categories of Medicaid voluntarily-- voluntarily beyond what is required of H.R. 1, the damage to Nebraska families and our health systems will be even more extreme. Instead of allowing deep and reckless cuts to Medicaid retroactive coverage, LB777 simply requires our state maintain the maximum amount of retro coverage allowed under federal law. Again, currently, that's three months prior to application. Starting January 1, 2027 under H.R. 1, that retroactive amount would be one month for the Medicaid expansion category and two months for the category-- of-- for all other categories of Medicaid. This is simple, and responsible approach maintains necessary retroactive coverage for Medicaid-- for Nebraskans with Medicaid. The second part of this bill specifically adds reporting requirements to Nebraska's Medicaid's annual report. This transparency measure will help the Legislature and other stakeholders monitor major changes in Medicaid, including the implementation of work requirements, strategies to address concurrent enrollment, and the status of co-pays and other cost-sharing. As this committee knows, the agency is already required to provide an annual report; this bill just adds specific data points to this existing report. LB777 requires that Nebraska Medicaid comply with federal law and provide the maximum allowed retroactivity, and ensures transparency regarding major upcoming changes to the Medicaid program. With that, I'll take any questions.

HARDIN: Questions? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. You must be living the good life to get the bill number 777.

M. CAVANAUGH: That's what I said. It was anointed by God.

RIEPE: That's right. And from there we go. I, I have a concern on this. I've come from a hospital standpoint, but particularly with neonatology. Oftentimes, these babies are born that you could hold in the palm of your hand like a little puppy,--

M. CAVANAUGH: Mm-hmm.

RIEPE: --and they're going to be there for more than 30 days, and the hosp-- and it's a very expensive 30 days. And if they're for maybe even four months, I mean, that's a reckless burden to place on the hospitals, to, to have to-- to not get paid. I don't know-- I think we share that, so maybe it's not a good question. But--

M. CAVANAUGH: I flipped just to the fiscal note just for you.

RIEPE: Oh, I looked at the fiscal note. You know I always do

M. CAVANAUGH: Thought you were going to ask me a question about it.

RIEPE: No, I know it is what it is.

M. CAVANAUGH: Well, I will--

RIEPE: It's expensive. It's very expensive.

M. CAVANAUGH: I will say that-- if I may answer a question that you didn't ask.

RIEPE: Please do.

M. CAVANAUGH: The fiscal note is-- we have currently accounted for this money in the budget. So, the, the Appropriations Committee has not taken this cut out of the budget, so when the budget comes to the floor, it will be held at the-- actually, at the three months. Because the way it works is we can either adopt the governor's proposal, which was the cut, or we can stay where we are, or-- not an option that we're going to take up-- we could do what's in another bill. But we're essentially doing

what's in this bill by doing nothing. So, we're holding it at level, so when we come-- this bill comes to the floor, there, there shouldn't be an A bill with it because the money's already there.

RIEPE: Mm-hmm.

M. CAVANAUGH: Well, there will be an A bill because we have to specifically appropriate it, but the money is accounted for. How's that? Clear as mud?

RIEPE: I, I know that you're on the Appropriations Committee.

M. CAVANAUGH: I am.

RIEPE: So, did you have to fight and champion for this?

M. CAVANAUGH: I championed it. I did not have to fight, I wouldn't say. This was viewed pretty broadly by the committee as something that we felt we should be keeping the resources there.

RIEPE: OK. Well, thank you for your effort. Thank you for being here today.

M. CAVANAUGH: Thank you.

RIEPE: Thank you, Chairman.

HARDIN: Other questions? Will you stick around?

M. CAVANAUGH: I will not. I need to head back to Appropriations. So, I know that there are going to be lots of people here today talking about this and educating you, so I will speak to you all individually afterwards, if necessary.

HARDIN: All right. Thank you. Proponents, LB777. Welcome.

CHRIS ACKER: Thank you. Hi. Good afternoon, Mr. Chairman, members of the Health and Human Services Committee. My name is Chris Acker, C-h-r-i-s A-c-k-e-r. I am the Chief Medical Officer for CHI Health. CHI Health is a regional health network consisting of 14 hospitals, two standalone behavioral health facilities, 150 employed physician practice locations, and 12,000 employees in Nebraska and Southwest Iowa. It's part of CommonSpirit Health, which is a 2,200-care site in 24 states. I

appreciate the opportunity to speak with you today as a proponent of LB777, and thank Senator Cavanaugh for introducing it. The primary objective of LB777 is to ensure that Nebraska Department of Health and Human Services uses the maximum time allowed by federal law for retroactive Medicaid coverage. Retroactive Medicaid coverage refers to the period of time in which patients present themselves in a healthcare setting without insurance and health care providers like ourselves assist them in getting registered for benefits for which they are eligible while they are receiving necessary and sometimes life-saving care. Some practical examples might include a pregnant mother who delivers early, a patient who presents to the emergency department and is experiencing a major health event, or a patient receiving outpatient care who is treated and released but has yet to fill out the necessary paperwork. Historically, federal law has allowed a 90-day look-back period in which qualified patients would be considered covered. Under the recently-adopted H.R. 1, however, all states are required to reduce this 90-day timeframe to two months for the traditional Medicaid population, which generally are babies and disabled Nebraskans, and then 30 days for our, our Medicaid expansion population. Our simple message today is, we know that the state of Nebraska must reduce its retro eligibility timeframe 30 days, and we'd like to be good partners to make that work. But to reduce that time frame to zero as currently proposed in the state budget is not required, and we do not believe it is a workable solution. In addition, it leaves \$9 on the table from the federal government for every \$1 spent, and it will leave families with-- who are otherwise eligible for coverage having to deal with the cost of care without insurance. Here are some statistics to illustrate the problem with this condensed time frame. Last year, CHI Health submitted almost 20,000 new Medicaid applications within the allowed 90-day retroactive period, and 93 percent of those applications resulted in successful enrollment. We were able to screen patients within 48 hours, and file applications within the first few days of the date of admission. In our experience, however, it took the state an average of 28 days to then review and enroll eligible Medicaid patient. It's for these reasons that health care providers testified against that provision in the Agency 25 portion of the state budget, that we testify in favor of LB777, and that we will testify against the proposed 1115 waivers this Friday that seek to eliminate retroactive coverage. We appreciate the legislators' interest in these issues, and stand ready to work with you on practical solutions. Thank you for your service, and I'm happy to answer any questions.

HARDIN: Thank you. Questions? Senator Fredrickson.

FREDRICKSON: Thank you for being here and for testifying. So, can you-- you're the Chief Medical Officer of CHI, correct?

CHRIS ACKER: Correct.

FREDRICKSON: OK, so, so can you, I guess, maybe translate this a little bit? Let's say if, if, if we were not to pass this legislation and the department moved forward with their plan for the waiver for zero days,--

CHRIS ACKER: Mm-hmm.

FREDRICKSON: --can you kind of just, you know, describe how that would impact your hospital system?

CHRIS ACKER: Yeah. So, so, if you kind of think about it-- so, patients-- not everybody can predict when they're going to have a health emergency. I'm an emergency physician by background. I trained at Nebraska Medicine for my residency. I've been in the, the state since 2011. So, patients don't always know when they're going to have a medical emergency. We don't know when babies are going to need NICU coverage or other medical expenses. People can get in car accidents, have heart attacks, and end up-- and so, that patient population--

FREDRICKSON: Or a sinkhole, like in Omaha, for example, yeah.

CHRIS ACKER: Or a sinkhole, which can lead to traumatic injuries. And so, those patients who are eligible for those benefits may show up to the emergency department and require life-saving care, sometimes very expensive care. Without that retroactive, that care is not covered, and so now they have the potential to be responsible for those bills, and that's, that's not good for our Nebraskans.

FREDRICKSON: How-- I mean, this is maybe in the weeds, but just-- and I know you're just one hospital system, but I mean how-- like, from, like, a, a numbers figure, what are we talking about for, like, your hospital? Like, if it, if it were zero-- like, in the last-- like, on a monthly basis? And I know that's going to fluctuate, of course. But what would that look like?

CHRIS ACKER: Yeah. So, so we take care of-- so, across our system, we take care of 55,000 inpatient admissions. We take care of hundreds of thousands of outpatient admissions. We take care of close to 200,000 ED visits across, across all of our hospitals. So, if you kind of go back and you take a look at, you know, 20,000 new Medicaid applications, a lot of those are going to be the retroactive; almost all of them are going to be, because they've already been in a phase of care that we're able to assist them with getting the benefits that they're eligible for.

FREDRICKSON: So, are we talking, like, hundreds of thousands a month? Are we talking tens of thousands a month? I mean--

CHRIS ACKER: So, so-- yeah. So, so, 20,000 a year is-- of, of these patients, is what we're talking about.

FREDRICKSON: Patients, but not a dollar figure.

CHRIS ACKER: Oh. In terms of a dollar figure, we're taking about probably, probably tens of millions.

FREDRICKSON: Per year?

CHRIS ACKER: Potentially. [INAUDIBLE].

FREDRICKSON: Thank you.

HARDIN: Other questions? Senator Quick.

QUICK: Yeah, thank you, Chairman. Do you have any-- and I know it's all-- it would all be speculation, but with H.R. 1 and also not-- the, the federal government not approving the subsidies, you know, what numbers you might be looking at of people without insurance or not? Because they'll-- probably, some people won't even take the insurance because of the high cost now, without the subsidy.

CHRIS ACKER: Yeah. And what the kind of the potential effects of that for our-- for being able to take care of patients, we're, we're working through all those facts and figures right now, of trying to sort out what that is going to look like. It's going to have a very significant impact on our ability to continue to care for patients. I don't have exact figures for you, but I can get those to you.

QUICK: OK. And then one other question is on-- so, when someone comes in and they're having the baby, how, how does that-- I mean, if the mother's already on Medicaid, does the baby have Medicaid, or how does that work? How does--

CHRIS ACKER: No, we have to enroll them.

QUICK: You have to enroll the baby.

CHRIS ACKER: Right.

QUICK: OK. So then, if-- like, with the NICU care and that kind of stuff, I mean--

CHRIS ACKER: Which can be hundreds of thousands of dollars, yes.

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

HARDIN: Senator Ballard.

BALLARD: Thank you, Chair. Thank you being here, doctor. So, you said H.R. 1-- in testimony, H.R. 1 allows for two months, but we're asking for 30 days. How-- what percentage of your patients fall within that 30-day retroactive? Is it majority, vast majority would fall in that 30 percent, or how many would fall off?

CHRIS ACKER: So--

BALLARD: [INAUDIBLE] 31?

CHRIS ACKER: Yeah, so that's a good question. I don't have those exact figures. Getting-- we were working on getting some of that data, and it's a little bit difficult too. But what we know is that we're able to screen our patients within the first 48 hours and-- of a patient's admission. And then, within, you know, the the first few days-- well, five, five days or so, we're able to get that application off.

BALLARD: So from your operations, 30 days is plenty.

CHRIS ACKER: 30 days should be good, yes.

BALLARD: OK. Thank you.

HARDIN: Other questions? Seeing none. Thank you.

CHRIS ACKER: Thank you so much.

HARDIN: Proponents, LB777. Welcome.

MEGAN CONNELLY: Good afternoon, Chairman Hardin, and members of the Health and Human Services Committee. My name is Megan Connelly, M-e-g-a-n C-o-n-n-e-l-l-y. I am the vice president of ambulatory services and community outreach at Children's Nebraska. I am here today on behalf of Children's Nebraska in support of LB777. Children's Nebraska is the only full-service pediatric specialty hospital in the state. Through our 279-bed hospital and behavioral health and wellness center in Omaha, and our clinics across Nebraska, we see-- we serve children from almost every county. Medicaid is vital to kids in Nebraska. Nearly half of all Medicaid enrollees in our state are children. In 2025 alone, 45 percent of all patient visits at Children's were covered by Medicaid. That is why we are deeply concerned about the Department of Health and Human Services' decision to pursue an 1115 waiver to limit retroactive Medicaid coverage. Retroactive coverage was approved by Congress in 1972. It protects eligible families from devastating medical bills incurred before their application is formally approved. Currently, Nebraska provides up to 90 days of retroactive coverage to ensure eligible children are not penalized because paperwork could not be completed immediately. Beginning January 1, 2027, federal law will already reduce the required retroactive period to 60 days for traditional Medicaid populations, including babies and children, and 30 days for the expansion population. Even with that reduction, retro-- retroactive coverage remains a critical protection. Limiting it further would shift an enormous, enormous financial risk onto families and providers. At Children's, when we help families apply and they are ultimately approved, 62 percent receive approval within 30 days, but 23 percent take 31 to 60 days, and 15 percent take more than, than 60 days to be approved. Those are not delays caused by inaction; they reflect families in crisis, gathering documents, navigating eligibility rules, and caring for a critically-ill baby or child. A newborn cannot apply for Medicaid while still in utero. Families must wait until birth to begin the process, and many times, that baby is already in the NICU. We recently cared for a newborn born extremely premature with severe lung disease. The baby spent 122 days in our NICU. 41 of those days were covered retroactively,

totaling \$414,000 in charges, and approximately \$101,000 in Medicaid reimbursement. Without retroactive coverage, those costs would have been shifted to the family and to the hospital, despite the baby being eligible. Retroactive coverage does not expand Medicaid; it simply ensures that eligible babies and children are protected during medical emergencies. LB777 preserves that protection for Nebraska families. We thank Senator Cavanaugh for introducing this bill. We respectfully urge this committee to advance LB777. I'm happy to answer any questions.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. It's always good to see someone from Children's. Of that 45 percent that you talked about of Medicaid children, is it safe to say that those are the-- that percentage of Medicaid children are the highest medical needs, if they're coming to the hospital?

MEGAN CONNELLY: I cannot answer that for sure.

RIEPE: OK.

MEGAN CONNELLY: I will say that the kids that are in our ICUs for many, many months, many of them are on Medicaid.

RIEPE: OK, but they would be much higher than many Medicaid patients at a lesser because you're a regional hospital, so [INAUDIBLE]

MEGAN CONNELLY: Yes. And delivering specialized care.

RIEPE: Well, my second one, if I may, sir, is the-- what's the approval time if-- for-- to get-- you said 62 percent receive approval within 30 days. Is that the 30 days, is that what it takes?

MEGAN CONNELLY: We try, just like our-- my colleague from CHI. We try within the first 48 hours. We try to talk to those families and get the application process started. As you can imagine, when-- especially when a baby is born and is in NICU, the cost is incurred mostly right away. They have to go to surgery, they get the high-cost dollars. And that is the most stressful time for those families, and so we try to get them enrolled within the four-- the first 48 hours, but often we just

want them to take care of their baby and focus on their baby. So then, we get-- we are able to go through the process, and then you can see the time spread that we, we see at Children's from the 2025. We do attempt, though, right away. This is with our best efforts.

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

HARDIN: Other questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here, and for your testimony. I was-- you, you, you sort of shared a, a, a very explicit-- specific example of, like, the recent [INAUDIBLE] care for a newborn that had the premature-- with the severe lung disease; 120 days in that NICU, 41 of those days covered retroactively. If they weren't able to be covered retroactively, would, would that family then be given that \$414,000 bill? Would that be something that Children's would have to absorb? I mean, what-- it-- I'm just trying to think through just, like, practically, the impacts this would have both on obviously patients, but, but on the hospital as well.

MEGAN CONNELLY: When a child-- when we know that they are ultimately going to be eligible, the hospital will take the brunt of that. We, we know what a financial stress that would be to a family, so we would see that in our community benefit, and we would do all we could so it doesn't put that family in that position.

FREDRICKSON: OK. OK. Great. Thank you.

HARDIN: Senator Quick.

QUICK: Yeah, thank you, Chairman. And my question is-- and I don't know if it's maybe part of this bill or not, but we heard some of the appointees talk about issues with paperwork and trying to get that paperwork all situated. I mean-- and I'm sure that's some of application process too. I mean, can you talk a little about that?

MEGAN CONNELLY: Yeah, thank you for the question. You know, we, as Dr.-- or, excuse me, I-- Senator Riepe. I do that often. Senator Riepe had said we are a regional pediatric center, so we get kids from all over not only Nebraska, but all regional

states. And so, if they-- if a child is flown in and a parent has to leave their home, so someone from western Nebraska comes in, they may not have the documents that they need to apply. So, even to get what they need to apply-- now, technology has helped, but it hasn't helped to the point that we can make this any faster. Like I said, we try as soon as we can, but we are also very sensitive to the family, and we try to do everything we can so they, they don't feel that burden.

FREDRICKSON: OK. And do you ever have any issues where maybe they're just one thing wrong on the application, and you have to redo the whole thing?

MEGAN CONNELLY: Mm-hmm. Yes. And we, we assist those families with that. We try to do everything we can so when it's turned in, we have double-- we'll double check it and make sure everything is there before we turn it in, because we don't want to cause that delay. But there are times when it does get sent back, and we'll have to clarify something else.

QUICK: How long would that delay take from-- if you've did one wrong from this [INAUDIBLE]?

MEGAN CONNELLY: I can't answer that specifically. I would have to go back to what we have for-- you can see how many were approved within 30 days, 60 days, and over 60 days, but I can't answer that directly.

QUICK: OK. All right. Thank you.

HARDIN: Senator Ballard.

BALLARD: Thank you, Chair. Thank you for being here. It's good to see you. And I'm back to the question a previous testifier-- so, 62 percent of your current patients are approved within 30 days. That means if we pass this bill, that means 38 percent will fall off or not be approved that that have to be-- so [INAUDIBLE] current. So, is there any mechanism a hospital to-- or is that just the cost of doing business? So-- I'm, I'm just trying to wrap my head around what the hospital can do, what the patient can do just to help get approved within 30 days. Is there some mechanism you use, or is it just trying to work with the family?

MEGAN CONNELLY: That's another good question. Like I said, we already work with the families as much as we can within that first 48 hours. But when a child, especially a baby, comes into our NICU, we can only do so much while that-- where that family is able to meet us where we are. So, we'll be prepared. We'll just tighten our belts and get our systems together to do that more. But we already are as efficient as possible in trying to help these families. So I-- it'll be just another part of our book of business.

BALLARD: OK. Thank you.

HARDIN: Other questions? Seeing none. Thank you. Proponents, LB777. Welcome.

