FREDRICKSON: All right. Welcome to the Health and Human Services Committee. I am Senator John Fredrickson. I represent District 20, and I serve as vice chair of the committee. The committee today will take up bills in the order posted. This public hearing today is your opportunity to be part of the legislative process and to express your position on the proposed legislation before us. If you are planning to testify today, please fill out one of the green testifier sheets that are on the table at the back of the room. Please be sure to print clearly and fill it out completely. Please move to the front row to be ready to testify. When it is your turn to come forward, give the testifier sheet to the page. 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 will begin each bill hearing today with the introducer's opening statement, followed by proponents, opponents, and finally anyone speaking in the neutral capacity. We will finish with a closing statement by the introducer should they wish to give one. We will 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 is-- this has nothing to do with the importance of the bills being heard. It is just part of the process, as senators may have bills to introduce in other committees. A few final items to facilitate today's hearing. If you have handouts or copies of your testimony, please bring up at least 12 copies and give them to the page. Please note that thumb drives, CDs, DVDs, oversized documents, books, lists of signatures, and similar items will not be accepted as exhibits for the record. Props, charts, or other visual aids cannot be used simply because they cannot be transcribed. Please silence or turn off your cell phones. Verbal outbursts or applause are not permitted in the hearing room. Such behavior may cause for you to be asked to leave the hearing. I will now have committee members with us today introduce themselves, starting with my le-- on my left.

RIEPE: Welcome. I'm Merv Riepe. I represent District 10-- or, 12-- close-- to-- which is Omaha, Millard, and the good, little town of Ralston. Thank you, Chairman.

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

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

QUICK: Dan Quick, District 35: Grand Island.

FREDRICKSON: Also assisting our committee today: to my left is our committee legal counsel, John Duggar; and our committee clerk on the far left is Barb Dorn. Our pages for the committee today are--

SYDNEY COCHRAN: Hi. I'm Sydney, and I'm studying history at UNL.

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

FREDRICKSON: Excellent. And with that-- so pursuant to Nebraska Revised Statute Section 81-604, the Department of Health and Human Services is required to notify the chairperson and members of the HHS Committee prior to submitting a demonstration project waiver under Section 1115 of the Social Security Act to CMS. Subsequently, the Health and Human Services Committee is required to hold a public hearing on such waiver application during the period for public comment. Today's hearing for an 1115 waiver on retroactive eligi-- is a, is a hearing-- today's hearing is for an 1115 waiver on retroactive eligibility. With that, we will open with the department to explain more about this waiv-- waiver. Mr. Meals, welcome.

JOHN MEALS: Good afternoon, Chairman Fredrickson and members of the Health and Human Services 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. Today's hearing is pursuant to Nebraska Revised Statute 81-604, requiring the department to inform this committee about our intent to submit an 1115 demonstration waiver amendment to the Center for Medicare and Medicaid Services. The department is currently in the process of submitting this waiver to enact changes related to retroactive eligibility rules for the medical assistance program. Current federal law requires states to provide three months of retroactive eligibility for Medicaid if an individual would have been eligible during that period of time. In 2027, this rule will change to one month for Medicaid expansion population and two months for all other populations under H.R. 1. With this waiver, DHHS seeks to promote timely Medicaid enrollment and program sustainability. In particular, individuals will be encouraged to apply for Medicaid immediately whether or not they have an immediate need for care, which will promote continuity of coverage. Medicaid will

align better with the commercial market, which does not have retroactive eligibility, making individuals more prepared should they transition to commercial coverage in the future. The change to retroactive eligibility will also encourage providers to work with individuals to complete Medicaid applications in a timely manner. We are currently in the public comment period. And after this period ends, we plan to submit the waiver for approval with an anticipated effective date of October 1, 2026. Thank you for your time. I'd be happy to answer any questions.

FREDRICKSON: Thank you for your testimony. Do we have questions from the committee? Senator Riepe.

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

JOHN MEALS: Mm-hmm. Yes, sir.

RIEPE: Is it fair to say that this is fundamentally the state stepping aside and the providers then fundamentally have to pick up any-- I'll call it bad debt or any financial difference? That's particularly painful when you have a high percentage of Medicaid or-- particularly in a children's hospital where you have a lot of newborn infants that are-- can be there for a very-- extended period of time.

JOHN MEALS: Sure.

RIEPE: I'm trying to square that in my head that says-- that doesn't seem fair that the state abdicates or-- on its, on its responsibility only to give it to the, to the providers as such.

JOHN MEALS: Sure. So I'll, I'll explain it this way. So it, it-- to be clear on the financial impact of, of the waiver. So when-- whether it's in our-- you know, the bill that we talked about on Wednesday, LB777, or in our budget recommendation-- or, request that's in the Governor's recommendation, the financial impact covers any claims that fall outside of that month of application, right? So right now, the month of application is covered plus month one, two, and three prior to the month of application, right? So if you apply today on February 27, this entire month would be covered plus January, December, and November. OK?

RIEPE: And that's guaranteed.

JOHN MEALS: That's gua-- that's, that's what is in, in law right now.

RIEPE: OK.