ANN ANDERSON BERRY: Hello. Good afternoon, Chair Hardin, and members of the committee. I'm Dr. Ann Anderson Berry, A-n-n A-n-d-e-r-s-o-n B-e-r-r-y. I am a neonatologist and medical director of the Nebraska Perinatal Quality Improvement Collaborative. I am here today on behalf of the Nebraska Medical Association to testify in support of LB777. Reducing the period of retroactive eligibility beyond what federal law requires will put mothers and infants at risk, and place additional strains on our hospitals and communities. LB777, which will direct Nebraska to ensure the longest retroactive eligibility allowed by federal law, is critical to outcomes of mothers and infants in Nebraska. Too often, financial barriers are the root cause of a mother's reluctance to seek early and regular care. When cost is a concern, appointments are postponed, warning signs are missed, and manageable conditions can become emergencies. Presumptive eligibility for pregnant women coupled with retroactive coverage has been an effective way to improve early entry into adequate prenatal care, which is associated with better pregnancy outcomes. Adding barriers to coverage and complicating systems is not the right step for a healthy Nebraska. At NPQIC, our work aims to decrease Nebraska maternal and infant mortality and rates of prematurity, all of which are unacceptably high. Babies born pre-term face increased risk of developmental delays, impairments, and death, costing millions for one hospitalization for the smallest and sickest infants. Hospitalizations for parents are filled with intense stress, uncertainty, and feelings of helplessness, often accompanied by postpartum depression and anxiety, all while mother herself is ill, recovering from major surgery, on medications like IV magnesium that make focusing almost impossible. Now, imagine you are that

parent of a NICU baby. These infants, as we've heard, could easily fit in the palm of your hand, and they're connected to breathing machines, IV pumps, and feeding tubes; they require regular transfusions. As the parent, you are learning about illnesses that you've never even imagined while getting difficult news about your child day after day. Families facing a medical crisis like this deserve compassion and support, not the added burden of racing against strict Medicaid deadlines without the safeguard of retroactive coverage. The financial consequences of a missed application window could be devastating for families already facing unimaginable stress of caring, caring for a critically-ill newborn. During pregnancy and infancy, a time where all the data supports a positive return on investment for the state, we should be decreasing barriers to care and coverage, not raising these barriers. Nebraska should maintain the longest allowable time of retroactive eligibility permitted by federal law, and I urge you to move LB77 [SIC] forward. As a neonatologist for 23 years at Children's, CHI, Nebraska Medicine, I have seen amazing advances in the care of pre-term infants, but none are as impactful as improving access to our healthcare systems. Thank you to Senator Cavanaugh for sponsoring this important bill, and to the committee for your time and attention to this critical matter. I'm happy to answer any questions. Thank you.

HARDIN: Questions? Senator Quick.

QUICK: Yeah, thank you, Chairman. I didn't think of this question earlier to ask some of the other testifiers, but I know, like, in rural Nebraska-- so, if someone's having a baby, I know they would want to keep that-- the baby-- you know, not have her have the baby until they could get to another hospital, if they knew there were some conditions. But sometimes it's going to happen where that baby is born, and then they have to fly that baby to a--

ANN ANDERSON BERRY: Yeah, we bring the baby to Children's.

QUICK: Yeah. So then that also is part of the delay process, right? I mean, you're-- before you can even start filing the application--

ANN ANDERSON BERRY: Yeah. The mom's not even there, sometimes, for three or four days, if she's critically ill back in her delivery hospital. Absolutely.

QUICK: Yeah. I know even my-- my wife was a labor and delivery nurse in Grand Island, so I know.

ANN ANDERSON BERRY: Yeah.

QUICK: They even once in a while would have to fly babies to maybe Lincoln or Omaha, so.

ANN ANDERSON BERRY: Mm-hmm. Yeah, that's absolutely true.

QUICK: OK.

ANN ANDERSON BERRY: And-- oh, go ahead.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair Hardin. Welcome. Very good to see you here today. The-- we're not talking exclusively about maternity with regard to our, our 30, 60, 90 days. It, it-- it's not all about maternity, is it?

ANN ANDERSON BERRY: No, but that's my area, so I can speak to that.

G. MEYER: Sure. Sure. And so, I did have a question to ask about that. It says Nebraska's pre-term birth rate has risen 11.1 percent. Why, why do you think that is we're increasing our pre-term birth weight?

ANN ANDERSON BERRY: Yeah, I think the numbers would point to worsening maternal health, including increased obesity, increased hypertension, and increased diabetes as a direct cause of the increased poor outcomes that we're seeing with pre-term delivery.

G. MEYER: Are we addressing that somehow?

ANN ANDERSON BERRY: I do believe that there is some work in Nebraska that is starting to address that. I have information in my inbox about a committee I can apply to be on to start to help with some of that work, but I don't think that we're investing enough in primary care, early access to healthcare. You know, the preconception visit I don't think is something that most women have access to. Being able to go to a physician, say "I want to have a baby in a year, what do I need to do to make

myself optimally healthy before I enter into the state of pregnancy?" You don't hear people recommending that or talking about that, right? We aren't focused on prevention. Unfortunately, we invest most of our funds in acute care, which is-- you know, that's my profession. But you've seen me here enough, you know I've spent the last 10 years trying to work myself out of a job, unsuccessfully.

G. MEYER: I had to smile a little bit. I've never heard the term preconception visit to maternity. I'd--

ANN ANDERSON BERRY: Yeah. It's a thing. It's an important thing.

G. MEYER: I-- I'm quite certain it is. But if we're dealing with health issues prior to becoming pregnant and in the process of being pregnant, and we're seeing pre-term birth rates being challenged and increasing, where's the disconnect? Is, is it society in general?

ANN ANDERSON BERRY: Yes. It's a, it's a problem in Nebraska.

G. MEYER: Can we fix that medically?

ANN ANDERSON BERRY: Can we fix that medically?

G. MEYER: Can we fix that medically?

ANN ANDERSON BERRY: We can fix that with simple things that people don't like. Prescriptions for diet and exercise.

G. MEYER: We can't force people to do that.

ANN ANDERSON BERRY: We cannot force people to do that, and so we're situated within the United States, and in Nebraska, we have a population that shows increasing rates of diseases and physical states that lead to increased risk for pre-term delivery.

G. MEYER: Thank you.

ANN ANDERSON BERRY: Yes.

HARDIN: Other questions? Senator Quick.

QUICK: One more. Thank you, Chairman. You know, just talking about the-- I mean, I'm guessing that you find, too, that there are, even just for prenatal care, there may be some women that maybe don't have access to health care that maybe don't seek that prenatal care so that they know what kind of outcome they're, you know-- the-- if they're seeing a doctor regularly, they can-- the doctor can help work with them throughout the prenatal--

ANN ANDERSON BERRY: That's exactly right. Once you are pregnant, you're presumptive eligible, but many women don't know that. And once they do seek prenatal care and get into the system, as we've mentioned earlier, then we still have to get their baby enrolled at delivery. And if they're late entry into prenatal care, much higher risk for a pre-term delivery and for a sick mom at delivery. And then, you're in situations where either mom and baby are separated, or, you know, I'll see social workers in all of our units sitting with moms, working on this paperwork day after day. And then, I'll come back, you know, on a-- say that was Tuesday, I'll come back on Friday, and they're on the phone with Medicaid for hours and hours at a time, on hold. And so, I can tell you, we're putting the work in. Our systems are trying to meet these deadlines. The systems are cumbersome, the moms are sick, the parents are floored with all of the stress that they are having to encounter with these infants being so sick. And this is going to hurt patients, and it's going to our hospitals. And I can tell you, from the hospital and physician's standpoint, we are trying so hard for health, to Senator Meyer's point. All we want is a healthy population, right? We would prefer empty NICUs and healthy kids. That's the goal, 100 percent.

QUICK: OK. Thank you.

ANN ANDERSON BERRY: Yeah.

HARDIN: Other questions? Seeing none. Thank you.

ANN ANDERSON BERRY: Thank you.

HARDIN: Proponents, LB777. Welcome.

MARSHALL BIVEN: Good to see you all again. Good afternoon, Chair Hardin, and members of the Health and Human Services Committee. My name is Marshall Biven, M-a-r-s-h-a-l-l B-i-v-e-n. I'm a

medical student at Creighton University, and today, I want to share the importance of LB777 in light of my personal experience. Two years ago, my partner Sydney [PHONETIC] passed the Nebraska State Bar Exam. She found employment as an attorney representing clients on behalf of the state, and secured for the first time health insurance on her own volition. Yet, six months in, she began experiencing severe bouts of insomnia, many times sleeping two or three hours a night for weeks at a time. She ultimately could not continue working, or driving for that matter, in good faith. She was forced to resign, losing her employee-sponsored health insurance. Sydney had been seeing multiple doctors, undergoing various heart, lung, and sleep tests to understand why her sleep had collapsed over the past months. Now, she was without an income and insurance, but still in dire need-- excuse me-- still in dire need of health care. We immediately began applying for Medicaid. Her approval took less than two months, but we accumulated bills for visits and treatments during that waiting period. Sydney, having lost her income, and me, a student supporting us on loans, were struck by the anxiety of these mounting costs. We'd done everything right: gone to college, pursued professional degrees to serve our home state. Yet, her unexpected health decline put us in a precarious situation. Here's the kicker: the state had our back. Retroactive Medicaid coverage was an option for us. It brought me great pride knowing our government would recognize our struggle and help us pay for those much-needed visits as Sydney got back on her feet. LB777 recognizes the dignity of hard-working Nebraskans who fall on hard times by helping bridge major gaps in health coverage. Nebraskans like Sydney and myself who are steps away from self-sustaining success have kept on our upward trajectory through the support of retroactive Medicaid coverage. I urge you to support LB777. I also wanted to just share that my mother was born in Ord, my grandparents have received health care in Ord, lived in a nursing home in Ord and in Burwell, and I spent much of my childhood in rural Nebraska, and I've been considering a hybrid practice between those states, and so I just wanted to also offer the opportunity as somebody who is considering practice in rural Nebraska, who grew up here in Omaha. [INAUDIBLE] Omaha. I'd be happy to answer questions about retroactive Medicaid, or about rural health care.

HARDIN: Questions? Seeing none, thank you.

MARSHALL BIVEN: Thank you.

HARDIN: Proponents, LB777. Welcome.

KELSEY ARENDS: Thank you. Good afternoon, Chair Hardin, and members of the Health and Human Services Committee. My name is Kelsey Arends, K-e-l-s-e-y A-r-e-n-d-s, and I'm the senior staff attorney for the health care access program at Nebraska Appleseed, testifying in support of LB777 on behalf of Nebraska Appleseed. Because this bill establishes necessary and responsible guidelines for retroactive Medicaid coverage and promotes transparency, Nebraska Appleseed supports this bill. As you all know, and we've talked about many times, H.R. 1 changed a lot for Medicaid, including reductions to retroactive Medicaid. What we know about the proposed 1115 waiver that the department has made publicly available this week and that you will have a hearing on, on Friday is that DHHS has made clear they intend to be even more restrictive than the changes in H.R. 1, and plan to entirely eliminate retroactive coverage for all categories of Medicaid. To be clear, this is not currently required or permitted by federal or state law. Instead, DHHS is seeking a federal waiver to eliminate retroactive coverage entirely. After reviewing the draft 1115 waiver, we expect that DHHS will say that they are not entirely eliminating retroactive coverage because the eligible applicants will still receive coverage for the month in which they apply, if their application is successful and they're actually deemed eligible. However, that's not what retroactive coverage is. Retroactive coverage is coverage for the months before you submit your application, and that is what DHHS is elim-- proposing to eliminate entirely. That's what LB777 protects as well. Eliminating retroactive coverage would be harmful for Nebraskans and for our health care system, as you've heard. Retroactive coverage can be especially helpful for individuals who have experienced a medical emergency, for pregnant or newborn patients, for folks who need nursing home or long-term care services. Retroactive coverage prevents crushing medical debt for Nebraska families, and supports our health care providers and systems. By eliminating retroactive coverage entirely, DHHS would leave low-income families on the hook for often-emergent or unforeseen medical costs, and stick our healthcare systems with even more uncompensated care. These harms are entirely at DHHS's option. Eliminating retroactive coverage is contrary to existing state and federal law. Additionally, despite DHHS including this elimination in their budget request, as you heard earlier, the Appropriations Committee did not account for that requested change in retroactive coverage in their preliminary report released earlier this month. And so, I have some notes about the

fiscal note that I think Senator Cavanaugh discussed a little bit earlier, but it seems to improperly characterize DHHS's estimated savings from their unapproved, still-pending 1115 waiver as costs for this bill, which is just not an accurate depiction. Today, the budget accounts for a full three months of retroactive coverage; all LB777 does is require that the state maintain the maximum amount of federally-required retroactive coverage, which will remain three months until January, and then it'll switch to two months or one month. So, this is a very simple solution to a problem we don't have to create. We can just keep Nebraskans with Medicaid and our hospital systems able to use the retroactive coverage that they need.

HARDIN: OK, questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here, for your testimony. So I'm-- can, can you kind of explain this to me like I'm a five-year-old? And I-- like, I-- like-- so, if you are-- my understanding is, like, if I-- let's say I, I get hit by a car, God forbid.

KELSEY ARENDS: Yeah. Yeah.

FREDRICKSON: And I go to the hospital, I don't have coverage, it's April 12, right?

KELSEY ARENDS: Mm-hmm.

FREDRICKSON: If I'm approved for Medicaid, then I'm covered-- even if we do zero look-back, I would be covered for the month of April, because-- if I applied in the month of April. The-- so, the retroactive coverage would be-- like, let's say, same thing happens. I go in, like, February 27, right? And, and maybe I'm in there until March 16, right?

KELSEY ARENDS: Yeah.

FREDRICKSON: And maybe I don't apply until March 1. So, like, so my March would be covered, but if I were in there in February, anything in February would not be covered with zero look-back. Is that--

KELSEY ARENDS: If you don't pass LB777 and the department's allowed to eliminate retroactive coverage entirely, yes. Yeah. So, the way it works right now is if you apply, if you submit an

application today, you're determined eligible and approved, you should be covered for February. If you have a, a medical emergency, you have a baby, something crazy happens on February 28 and you don't submit an application until March 1, under a system that doesn't have any retroactive coverage, they're not going to cover anything that happened when you got that emergency care, probably in the first, first days of an emergency. Only March would be covered. So, that's right. Right now, as it exists, the month you submit your application, if you're successful, you're covered for that month. Retroactive coverage is anything before that. Again, depending on when your emergency happens, that could be not much, or it could be a whole lot.

FREDRICKSON: OK. So, schedule your emergency accordingly. OK. Understood. Thank you.

HARDIN: Other questions? Senator Riepe.

RIEPE: Thank you, Chairman. Can you give us a probability of whether the 1115 waiver will or will not be approved? That could change anxiety, I think.

KELSEY ARENDS: Sure, sure. Well, we saw other states per-- pursue 1115 waivers to eliminate retroactive coverage during the previous Trump administration, so-- and they were-- those 1115 waivers were granted. We have seen states carve out exceptions, realize that it's a really bad idea and doesn't work for their systems or their people. Iowa, as an example, they, they eliminated retroactive coverage and then saw incredible costs, especially for nursing home and long-term care facility folks, and so they've created an exception. And so, what we're seeing now is they, too, decided to do that, carving out exceptions and trying to figure out a way to build back in retroactive coverage. Again, it's just a problem that we don't have to create, and LB777 could just preserve access to retroactive coverage.

RIEPE: In other states, what's the time requirement on the build back, assuming that it's accepted, determined to be a real disaster? What's the, what's the recovery time? And then, is there a retroactive recovery of funds lost as well?

KELSEY ARENDS: So, like, for states who regret their decision to eliminate?

RIEPE: I'm thinking of Iowa, I think you said.

KELSEY ARENDS: Yeah, yeah. I would have to double-check, Senator Riepe, and I could get you a timeline of, of how quickly they changed course on that. I don't know off the top of my head.

RIEPE: We're talking about a lot of money.

KELSEY ARENDS: It-- yes.

RIEPE: Yeah.

KELSEY ARENDS: Yeah.

RIEPE: OK. Well, thank you. Thank you very much.

HARDIN: Senator, Senator Quick.

QUICK: Yeah, thank you, Chairman. So, you mentioned something about nursing homes.

KELSEY ARENDS: Yeah.

QUICK: So, what does that look like? I mean, I mean, can you talk about that and tell me what that means?

KELSEY ARENDS: Sure. Yeah, I can tell you what I know, which is that oftentimes, when folks are admitted to nursing homes or long-term care, oftentimes, folks are-- have spent their whole lives building up assets and, and resources. And so, in order to be eligible for Medicaid, it's a pretty complex calculation about how they need to spend down those assets to become Medicaid-eligible. So, once folks are in that process of making sure they spend down their assets, they're paying for their own care, but anticipate eventually they're going to run out of money and need to be Medicaid-eligible, it can take a while to process that back-and-forth between the person in-- enroll-- trying to seek enrollment in Medicaid and their nursing facility and the department to assess, like, OK, yep, now you've met the, the threshold and we can turn your Medicaid on. Sometimes, that delay can be months. And so, that's a really critical piece, and that's where we see in other states that have tried to do this. Costs get really out of control because that care is expensive, and because folks don't know when they've become eligible. There's a delay, and then if they don't have any retroactive

coverage, the facilities, the, the patients are stuck with crushing medical debt or uncompensated care.

QUICK: OK. All right. Thank you.

KELSEY ARENDS: Yeah.

HARDIN: Other questions? Senator Fredrickson?

FREDRICKSON: Thank you, Chair. Sorry, I apologize if this has already been asked, but have-- so, have any other states applied for zero-day active coverage, retroactive coverage?

KELSEY ARENDS: Previously, yes.

FREDRICKSON: OK.

KELSEY ARENDS: I don't know the current status of any other states', like, active 1115 waivers. I don't have that information in front of me. I can look into it.

FREDRICKSON: OK, but, but there are-- but there-- but what I'm understanding is that there might be some states that do have [INAUDIBLE].

KELSEY ARENDS: That have done it before, yes. Yeah. And--

FREDRICKSON: OK. OK. Yeah, that'd be-- that would be helpful just to kind of get a sense of historical precedent.

KELSEY ARENDS: Yeah. Yeah, I'll look into that more. And, and what we've seen is usually states are trying to claw their way out of that, and, and build in more retroactive coverage because it causes huge costs.