JOHN MEALS: Right? So we-- so, like, the example would be if someone came in, you know, had an episode, went to the hospital, did not sign up for Medicaid, went home. Two months later, they had another episode, you know, and then came back to the hospital, that time they did sign up for Medicaid, then retro would say, well, if you were eligible two months ago, because it's within that three-month period, we'll cover both the current expense plus the one that happened two months ago, right, because it's within that three-month period. So what the, what the fiscal impact of our budget recommendation said was anything prior to that month of application obviously wouldn't be covered, so that would result in a budget reduction. What is difficult for the department to kind of quantify in this is-- and, and part of the-- like when I say we, we are going to promote Medicaid enrollment and it, it encourages providers to work with individuals in a timely manner, it creates kind of a financial incentive for timely-- and, and for hospitals to be more thorough in their-- you know, helping people become Medicaid eligible and, and complete those applications because, to your point, the majority of this cost, it-- it's, it's not going to fall to the individual. The majority of it's going to become charity care for the hospitals. So they have a-- an incentive to, you know, help individuals become Medicaid eligible and, and process those applications timely. To your point, yes, if, if those three months are cut off, then the vast majority of that cost is shifted to hospitals. This-- you know, going to a zero retro eligibility or just the month of application and eliminating those three months really creates a, a financial incentive for hospitals to focus on anytime someone comes in their door to make sure they have the conversation about Medicaid eligibility and, and ensuring that they complete their Medicaid applications in a timely manner.

RIEPE: I-- you know hospitals are just judged partially for asking about financial before they ask about what's your symptoms.

JOHN MEALS: Right.

RIEPE: So it-- and I'm-- and my experience is, is-- you know, negotiating with managed care organization's not-- is not a productive meeting either, so.

JOHN MEALS: So the one thing I would say with this is the-- I, I think I mentioned this the, the other day on Wednesday-- the department is happy to work with hospitals. And whether that means embedding, you

know, HHS employees in hospitals to help with Medicaid eligibility, providing training for, for the hospital employees that, that work through this, working with hospitals on a presumptive eligibility process, because I know-- I think, Senator Fredrickson, you had brought up the point of, like, if someone come in today on February 27, you know, even-- I think it was the gentleman from CHI that had mentioned the vast majority of theirs are done in 48 hours. But if they came in today, they may not get done by the end of tomorrow. And so then, you know, these couple days may not be covered. There is a process for presumptive eligibility that we can work with hospitals on to where if they come in, you know, these last couple days of the month that we could have that covered. There's also-- I mean, things that internally the department is looking at as part of the 1115 waiver that-- we could write in an exception process that says, if someone shows up on the last day, second-- you know, two days, three days of the month, there's a presumptive eligibility component to make sure that-- you know, if-- this issue of spanning those last couple days of the month is a nonissue and, and we make sure that it's covered under the 1115 waiver. So we can write that type of exception in, and that's something that we are internally working through.

RIEPE: I've also heard that-- some testifiers say, well, the hospital has its community report. Well, that's just reporting it under obligation. Does-- that doesn't mean any money at all.

JOHN MEALS: Sure.

RIEPE: That just means you've given up on collecting it.

JOHN MEALS: Yes.

RIEPE: And fact is some of the rules are so strict. If you even try to collect it, then you no-- it doesn't qualify for the community report, so. I-- you know, I have serious concerns. But thank you very much. You-- you're always good to work with. Thank you. Thank you, Chairman.

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

G. MEYER: Thank you, Vice Chair. Good to see you, Mr. Meals.

JOHN MEALS: Yes, sir.

G. MEYER: If-- let's say I qualify for Medicaid benefits. I go to a clinic, you know, that paperwork's all done. I have a medical

emergency, I'm in the emergency room. Does that-- is there a continuity with that paperwork? Do they automatically know that I am a Medicaid patient?

JOHN MEALS: Once you're enrolled in Medicaid--

G. MEYER: If I'm enrolled-- if I'm, if I'm receiving Medicaid benefits in a clinic setting. I end up having an episode of some type and I end up in the emergency room, does that paperwork-- is there-- is that-- does-- is there continuity with regard to being signed up for Medicaid?

JOHN MEALS: My understanding is yes. I mean, there, there would be. I mean, I can get-- I, I can get from our team the specifics of how that goes from a clinic to, like, the health information exchange platform that, like, CyncHealth runs for us or the, like, [INAUDIBLE], like, the other, you know, health information exchange platforms. I don't know the detail of how that goes from a clinic to a hospital, but my understanding is-- I mean, once they are deemed eligible, that-- paperwork is not going to stop, you-- or create an issue with continuity of coverage. It would-- I, I don't know the details of how those platforms share that information, but my understanding is it is shared.

G. MEYER: Put it through the HIE or whatever.

JOHN MEALS: Yes.

G. MEYER: Once you're in the system, you should show up in the system--

JOHN MEALS: Correct.

G. MEYER: --if, if the computers [INAUDIBLE].

JOHN MEALS: That's my understanding.

G. MEYER: OK. Thank you.

JOHN MEALS: Mm-hmm.

FREDRICKSON: Other questions? Senator Quick.

QUICK: Yeah. Yeah. Thank you, Vice Chairman. And I'm sure this has probably been all, all within your explanation and probably talking

about the bill, but I guess what is the reason for requiring more than what the federal government's going to require?