FREDRICKSON: OK. Thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you. What do you anticipate would be a turnaround? The reason I say that is I know we have a 1115 waiver in on a bill that I had for a respite center-- that's St. Francis-- and, and, and it's taking months. Would this take months to get approved, or is this, is this on a fast track? [INAUDIBLE]

KELSEY ARENDS: I don't work at CMS, so I don't know for sure. I do know--

RIEPE: You don't have a spy on that?

KELSEY ARENDS: I-- it would be nice. If you know somebody, connect me. No, no. So, I don't know what the federal government will do. But I, I know that these are 1115s that the previous Trump administration had seen before. We-- I don't know what their approach will be this time, but-- yeah.

RIEPE: OK. Good as we get, I guess. Thank you. Thank you, Chairman.

HARDIN: Other questions? Seeing none, thank you.

KELSEY ARENDS: Thanks.

HARDIN: Proponents, LB777. No more proponents? Opponents, LB777. Welcome.

JOHN MEALS: Good afternoon, Chairman Hardin, members of the HHS committee. My name is John Meals, J-o-h-n M-e-a-l-s, and I'm the chief financial officer for the Department of Health and Human Services, and I'm here to testify in opposition to LB777. States currently have the discretion to set limits on retroactive coverage under Medicaid, which is coverage that applicants can request for unpaid medical expenses that they have incurred in the months prior to the month when they apply for Medicaid coverage. As of today, states can provide up to three months of retroactive coverage before the application month. This will change January of 2027 when provisions around retroactive coverage from H.R. 1 take effect. These new provisions will limit retroactive covers for individuals eligible for Medicaid under the adult expansion group to one month prior to application month, and to two months for everyone else eligible for coverage. This week, DHHS began the public comment period for a Section 1115 waiver application to limit retroactive coverage for all Medicaid applications in-- or, applicants in Nebraska to just the month of application. This would mean that in situations when it takes longer for our programs to determine eligibility, that applicant will still receive coverage back to when they initially applied if they are ultimately found eligible. The agency is proposing an October 1, 2026 effective date for this waiver. We oppose this bill because the provision

includes-- it includes related to retroactive coverage would pre-empt our to develop this demonstration waiver. Given the state's current fiscal environment, this effort to limit retroactive coverage was included in the budget proposals in order to reduce costs to the state while balancing our responsibility to provide quality health care coverage to those in need. We believe this proposal fulfills part of our obligation to be good stewards of taxpayer dollars. We respectfully request the committee not advance the bill to General File. Thank you for your time. I'm happy to answer any questions.

HARDIN: OK. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. My question is this: is this action part of the governor's reported intent to reduce H-- DHHS funding by \$152 million?

JOHN MEALS: Yes, it is.

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

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here, and for your testimony. So, I, I had asked this from the previous testifier, and, and I don't know if you have this information. Do you-- are you aware of other states who currently have a zero-day retroactive?

JOHN MEALS: We're not aware of any that have, like, come out publicly with wanting to do the same thing.

FREDRICKSON: OK. And, and, and, and, and haven't-- and, and, and [INAUDIBLE].

JOHN MEALS: Correct.

FREDRICKSON: OK. And then my other question is, am I, am I understanding this correctly? Is this your understanding as well? I kind of gave that example earlier, like, if you apply, like, mid-month, for example, that month would be covered under-- say the waiver was approved, right? But, you know, if you-- at the end of the month, for example, you apply the next month,

those, those, those costs from the previous month would not be covered. Is that correct?

JOHN MEALS: Correct. So, I mean, I would use the example-- I think it was the gentleman from CHI that mentioned that I think 93 percent of their applications are done in 48 hours. So, like, that's what I want to make clear, is this goes back to the application date. So, it doesn't matter how long DHHS takes to approve it. If we take a week, if we take six months, it goes back to the date that the application is completed. So, like, in that case, if it's January 30 or January 31, there you run the possibility of not completing the application until February 1, and then yes, those first two days would become uncompensated care for the hospital. But if 93 percent are done in 48 hours, and I think that probably is a pretty typical, that the vast majority are done within a few days, that-- even our fiscal note, when we're talking about \$13 million or \$14 million per year, the vast majority of that is still going to be covered because it's within that 30-day period, right?

FREDRICKSON: So, your fiscal note is, is not-- I, I guess I'm, I'm trying to grapple that, because I can-- I, I, I-- I'm hearing you. Like, if it is in fact done in the first 48 hours, great, covered. You know, that-- that's ideal. But there-- you know, the assumed savings based on the fiscal note, again, assuming that the waiver were approved, seemed pretty significant. And so, that, to me, seems to be, like, a little bit of a-- help me understand. Like, I feel a disconnect there

JOHN MEALS: So, we are kind of operating on assumption that part of what's going to be a result here is that hospitals are going to work more closely with us to help people get approved faster, right? And they're-- there's going to be a greater focus on getting people eligible for Medicaid and completing that application quicker, and so-- I mean, our fiscal note is-- I mean, we looked at, you know, the total number of people that are in that, you know, 30, 60, 90, outside of that time frame. So, for the, the fiscal impact for us-- like, we're guessing that some of that, or we're assuming that some of that is going to be mitigated by working with people to-- if 93 percent are within 48 hours, more people are going to want to achieve that type of ratio so they aren't-- it doesn't shift to uncompensated care. OK?

FREDRICKSON: So, so the department's savings might not be as high as you're projecting?

JOHN MEALS: Correct.

FREDRICKSON: So, if the goal is to make sure people are still covered, why, why do this?

JOHN MEALS: Again, it was, it was proposed as a, as a budget savings and within our, our state's current fiscal environment. Again, if people don't get signed up, it would largely shift to-- I mean, I know people reference families that could be affected, that's possible. Our assumption is that the majority of this would become uncompensated care. And just to give, like, a point of reference, because of the hospital assessment that was passed last year and, and, and, and started this past summer, there's so much additional revenue within the hospital systems in Nebraska that collectively-- again, I get that there may be some individual hospitals that may be specifically affected in a different way. But when we look as a, as a whole, the hospital systems would have to provide over \$500 million worth of uncompensated care to requalify for the, the DSH payment, the disproportionate share, which is money that the federal government provides to make up for uninsured and, and Medicaid that results in uncompensated care.

FREDRICKSON: So, so in order to realize the cost savings that the department is striving for, Nebraskans would have to lose coverage.

JOHN MEALS: Or hospitals incur higher uncompensated care. I mean, that's what it would-- that's what it would become, it would become uncompensated care for hospitals.

FREDRICKSON: And so the-- when you say uncompensated care, meaning the hospital would--

JOHN MEALS: They'd eat the bill.

FREDRICKSON: --would-- they would have to absorb the cost.

JOHN MEALS: Yes.

FREDRICKSON: OK. Thank you.

JOHN MEALS: After-- and again, I mean, and our perspective is when you talk about the hospital assessment, they were just given over \$900 million a year. This fiscal note is \$13 million

and \$14 million in those two fiscal years. It's a fraction of that.

FREDRICKSON: Yeah, I mean, I guess my concerns are-- I'm, I'm thinking too, again, we hear a lot in here about, you know, rural hospitals, the strain, the fiscal strain that a lot of these are facing. I mean, selfishly, I'm in Omaha, right? I mean, I, I, I think this is something that I-- you know, not to say that this would have minimal impact on Omaha. I think it would impact Omaha certainly. But my concern is that this would disproportionately harm the rural parts of the state in terms of just the fiscal impact.

JOHN MEALS: It, it-- I don't know that we have data, individual by hospital, like, what that effect is on whether it's, it's uncompensated care or their DSH payment. I-- we can look into it, though.

FREDRICKSON: OK. That'd be helpful. Thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. In your own words here, you refer to this as a demonstrational waiver. How, how long is the demonstration, and what's the recovery possibilities?

JOHN MEALS: I actually don't know the answer to that off the top of my head, Senator. But I can, I can get that time frame for you.

RIEPE: OK. I know Senator Fredrickson expressed a concern about the rural hospitals, which I share as well. I also have a great concern about the regional, the-- like, the Children's Hospital and the Med Center take the worst of the worst cases, and so, you know, they're-- and the more complicated, their costs are going to be massive by absorbing this extra loss, if you will. That, that-- that's a concern, with all the other issues we have going on in healthcare. But thank you very much. Thank you, Chairman.

HARDIN: For the sake of the record, when someone goes into a hospital and they do the application process, is it a long application? How long does it typically take? I mean, if you're able-bodied and, and whatnot-- granted sometimes, when you get there, you're not able-bodied anymore. And so, what is that

process kind of typically like, and/or is there personnel available in the hospital to help out? Can you just kind of speak to some of those pragmatic issues?

JOHN MEALS: Sure. I, I don't have the timeframes off the top of my head. I asked someone while I was sitting over there, and I-- we can get the, the time frames for you. As far as-- again, this is my understanding, it's actually hospital staff that are working with these individuals. It's not, like HHS, staff that is working in a hospital to do this. Although, I, I think if that were something that hospitals wanted to entertain, I think we would be happy to do that. But that's-- it's actually hospital staff that work with that. So, we, we do understand that-- I mean, if someone comes in and is, is unable to fill out an application, there is other possibilities in the long-- along the lines of presumptive eligibility that we can work with hospitals for, that I don't think has been really taken advantage of. And so, that's something that-- and again, I don't have a-- I can't walk you through the details of what that would look like or change. We can provide that to you, though, but that is something that I know was said to me that's something that we'd be happy to work with hospitals on, whether it's, it's having our people either in the hospital provide more training, because I do know the Medicaid application is not easy to fill out. A lot of that is just federal requirements that we have to go through. But whether it's providing our people, providing training, working with them on presumptive eligibility, those types of things, I, I know our, our eligibility staff would be happy to work with them.

HARDIN: OK. Senator Meyer.

G. MEYER: Thank you, Chair Hardin. Welcome, Mr. Meals. Currently, we're at 90-day-- we've got a 90-day retroactive coverage. January of 2027, provisions around H.R. 1 will change under the adult expansion group for one month prior to application month, and to two months for everyone else. Can we project any savings as compared to today, with, with the 90-day?

JOHN MEALS: Yes. So, [INAUDIBLE]. So instead, that's basically what the, the cost represents, because our-- if we, if we implemented the waiver, our-- the actual annual savings is about \$24 million a year. It's less in the first year; it's \$18 million, because that's-- it starts in October, so it's only three-four-- three-fourths of the first fiscal year. If you-- if

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we just adhere to H.R. 1 and started this in, in January of '27 and did the one-month and two-month, you know, per the law, what we have projected is that in fiscal year '27, there would be a cost reduction of about \$4.6 million in total, and then \$9.3 million in fiscal year '28.

G. MEYER: So, on a yearly basis, it'd be about \$9.3 million in savings.

JOHN MEALS: 9.3, yes. And of that, about \$3.5 million is general funds.

G. MEYER: OK. Thank you.

HARDIN: Senator Quick.

QUICK: Yeah, thank you, Chairman. Do you know, is there a-- or-- and maybe you don't have that number, but a percentage of, of applications that are denied, or-- because of one reason or another?

JOHN MEALS: I don't, but we can-- I don't have that off the top of my head, but we can do that. Denied applications?

QUICK: And maybe-- I don't know if they would include, like, a time frame of, you know-- so, you apply, it's rejected, and then that time frame to get it re-approved again. What's that?

JOHN MEALS: We, we can provide that, but I do want to be clear that that-- the number of denied applications in that time frame doesn't have any bearing on the 1115 waiver or the H.R. 1 changes. Because if-- again, it-- the amount of time that we take to approve the application is already covered. It goes back to the, the original application date.

QUICK: [INAUDIBLE]. OK.

JOHN MEALS: The other thing is, if someone is denied today, then they're denied. I mean, that still won't change, because it's, it's ultimately depend on whether or not they're eligible for Medicaid. But I'm happy to get you the numbers, but it doesn't actually have a bearing on the 1115 waiver.

QUICK: OK. All right. Thank you.

HARDIN: Other questions? Seeing none. Thank you. Those in opposition, LB777. Those in the neutral, LB777. Senator Cavanaugh waived her closing, and we did online have 40 proponents, 2 opponents, 0 in the neutral. And so, with that, we are going to move on to LB949 and Senator Ballard. We'll get going in just a moment, Senator Ballard. I think we are ready.

BALLARD: Ready to roll?

HARDIN: Yes, sir.

BALLARD: All right. Good afternoon, Chairman Hardin, 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 in northwest Lincoln, northern Lancaster County, and I'm here today to introduce LB949. LB949 is solely about ensuring the Department of Health and Human Services has the flexibility it needs to responsibly manage taxpayer dollars while continuing to support critical health information systems that providers and patients rely on across Nebraska. Under current statute, the state's health information exchange and the Prescription Drug Monitoring Program are effectively required to operate under a single contract structure. While the arrangement may have made sense when the system was first established, it now limits the department's ability to manage them effectively and accountably. As many of us in this committee know, there are, there are two large, complex systems that serve different but equally important purposes within our healthcare infrastructure. When they are permanently tied together in statute, it reduces DHHS's ability to evaluate vendors independently, compare costs and performance, and ensure the state is receiving the best value for the service being provided. As technology evolves and as Nebraskans' need-- needs may change, it becomes even more important that the state maintains the flexibility to adapt. Locking programs together in statute can make the harder and-- to respond to improvements in the marketplace, new innovation, and better service options that may become available over time. LB949 recognizes the reality, and gives DHHS the ability to manage these programs in a way that reflects today's environment rather the "insumptions"-- assumptions of the past. Importantly, LB949 does not eliminate or weaken either program. The health information exchange will continue to play a critical role in improving care coordination, allowing providers to securely access and share patient information when and where it is needed. The Prescription Drug

Monitoring Program will continue to be a vital tool in addressing prescription drug misuse, supporting clinicians in making informed prescribing decisions, and protecting patient safety. Those functions remain unchanged. Again, this bill-- what this bill does is straightforward. It removes the statutory requirement of these programs must be tied together under one contract. By doing so, it allows DHHS to review and manage these contracts separately in the future; that means the department will be better positioned to assess performance on its own merit, encourage competition when appropriate, and pursue better value for, for the state while maintaining high-quality service. This flexibility is especially important in the fiscal environment we face today. The Legislature and department must take a thoughtful look at major contracts to ensure the state has a tool necessary to negotiate effectively and manage them responsibly. LB949 helps make that possible. Beyond the media budget consideration, this bill is also about long-term stewards. Today and tomorrow's leaders at DHHS will have the ability to evaluate these systems independently, determine what is working well, and make adjustments when needed. Providing that flexibility now helps ensure Nebraskans continue to improve health information infrastructure while protecting taxpayer dollars. Ultimately, LB949 is a practical and straightforward measure. It keeps both programs in place, preserving the important service when provided to clinicians and patients, and give the department the flexibility it needs to strengthen oversight, improve accountability, and ensure Nebraska is getting the best value possible. I look forward to the conversation today, and I would be happy to answer any questions you might have.

HARDIN: Thank you. Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Senator Ballard, for--

BALLARD: Thank you.

FREDRICKSON: --being here. So, I'm reading the bill. I, I, I looked into this a little bit. So, is there-- can-- so, I, I-- currently, the statute is that these two are tied together? Are you able to provide any legislative history there?

BALLARD: Yes. So, I did some legislative looking last night.

FREDRICKSON: You can call it research.

BALLARD: Research. His research. So, the first, the first research I found was 2004.

FREDRICKSON: OK.

BALLARD: Then-Senator Howard introduced a prescription drug monitoring program,--

FREDRICKSON: OK.

BALLARD: --and then it's just been evolving over time, 2014, 2000-- or, 2014, 2020, and so on. So, it's just been evolving over time.

FREDRICKSON: OK. And your argument is that if we were to uncouple these, that it provides just more opportunity as a state to--

BALLARD: Correct. So--

FREDRICKSON: --sort of make decisions that--

BALLARD: Correct.

FREDRICKSON: --you know, whether that's--

BALLARD: Yes.

FREDRICKSON: [INAUDIBLE] a fiscal, like--

BALLARD: Yes, yes.

FREDRICKSON: Is there any-- and I could-- maybe I'll just ask a testifier as well, if it's more appropriate. But is there, is there a benefit to keeping it coupled together?

BALLARD: There's, there's going to be an argument for the benefit.

FREDRICKSON: Sure.

BALLARD: I don't, I don't necessarily agree with those arguments.

FREDRICKSON: OK.

BALLARD: There will be opposition to LB949 that will outline those benefits.

FREDRICKSON: Yup. Sure. OK. OK.

BALLARD: So I'll defer that question to them.

FREDRICKSON: OK, understood. Thank you.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair, Chair Hardin. Senator Ballard, when Senator Howard initiated the original program, was that part of a bid process? Did they just select a provider?

BALLARD: No. It was not part of a--

G. MEYER: There was no-- there was no bid process involved?

BALLARD: Not to my knowledge.

G. MEYER: OK.

BALLARD: Yeah, I'll have to look at some legislative history, but not to my knowledge, there is no bid process.

G. MEYER: Any idea what, what the cost is on a program like this?

BALLARD: It's-- it fluctuates by year. I believe last year it was about \$4.5 million. It's gone down a little bit this coming year, but it, it hovers around that \$4 million mark.

G. MEYER: I realize on the fiscal, it's impossible to project savings or, or additional expenses if we change the process, so. It's, it's hard to know that, it's hard to quantify that on that basis, so. Thank you.

BALLARD: Thank you.

HARDIN: Senator Riepe.

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RIEPE: Thank you, Chairman. Thank you for being here. My question is, was the Nebraska Hospital Association engaged in the building of this bill?

BALLARD: In the building of this bill?

RIEPE: Yeah. Putting it together.

BALLARD: Not putting it together, no.

RIEPE: OK. The reason I say that is I do have a, a letter opposing it from one of the rural hospitals, of an administrator I greatly respect. But we can get into that maybe a little bit later.

BALLARD: Mm-hmm. OK.

RIEPE: And part of that is, is a concern with CyncHealth of basically just blowing it out. And I will admit-- and this is not a question as much as a statement-- I suffer from the ghost of St. Francis and our foster care experience, so. That's where I'm at right now. Thank you, and thank for being here.

BALLARD: I appreciate it.

RIEPE: [INAUDIBLE] those valances. I admire that.

BALLARD: Thank you, Senator Riepe.

HARDIN: Other questions? Will you stick around?

BALLARD: I'll be here. I appreciate it.

HARDIN: Nice. Proponents, LB949. Welcome.

ANDREW FUNK: Thank you. Thanks for having me. Good afternoon, Chairman, and members of the HHS committee. My name is Andrew Funk, and my last name-- first name is A-n-d-r-e-w, last name F-u-n-k, and I'm a licensed pharmacist in the state of Iowa, and currently the director of member relations and government affairs for the National Association of Boards of Pharmacy. Prior to my role, I served as the executive director of the Iowa Board of Pharmacy for eight years, which houses our state's prescription drug monitoring program. The state's health insurance-- health information exchange resides with the

Department of Health and Human Services. I'm here today to hopefully provide a unique perspective on what LB949 can do for the state of Nebraska. Bundling the PMP and the HIE into one program limits Nebraska's options and stifles competition. PDMPs and HIEs serve distinct purposes and require different technical and operational expertise. Allowing separate procurements enables the state to select best-in-class and fiduciary-responsible solutions for each system rather than limiting options through a bundled requirement. I know firsthand what a cost-effective specialized system looks like. In Iowa, the Board of Pharmacy successfully operates its state's PDMP with just 0.8 full-time-equivalent staff. According to our most recent annual report, the annual cost to the state for Iowa-- for Iowa's PMP is just over \$117,000. Separate procurements promote healthy competition, which can drive innovation, improve service delivery, and cost-effectiveness. Decoupling also ensures the state retains flexibility to adapt to evolving technology, public health priorities, and market innovation. One of the most urgent public health priorities in the PDMP space is interstate data sharing, an area where Nebraska currently lags behind. I've worked with Nebraska to try to get the state to share its data with the Veterans Health Administration and other states using the PMP InterConnect. Unfortunately, the department continues to drag its feet, primarily citing cost as their barrier. And I want to be very clear, there's absolutely no cost assessed by NABP to the state for its use of PMP InterConnect. In Iowa, we seamlessly share our data with 45 other states, but not with Nebraska, and Nebraska doesn't share its data with Iowa. This creates a disruption for-- of-- in care for patients in both states, and frustrates pharmacies and prescribers who rely on each state's PDMPs. Flexibility reduces long-term tendencies on a single-vendor structure, and supports more responsive governance. Passing LB949 will allow Nebraska to choose an effective vendor, drastically reduce your operational budgets, and remove the artificial barriers preventing critical data-sharing of PDMPs across state lines. Thank you for your time. I'd be happy to answer any questions.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. I [INAUDIBLE] guess. Are you familiar with CyncHealth going into Des Moines and helping one of its major hospitals recover from a crash several years ago?

ANDREW FUNK: I am not.

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RIEPE: Well, it happened. The other one that I would say is, in development of systems, did the Nebraska system through CyncHealth precede the Iowa and all of the other partners? Because I have been at some conferences when Nebraska's applauded for being in the leadership of this particular pharmaceutical piece.

ANDREW FUNK: I can tell you that--

RIEPE: Yes.

ANDREW FUNK: --for Iowa, the PMP was established in 2009, we began data sharing in 2013.

RIEPE: OK. OK. I'm not sure if I have to put dates together, but-- thank you, Chairman.

HARDIN: Curious. Does Iowa have just one HIE, or multiple?

ANDREW FUNK: As far as I know, just one.

HARDIN: OK.

ANDREW FUNK: Mm-hmm.

HARDIN: Very well. Other questions? Seeing none, thank you. Proponents. Mr. McIntosh, are you a proponent?

RYAN McINTOSH: I am.

HARDIN: Well, nice. Good to have you.

RYAN McINTOSH: Thank you, Senator Hardin, members of the committee. My name is Ryan McIntosh, R-y-a-n M-c-I-n-t-o-s-h, and I appear before you today as a registered lobbyist for the Nebraska Pharmacists Association in support of LB949. I've distributed for you the testimony of Haley Pertzborn, our CEO, who knows much more about the PDMP than I do. However, I have been working on the PDMP issues for the last few years. We echo much of what Mr. Funk said. I need to take some more on the main points. As you did indicate, Senator Riepe, Nebraska has long been a leader in the prescription drug monitoring space, as one of the first states to require all dispensed medications to be reported into a PDMP. The PDMP is the statewide database that collects and displays dispensing information so pharmacists and

prescribers can identify potential misuse, improve collaboration, and enhance patient safety. Our PDMP works well and remains an important clinical tools. As Mr. Funk mentioned, we do have some shortcomings in our current system, for instance with the VA and interoperability with other states. This creates gaps in patient care and limits true interoperability. The Nebraska Pharmacists Association supports LB949's goals of strengthening and updating the PDMP. We also support opening the system to competitive bidding so long as the quality, reliability, and continuity of the PDM are maintained. I appreciate your consideration. We urge the committee to advance LB949.

HARDIN: Questions? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you, sir, for being here. I, I guess I go to the line in your statement says that as-- it talks about Nebraska, says as the first "states;" I believe it was the first state, singular.

RYAN McINTOSH: Correct.

RIEPE: Thank you.

RYAN McINTOSH: Yes.

RIEPE: Clarification. Thank you, Chairman.

HARDIN: Other questions? Seeing none. Thank you.

RYAN McINTOSH: Thank you.

HARDIN: Proponents, LB949. Welcome.

BRANDI van PATTON: Thank you. My name is Brandi van Patton, B-r-a-n-d-i v-a-n P-a-t-t-o-n, and I'm a pharmacist here in Nebraska. I live and work in Elkhorn, and I am the chief clinical officer for LogiCoy, which is a PDMP vendor. I'm a former CyncHealth employee. I came in under the NEHII name and mindset in 2019. I was hired by and worked with Dr. Kevin Borchert, who is also a Nebraska pharmacist and a premier PDMP subject-matter expert. When I first started with the PDMP, we had an amazing staff. I was the third pharmacist hired, and we proceeded to hire another pharmacist, a nurse, and a support analyst to push the PDMP agenda forward. We even had Dr. Ann

Polich, who was a NEHII CyncHealth board member, to join as our medical director. At that time, Nebraska was a trailblazer in the PDMP space. We were requiring all medications to be submitted, making the Nebraska PDMP the most comprehensive and clinical PDMP in the nation. Kevin was asked to speak all over the country, testifying not just here in Nebraska, but in other states as well regarding our all-meds approach. The Nebraska PDMP and staff were well-respected. We were on the DrFirst PDMP system when I joined the team, however, we were transitioning to NIC's RxGov platform, which is now Leap Orbit, because DrFirst was getting out of the PDMP business, and we needed to move quickly. We knew NIC had very limited product-- had a very limited, limited product and no PDMP experience. We had no integrations, no compliance dashboards, no built-in educational resources, and limited reporting abilities. It was up to our staff to grow the system. When I left in early March of '22, the RxGov platform was still limited. After all that time, not much had happened. We still couldn't share all medications through integrations. MySQL was required to run reports, and the compliance dashboard was non-existent. Now, it's 2026, and the Nebraska PDMP is still not integrated with the vast majority of pharmacies and small practices throughout the state, and all meds are still not displayed. I'm in support of this bill because I believe it's time for Nebraska to be a PDMP leader again. The state deserves that, and so do our providers. The first step is taking back-- the state taking back buying power and price transparency, which controlling the RFP process will do. Through an RFP, Nebraska can add in features they want, and bind the vendor into a contract for deliverables, which means Nebraska will automatically gain PDMP functionality with fair contract on day one. I'm also in support of the-- I'm also in support of this bill because when I was a CyncHealth employee, I was told we were only administering the PDMP on behalf of the state, not owning it and not controlling it. In short, CyncHealth PDMP staffing has greatly decreased, functionality's about the same, integrations aren't growing, and no one knows the price. Thank you.

HARDIN: Questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here, and for your testimony. So, I'm sorry, I had to step out a little bit, so if this has already been said, let me know. But so, currently, obviously, CyncHealth does our PDMP for our state. Are you-- am I understanding correctly, are you saying,

like, the technology is not what it needs to be? Like, I'm just--
- help me understand, like, what's the--

BRANDI van PATTON: So, even though I'm a pharmacist in the state of Nebraska, I don't have a patient-provider relationship right now, so I couldn't tell you as a pharmacist what that functionality looks like. All I can say is when I left in 2022, what we were hoping the functionality would become had not made it there yet.

FREDRICKSON: OK. And is it your understanding there are other platforms that have that functionality?

BRANDI van PATTON: Yes.

FREDRICKSON: OK.

BRANDI van PATTON: And I do represent one of them, is LogiCoy. We are the PDMP provider for the state of Pennsylvania. We also do submissions for the state of Illinois.

FREDRICKSON: Thank you.

BRANDI van PATTON: Thank you.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair Hardin. Thank you for being here today. Why doesn't CyncHealth play nice with the other kids?

BRANDI van PATTON: Well, I feel like I have a good relationship with them through LogiCoy, both of my time while I was with CyncHealth and even coming to LogiCoy. I found LogiCoy through CyncHealth, and I could already tell that LogiCoy integrations were doing things that I wanted our PDMP to do, but I was having to do it through integrations. So, I feel like I still have a working relationship with them, but I feel like the focus a lot of times is on the HIE and not the PDMP. The PDMP gets overshadowed, and that's my concern.

G. MEYER: So, we're not sharing reporting, we don't have full transparency; we don't see through CyncHealth what the other states are doing, they don't see what we're doing.

BRANDI van PATTON: Correct. With interstate data sharing, that is correct.

G. MEYER: Could they do that?

BRANDI van PATTON: Yes. There are two data sharing hubs, RxCheck and PMPI, which Andrew mentioned, that are data sharing hubs that we use to share with other states. Well, we do in Pennsylvania, as a vendor. We share with the other states the information that's in Pennsylvania PDMP so they can, you know, people can go across state lines, still see what people are doing.

G. MEYER: OK, thank you.

BRANDI van PATTON: Thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. Are you-- and, and thank you for being here. Are you now an employee of a, of a provider--

BRANDI van PATTON: LogiCoy, yes.

RIEPE: --that seeks to replace CyncHealth?

BRANDI van PATTON: It's-- no, sir. We would not replace CyncHealth. We are only simply the platform for the PDMP.

RIEPE: OK, well I'm not--

BRANDI van PATTON: No, you're fine.

RIEPE: I'm not good enough in--

BRANDI van PATTON: So, RxGov is the current name of the platform. Our platform at LogiCoy is PMPcentral.

RIEPE: OK.

BRANDI van PATTON: And so, other states are-- use our platform, other states-- some have their own, some use Bamboo Health is theirs. And BizTech.

RIEPE: OK, well, I don't know enough to be able to get into platforms and different things. Is this a-- your company that you're now employed with, is that a for-profit?

BRANDI van PATTON: Yes, sir.

RIEPE: And based in Pennsylvania?

BRANDI van PATTON: No, sir. Actually, Glendale, California

RIEPE: OK. I'm not sure that's better, but OK. Thank you. Thank you, Chairman.

HARDIN: Other questions? Senator Hansen.

HANSEN: The testifier before you mentioned that pharmacists practicing in federal systems such as the VA cannot currently access prescription data from other states. Isn't there some kind of federal law that requires that, with controlled substances? Like, they--

BRANDI van PATTON: Federal law does require the sharing of that data, and then they'll leave it up to the states. So, every state then has to say, our providers have to look at the data, our pharmacists have to look at the data. So, it's essentially a best practice. And up until a couple years ago, even the state of Missouri did not have a PDMP, but now they have decided it is best practice to follow, you know, the standards set as far as federal guidelines. And of course, data sharing via integrations, via state, it's best practice, clinically.

HANSEN: So then also, in your opinion, the state has kind of fallen behind when it comes to the--

BRANDI van PATTON: Yes.

HANSEN: --specifically VA information-sharing.

BRANDI van PATTON: Yes, yes.

HANSEN: I mean, it's-- I mean, I want to make sure we don't get in trouble with the federal government by not doing something.

BRANDI van PATTON: VA, but also, you know, there are lots of pharmacies in the state. Currently no big box pharmacy-- and,

and by that I mean CVS, Walgreens, Walmart, Kroger, Bakers-- are actually doing the integrated part. So, I can go to the platform and the PDMP as a pharmacist, use my credentials, log in, look up, you know, my patient and see their profile in there. But I'm also looking at a whole other system. So, as a pharmacist, if I'm in a pharmacy setting, I've got my pharmacy dispensing system machine pulled up with me, where I'm basically taking that information and I'm transposing it into another system. I have error-- you know, if I "fat finger" something, there's an error; if I misspell something, there's an error. I may not see what I'm looking for, but we can integrate. And what I mean by that is it's-- the easy button is what I called it when I was at CyncHealth. So basically, as a pharmacist, I can be sitting there, I'm in my system, QS1, Pioneer, lots of them, or I'm the CVS system, whatever, and I can click one button and it will go fetch that information from the Nebraska PDMP and display that right in front of me. I don't even have to leave my system. So, it's saving me time, it's saving me any kind of errors, it's patient safety. And right now, the, the philosophy is if you don't participate in the HIE, you cannot get that functionality. It's a little different with pharmacies because they don't have any other information to give the HIE. They're pharmacies; they're giving all of their data to the PDMP. But a lot of times, because of funding, I'm told we cannot get that integrated ability put into our pharmacies across the state, either.

HANSEN: OK. All right. Thanks.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair Hardin. Iowa shares with 45 other states, and with Iowa, that's 46. Pretty good with math. Do you know what the other four states are that were not-- other than-- the other three, other than Nebraska, that they're not sharing with?

BRANDI van PATTON: I am not sure, to be honest. I'm trying to think logically. So, there are actually more PDMPs, because we do consider the District of Columbia a PDMP, so that gives us 51, and since Missouri--

G. MEYER: And probably our protectorates, also.

BRANDI van PATTON: We do the territories as well. We were just talking earlier how Northern Mariana Island actually doesn't share with anyone. They're Northern Mariana-- I don't know how many people are going there.

G. MEYER: That's all right. We'll give an exception. We'll except that, so.

BRANDI van PATTON: You know, fair enough. So-- right, right. I can tell you one state for sure-- two states. Probably New York has had just some-- they're a homegrown state, so they've had some technological difficulties, but I could get you a list for sure of the ones that they're not sharing with.

G. MEYER: I was just curious whether CyncHealth was working with them also, or if they, they were--

BRANDI van PATTON: I could not tell you that, yes.

G. MEYER: --and, and, and once again, that's probably a totally unfair question. And this has nothing to do with federal government or the states, but do we share information with, say, the Canadian provinces? Is there any overlap between, internationally?

BRANDI van PATTON: You know, that's a, that's a really good question. Canada's a little further behind. I'm not saying behind in a bad way, but they just haven't seen the need for it like we've seen the need for it. So, they are coming along with PDMPs right now. We're not sharing, and I'm sure it's probably an abundance of laws that they'll create where we don't share. Interestingly enough, we-- myself as a subject-matter expert has been contacted by folks even in Saudi Arabia because they see what we're doing in the United States as a whole, being able to share that information, and it's hard to recognize an impact sometimes because there's so many illegal medications now coming into the country. But PDMPs are making a difference, and if I can convince anyone to do an all-med PDMP like Nebraska, I will, because as a pharmacist, I just love that. So, as far as Canada, not yet. But again, other countries are definitely sitting up and seeing what we're doing, because unfortunately, they're seeing the problem too.

G. MEYER: Canada delivers-- has a different medical delivery system as opposed to the United States.

BRANDI van PATTON: Correct.

G. MEYER: And yet, many Canadians come to the United States for treatment, so you would think, given the, the prescription drugs and things of that nature, there should be some commonality between the two countries, and so--

BRANDI van PATTON: We actually have a lot of initiatives working with addresses, because of course we're all used to our American addresses. And so, doing a Canadian address or a foreign address in general, how do we work through that? How do our systems accept that information? So, that is definitely something that, you know, the PDMPs are coming together and looking at as well.

G. MEYER: OK. Thank you.

BRANDI van PATTON: Thank you.

HARDIN: For the sake of the record, thanks for being here.

BRANDI van PATTON: Thank you.

HARDIN: PDMPs track what kind of drugs?

BRANDI van PATTON: It depends.

HARDIN: So, unpack that for us.

BRANDI van PATTON: Traditionally, they can-- they track controlled substances.

HARDIN: Such as?

BRANDI van PATTON: And by that I mean-- so they're broken down into multiple categories. We have-- we do have Schedule Is, which are your illicit drugs, which used to sound scary until marijuana became a household name. But then they are Schedule II, which are of course the prescriptions that are more likely to be abused more than any others. They come down. A lot of Schedule Vs; different states, you could potentially go and get them from the pharmacy without a prescription. So, cough medicine, for example; promethazine with codeine, it's become huge because a lot of teenagers have figured out that they can mix that with certain things. But other states have gone a little further. Like I said, I'm affiliated with Illinois. They

have medications of concern, so they're looking more into muscle relaxants, gabapentin I'm sure all of you have heard about is it, you know, wax and wanes. Some states, it is a controlled substance; some states it's not, and federally, it's not. But then, they also have other medications on their list. And then, of course, you get to where we are in Nebraska, collecting all medications. And by that I mean, if you have a prescription for it, it needs to come into the PDMP. And of course, there's a lot of kickback. Why do you need my aspirin in the PDMP? Well, you got a prescription for it, and that's just part of what we're asking for.

HARDIN: It seems like there's some variety, state-to-state. Is that correct?

BRANDI van PATTON: Definitely.

HARDIN: OK.

BRANDI van PATTON: So, some will-- all, all of them collect II through IV, as far as the schedules, II being the most restrictive, IV being a little less restrictive. Some states do not collect Schedule V, unfortunately. And then, you look into the drugs of concern, and then there's just all medications which will cover everything.

HARDIN: Is there any analysis of the PDMP from any, oh, say, strange three-letter organization that may reside in Washington D.C. that basically looks at drug interactions?

BRANDI van PATTON: No. Traditionally-- and again, you would really have to have a comprehensive PDMP, such as we have in Nebraska, to be able to see that full picture.

HARDIN: So Cync does that?

BRANDI van PATTON: We don't-- here in Nebraska, the PDMP does not have that capability. Not that it couldn't be built in; that's not a limitation. It's just not looked at in that way at this time, if that makes sense. We're not running information on the background in a PDMP environment that we are in an e-prescribing system or an EHR system, or even a pharmacy system before that medication goes to the patient.

HARDIN: Within the PDMP world, is there anything resembling real-time data?