JOHN MEALS: So-- again-- I mean, I, I referenced it a little bit, but we're looking at-- like, in the-- towards the end of my-- the-- original testimony, we talk about it, it promotes and kind of creates a financial incentive for hospitals to put a greater focus on, you know, ensuring that everyone comes through the door, signs up for Medicaid. Now, I know you can't force someone to sign up for Medicaid, right, so there's always going to be that component. But putting a greater focus on it will help people in their continuity of coverage going forward. And-- I mean, not only de-- will the department continue to kind of advertise for this, but hospitals would as well because they would have a financial incentive to do so, trying to get people signed up prior to when they have a, a medical emergency. So we're not in the position to where someone is, is trying to fill out a Medicaid application while they're in the middle of dealing with, you know, what are some of the most difficult, you know, parts of their life, so.

QUICK: OK. Well, along those lines, how, how are you-- I mean, nobody knows when a medical, medical emergency's gonna happen. So how are the-- I don't know if you were putting it this way, but how do hospitals and clinics go out [INAUDIBLE] and tell people to sign up for Medicaid before the fact?

JOHN MEALS: The same way that we advertise for it. I mean, anytime that they're-- I mean, promotional material. I mean, it, it, it would be up to them how they'd promote it. And I'm not saying that they have to advertise for our program. But again, this-- you know, going to the-- only the month of application, by not covering those prior months, it creates that financial incentive for hospitals to help the department promote Medicaid however they are able to. Like, I'm not going to tell them how to advertise. And I don't know how specifically they would do that, but it would behoove them to, you know, advertise for Medicaid however they are able to. I mean, even if it's people coming in for regular checkups or if it's something that is more minor, like not necessar-- maybe they come in for a-- you know, something that is a more minor issue that wouldn't have a huge cost that they help them get coverage versus, you know, something that is a, a, a major incident.

QUICK: OK. So-- just one more question. Sorry. But-- so that's more or less like we're-- the state-- we're gonna put an unfunded mandate down

to-- because they're gonna spend dollars to try to help with that. So now we're putting another unfunded mandate down to them. And they're already strapped for money. And we're gonna ask them to do this work besides the work they do for caring for--

JOHN MEALS: So-- I mean, I guess-- I mean, the answer for that is-- I mean, I would go back to the hospital assessment. Again-- I mean, the state is pouring in $950 million of revenue into hospital systems statewide. I get that there are some individual hospitals that it depends on the Medicaid payer mix, right, their-- the actual benefit from the hospital assessment. But when you look statewide, you know, there's gonna be an injection of over $900 million into the hospital systems in the state. Separately, I would say, in, in this biennium, in '26 and '27, because we're actually backdating a year, they're getting three years' worth of the assessment in two. So they're actually gonna get about $1.4 billion this year and again next year in '27 before reverting to the $900 million per year. So-- I, I mean, there's so much excess revenue that-- again, this is statewide. There's individual hospitals that this may affect differently, but statewide, like, no one, no one is really going to qualify for DSH anymore, which is the disproportionate share. It's a federal program that basically makes hospitals whole if they, if they, you know, provide care to uninsured or to Medicaid patients. And the numbers that we have from our actuaries say that hospitals-- again, aggregates statewide-- will have to share roughly $500 million worth of charity care in order to requalify for DSH. So-- I mean, even if the max, you know, that we have in this fiscal impact, which is about $13 million, even if that max is-- you know, becomes charity care, it's a fraction of what they're receiving through the hospital assessment.

QUICK: All right. Thank you.

JOHN MEALS: Mm-hmm.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair Hardin. I almost called you vice chair. Apologize for that.

HARDIN: That's OK.

G. MEYER: As I understand it, this automatically goes into effect January 1 of 2027.

JOHN MEALS: The, the H.R. 1 mandates, yes. The-- so it'd be one month for those in Medicaid expansion population--

G. MEYER: Then two months--

JOHN MEALS: --two months for everyone else. Correct.

G. MEYER: For all of those?

JOHN MEALS: Yes.

G. MEYER: Which is what our, our waiver's asking for.

JOHN MEALS: Our waiver is ask-- asking to go to, to zero, basically. So, so in H.R. 1, they would still have the month of application plus one month for the expansion population and then the month of application plus two months for everyone else.

G. MEYER: We're just asking for--

JOHN MEALS: The month of application. Correct.

G. MEYER: I, I understood that first-- in previous conversations we had, but I wanted clarification.

JOHN MEALS: Yup.

G. MEYER: Reading through the testimony, I, I, I misunderstood that just a little bit. Thank you. I appreciate that.

HARDIN: Senator Ballard.

BALLARD: Thank you, Chair. Thank you, Mr. Meal, from-- Mr. Meals, for being here. I appreciate it. So you talked about the financial incentive for hospitals. What are the-- what are the co-- projected cost savings for, for the state, for taxpayers?

JOHN MEALS: Yep. So if it goes to the zero, it's about $24 million in, in total share for a full year. So this first year in '27, because it starts in October, it is three-fourths of a year, that's about $18 million in total funds. The General Fund portion of that is about-- let me see. That would be about $6.5 million on an annual basis.

BALLARD: From General Fund savings?

JOHN MEALS: Yes.

BALLARD: OK. So the other half is, is federal. OK.

JOHN MEALS: Correct.

BALLARD: And that's just the hope that-- not the hope-- I shouldn't say it like that. That's the projection that the individuals are going to [INAUDIBLE].

JOHN MEALS: Correct.

BALLARD: OK.

JOHN MEALS: And, and again, I, I made the-- kind of made the point earlier, but to make it clear here: if hospitals-- you know, when I talk about the financial incentive, because that would-- this is the number that would basically become charity care-- if they work faster or are more thorough and get people signed up for Medicaid, you know, on a faster basis, let's say, that number would obviously be reduced, because this just assumes right now anything outside of that month of application one, two, and three, those, those three months, that all basically just wouldn't be covered anymore. If hospitals create a greater emphasis on getting people signed up faster, then there may not be as much in months one, two, and three because they're all happening within that month of application. Does that make sense?

BALLARD: That makes sense.

JOHN MEALS: OK.

BALLARD: OK. And I just had a quick clar-- car-- clarification on your testimony about-- individuals are more prepared to enter commercial coverage in the future. Can you explain a little about what you mean?

JOHN MEALS: The commercial market doesn't have any retro elig-- ac-- active coverage, right?

BALLARD: I see.

JOHN MEALS: So-- I mean, that's-- this basically mirrors what the commercial market does.

BALLARD: OK. I appreciate that. Thank you.

JOHN MEALS: Mm-hmm.

JOHN MEALS: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Director Meals, for, for being here. It's good to see you again this week. So I know we had a little bit of a conversation on LB777, which is kind of-- somewhat related to this-- or, very much related to this. So is, is-- my, my read so far is that the, the-- kind of the driving factor behind this for the state is, is, is fiscal. Is that-- am I reading that correctly?

JOHN MEALS: That's-- that is part of the driver. I mean-- yes. It is a-- it is a savings for taxpayers. But also to-- I mean, what Senator Ballard just brought up. It does prepare individuals for if they were to transition to the private market. And it-- again, it creates that incentive for hospitals to put a greater focus on getting people signed up for Medicaid and to do it timely.

FREDRICKSON: OK. Is there any other driving reason why this is in the best interest of the state?

JOHN MEALS: Not beyond what we've talked through and, and-- I mean, in these questions thus far, I don't think.

FREDRICKSON: OK. And so kind of-- I've-- the-- I know there's not a fiscal note on, on this hearing, but I've-- I'm just kind of looking at the fiscal note from LB777, which I think would be-- I don't know-- I, I-- but don't know if you would agree, but that seems to be-- would be accurate for, for this as well. So you, you-- obviously with Medicaid, you-- there's some state expenditure and then federal expenditure. It looks like we're looking at, you know, fiscal year '26-27, $13.3 million total when you add federal and state. '27-28, $14.8 million total. So that's, that's revenue that's not going to be-- help me understand that a bit more.

JOHN MEALS: So, so the di-- the difference in what, in what was in that fiscal note and what we're talking about here is that fiscal note represents the difference between going from, you know, zero retro el-- eligibility to just the one month and two month, right?

FREDRICKSON: So H.R. 1.

JOHN MEALS: H.R. 1. Correct. So if, if we weren't allowed to-- like, like, if, if LB777 were to pass and we were forced [INAUDIBLE] H.R. 1, we would pro-- pro-- project to spe-- to spend about $14 million more than, you know, what we would if we could go back to zero retro starting October 1. Does that make sense?

FREDRICKSON: It, it, it does. And, and so-- and, and so they-- the-- would that be a fair projection for whether that's hospitals or providers? Like, that's statewide what they would have to absorb?

JOHN MEALS: Correct. And so that-- when I talk about the financial incentive, the vast majority of this-- I mean, our assumption is that the vast majority does not become a bill for the person walking through the door receiving the care. The majority of that is going to become uncompensated care-- charity care for the hospital. So again, I know I've said it several times, but that's basically the financial incentive for hospitals to focus on getting people signed up for Medicaid. Because if not, then the theory is that that would become their cost.

FREDRICKSON: Is there a risk that that would trickle into health care cost in general? So for example, if, if providers or facilities are having to absorb a pretty significant amount of more money, how mu-- I'm just kind of thinking through-- ecosystem of finances here.

JOHN MEALS: It-- I mean, theoretically that's possible. Again, we would go back to the hospital assessment and the significant amount of money that is being pushed into the hospital systems, the additional revenue. This represents a, a fraction of what that, that number is. But yes, you are-- theoretically, that is possible.

FREDRICKSON: OK. The-- it's, it's, it's a pretty heavy lift to do an 1115 waiver. I know you, you know this well as, as someone who works in the department. What, what do we expect the cost for the department to be to actually just apply for this waiver?

JOHN MEALS: If we go through the whole, you know, steps right now, there haven't been a-- because we're just in the co-- public comment period. We're at the very beginning, so we haven't actually gone through the-- we'll take the public comment and then we go to the process of, of doing the whole su-- submission through CMS. The average submission is, like, $250,000 would be an average that the-- we have a vendor that helps us with these submissions. So that would be the average cost. But we wouldn't have incurred that yet because we haven't gotten that far. We're just in the public comment period.

FREDRICKSON: OK. So typically we hire a third-party contractor.

JOHN MEALS: Correct.

FREDRICKSON: OK. And do you anticipate we would hire one for this?