BRANDI van PATTON: Yes, yes.

HARDIN: And that's uniform?

BRANDI van PATTON: No.

HARDIN: Can you unpack that for us?

BRANDI van PATTON: Yes. So, I think when we think about real-time data, we have to think about "what is that?" So, for me as a pharmacist, if you tell me a patient has picked up their medication, they are now owning that medication, it is going with him. Maybe it's their agent, maybe it's even for their animal, for states that do veterinary medicine, like here in Nebraska. And so, that date sold can then be on all the information. It's packaged up, it's in an ASAP standard so all systems can read it; it's packaged up, its immediately sent to that PDMP if they have some kind of, you know, connecting system with that pharmacy management system. To date, the only real-time prescription monitoring program that does true real-time, instant, with your ADP is Pennsylvania. Not a lot of people use it because it requires work on the prescription-- I mean, excuse me, on the pharmacy management system, what pharmacies are using to fill their prescriptions. It requires work on their part. I get that. That's money.

HARDIN: They got to hook up an API or something.

BRANDI van PATTON: Right, they have to build out those APIs. So, what we started doing in Nebraska when I was here-- and it was a huge initiative, and I was very excited about it; we had a lot of pharmacists very excited to do this-- was at least do as best we could, and set off a scheduler that would grab medications that had just been taken out of the pharmacy, whether it was mailed, whether it's picked up, and, and submit that to the PDMP. So you're getting, as near real time. Oklahoma was the first state to start doing that, and it worked out really well. Now again, not all pharmacies can do this. It's just limitation. Kroger, we worked with them. We said how much money would it take? We couldn't do it. It was too much money. So, it-- there are a lot of limitations because there's so many players in the

system. But typically, every state requires at least daily submissions

HARDIN: OK. Seeing no other questions. Thank you. Appreciate it. Proponents, LB949. Welcome.

JACOB COOPER: Hello. Good afternoon, Chairman Hardin, members of the Health and Human Services Committee. Thank you for the opportunity today to provide testimony in support of Nebraska LB949. My name is Jacob Cooper, J-a-c-o-b C-o-o-p-e-r, vice president of state accounts. I'm submitting my testimony on behalf of Bamboo Health, a national healthcare technology company. Bamboo Health has supported prescription drug monitoring programs for more than 13 years, and today works with 46 states, territories, and federal agencies, serving over 1.3 million users across more than 160,000 health care facilities. Our work focuses on helping clinicians, pharmacists, and public health officials use PDMP data to make safer prescribing decisions and identify risks before harm occurs. Bamboo Health strongly supports the intent of LB949, particularly the provision that would remove the requirements of the Prescription Drug Monitoring Program, or PDMP, and the health information exchange, or HIE, be operated by the same vendor. We believe this change will promote innovation, preserve state flexibility, reduce operational risk, and ultimately better serve clinicians and patients in Nebraska. An additional benefit of LB949 is improved transparency and competition. Today, the state does not directly control procurement decisions related to the PDMP, and policymakers may not have full visibility into costs or vendor selection processes. Allowing independent procurement ensures Nebraska can evaluate options openly, encourage competition, and make decisions based on value and performance. Although competitive vendor processes may still occur within the current structure, when procurement authority sits with an intermediary organization like an HIE rather than the state itself, policymakers innately have less direct oversight into how those decisions are made. LB949 restores that visibility and ensures competition occurs under state direction and accountability. From both the technical and public health perspective, PDMPs and HIEs serve different functions and require different areas of expertise. PDMPs are regulatory and public health systems focused on controlled substance stewardship, while HIEs are broader care coordination platforms. In our experience, states achieve better outcomes when they can select best-in-class solutions for each system while requiring-- while still

requiring strong interoperability between them. Requiring a single vendor also concentrates operational and procurement risk. If a challenges arise, whether technical, financial, contractual, the state has fewer alternatives and less flexibility to respond. Independent systems with strong interoperability allow continuity of service while preserving state control. LB949 takes a thoughtful approach by preserving integration goals while allowing Nebraska to make technology decisions that best support clinicians and public health priorities. By decoupling the PDMP and HIE procurement, Nebraska would also align more closely with the procurement models used by the vast majority of other states, prioritizing interoperability standards that allow systems to work together while still allowing independent procurement decisions. For these reasons, Bamboo Health supports LB949, and appreciates Senator Ballard's leadership on this issue. Thank you for your time. Happy to answer any questions.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. Is your system integrated with Epic and other EV-- you know--

JACOB COOPER: Emergency health record systems?

RIEPE: Yeah.

JACOB COOPER: Yes, we have dozens if not hundreds of Epic and Cerner integrations across, across the country. We actually integrate directly with over 500 EHR systems, so 500 companies like Epic of all shapes and sizes.

RIEPE: OK. OK.

HARDIN: Senator Hansen.

RIEPE: Thank you, Chairman.

HANSEN: You're the PDMP vendor in Iowa?

JACOB COOPER: Yes, sir.

HANSEN: So, have you worked with CyncHealth before?

JACOB COOPER: We have encountered CyncHealth. We don't work directly with them in Iowa. We do inter-- we do provide interoperability with many HIEs across the country. In Iowa, we, we don't do that in CyncHealth. We haven't been, you know, directed or asked to. But we have run the PDMP in Iowa since 2018.

HANSEN: OK. And you're in how many other states did you say?

JACOB COOPER: 46 states, territories, and we run a federal PDMP as well.

HANSEN: OK, thank you.

HARDIN: Other questions? And so, Bamboo has never been involved in Nebraska. Is that correct?

JACOB COOPER: No. Well, we bid on-- we, we bid on the most recent procurement in November for the PDMP, --

HARDIN: OK.

JACOB COOPER: --which was released by CyncHealth. But that's not direct involvement, I suppose.

HARDIN: OK. Seeing no other questions-- oh, I-- now I see another question. Senator Meyer.

G. MEYER: And, and I think Senator Hansen kind of covered this, but as I read, it says today you work with 46 states, territories, and federal agencies. Of the 46 states that are not perhaps operating with CyncHealth-- and, and that might not be accurate, but of the 46 states, territories, and federal agencies, are you the exclusive provider?

JACOB COOPER: So, in 40-- 45 states, we're the exclusive provider. In one state, California, we run half of their system.

G. MEYER: OK.

JACOB COOPER: If I may make a distinction between PMP InterConnect, which is the interstate data sharing hub, there are 52 out of the 54 programs currently connected to that. The two that are not would be Nebraska and California.

G. MEYER: So, you, you can work within other systems, talk back and forth, cooperate, have a cooperative venture within a state-- within the state environment.

JACOB COOPER: Yes. It is extremely common that states want to integrate their-- and have interoperability between their HIE and their PDMP. That is critical, and I, I think you'll probably hear it from folks who-- I think that that would be the most compelling reason to keep these two programs coupled. However, it's something that can be accomplished using interoperability standards elsewhere. It, it doesn't need to be done in procurement, in my opinion.

G. MEYER: Thank you.

HARDIN: Has Bamboo ever supported an HIE?

JACOB COOPER: An HIE?

HARDIN: Yeah.

JACOB COOPER: We have never run an HIE. We have integrated our PDMP solution. We don't-- we're not an HIE company. We don't have an HIE solution. We only run PDMPs, and we integrate with them across the country.

HARDIN: Very well. Other questions? Senator Riepe.

RIEPE: Thank you. Your funding source, are you venture capitalists-based? Or--

JACOB COOPER: We are owned by private equity.

RIEPE: Private equity? OK. OK.

JACOB COOPER: I would think the majority of our PDMP funding comes from agency budget, federal grants.

RIEPE: OK. That's interesting to know. Thank you.

JACOB COOPER: Mm-hmm.

RIEPE: Thank you, Chairman.

HARDIN: Thanks for being here.

JACOB COOPER: Of course.

HARDIN: Proponents, LB949. 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 B-e-l-l. I'm the executive director and registered lobbyist for the Nebraska Insurance Federation. I appear today in support of LB949. The federation is the primary trade association of insurance companies in Nebraska. The federation consists of 50 member companies of all types, including most of the major health plans operating in Nebraska Aetna, Ambetter, Blue Cross Blue Shield of Nebraska, Cigna, Medica, and UnitedHealthcare. The federation members are big believers that, that in the utilization in technology will have a tremendous impact on the future of insurance. In fact, the federation is a co-host of one of the premier annual Insurtech conferences in the world, Insurtech on the Silicon Prairie, which will be held in Omaha on October 19 and 20, 2026. Find out more at siliconprairienebraska.com if you're interested. In the health insurance space, the use of electronic health records and information exchanges is key to reducing inefficiency in health provider/health payer interfaces. And health insurers are making continued investments in new technology that will increase transparency, streamline workflows, and improve turnaround times for consumers and health care providers. LB777 from last year was the prior authorization reform legislation that health insurers worked closely with our partners in the health care provider community, and that bill has an emphasis on the utilization of technology. Federation members are wholly supporting-- supportive of the work done by this committee and the legislator related to the Prescription Drug Monitoring Program, and the statewide health information exchange, but we believe that LB949 highlights a fundamental legal structure issue: that the statutes that created the statewide Health Information Exchange create a closed class in violation of Article III, Section 18 of the Nebraska State Constitution. This provision of the constitution states in part that the Legislature shall not pass any special laws granting to any corporation, association, or individual any special or exclusive privileges, immunity, or franchise, whatever. Section 3 of LB949 amends Nebraska Revised Statutes Section 71-7455, which is at the heart of the creation of this closed class, by requiring the Department of Health and Human Services to collaborate with the Nebraska Health Information Initiative to form the Prescription

Drug Monitoring Program, and must contract with the initiative to administer a state board, the Health Information Technology Board. It is unclear under current law how another private entity may be awarded these privileges. LB949 provides an elegant solution to this problem by, by requiring the department to contract for these services, thereby opening the class and solving the constitutional defect in these statutes. Again, the federation supports the efforts of the exchange and the monitoring program. It would prefer to see this constitutional defect be removed for future success. And for these reasons, we support LB949.

HARDIN: Questions? Senator Hansen.

HANSEN: I don't think we've ever had somebody testify-- it sounded like a commercial there, for a second.

ROBERT M. BELL: I-- I'm sorry.

HARDIN: I think we have a swear jar for that.

ROBERT M. BELL: I-- OK.

HANSEN: 8, 8 years. That was the first [INAUDIBLE].

ROBERT M. BELL: I do that from time to time, Senator. I'm sorry. It's a great conference.

HANSEN: No, it's good.

ROBERT M. BELL: And you can get these sweet socks that I have on today if you attend, so. I-- you can't see them now.

HANSEN: You had me at socks.

ROBERT M. BELL: All right.

HANSEN: Article III, Section 18, I think that's if you have-- you specify a company directly, right? Because you can still say the qualifications.

ROBERT M. BELL: It's a long statutory or constitutional provision, but it's the closed-- I think it's the closed-class provision, so-- and special legislation. Yeah. So, if you look at that statute that I spoke about, which is Section 3 of this

bill that talks about the Nebraska-- oh gosh, what is the word? The Nebraska Health Information Initiative. It defines-- or it talks about a private entity. I think it's a private entity, at least. So, I don't know. There's some questions around that, I suppose.

HANSEN: Like, is, is that the Section 71-24--

ROBERT M. BELL: Mm-hmm. 2455. Yeah, it's in the bill, Section 3 of the bill, so. OK. All right.

RIEPE: I'm impressed.

HANSEN: I'm a nerd.

ROBERT M. BELL: Nerd for socks, or?

HARDIN: Other questions?

HANSEN: Thanks.

ROBERT M. BELL: Yeah.

HARDIN: Seeing none. Thank you.

ROBERT M. BELL: You're welcome.

HARDIN: LB949, proponents. LB949, opponents.

MIKE CASSLING: OK.

HARDIN: Mr. Cassling.

MIKE CASSLING: Chairman Hardin, I'm going to keep this short. I didn't think I would be able to be here because I was testifying in another for LB1180 or 65, so. We're fortunate in this state. We have one of the top-- top HIEs in the country. We're probably in the top two. Due to that fact, we just brought in \$18 million, \$8 million going to HHS in the state from the CDC. If you go forward with this plan or this bill, it will cost Nebraska hospitals and patients millions of dollars, and it's outlined in my letter. I did meet with Senator Ballard. We had a great discussion, and we plan to sit down again to further discuss his concerns in some of these, so. I think we have a huge opportunity with CyncHealth, both on the PDMP as well as

the HIE, to truly make a difference. Data in healthcare makes a difference, and as-- where we're going-- and I'm happy to sit down with you, with Cync 2.0-- we're on a path to make Nebraska the healthiest state in the country. You talked earlier about maternal health. We're actually starting to figure out how do we track that data, how do we get the mothers to know they're pregnant, and then to get them prenatal care ahead of time? So there's all this stuff that's going on, and I'm happy to discuss it, but-- and happy to open it up for questions. As you can see, I wasn't very prepared, but--

HARDIN: So, you're saying that there evidently are hospitals and others involved; if we knock over a domino here, there's repercussions.

MIKE CASSLING: All the connections would have to be redone. Rural hospitals would be devastated. They can't afford to do it. The connections right now, when you go-- if you're in Broken Bow and you go get a CT scan, which I know all about, and then you have to go to Bryan, without the HIE and those connections, you would have to repeat that proced-- that exam. It costs millions of dollars for the-- for insurance companies who just testified in favor of this. It would cost millions of dollars for Medicaid, and then the hospitals just to redo all the connections. It would be a complete-- and I think you'll see, if you wait a year in Iowa, you'll probably see the disaster that they're going to have.

HARDIN: So, if you were to make changes as they're being proposed in LB949, in a perfect world, what's the soonest that all of the hospitals who are participating might be able to switch over to a program like that one, and unhook from what they've currently got?

MIKE CASSLING: Years. I mean, if you look at rural hospitals and just the challenge hospitals have in general for dollars-- you heard in the earlier testimony from Senator Cavanaugh about some of those things-- they're, they're hurting. So, this would be a very low priority.

HARDIN: OK. Senator Riepe?

RIEPE: Thank you. Thank you for being with us.

MIKE CASSLING: Thank you.

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Rough Draft

RIEPE: I know you-- you currently, I believe-- I believe in leadership and continuity. You are the chairman of the board of CyncHealth?

MIKE CASSLING: I am not chairman. I'm on the executive committee.

RIEPE: Oh, OK.

MIKE CASSLING: I should have said that up front. Sorry.

RIEPE: No, that-- I, I, I just thought-- I've always accredited you with being the chairman of it, and you've been with them for how long?

MIKE CASSLING: I'm heavily involved in, in the work towards Cync 2.0.

RIEPE: OK. Thank you very much. And we're going through some-- you're going through some changes with CyncHealth right now, and its leadership.

MIKE CASSLING: We are, yep, yep.

RIEPE: You will recover from that, I assume?

MIKE CASSLING: Absolutely.

RIEPE: OK.

MIKE CASSLING: I think we're in a great position, just with technology and AI, and some of this that's coming down the road, to be able to analyze data faster, get data. And our ultimate goal is to get the data to the, to the doctor while they're with the patient. And if you do that and get the right data to them, they can make the right decisions and ultimately improve outcomes, which helps all patients.

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

MIKE CASSLING: Senator Hansen.

HANSEN: Thank you. Just to clarify, I think some of the examples you brought up, that was more HIE, wasn't it?

MIKE CASSLING: It was.

HANSEN: So-- and I think with this bill it's more on the PDMP.

MIKE CASSLING: No, it's actually both. This would take both out of statute, which would destroy both. Kari will talk a little bit more about the PDMP. We actually just put the PDMP out to bid and got bids from several people on here that are actually testifying. The one thing I will tell you, being in health care, private equity in health care-- and you can read the reports, it's all over Congress and the Capitol Hill-- private equity in health care is a very bad thing. All they care about-- sorry to some of the people here that are that way-- all they care about is profits. They do not care about the patients. I recently sold my business, health care business, to my employees in an ESOP purely because there was no way I would sell it to a private equity.

HANSEN: So in your opinion, for this bill to move forward, Senator Ballard would have to work on more clarifying language?

MIKE CASSLING: Well, as it's written, my understanding is you would take Cync out of statute for the HIE and PDMP,--

HANSEN: OK.

MIKE CASSLING: --and you would start all over again, and cost, and cost the, the people of Nebraska millions of dollars. And some of those dollars are spelled out in my letter.

HANSEN: OK. Thanks.

MIKE CASSLING: Thank you.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Mr. Cassling, for being here. It's good to see you.

MIKE CASSLING: Thank you, Senator.

FREDRICKSON: So, the-- I guess a, a couple of questions. So, we heard from some of the earlier testifiers about some of the concerns they might have with the CyncHealth from, like, a PDMP

specific example. You, you kind of briefly mentioned Cync 2.0 I think is what you-- is that-- did I say right? OK, yeah.

MIKE CASSLING: That's what I'm using.

FREDRICKSON: OK. So, can you maybe shed some light-- I, I, I, I-- or maybe educate us a little bit on, like, are those challenges things that Cync's aware of? Like, what are-- what kind of ironing out or things are just happening? Or what's the plan?

MIKE CASSLING: I'll let Kari probably address some of that specifically,--

FREDRICKSON: OK.

MIKE CASSLING: --but I think, as I talked to Senator Ballard about, we're very open to understanding where the concerns or the challenges are and addressing those. As I said, we just put out the PDMP to bid, and she can probably address that more. And we put that out to bid, and, and obviously look at the, the best price compared to the best technology. But, so--

FREDRICKSON: OK. And if, and if this bill-- and I heard your answer to Senator Hansen, and I appreciate that. I, I, I guess what I'm-- my-- and maybe I'm a bit confused here, but if this bill were to pass, certainly the statute would change in terms of CyncHealth kind of having that. But CyncHealth would still be able to apply to the state, is that correct?

MIKE CASSLING: Yes.

FREDRICKSON: OK. OK. Thank you.

MIKE CASSLING: But-- yeah. You would, you would open a can of worms.

HARDIN: Other questions?

MIKE CASSLING: It's my technical term.

HARDIN: Senator Meyer.

G. MEYER: It seems a bit complicated. Seems like right now, statutorily, that CyncHealth has a monopoly on the system.

Bamboo Health, theoretically, if they were the low bid, they could cooperatively work with the health information exchange. But I believe I heard you say that if we were to contract with someone like Bamboo Health, it would absolutely devastate our rural hospitals and clinics.

MIKE CASSLING: It-- if, if you're-- no, you're-- we got to separate-- you're talking about the PDMP, which Bamboo Health was talking about. The-- in stat--

G. MEYER: And, and that's-- that, that would be the portion that they, they, they would bid on, would be the PDMP.

MIKE CASSLING: Correct. And they, and they put a bid in. If you take Cync out of statute, it takes us out for the HIE and the PDMP, which we actually already put out to bid on a regular basis. So, if you put that out, what would cost millions of dollars and devastate rural hospitals and really all hospitals would be the HIE portion of that.

G. MEYER: So, why did we entertain bids with alternative providers--

MIKE CASSLING: For PDMP?

G. MEYER: --for Bamboo or other, or, or other-- if, if we would have accepted a bid from, from an alternative provider for the PDMP, isn't that exactly what this bill is kind of proposing?

MIKE CASSLING: Well, this bill is taking it out of statute. We, we are all in the process. And now, we just put it out to bid. We have four or five bids. Kari can confirm all this for the PN- PDMP portion of this. So, CyncHealth is putting it out to bid, and we're happy to share that with the department or anybody, to look at the bids, look at price of the bids. We're-- we-- we're transparent. We'll, we'll show you the numbers, we'll, we'll walk through-- I talked to Senator Ballard, you know, he's talk- - worried about we're expensive. We're happy to walk through all those and show that we truly show do an ROI to the state of Nebraska and to the taxpayers of Nebraska.

G. MEYER: But if we have another provider for the PDMP, as I understand it-- once again, I'm a simple man; this is a complicated situation. But if we're putting out bids for a PDMP, essentially, you're saying that the PDMP and the, the health

information exchanges are compatible right now if we do an alternative vendor for the PDMP. That's what I'm hearing you say. Otherwise, why put bids out?

MIKE CASSLING: Because we're looking for the best technology that can-- that integrates. Now, the plus of having the HIE and the PDMP combined is, is decreasing cost, because you, you have shared infrastructure. So, versus setting it out to a separate company and having an HIE and a PDMP, having those together will decrease your cost of overhead. I don't know if I'm answering your question, but--

G. MEYER: You didn't answer my question. That's fine. Thank you.

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

MIKE CASSLING: Thank you.

FREDRICKSON: Next opponent for LB949. Welcome.

SAI BARITALA: Thank you. Good afternoon, members of the committee and chairman. My name is Sai Baritala, S-a-i B-a-r-i-t-a-l-a. I'm a professor in the department of epidemiology at the UNMC College of Public Health. We have a focus on public health informatics and health data systems. But I appear before the committee today as a private citizen to oppose LB949. So, my comments will focus on how LB949 would separate PDMP from the HIE, and how this proposed legislation would affect data governance, patient safety, clinical decision-making, "publical" surveillance, and outcomes related to substance use-- misuse and overdose. Prescription drug monitoring programs are widely recognized as essential public health tools that support safe prescribing, identify patterns of misuse, and inform population-level responses to substance use disorders. Federal public health agencies like Centers for Disease Control and Prevention have found that PDMPs are most effective when they're integrated with health information exchange technology systems, such as health information exchanges, so that clinicians can access medication history efficiently at the point of care in conjunction with important clinical information. That can provide missing context that's not located in the PDMP alone. Integration of medication history through a HIE allows PDMP data to be incorporated into clinical workforce, rather than requiring providers to exit their electronic health record

systems to query a separate platform. Lack of integration is a major barrier to a PDMP utilization. Integration increases data use and improves the quality of prescribing decisions, contributing to reductions in things such as inappropriate opioid prescribing, overdose risk, and adverse drug events to your patient having multiple providers and multiple prescriptions. From a public health perspective, reduced PDMP utilization has a direct patient safety implications. PDMPs help clinicians identify overlapping prescriptions, high cumulative dosages and multiple prescribers of pharmacies, risk factors associated with overdose and adverse drug events. When access to this information becomes more cumbersome, like having to log in multiple times into multiple platforms, the likelihood of missed opportunities of early intervention increases. Beyond individual patient care, PDMP data are used to monitor and inform, identify emerging patterns of misuse, and inform statewide prevention and treatment strategies, all approved through a single robust governance model that has, that has both internal CyncHealth controls and external involvement for users and projects involving the PDMP data. I thank you for the opportunity to share these perspectives. I would happy to answer any questions.

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

SAI BARITALA: Thank you.

FREDRICKSON: Next opponent.

DAVID FINNEY: Good afternoon, members of the committee. My name is David Finney, D-a-v-i-d F-i-n-n-e-y. I am a co-founder of Leap Orbit, an independent and employee-owned small business that serves as the, as the technology partner for Nebraska's PDMP. I'm here to testify against LB949. If enacted, I strongly believe that this bill will dismantle a public-private partnership that is not only improving care for Nebraskans, but is a well-known model for the rest of the nation. I say this from experience, having spent my 20-year career supporting such programs across the country. First, let me address the question of fiscal responsibility and efficiency. The current PDMP structure is a trailblazing public-private partnership that has served Nebraska well for more than 10 years under the management of the Nebraska Health Information Initiative, which is now known as CyncHealth. This delivers maximum value for every state dollar. By establishing a partnership with CyncHealth over 15

years ago as the statewide HIE, and then by adding the PDMP 5 years later, this legislator built us-- this Legislature built a structure where accountability is shared. It's been my experience that Cync takes its financial responsibility to the state of Nebraska very seriously in the management of the PDMP. My company and our technology are fairly procured every few years to ensure that Nebraska is getting the solution that it needs at a fair price; this happened most recently in December. My company is accountable not just to CyncHealth but also to DHHS, as well as to the Health IT Board. As you know, this board provides a shared governance model that includes members appointed by the governor, as well representatives of the hospitals and clinics that use the data every day. This accountability structure has also allowed Nebraska to maximize federal financial participation. Nebraska was the first state in the country to have its PDMP certified as a module of its Medicaid enterprise. This certification unlocks significant federal matching dollars that a stand-alone, non-integrated vendor might put at risk. Second, this bill threatens a unique and valuable data set. For over a decade, due to the forward-thinking approach of this Legislature, Nebraska has been a pioneer in collecting all medications, not just controlled substances. While other states are blind to non-controlled prescriptions that can cause deadly interactions, Nebraska clinicians can see the full picture of a patient's medication history, alongside other clinical information. We've developed special expertise to manage this massive volume of data from collecting all dispensed medications. To rip it out and replace it with a new vendor would be incredibly expensive and technically perilous. States like Maryland, Nebraska-- Maryland, Montana, and Connecticut are now beginning to replicate this comprehensive model. Finally, regarding cost and the intent of this bill, my company is not afraid of competition. We've competed for this contract twice in full compliance with Cync's process, winning in 2019 and again in 2025. I've looked closely at the intent of this bill. Throughout the text, it systematically strikes references to a collaborative partnership and replaces them with "vendor." I can assure you, there will be a steep price tag for that regression.

FREDRICKSON: And Mr. Finney, you're in the red, so if you could just wrap up your final thoughts.

DAVID FINNEY: Sure. The dominant commercial model in other states is one of value extraction. Health departments often sign

small-base contracts that are comparable to ours here, but they deliver less value. They also control-- cover only controlled substances, and they have gateway fees to charge for access to the data within the hospital workflow. I'd be happy to answer questions.

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

HANSEN: I'm sorry, I missed it. Who did you say you worked for or with?

DAVID FINNEY: My company is called Leap Orbit. I'm one of the founders and owners.

HANSEN: Did you work in other states at all?

DAVID FINNEY: I do. We work in five other states and three Canadian provinces.

HANSEN: See? Canada. And so, with those other states, do you work directly with the state, or do you work with the vendor like we have here in Nebraska?

DAVID FINNEY: We do both. So, we have contracts directly with state agencies, and we also have a contract with other health information exchanges like CyncHealth.

HANSEN: OK. And works seamlessly in the other states, when you work with the vendor as well? Or--

DAVID FINNEY: Absolutely.

HANSEN: OK.

DAVID FINNEY: I think one of the benefits of an HIE/PDMP combination is it gives the state the ability to build a true best-of-breed public health technology platform.

HANSEN: How does it go when you work with the state directly?

DAVID FINNEY: Sorry, could you say that again?

HANSEN: So, how does it-- how does it-- how is it different when you're working with the state directly as opposed to through a vendor?

DAVID FINNEY: It, it can be very similar. We work with state boards of pharmacy, we work with state health departments. And typically, the programs are more siloed. We, we don't have the opportunity to present a full clinical dataset to the user in their workflow in the way that we do when we work with an HIE.

HANSEN: You're saying government is siloed? That's weird.

DAVID FINNEY: Plead the Fifth.

HANSEN: It can be. Thank you.

FREDRICKSON: Thank you, Senator Hansen. Other questions from the committee? Seeing none. Thank you for being here. Next opponent. Welcome.

MICHEAL DWYER: Good afternoon, Vice Chairman Fredrickson, and members of the Health and Human Services Committee. My name is Micheal Dwyer, M-i-c-h-e-a-l D-w-y-e-r. And I would like to thank Senator Ballard for introducing this bill, however, my testimony today will be in opposition. I'm a 42-year-old-- 42-yearold. 42-year veteran of volunteer fire and EMS with a resume of nearly 2,800 calls, the author of the, of the fifth version of the Future of EMS in Nebraska report. I'm also co-chair of the Nebraska EMS Task Force, however, my testimony today is my own and not on behalf of the Task Force. I want to offer a perspective of LB949 from the back of an ambulance. It's 2 a.m., it's dark, the ambulance is bouncing down a country road, and I'm the only EMT in the back, without a respiratory therapist or a CT scanner. What I do have is a critical patient, and I have no idea what's wrong. You and I, we, as partners in this, have a very few minutes to diagnose, treat, and transport her, or she will die. My dream is through the advancements in our health information exchange, I could get basic, secure patient history and medication information that would quickly point me in the right direction. I-- excuse me-- believe that CyncHealth is well on its way to being able to give that lonely EMT in the back of the rig at 2 a.m. that information. Data from over 400 EMS services in Nebraska gathered in pre-hospital care, and managed and governed by CyncHealth is critical information for pre-hospital health care providers, and an important part of a

patient's comprehensive clinical record. This partnership can transform pre-hospital EMS workloads, and would give EMTs like me greater insight into a patient's clinical and medication history during pre-hospital care. In my opinion, moving away from the investments that Nebraska has made in-- towards a vendor-based model would bring significant risk to the continuity of care with all of the changes coming to EMS, particularly with the Rural Health Transformation Program, and change-- making the-- it's not a good-- excuse me. It's not a good time to abandon the progress CyncHealth has made and risk the instability and lack of continuity in EMS-- in the EMS workforce, which by the way is and will remain largely volunteer. I would encourage the Health and Human Services Committee not to advance LB949, and will welcome any questions. Very quickly, in the couple of seconds I have left: comments about leadership are, I think, in a general conversation, very good. But I'm a real strong scrutiny of leadership. I've worked with 10 companies my entire career, and I've had great conversations with the leadership at CyncHealth, and in my opinion, they're, they're solid. Finally, interestingly this morning, I had my annual physical checkup with my doctor in Fremont. Going through the whole process, and I mentioned I was coming down to testify on this bill, and she immediately said loves health information and the importance of that for her practice in Fremont, and really has interacted with CyncHealth several times, and, and appreciates what they do. And with that, I'm-- take any questions.

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

MICHEAL DWYER: Thank you.

HARDIN: Those in opposition to LB949. Welcome.

JERROD ANZALONE: Good afternoon, Chair Hardin and members. My name is Jerrod Anzalone, J-e-r-r-o-d A-n-z-a-l-o-n-e. I am an assistant professor in the Department of Biostatistics in UNMC's College of Public Health, but I'm a clinical informaticist by training. I hold multiple leadership roles in research informatics at UNMC, and I've had the privilege of working with CyncHealth since 2019. Today, I speak in my personal capacity as a Nebraska citizen and a clinical informaticist in opposition to LB949, as it would separate the state's PDMP program from state HIE. This separation would weaken public health, patient safety, and Nebraska's overall health information infrastructure.

Nebraska's PDMP serves vital clinical and public health purposes. It was intentionally designed to operate within the statewide HIE, which is nationally recognized for its leadership in data management and health information exchange. The PDMP supports patient safety and clinical decision-making in addition to compliance and surveillance. The Legislature incorporated medication history into the HIE structure as codified, codified in Nebraska Revised Statute 71-2454. This law requires that prescription drug information be accessible to authorized HIE participants in accordance with HIPAA and privacy protections. And just as a reminder, medicated-- medication history is most valuable when part of a comprehensive interoperable patient record rather than a separate system. The public health benefits of the PDMP are truly realized within this context. When integrated into the HIE, medication history can be seen alongside clinical encounters, care transitions-- if the PDMP operates outside the HIE, it becomes a siloed reporting system with diminished clinical and analytical value. Nebraska has invested nearly two decades into a governance model that manages the PDMP and the HIE together under coordinated leadership; separating them would force providers to use additional systems and credentials, increasing administrative burden and reducing consistent use. Even small workflow barriers can significantly lower utilization. If access becomes less seamless, utilization will decline, undermining the program's goal of present-- preventing this use, ensuring proper prescribing, and improving patient safety. Nebraska's HIE and PDMP are effective because they are managed together, enabling statewide interoperability, supporting clinicians, protecting patients, and guiding public health policy. Separating the two would fragment data, diminish clinical and population health, increase provider burden, and weaken the public health protections intended by the Legislature. For these reasons, I respectfully ask the committee to postpone LB949 indefinitely, and I will take any questions.

HARDIN: Thank you. Appreciate you being here. Have you, in your capacity, taken a look at other situations like this in other states?

JERROD ANZALONE: I think Nebraska is kind of a beacon for what other states should be doing. So, so we're unique in our alignment of the PDMP with the HIE.

HARDIN: OK. Can you make any-- have states reached out to you and said, "How are we doing?" Have you, have you actually taken

a look at their data in other places to see how it's being gathered and so on and so forth? The thoroughness of it, and so on and so forth. I'm-- I, I guess I'm just curious if you can unpack that statement a little bit more for me.

JERROD ANZALONE: Yeah. Kari would, would know more about states reaching out about the PDMP structure and the HIE, but I can tell you from national studies that we are routinely one or two in data quality among HIEs. I sit on the Nebraska Health Care Collaborative board of directors, and we routinely receive requests to use our PDMP data for surveillance, public health, research questions, particularly as the landscape around mail-order pharmacy has changed. We are in a unique position to answer questions that others cannot.

HARDIN: OK. Other questions? Senator Hansen.

HANSEN: Thank you. Now, I'm not doubting your knowledge as a clinical informaticist. I've never heard that term before. I'm going to use that in Scrabble next time. Like, it's-- that's interesting.

JERROD ANZALONE: Yeah. Please do, yeah.

HANSEN: But why would-- why do you say separating the PDMP from the HIE would fragment data, diminish clinical and population insights, increase provider burden, and weaken the public health protections intended by the Legislature? What, what-- where, where does that basis come from? Like, are we seeing that in other states? And again, just out of pure curiosity. I-- because I'm--

JERROD ANZALONE: Yeah, I, I, I think that health data is shockingly difficult to, to get together. We use interoperability as, like, it's a possibility, but it doesn't happen very easily in the wild. Health systems don't speak very well together unless we have independent organizations like CyncHealth that are able to connect the dots between health systems. And so, I think having the PDMP disconnected from the HIE, at least from a research perspective and a public health perspective, limits the ability to marry the two and, and more easily address population health questions.

HANSEN: OK, so that's-- I think, I think that's the crux, here. Because when we had the people coming here testifying in favor

of this, saying there's interoperability between the two. Like, where, where, where they-- where they're involved in other states. So, like, their HIE and their PDMP are kind of--

JERROD ANZALONE: Yeah.

HANSEN: --are in sync, I guess, right? And so, they're not seeing as much, maybe--

JERROD ANZALONE: There there's this [INAUDIBLE] going around, really.

HANSEN: --the disruption, I guess, yeah in the information exchange. Because they're saying in order for them to be able to-- I would think-- be classified as a vendor, they would have to be-- have-- you know, work well with the HIE and work together. But you're saying you separate them, then, then it sounds like the end of the world, I guess. You know? Not saying that's [INAUDIBLE]

JERROD ANZALONE: Yeah, I mean from, from population health management, I think that they can connect different pharmacy systems together, but getting the entire complete picture of a patient's health information in a single setting is, is truly powerful. And interoperability in the wild is, is very hard to achieve. Yeah. So, so decoupling them, I think, weakens the ability to do that natively.

HANSEN: OK. All right. Thanks. Appreciate it.

JERROD ANZALONE: Yeah. Thanks.

HARDIN: Other questions? Seeing none, thank you.

JERROD ANZALONE: Thank you.

HARDIN: Those in opposition, LB949. Welcome.

KARI MAJORS: Good afternoon, Chairman, and members of the Health and Human Services Committee. My name is Kari Majors, spelled K-a-r-i M-a-j-o-r-s. Thank you for the opportunity to testify today. I'm the vice president and executive director of CyncHealth, Nebraska's designated Statewide Information Exchange, HIE, and the host and administrator of the state's Prescription Drug Monitoring Program, PDMP. I'm here today in

opposition to LB949. The state of Nebraska, Nebraska DHHS, and CyncHealth have deliberately built one of the most connected and utilized statewide health data infrastructures in the nation. LB949 would separate the state's PDMP from the statewide HIE, effectively dismantling Nebraska's integrated and certified health information infrastructure, robust governance framework, and successful public-private partnership model. CyncHealth is a Nebraska-based, locally governed, not-for-profit organization selected by this Legislature to serve as the single statewide designated entity within this public-private partnership model. Since 2008, Cync has been-- and the-- and has been entrusted to securely collect and exchange Nebraskans' health and medication information, establish data governance through shared accountability with stakeholders, and responsibly steward both public and private funds. This stewardship and the integrated data infrastructure we support is what makes Nebraska's health data ecosystem stable, cost-effective, nationally respected, and most importantly, a highly-utilized, trusted source of clinical data for approved use by DHHS, public health providers, and payers across the state. Integrated data expands access and reduces access burden, provides clinical relevancy, and increases the value of the data and the investments. LB949 proposes replacing this model with a fragmented vendor-operated approach. Experience from other states shows the disparate vendor-centric models with no neutral convener and integrator such as CyncHealth creates disparately-governed, disconnected systems, redundant and costly contracts, inconsistent data quality, and siloed platforms that require significant additional investment to make data accessible, meaningful, and actionable. It undermines the purpose of the public-private partnership model, and as written, LB949 places Nebraska at risk of replicating costly re-implementation and reconnection challenges, and unfavorable financial and governance outcomes experienced in other states. As part of our partnership model, CyncHealth already procures and manages technology vendors on behalf of the state, while ensuring transparency, shared oversight, and stakeholder engagement and decision-making. For example, in partnership with Nebraska DHHS, CyncHealth recently issued a request for proposals for the PDMP vendor. While two vendors scored well on the technical requirements, the unselected vendor was nearly double the cost for their proposed uncertified platform. Certification is an extensive process, and would cur even more-- and would incur even more costs. Lastly, the bill creates ambiguity on management responsibility for the PDMP vendor, the proposed vendor role within the Health Information Technology Board, the future of the statewide HIE,

and continuity of data across these systems. LB949 dismantles Nebraska's intentionally-designed, integrated, certified, and stakeholder-governed system. For these reasons, I respectfully urge the committee to reject LB949 to preserve Nebraska's existing model. Thank you for your time and thoughtful consideration, and I'd be happy to take any questions.