JOHN MEALS: I would assume so, yes.

FREDRICKSON: OK. OK. And you said on average $250,000?

JOHN MEALS: Yes.

FREDRICKSON: OK. You mentioned a bit earlier presumpti-- presumptive eligibility. I took a note about that. Who, who is, who is eligible for presumptive eligibility?

JOHN MEALS: So, so that's one-- I apologize. I, I will get-- I-- if you-- if it's OK, I'll get back to the committee. We can provide a response after on the details of what presumptive eligibility would look like here. I, I know it, it becomes a-- if individuals that, that have certain markers when they come in, then the hospitals are able to say, we're gonna presume that you're eligible for Medicaid. If they're uninsured, if they make statements about their, you know, income being at a certain level, you may be able to presume eligibility and then have to verify it after the fact. I know that is a-- it is an allowable process that we can use that hasn't really been used all that much, and it is something that we could look into for the 1115 waiver. But I'd be happy to provide the details for you after.

FREDRICKSON: OK. If I, if I recall correctly-- I was on the-- background's in social work. I, I believe-- and I don't know if this is still the case-- I think it's only pregnant women and children. I think, like, people with developmental disabilities, et cetera, do not qualify for that.

JOHN MEALS: I'll find the details for you. I don't know off the top of my head. But I can-- we'll provide all the detail for you.

FREDRICKSON: OK. So the, the presumptive eligibility recovery that's being presented as a possible salve to the losses that are coming here would, would, would not be applicable to the majority of these [INAUDIBLE]?

JOHN MEALS: That-- the, the idea behind that is to help with the issue of someone coming in on, like, the 27th, the 28th, the 26th, right, those last few days of the month. And so there's kind of one of two things. It's either we can work through a presumptive eligibility process or we have the ability to just write into the 1115 waiver that we want to make an exception for anyone that comes in in the last few days of the month. We want them to fall under a presumed eligibility process. So there's, there's flexibility there on kind of two fronts.

We can either do presumptive eligibility or we can just write it into our 1115 waiver. I mean, 1115 waiver, there's kind of broad flexibility there that we can, you know, use. And so we are internally looking at what those possibilities look like. We don't want to just make it completely open-ended, but it-- there are possibilities there to solve for this issue of-- because I do completely agree. Sometimes when someone comes in on the 27th-- like, the last few days of the month-- it's difficult to finish an application in a day or two. I mean, I, I think the average is-- it takes less than an hour to complete the application, but that's if you have all of your paperwork and you have everything together. Sometimes-- and especially for people that don't do this on a regular basis, it can be, you know, an arduous process. And so to try to account for some of that, there is flexibility that we could write into the waiver.

FREDRICKSON: Well-- and I, and I would imagine as well those, those first couple of days when you might not be able to apply are, are likely the most costly, right, in a, in a catastrophic event. That's when you're going to be requiring the most extensive care.

JOHN MEALS: Correct.

FREDRICKSON: So H.R. 1-- so currently, we have 90 days of retroactive eligibility. H.R. 1 would bring that-- is going to be bringing that down to 30 days. This of course will bring that down to zero days if this is approved. Why, why not keep it at 30 days?

JOHN MEALS: So what I want to make clear, though, is it-- really, what the current federal law is, it's 91 to 120 days of, of coverage, right, because you have the current month plus 90 days.

FREDRICKSON: Understood.

JOHN MEALS: So what we're going to is basically between 1 and 30 days, right? Because if you came in today, you're covered for the entire month of February. So it's be-- it's going from 91 to 100 and 20 to just 1 to 30 days, depending on when you came in during the month. Does that make sense? So we really are still doing up to 30 days of retroactive coverage. It's just as long as it falls within the month of application. And as we just talked, we're working on a process to make sure that, that really always is a 30-day process and, and we can create an exception for those that come in and, and-- if you come in on the 1st, right, you-- or, on the 27th, 28th and don't get your app-- application in until the 1st, then we don't want you to be-- the

hospital or the individual to be upside-down with a bill that may be associated with that first day that they come into care. Does that make sense?

FREDRICKSON: I, I think so. I-- what I'm a bit confused by is I, I hear you in terms of, like, the, the month being covered, but that-- that's from once application is completed, correct?

JOHN MEALS: It, it i-- it's from when the application is completed. It doesn't matter whether or not the-- it, it doesn't count the time that the department is processing, right? It's when the application is completed. So if we take-- I think our average time frame is around 15 or 16 days right now to approve an application. But even if that takes six months, it goes all the way back to the, the date that the application was completed.

FREDRICKSON: OK. My last question here and then I'll, I'll stop for a bit, but. So are, are, are you-- are-- do we know of any other states who are requesting zero days of retroactive coverage?

JOHN MEALS: No, we do not at this time. No-- none that have come public with it.

FREDRICKSON: OK. I guess that, that, that to me seems unique for the only state doing this. I mean, we're seeing a significant decrease happen federally already. And so I guess I'm, I'm still-- I-- I've yet to hear kind of the-- what's the compelling interest for the state for this.

JOHN MEALS: I mean, there's the, there's the fiscal impact and then, again, it's the, the aligning with the commercial market, more encouragement with-- from the hospitals to get people signed up for Medicaid in a more thorough and, and timely fashion. I mean, every time that there's a touchpoint with an individual-- because, again, it creates that financial incentive, but those are-- I mean, those are really the, the reasons.

FREDRICKSON: OK. Thank you.

JOHN MEALS: Yup.

HARDIN: Senator Quick.

QUICK: Yeah. Thank you, Chairman. So-- and I'll put it in two parts. So first, the federal government didn't pass subsidies for the

marketplace insurance. And so I-- I'm going to see-- say we're probably going to have people coming off of the marketplace insurance because they can't afford it. And then you said there would be a push-- this would help push people towards the private mark-- well, it would be the, the marketplace insurance, of course. But they already can't affor-- can't afford the insurance. So even withou-- without the subsidies, this is going to be harder. So have you guys e-- ever done any projections to that? And how do you actually incentivize people to do that when they can't afford it?

JOHN MEALS: So the-- this doesn't-- it doesn't push them to the, to the marketplace or to the commercial market. It, it aligns with what the commercial market does so it could prep them for, you know, what their treatment would be in the commercial market. Because the commercial market doesn't have retro eligibility, right? Medicaid as a program has retro, but the commercial market does not. So this doesn't push people to the marketplace. It aligns with what the commercial marketplace currently is. So if they were to get a job that then has, you know, commercial insurance, that-- then they would be treated the same as what we are treating them now.

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

HARDIN: I was just doing a little bit of jumping into AI on presumptive eligibility because it's such a fun and squishy thing.

JOHN MEALS: What does it say?

HARDIN: And so it seems-- and just wanted to check your knowledge as well as my own understanding of it. So CMS essentially can allow that to be defined, it seems, somewhat flexibly, but it is an application process. Is that your understanding?

JOHN MEALS: Yes. I mean, as-- Senator, I think we have flexibility within what we submit in the actual 1115 waiver, and that's something that we are internally looking at, whether it is presumptive eligibility or this time frame at the end of the month. My-- again, my understanding is we have the ability to--

HARDIN: Define it to a degree?

JOHN MEALS: Correct. How, how it works for Nebraska.

HARDIN: OK. Very well. Thank you. Any other quest-- yes, Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you. One more question. So it-- Senator Quick was kind of asking-- and you had mentioned about the kind of commercial insurance and sort of kind of trying to align this with commercial. I mean-- so how, how, how would you compare commercial insurance reimbursement rates to Medicaid reimbursement rates?

JOHN MEALS: Oh, I don't know the ans-- I don't know if I can answer that, but I can get back to you.

FREDRICKSON: OK. I'm just thinking if we're trying to align Medicaid with commercial insurance, I think reimbursement rates should probably align as well.

JOHN MEALS: Yup.

FREDRICKSON: OK. Thank you.

HARDIN: Seeing no other questions. Thank you.

JOHN MEALS: Thank you.

HARDIN: The 1115 waiver, proponents for this. The 1115 waiver. Are you a proponent, sir? I see you standing. Or opponents. Now are we giving you a workout?

ARLAN JOHNSON: [INAUDIBLE] remember what I'm doing here.

HARDIN: O-- OK. Are you a proponent or an opponent, sir?

ARLAN JOHNSON: Opponent.

HARDIN: OK. Let's move on to opponents. There don't seem to be any proponents in addition. So please, opponents. How many other opponents do we have just so we can kind of get a sense of it? So-- OK. Great. Welcome.

ARLAN JOHNSON: OK. Thank you. My name is Arlan Johnson, A-r-l-a-n; Johnson, J-o-h-n-s-o-n. Thank you for the time today. I am the CEO of Howard County Medical Center in St. Paul, Nebraska. I am here to strongly oppose the proposal to eliminate retroactive Medicaid eligibility. Retroactive eligibility is not a loophole. It's a lifeline. It ensures that people experience sudden illness, injury, or loss of income are not left with crushing medical debt simply because they could not apply for Medicaid in advance. Illness does not wait

for paperwork. Many individuals, especially seniors, people with disabilities, and those facing language or literacy barriers do not even know they qualify until after a medical crisis occurs. Without re-- retroactive coverage, a person suffers a stroke, is hospitalized, and then later learns they qualify for Medicaid could still left with tens of thousands of dollars in bills. This is not a financial burden, as it can mean bankruptcy, loss of housing, long-term instability for the entire family. Hospitals and clinics also rely on retroactive eligibility to be reimbursed for care they are ethically and legally obligated to provide. Removing it shifts cost to providers, which can lead to reduced services, especially in rural and underserved areas. Retroactive Medicaid eligibility is a safeguard that protects both patients and the health care system. Eliminating it would punish people for not predicting a medical emergency and would disproportionately harm our most vulnerable neighbors. I urge you to preserve this essential protection, aligning with the federal guidelines of H.R. 1, and keep our health care safety net strong. Thank you for your time.

HARDIN: Thank you. Questions? Senator Quick.