HARDIN: Questions? Can you compare for me what Nebraska does in its process compared to others, maybe others who've been here today, or what is typically done across the country? Give me an A-B.

KARI MAJORS: Specifically for procurement, for our procurement policy. Is that what you're asking, Senator?

HARDIN: Yes.

KARI MAJORS: CyncHealth has a procurement policy in place in which we, every five to eight years, we re-evaluate our vendors based on fair processes. They can be competitive or non-competitive. There's various different tools that can be used, such as a request for information or a request for proposals. We do this as we are, we are listed in statute, named in statute, and so their procurement happens at our level through the statewide designated entity, and we use best practices in our policies to continue to bring-- to, to look at the, the vendors so that we can ensure that the-- in good faith that there's fair market value, and that we are keeping up with technology advancements and developments by, by revisiting the vendor contracts every five to eight years. And at least doing an evaluation of, of those technology systems against the technical requirements in conjunction with DHHS that are decided on, that are requested and required, and that fit within the financing model and, and the budget afforded to us through our state match, which, which also provides the federal match and, and our CMS applications that codify these, these projects and the financing for these projects and these vendors.

HARDIN: In addition to that, can you speak to the granular level of what kind of data do-- does Cync collect versus what kind of data overall? Do you guys collect more than just the drugs?

KARI MAJORS: We do.

HARDIN: Do you track other things?

KARI MAJORS: Yeah, so the Health Information Exchange aligns to the assistant secretary for technology and policy data standards. We adopt the data standards and include them in our specifications, and we work with hospitals to send data according to those federal data standards. Those data standards include clinical information on admit, discharge, transfer, labs, radiology, transcription notes, vaccines, et cetera, and we pair that with the medication history that we integrate into those clinical records to bring additional clinical relevancy with that integrated approach under a streamlined and, and seamless governance model that helps ensure that the data is only being accessed and used as appropriate, both from clinical users under HIPAA as well as through the state HIT board for uses of, of the Prescription Drug Monitoring Program data, and for access to that.

HARDIN: Some of this was mentioned a little bit earlier with, I believe, a, a vendor of Cync's on the IT side, but how does this affect the HIT board if, in fact, we change out an opportunity, like a situation where Cync has been here for a long time and someone else comes in. How does that affect the HIT?

KARI MAJORS: Sure. So currently, CyncHealth has one seat on the Health Information Technology Board, and we are required by state statute to administer the Health Information Technology Board. We do not have a contract in place with DHHS that, that requires us or pays us to do that administration. And so, that's one of the questions about the confusion that I, I noted in my testimony about this bill, is what is the management plan, then, for the state HIT board, the administration of that? Would that go to a private vendor, and it would be just for the PDMP only? And, and how would that look? That-- this bill is very unclear about how those changes would be made.

HARDIN: I'm a little unclear when it comes to transitioning a situation like this. If we were to replace you with someone else-- and Mr. Cassling mentioned before that that causes unintended consequences, because there are a whole lot of hospitals out there that have to go through a lot of transition. Does it affect, for those hospitals, I don't know, other softwares? Other APIs? Are there accounting plans? Are there other kinds of things that are, shall we say, baked in after so many years, that are dependent upon the information they're receiving from you? Is this-- is that part of the heartache--

KARI MAJORS: Yeah.

HARDIN: --that, that takes place for those hospitals? What is that like on the hospital end, as far as you know?

KARI MAJORS: Sure. On the hospital end, there's a couple of different approaches. We do a single sign-on, which, which gives them more seamless access through their EHR-- I think one of the testifiers talked about this-- as to-- you know, it passes login credentials, et cetera, so they can have more rapid access to, to the data sets. The-- with the, the PDMP integrated into health information exchange, it allows that to all happen in one workflow versus having-- versus hospitals and providers in those hospitals having to go out to the website, log into a platform, go through multi-factor authentications with numerous different platforms where there's siloed data systems that aren't integrated, and log into those systems in the small time frame that they have to obtain the information that they're looking for. So, we are constantly trying to work with systems and hospitals to integrate further through seamless-- more seamless access, so that they can stay within their workflow and continue to access all of the information within their EHR. There are a few ways that that happens through single sign-on currently, and in the future, there's additional functionality that will actually push data directly into the electronic health records. Today, that has limited possibilities due to configurations on the electronic health record side. And so, industry-- from the industry standpoint, everybody is working towards advancing to those additional-- what we would call pushing the data out versus providers having to go log into systems and query the data. And so, we've solved for a portion of that by integrating the PDMP with the HIE so that they can get all of that data through a single login or, or single sign-on through their EHR, and we are working towards more advanced innovation of actually just pushing the data directly back into their EHR so they only do a single query within their electronic health record when you're in front of them and all of the data is populated within the EHR workflow.

HARDIN: Thank you.

KARI MAJORS: You're welcome.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair. Would it be safe to say that CyncHealth is essentially the gatekeeper, identifying and hiring vendors to provide reporting uniformity for the PDMP and the HIE?

KARI MAJORS: So, we are part of the public-private partnership model with DHHS. We have shared accountabilities, we have shared decision-making. This all happens through our, our funding model and the applications that we request for infrastructure support through CMS, as well as projects and identified and prioritized use cases that we work on with DHHS to help reuse the data in the systems and drive more value by looking at different use cases in which the data can be used and accessed, whether that be through various different divisions at DHHS, providers in the hospitals, our payer partners that also utilize and access our data. So, none of the decisions we make are, are on our own; they are all through the public-private partnership and the public and private funding model, which requires involvement with us, DHHS, and CMS.

G. MEYER: According to your testimony, you put out bids among various vendors to, to provide technology within HHS. So essentially, you are the gatekeeper that vets and puts out bids for providers.

KARI MAJORS: We are. So, we jointly develop technical requirements that are needed for the systems, and in accordance and in alignment with the funding that is available to CyncHealth. So, you know, it's our, it's our stewardship and responsibility to work with the department to determine, you know, what can we afford? I mean, can-- we, we can't just go out and, and spend dollars, right, that we don't have; we have to stay within the parameters of the funding cycle of the biennium, as well as the funding cycle of those applications with CMS. And so, we try to align those procurements on a regular basis every five to eight years, and we continue to work towards, you know, fulfilling the technical requirements that, that make these systems work.

G. MEYER: Thank you.

KARI MAJORS: You're welcome.

HARDIN: It seems to me that the picture that's emerging for me is that comparing Nebraska's system to others is not an apples-

to-apples, but an apples-to-orangutans type of comparison. They're not the same. Would that be safe to say?

KARI MAJORS: I think if you're asking in context, are there other states that have nonprofits that are designated in statute that do similar convening and integrations, there are numerous other states-- Maryland, Arizona, Michigan-- that are, are classified as a state-designated entity, and they have those awarded contracts to operate as a state-designated entity. If you're asking about data, like, from a data perspective, Senator Hardin, the-- we are one of two states that have all medications that are reported in the Prescription Drug Monitoring Program. Maryland is the other state currently that has policy, and they are working on implementing moving from just controlled substances reported into their PDMP to all medications reported into the PDMP, and then integrating that with the HIE.

HARDIN: Bamboo's here, they're in 46 states. Put it in plain language for us: what do they do versus what you do?

KARI MAJORS: So, the, the fundamental, I think, differences and challenges right now, they, they are a PDMP vendor, as is Leap Orbit with RxGov, as is LogiCoy that you heard from as well. They are all vendors that offer these platforms, which is why we do procurement and evaluate every so often "are we getting the technical and functional requirements that meet the needs of the state?" and "are we getting that at a fair market value and a fair price for the state, and in alignment with what we can forward based on our funding model?" If we think about the two interstate data-sharing hubs that have been brought up today, the PMPI hub run by NAMB-- NABP, and the one from RxCheck, which is the RxCheck Hub. RxCheck Hub is federally-funded; it has been at the direction of DHHS to CyncHealth to continue to utilize the RxCheck Hub as the federally-funded model that has no cost for data-- interstate data sharing. That fits well within our financing model here in Nebraska. In addition, we have a few grants in Nebraska that are from the Bureau of Justice Assistance, which has required in the past, and is still strongly recommended, if you accept that funding, that you use the RxCheck Hub to conduct interstate data sharing. The PMPI Hub has not transparently provided costs, historically, to us in the state. We are unsure what the subscription model looks like, and also have plenty of evidence of gateway charges that have been charged to states that use their technology platform and then are charged additional fees, which they call gateway fees, in

order to access and utilize the interstate data-sharing platform.

HARDIN: Senator Hansen.

HANSEN: And this is more for clarity's sake. So, who determines-- I, I could guess, but I just want to make sure-- who determines which vendor to go through? You said you put it out for bid for vendors, we decided to go with Leap Orbit-- like, who determines that? Is that just the CyncHealth board, or is that [INAUDIBLE]?

KARI MAJORS: Yeah, so we, we evaluate it-- we evaluate them at CyncHealth, and then we have a discussion with DHHS. In regards to, like, with the recent PDMP, we looked at the, the scoring, you know, we asked for redacted copies and they said we'll make everything available to show that it was a fair competitive process, and we look at that. And in this case, we had two vendors that met the technical requirements and could serve the needs of Nebraska well, from a technical standpoint. One of them was double the cost, and we simply can't-- we, we simply couldn't go forward with that in joint decision with DHHS because of the funding positions that we're in, and attempting to control costs.

HANSEN: Does CyncHealth-- do you as an employer, like, hire or contract anybody as a consultation?

KARI MAJORS: No.

HANSEN: OK. CyncHealth, the board themselves make the decision? OK. Just making sure.

KARI MAJORS: Correct. Yep, CyncHealth. Yes.

HANSEN: And so, the, the qualific-- the technical qualifications that you're talking about, is that what I think Mr. Bell was talking about? The insurance association? The qualifications that have to be met for a vendor in order for you to hire them, per statute?

KARI MAJORS: I-- I'm not sure, in relation to his testimony.

HANSEN: OK, that's fine. OK. Just kind of curious, because-- I'm sure there's certain things, qualifications have to be met by a vendor in order for you to hire them--

KARI MAJORS: Absolutely.

HANSEN: --and I think some of that is in statute currently.

KARI MAJORS: As far as-- as far as-- to my knowledge, in any legal assessment we've done, we need everything that's required in the statute.

HANSEN: OK. All right. Thanks.

HARDIN: Other questions? Seeing none. Thank you.

KARI MAJORS: Thank you.

HARDIN: Opposition, LB949. Those in the neutral, LB949. Those named Senator Ballard. Welcome back. Online, we had 1 proponent, 3 opponents, zero in the neutral.

BALLARD: Thank you for having me back. I appreciate it. This has been a fun conversation, hasn't it? So, I'll tell you how, how I got here. So, 2023, I was a senator for maybe 30 days, 20 days. Newly-minted senator. And we had a, a budget deficit request from, from CyncHealth for \$8 million, and I was curious. I-- it struck me as odd. We had a lot more money back then, but it was, it was about \$7 or \$8 million, and it just flew through, and I didn't fully understand, so I started asking questions from providers, from hospitals, from insurance to agency, and, and everyone had mixed reviews. And so, I-- as I dug deeper, I started also working through some of the issues that Mr. Bell addressed with the constitutionality. It just struck me as odd from a, from a free-market capitalist's philosophy guy like myself, it just struck me odd that we enshrined a private company into statute. And so, it-- and so the more I dug into it, I wanted to do a little more research, and that's what brought us here today in 2026, 3 years later. But I, I do want to be clear that this has nothing to do with CyncHealth, and I made it very intentional not to, to include them in my opening. That's not what I want. They, they very well could be the best HIE, they very well could be-- have-- make the best procurement for PDMPs. That very well could be the case. We just don't know, because they are enshrined in statute. And so, that is what this

bill does: it focuses on the PDMP portion of the HIE, and that is the conversation I want to have today. You heard from pharmacists, and in my research, Nebraska is kind of an, an island in the middle of the, the country on-- this is one of the only systems that we outsource this program to a private company. And so, I'm still trying to wrap my head around the fragmented care portion of that. We haven't seen that fragmented care. We-- we've heard hypotheticals about potentially there could be some fragmented care, so I'm willing to do some research, willing to have conversations over the interim to make sure that doesn't happen. But also, I, I think you heard from the last testifier, that is exactly what we want. We want-- if the vendors are the highest bidder and they don't satisfy the needs of Nebraskans, they're not going to be Nebraska's vendor. And so, we are just taking what this currently happening from a private company with Nebraska tax dollars and transferring that to the Department of Health and Human Services, and that's all this bill does. Look forward to continuing conversations. I really appreciate Cync, in the last 2 years, 2 years to 18 months, really trying to reinvent themselves into focus on protecting patient data, continuity of care, and willing to be a partner in that in the foreseeable future. With that, I will be happy to take any questions.

HARDIN: Questions? Senator Hansen.

HANSEN: Thank you. I don't know-- and this is what I mentioned earlier-- if you would have to put anything in the bill that would specify interoperability or seamless transition, or any of that kind of stuff that was a concern among the people in opposition about effectively dismantling Nebraska's integrated and certified health information infrastructure. So, to prevent-- I don't know if you have to put that in statute, or you just say "vendor," you know what I mean?

BALLARD: Yes.

HANSEN: But, like, I think with-- to make sure these things happen, in order for them to happen seamlessly-- I don't know if that's something you've even thought about, or--

BALLARD: Yes, absolutely. And that's going to be-- I don't want to put that in statute. That is a-- that is a-- dis-- at the discretion of the Department of Health and Human Services, and that's all this bill does. This is a first step in just giving

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the Department of Health and Human Services that authority, and they make that determination on making sure we're not fragmenting care across the state.

HARDIN: OK. Other questions? Seeing none.

BALLARD: Thank you, Chair. Thank you, committee.

HARDIN: Thank you. This concludes LB949. We will be moving on to LR296. Senator Hallstrom. We'll wait, Senator Hallstrom, just a moment or two for the room to transition.

HALLSTROM: Chairman Hardin, members of the Health and Human Services Committee--

HARDIN: We'll be ready in just a moment, Senator Hallstrom.

HALLSTROM: Oh, OK.

HARDIN: I think we are ready.

HALLSTROM: Chairman Hardin, members of the Health and Human Services Committee, my name is Bob Hallstrom, B-o-b H-a-l-l-s-t-r-o-m, representing Legislative District 1, here today to present LR296 for your consideration. I do want the committee to know that this may be the first day that I finished Judiciary before another committee, and here I am at almost 5:00 waiting to finish up your day, so I'll try to be brief. LR296 recommends that the President of the United States and Congress change the Federal Child Care and Adult Food Program, which I will refer to as CACFP, to reimburse all participating family daycare homes at the same rate, or family child care homes as we know them in Nebraska. Family home programs, regardless of their location, share the goal of CACFP in promoting a healthy well-balanced diet and sustainable eating habits for our nation's youngest children. However, not all programs are treated the same. Reimbursements under CACFP prioritize children from lower-income households who may otherwise have limited access to a varied diet, relying instead on highly-processed foods. Family home programs located in a census tract with at least 50 percent of school children eligible for free or reduced lunch may receive the higher Tier 1 rate; family home programs in all other areas receive the lower Tier 2 rate, unless they can satisfy other eligibility criteria, regardless of their proximity to these, these, these zones or the populations they serve. I have

provided the committee with a table that shows the differences in reimbursement between Tier 1 and Tier 2 daycare homes for breakfast, lunch and supper, and snacks. The Federal Keep Kids Fed Act of 2022 rectified that difference prior to expiring in 2023. While it is no longer in effect, it provides us with the template that the federal government can implement to support all family home programs who carry out the mission of CACFP. The act reimbursed all participating family home programs at Tier 1 rates, and provided an additional reimbursement of ten cents per meal and supplement. This LR simply calls for the change to be made permanent. LR296 represents a commitment to moving the country toward a more sustainable and healthier future for all children, recognizing the vital role that family home programs play in that role. There are some testifiers behind me who can answer any technical questions you may have about CACFP's administration, as well as some family home programs who can share their experience with the committee on the issues with the two-tiered system. Among the witnesses is Taylor Furnas, who's from my hometown in Syracuse. She operates Taylor's Tiny Friends in Syracuse. I was pleased to have the opportunity to read *The Wonky Donkey* to her children that are under her, her care. If you have not heard of *The Wonky Donkey*, I commit it to you, to your reading pleasure. One of the things when I was campaigning, I came to the understanding that child care is vitally important, along with a, a, a number of other-- rural health care, rural workforce development, rural workforce housing. And one of the things that struck my eye and my ear was seeing and hearing about daycare programs and family daycare homes that are similarly situated. And my-- in my district, for example, my understanding is if you have a child care facility in Syracuse which is considered Tier 1-- or, Tier 2, the higher-income compared to Nebraska City, which is a Tier 1, that the differential of reimbursement is, as seen on the handout that I gave you-- even though those child care facility providers are providing the same meal, shopping presumably or potentially at the same grocery stores so they're paying the same cost for the groceries and yet being reimbursed significantly differently. And the legislative resolution that we have is not anything that's going to cost the state any money; it's just our indication, our recommendation, and our request of Congress to consider implementing the program that they had back during the, the days of COVID to provide for equal reimbursement, notwithstanding the differences that currently exist between Tier 1 and Tier 2 daycare homes. And if you look at the bill, we've got, I think, 36 co-sponsors, a nice bipartisan flavor to that. And I think the other issue, in case anyone is, is

interested or concerned about a pathway to getting something done this session-- I spoke with the Clerk of the Legislature; it's my understanding that the legislative resolution, if moved forward, would be set up on Day 59. It only has to go through one vote, and it will not take up any valuable time that we have since we'll be on Day 59, and presumably and hopefully we'll have an opportunity to vote on this quickly, and then formally make the recommendation to Congress to take action in accordance with the legislative resolution. So, I'd be happy to address any questions that you may have. I will just-- this is not a prop. Mr. Clark from First Five had showed me, had shared with me. If you see the green, green is the, the low income. So, you can see there are areas right next door to each other, some in the same communities. I think Scottsbluff, Gering might be an example.

HARDIN: How is it not a prop, again?

HALLSTROM: Where-- I just don't have enough copies.

HARDIN: Oh, I see.

HALLSTROM: Maybe Mr. Clark will, will--

HARDIN: We'll count that against Mr. Clark's time.

HALLSTROM: --get you copies. But it, it just shows that they're-- even within the same community in Omaha, you can have people right across the street from one another that are in the different tiers and so forth, so. I'd be happy to address any questions.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Senator Hallstrom, for being here, for bringing this LR. So, a bit of a process question. Certainly, it's one round of debate. So, what, what-- I should know this, but what happens if we pass this? Is this like a formal recommendation, then, from the Legislature? Does that get sent to--

HALLSTROM: Right, right. We, we would, we would send-- I-- I'd probably have to check out-- I would assume that we will have a separate letter that says that the Legislature has adopted LR296 and hereby provide you with a copy of that resolution, and go forth and do something productive.

FREDRICKSON: Understood. And then, my second question for you is, have you considered recording the audio book for Wonky Donkey? Because that could--

HALLSTROM: I have, I have listened to it. It's probably more riveting than, than my reading of the book.

FREDRICKSON: Understood. Thank you.

HARDIN: Senator Hansen.

HANSEN: So, you're assuming we're going to be towards the end of our session on Day 59, assuming we agree on a budget. So, hopefully by then, we'll be close to being done--

HALLSTROM: Well, if we have more day-- if we have more days, it gives us more time to do that. I'm not, I'm not promulgating that we ought to go that direction.

HANSEN: So, since I don't have a federal fiscal note in front of me, what will this cost the federal government if they end up doing this or implementing this?

HALLSTROM: I, I have not seen that fiscal note either. I can certainly check with First Five and see if they have any estimates on, on what the additional cost might be.

HANSEN: Yeah. Just out of pure curiosity. Thank you.

HALLSTROM: Yeah. I'll send that subliminal message to the back of the room.

HANSEN: There you go.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. My question gets to be, is how does this vary from a SNAP program?

HALLSTROM: Senator, I, I, I can't tell you how it varies, other than it's, it's income-based in terms of the current law providing a differential between the manner in which reimbursement for, for the food, for the, for the lunches and the snacks and the dinners are, are reimbursed, the rate that they're reimbursed at.

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RIEPE: OK. So, my understanding, SNAP is income-based as well. But is this limited to-- and I've just briefly looked at-- is this is limited to primary child care centers?

HALLSTROM: They're, they're, they're defined as family daycare homes. I would have to look and see what that specifically--

RIEPE: So, it doesn't apply to the school food programs, and--

HALLSTROM: I, I don't know whether that's the case. I'm sure one of the witnesses or Mr. Clark may be able to whisper to me before now and the closing, and my closing is the only thing between me getting to the Husker basketball game tonight, so I will be brief when we, when we get to that point.

RIEPE: Oh, we'll be kinder to you. Thank you. Thank you, Chairman.

HARDIN: Seeing no other questions, will you stick around?

HALLSTROM: I will stick around.

HARDIN: Wonderful.

HALLSTROM: Thank you.

HARDIN: Proponents for this legislative regi-- resolution. Welcome.

CARRIE SULLIVAN: Thank you. Good afternoon, Chairman Hardin, and members of the Health and Human Services Committee. Thank you for the opportunity today to testify. My name is Carrie Sullivan, C-a-r-r-i-e S-u-l-l-i-v-a-n, and I am the executive director for Providers Network, and we are one of the federal food program sponsors of in-home providers here in Nebraska. I'm here today to speak in support of LR296. I want to briefly explain how sponsorship works, who we serve, and why this program is essential to family child care homes across Nebraska. In Nebraska, CACFP home sponsors handle the administrative work, enrolling providers, training them, monitoring for compliance, and processing claims so home-based providers can focus on feeding children. Nebraska has four sponsors covering both urban and rural areas. CACFP is highly regulated; providers must follow USDA meal patterns, keep daily records, complete annual training, and allow unannounced visits. Sponsors support them

with technical assistance, monitoring visits, and strict internal controls, and we are audited biannually by the Nebraska Department of Education. This structure ensures strong oversight and high-quality meals for children statewide. Providers are classified as Tier 1 or Tier 2, based on eligibility rules. Tier 1 providers receive the higher reimbursement, while Tier 2 providers, often in rural communities, receive 52.2 percent less for serving the exact same meals and following the same state and federal requirements. This has created a long-standing imbalance for many of our rural areas. In fiscal year 2024-25, Nebraska had 1,594 licensed family child care homes. Of those on CACFP, 943 were Tier 1 and 284 were Tier 2. Another 367 licensed homes were not participating at all. Many of them left the program when the COVID-era waiver expired that had temporarily reimbursed all providers at the Tier 1 rate. When that ended, many Tier 2 providers felt penalized simply for where they lived. A family child care home can qualify for Tier 1 in three ways: by being in a school district or census-eligible area where at least 50 percent of the children qualify for free or reduced price meals; by meeting provider household income guidelines; or by serving a family who meets those guidelines. School or census eligibility lasts for five years, while provider and family income eligibility must be renewed annually. In closing, family child care homes are vital to Nebraska's child care system, especially in our rural communities. CACFP ensures children receive nutritious meals every day, and strong sponsorship makes that possible. As you consider LR296, I urge you to support policies that strengthen provider participation by leveling the playing field within the tiered reimbursement structure. Thank you for your time, and I'm happy to answer any questions.

HARDIN: Thank you. Senator Quick.

QUICK: Yeah, thank you, Chairman. Do you know, like-- well, like, in Grand Island, we have a bigger facility like YWCA. They might have kids from all different areas of our community. How does that work? Or can they even qualify for the--

CARRIE SULLIVAN: So, centers are a little bit different than home providers--

QUICK: OK.

CARRIE SULLIVAN: --and we work with just home providers. Centers usually will sponsor themselves, and they have to qualify by family income. And then those-- it's my understanding they have to meet that 50 percent eligibility for that center to qualify them to participate in CACFP. So, not all centers qualify. Like, in my hometown of Sutton, there is a center there, but because they are in a Tier 2 area and the families that they serve do not qualify by income, they are unable to participate in CACFP. So, centers are structured differently than, than homes.

QUICK: OK. All right. Thank you.

HARDIN: Other questions? Seeing none. Thank you.

CARRIE SULLIVAN: Yeah, thank you.

HARDIN: Proponents, LR296. Welcome.

TAYLOR FURNAS: Good afternoon, Chairman Hardin, and members of the Health and Human Services Committee. Thank you for the opportunity to testify today. My name is Taylor Furnas, T-a-y-l-o-r F-u-r-n-a-s, and I'm the Wonky Donkey guest speaker. I'm the owner of Taylor's Tiny Friends LLC in Syracuse, and I'm here to encourage you support LR296. I want to thank Senator Hallstrom for his support of this issue. As a dedicated child care provider, I know the importance of whole balanced meals, but I also know that my food budget no longer covers a week's worth of non-processed and healthy foods. I want to briefly share why this issue is important for Nebraska families and the child care workforce. As a provider who participates in the child and adult food-- or care food program, or CFCAP-- CACFP, I am required to serve milk, fruit, preferably fresh, and a grain or meat for breakfast. My total reimbursement for that meal is 62 cents. I would also like to add that I have to drive to a Tier 1 area to get my groceries, as my town only has a very small grocery store with a very small selection, or a Dollar General with no produce and a very limited selection. Tier 1 providers receive \$1.70 for that same breakfast served. That means there's \$1.08 difference for breakfast, \$1.28 for lunch, and \$0.66 for snack between Tier 1 and Tier 2. For better reference, this is a daily difference of \$3.02 per kid in reimbursements. This experience has given me first insight-- first-hand insight into how inadequate tiering affects children, families, and providers across Nebraska. I'd like to share two key-- or, two important issues with you today. Nebraska is already in a child care desert, and now we are

seeing providers dry up-- jumping off the CACFP program, or even worse, closing their door because the business math just isn't working in today's economy. Throughout my research, I talked to providers from all over the state who struggle with the Tier 1 and Tier 2 system. Some are sharing that they are having to serve smaller portions, take from their own family's grocery budget, or simply not eat themselves so that they can give that food to the children. Secondly, we know that child care costs are already too expensive, but we as providers make little to no profit. All the child care spots in my program are full, and last year, my child care made \$42,000. After groceries, curriculum, house revamps to stay within requirements for DHHS, licensing fees, and everything else that comes with running a child care business, I was left with under \$2,000 dollars. The passing of LR296 will not fix this, but it will be a much-needed support to sustain my quality program that the state of Nebraska so strongly encourages. I'm hopeful this change will keep providers from jumping off the food program, have less financial burdens, and all children will have access to healthy meals. Based on this, I respectfully urge the committee to support LR296.

HARDIN: Thank you. Questions? Senator Quick.

QUICK: Yeah, thank you, Chairman. Do you know, like, how many of the kids that come there, maybe the parents use a child care subsidy like TANF funds to help assist with their daycare?

TAYLOR FURNAS: So, like, in my program, I don't have any subsidy children currently.

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

HARDIN: Seeing no other questions, thank you.

TAYLOR FURNAS: Perfect. Thank you.

HARDIN: Proponents, LR296. Welcome.

ERIKA FELT: Hello. Good afternoon, Chairman Hardin-- short seat. Members of the Health and Human Services Committee. My name is Miss Erika Felt, E-r-i-k-a F-e-l-t. I want to thank you for this opportunity to testify today, and thanks to Senator Hallstrom for introducing this resolution. I am a child care provider of over 24 years with a licensed in-home program serving Omaha

families. I lead Nebraska Providers' Spot, which is a resource-- a statewide resource and support group for in-home child care business owners as well. As-- I am here to testify speak to support of LR296. I would like to note I submitted a comment online, and after, was asked to testify. This testimony will serve as my official position for the record. I didn't know any better. So, I'd like to share why LR296 matters for Nebraska families and the child care workforce. Early in my participation with the Midwest Child Care Association, which is a CACFP sponsor organization, the one that brought it to Nebraska in 1980 for in-home child care providers, I learned real quickly that clear documentation and compliance are central to the program. I also learned shortly afterwards an example of why. I had a family come to interview with me whose child was being served a bowl of popcorn and a red drink every day for lunch at the program they were leaving. They thought the child was just saying what they wanted to have because children will say-- and then they did a drop-in visit, and all the children were lined up in front of the television. The choking hazards, lack of nutrition, developmental risks that come with that kind of diet are exactly why this program exists, and why equitable, equitable access to it matters. The two-tiered reimbursement system was built on the assumption that providers in higher-income areas can absorb the additional cost of compliant meals, but that simply isn't true. All licensed in-home child cares must adhere to CACFP meal rules whether they're enrolled or not; it is part of licensing regulations. Yet, Tier 2 providers receive far less support to meet those same standards. Consider this. Mary, a Tier 2 provider, all right? On the edge of-- on the edge of town, edge of the city. She drives 35 minutes for groceries and receives about \$247 per month for 10 children that she's been feeding. Terry, a Tier One provider, drives about seven minutes to get the same groceries, same cost, and receives around \$660 for eight children. That's still not enough. It's a partial reimbursement. Neither can raise their rates to cover the difference, so Mary makes the only sensible business decision: she drops the food program. Her family's already stretched to afford child care, must now either send meals from home, or Mary offers lower-quality food to get by, like popcorn and red drink. CACFP has taught me how to provide balanced nutrition meals, and gives me opportunities to learn how to share those-- that information with families, young families that are just learning. Healthy food is costly in every zip code. The tiered system puts providers and children at a disadvantage based solely on geography and not need. I respectfully urge this committee to support LR296. It would help

stabilize quality child care, support healthy childhood development, and better serve the working families who are Nebraska's backbone. I thank you for your time and service to Nebraskans, and I'm happy to answer any questions that I can.

HARDIN: Questions? Seeing none, thank you.

ERIKA FELT: Uh-huh. Thank you for your time.

HARDIN: Proponents, LR296.

MITCHELL CLARK: Hopefully we remain compliant with the no-prop policy. I brought some handouts that will hopefully satisfy that policy.

HARDIN: Good. Those are fine. Thank you.

MITCHELL CLARK: All right. Good evening, Chairman Hardin, and members of the Health and Human Services Committee. Thank you for the opportunity to testify today. My name is Mitchell Clark, M-i-t-c-h-e-l-l C-l-a-r-k, and I am a policy advisor at First Five Nebraska. We are a statewide public policy organization committed to the early care, education, and healthy development of Nebraska's youngest children. I am here in support of LR296, and want to thank Senator Hallstrom for spearheading this effort. And in interests of time, and so that I do not get in the way of dinner and/or a basketball game, I am not keen to remain in the way for that. But I just wanted to highlight a couple of things and maybe address a couple questions that came up earlier. So, you've, you've heard from providers about the importance of high-quality nutrition and the role CACFP plays, as well as in family home programs in Nebraska. You've heard about the two-tier system and the reimbursement rates, the differences between those. I just wanted to highlight kind of what you've heard is the proximity of some of these, as these maps will show you. I picked a, a couple of, of areas as an example. This comes from the USDA's Area Eligibility Mapper. So, one is in Omaha that covers portions of Senator Juarez's district and just a sliver of Senator Riepe's district in eastern Ralston; that shows-- those little red dots show you in-home programs that exist, and the green which would be Tier 1 eligible, and the gray area and Tier 2 eligible. And you can see that they're in very close proximity. They're oftentimes serving the same populations, oftentimes lower-income families who may not have access to high quality nutrition. I've also picked

something from western Nebraska. So, this is probably a little more familiar to Senator Hardin. That shows the Scottsbluff-Gering and Terrytown area. Most of those programs are in the Tier 2 areas, and-- as well as Alliance, those-- there's actually a couple of providers there. One is eligible for Tier 1, one is not. And so, you can see that even in that close proximity and serving those populations, kind of an unequal playing field. So, that's what this LR calls for, for Congress to address, is to reimburse all at Tier 1. This is, this is not a big moneymaker, but this is something that can help those programs provide that, that quality nutrition. And kind of what you've heard from, especially from Erika earlier, is this trade-off that programs have to consider. So, do I charge higher tuition for families, or do I absorb those costs? And what that means is that you get either the higher cost for families, or more pressure on programs participating in CACFP at all. So, with that, I will close my testimony, and just real quick address a couple of those questions. Senator Hansen asked about the federal fiscal note. We did look into this when we were drafting the LR. We were unable to obtain that. The USDA website was down at the time of drafting, and there's been limited information on the public side of things for specifically the daycare homes. But we will look into that and we will find what the daycare home-specific portion will be-- would be, as well as Nebraska. And then I know Senator Riepe had asked a question about family child care homes. This, this LR is calling for a change to the federal law just for family child care homes. The CACF program does include some other types of programs, but this is just specifically to in-home programs.

RIEPE: OK.

MITCHELL CLARK: And then I can also do some additional follow-up on SNAP. I'm not exactly the expert on SNAP, but I can get you some more information on that. So, with that, I'll close, and would be happy to take any questions.

HARDIN: So, since I know that you used to be in LA for a former chair of the Appropriations Committee, what happens if federal reimbursement ends on this type of thing? What happens then?

MITCHELL CLARK: For all?

HARDIN: Yeah.

MITCHELL CLARK: You would-- like I, like I had mentioned with the trade-off, you would see probably a more intense version of that trade-off. Is-- relying on lower-quality foods, raising tuition rates when they can, and probably more pressure on providers to even be in operation at all.

HARDIN: How many types of family daycare homes do we have in Nebraska?

MITCHELL CLARK: How many type?

HARDIN: How many type. So, we got-- we've got a two-priced-- a tiered-- a two-tiered system here. And is there, is there a way to have more kids, less kids within the, the home system in Nebraska?

MITCHELL CLARK: Well, what you'd be talking about would be a, a change in licensing. Yeah. Yeah.

HARDIN: OK. And can you spell that out for us, in terms of what that change of licensing--

MITCHELL CLARK: Sure.

HARDIN: How many numbers are those and so forth?

MITCHELL CLARK: Yeah. Yeah. So currently, family child care home 1 can care for up to 8 children with an additional 2 school children; family child care home 2 can care for up to 12. So, it's-- with an additional staff. So, you're talking about a difference of 2 more children for family child care home 2.

HARDIN: OK. This does say child/adult food programs, and so this would also equally apply to, like, adult programs?

MITCHELL CLARK: The change asked for in the LR would not apply to the adult care programs.

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

MITCHELL CLARK: All right. Thank you.

HARDIN: Proponents, LR296. Opponents. Those in the neutral? Senator Hallstrom, how can we get you to tip-off?

HALLSTROM: You can find a way to make me be brief at the end here. I do appreciate you sticking around, and your patience in listening to the story that we had to, to tell today. I think one of the things, Senator Hardin, that your, your question about the differentiation and the new licensing requirements is - and obviously, having to keep in mind the safety and the ability to care for children. But when you look at the logistics of perhaps having to have one more staff person and only being able to expand to two more children, from a, from a profit perspective, that doesn't necessarily make a lot of sense. So, we get bootstrapped into a situation where if we could afford to care for more children on a profitable fashion, that would address some of the shortages that we have in terms of the supply-and-demand issues that exist across the state.

HARDIN: OK.

HALLSTROM: Thank you very much.

HARDIN: Questions? Seeing none. Thank you.

HALLSTROM: Thank you.

HARDIN: And this concludes LR296, and our hearings for today.