QUICK: Yeah. Thank you, Chairman. So I, I know you heard me asking maybe the question about-- so they want you to sign people up before they have an emergency and then also maybe edu-- putting education out there and having people go out to find them to maybe sign them up beforehand. I'm, I'm going to guess that's going to be an unfunded mandate for you and you wouldn't even know how much that would cost your hospital, or do you--

ARLAN JOHNSON: Exactly. You know, it-- we put people in place to try to define-- take away maybe the bill payment part of it when someone comes in for a certain procedure. We try to help them get down the road of how you're going to afford this, not-- and then make decisions about that. You know, unfortunately, we don't know that until they walk in the door. And even in rural pu-- or, rural areas, people aren't as ready to give access to why they need that coverage. So sometimes it takes a lot of encouragement from their provider once they see them, neighbors. Maybe your local pharmacist has more of an impact to be able to get people to actually apply when they've already incurred a bill. A stroke is a big one. I mean, you think about somebody who comes in and has that happen. That's a long-term type of situation. That's-- you know-- and we offer behavioral health services too. That-- maybe that started with that and then moved into something else. We're trying to get people qualified for Medicaid in that

standpoint. It-- it's just a long process, and taking away that retro ability-- you know, right now, we're gonna shorten it up. We agree-- OK-- we're, we're will-- we understand H.R. 1 being part of the deal. Just-- let's leave it at that.

QUICK: OK. And then I know we heard somebody else the other day talk about-- so if a woman comes in to have a baby and then-- you have to sign the baby up after the fact. And if something happens and you have to transfer that baby to another hospital for-- maybe it has to go into the NICU-- because I'm going to guess you probably don't have a, a NICU that could serve someone in that situation. So getting to that point where they could actually get to the-- to, to the parents to have them actually help apply for the baby-- because you have to talk to them too, right?

ARLAN JOHNSON: Sure.

QUICK: OK. I don't know if you'll--

ARLAN JOHNSON: Well, even think about the people that I have working for me. You know, when a, when a tragic event is going on-- OK. Are-- do these people qualify for this situa-- we're probably not gonna walk in the room at that point when their-- still knowing where [INAUDIBLE] it's life-or-death situation. We-- we're making sure-- we're a public facility. Anybody that walks in our door gets service no matter what kind of insurance they have. So we make those decisions probably after a lot of things have already happened. And we wanna make sure that patient's stable and ready to go the next level, even. There's times and things we need to do there, but it takes time. And you've got to think of the-- a lot of people in my facility wear a lot of different hats. It's not just the only thing they do is sign people up for Medicaid, so.

QUICK: OK. All right. Thank you.

ARLAN JOHNSON: You bet.

HARDIN: Senator Riepe.

RIEPE: Thank you. Thank you for being here.

ARLAN JOHNSON: Thank you.

RIEPE: And my question would be, in your facility, what, what is your payer mix? How much, how much Medicaid do-- what percent?

ARLAN JOHNSON: We're about 17%.

RIEPE: 17%?

ARLAN JOHNSON: Yeah.

RIEPE: OK.

ARLAN JOHNSON: And split between commercial and Medicare on the other part of it.

RIEPE: I know we've heard that commercial health insurance doesn't have a lookback, but also Medicaid's a lower payer. So it's this kind of an equalizer piece, if you will?

ARLAN JOHNSON: You know, if the-- if we could define an equalizer in our industry, that would be great. It's a lot of oppor-- avenues that we have to do. Even our facility joining networks like clinically integrated networks or accountable care organizations to try and focus on populations, no matter what they are, whether commercial, Medicare, Medicaid, all the other insurers, trying to find ways for savings and sharing in those savings. But you need dollars to do that. It-- it's like the program we got passed last year with 340B. That was a big deal to us, being able to see some stability in cash coming in so we can offer these services that don't. But when you don't have all those opportunities, it, it gets harder and harder. And it's, again, about staffing, just the amount of people you need to focus on all the regulations, all the things you need to do. And what-- top priority's taking care of these patients, and that's what-- it-- and commercial and Medicaid, that's very different reimbursement situation.

RIEPE: Plus you have standards that you have to meet in terms of ratios, I think, in terms of staffing. So my question there would be is, if you lost revenue as a result of this, where would you first look to adjust?

ARLAN JOHNSON: Nursing staff.

RIEPE: Staff?

ARLAN JOHNSON: Yeah. The people that are actually touching the patient.

RIEPE: OK.

ARLAN JOHNSON: Or the people that are signing people up for Medicaid.

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

HARDIN: That 340B bill that passed, that was amazing. Who was the senator that brought that?

ARLAN JOHNSON: I think I'm staring right at him.

HARDIN: Oh, I see. OK. I was just trying to recall who that, who that was. Do a comparison for me--

ARLAN JOHNSON: Sure.

HARDIN: --as, as well as you know. 2026, 2025, Medicare 1.0. How are Medicaid rates comparing to that world in Nebraska?

ARLAN JOHNSON: Well, you think about a lot-- most things are analyzed against Medicare reimbursement. For us, you're probably thinking about 35% to 40% of Medicaid, Medicare reimbursement. That would be our Medicaid reimbursement.

HARDIN: 35% to 40%.

ARLAN JOHNSON: Yeah. And you-- you know, I think-- you know, we talk a lot about the provider assessment, which is doing things for the state which are awesome, but also remember that the next year's hasn't been approved yet. So that's looking into the future there that we can't do right now even with what our, our Medicaid reimbursement's going to go down to based on H.R. 1, the Big Beautiful Bill. We don't know yet. But we still have to continue to move forward and look for opportunities to do that. And stability for us is something better-- more than anything. And when you start changing the rules every-- all the time, it, it causes chaos in our world. Now, stability and being able to look into the future-- we used to do an analysis. You'd say, let's do a ten-year forward. I'm not sure anybody could look ten years into the future in, in health care right now. We try to manage it on a year-to-year basis. Hopefully in the second year we look at opportunities. But then you get retirements, you get more and more people moving into the market that weren't there before. Medicare Advantage is a struggle, but we have to have them as part of the conversation. Payers need to be part of this conversation to, to see if we can make headway in that, in-- you know, making sure that they're not requiring lengthy things to get something approved. We

have to start relying on our providers, our health care providers to make decisions and not the insurance companies for us, so.

HARDIN: Thank you. Other questions? Senator Quick.

QUICK: Just one more question. And-- so even on the private insurance side, I know-- like, for our-- my work insurance at the time when I was working, I know there were negotiated rates for different things within our insurance plan. So do you belong to like a-- well, you talked about the network a little bit, but with-- just your hospital alone-- I mean, are you part of a bigger network of hospitals or it just-- you alone, or how does that work?

ARLAN JOHNSON: So I just met-- I mentioned the clinically integrated network. There's 19 of us that-- all rural hospitals ha-- have joined that group. And our mission not just in our state but the group that's helping us go down that road in other states-- ten now-- is negotiating with payers on rates. And anytime you're negotiating with a payer on rates, scale is the key. Bringing covered lives to the table. It's just like in my employee insurance, we are self-insured. But we have an insurance company that covers us for the big losses. But we're part of a group that has 43 other hospitals in it, so we have scale so we can move that risk farther across. Medicaid, it-- that's about how many you have in your co-- community, to how you'd spread your risk from that. And the key to all of this is trying to get in front of these people that have that insurance to be able to get them healthy and talking to them more than just when they come in for a visit. We built a wellness center in St. Paul, Nebraska so we could give memberships to our Medicare population so they can walk the indoor track and swim the pool. But those are commitments as a community that we could make without revenue coming our way. Stability of the revenue, that's the key.

QUICK: All right. Thank you.

ARLAN JOHNSON: You bet.

HARDIN: Other questions? Seeing none. Thank you.

ARLAN JOHNSON: You bet. Thank you.

HARDIN: Opponents to the 1115. Welcome.

MIKE DEWERFF: Thank you. Good afternoon, Chair Hardin, members of the Health and Human Services Committee. My name is Mike Dewerff, M-i-k-e

D-e-w-e-r-f-f. And I serve as the chief financial officer for Bryan Health, a Nebraska-owned and governed health system with six hospitals across the state. I have worked in health care finance for over 35 years. I'm here today on behalf of Bryan Health and the hosp-- Nebraska Hospital Association in opposition to submission 1115 waiver that eliminates Medicaid retro eligibility in Nebraska. Medicaid retro-- retroactive eligibility currently covers up to 90 days before the application month for individuals who are eligible but not yet enrolled. The One Big Beautiful Bill reduces this to-- window to 30 days. When-- hospitals depend on this long-standing policy to receive reimbursement for emergency and medically necessary care delivered before a patient's complete enrollment. For many patients, such as trauma victims and NICU babies, those first few hours and days of care are the most critical and therefore the most costly. Working with a third party that is in our facility, we can typically ta-- we can typically identify that a patient is Medicaid eligible within the first 24 hours of admission and get the application complete in ten days, depending on availability of necessary documents. Now, once the application is submitted to DHHS, the average turnaround time for approval is 65 days. It's important to note that the type of patient does have an impact on this time frame. Applications for newborns are typically relatively quick due to the minimal documentation required. For other patient types, approval time can be significant-- significantly longer. A reduction to zero days for retro eligibility puts patients at the mercy of when their episode of care occurs. If care is required in the last ten days of a month, the risk of noncoverage is sig-- significant. This change would not only reduce reimbursement for care already provided, but also lower the number of Medicaid-covered encounters countered-- counted in federal utilization formulas. Medicaid volume determines eligibility for 340B dru-- drug pricing program and disproportionate share hospital status. For our hospital, the combined financial impact of losing retro eligibility alongside the potential changes to 340B, DSH, and state-directed payments have been modeled at about $35 million annually. Even considering the-- only the $9.1 million for fee-for-service reduction to Bryan, the numbers still fall short. The state saves only about half that amount, about $4.5 million. The Governor has asked his department leaders to run the government like a business. I don't know any business owner that would turn down an automatic 120% return on their investment. Put plainly, the state is spending $2 of provider impact to generate $1 of state savings. That's not fiscal prudence. That's inefficiency. There are smarter, more responsible ways to solve the budget challenge than creating a problem twice the size of the

solution. Getting rid of Medicaid retro eligibility is conflating the reduction of a program with the reduction in patients who need care. The patients still exist. They still seek care, and we provide high-quality, lifesaving care that they need. The cost of caring still exists. It's merely shrinking the state's responsibility. Thank you for your time this afternoon. I'd urge you hold on the submission of 11-- of the 1115 waiver to keep this vital program intact.

HARDIN: Thank you. Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here and for your testimony. Part of your testimony, you, you had mentioned kind of the in-- I-- so-- one thing I was thinking about earlier was this idea of, like, the first initial days oftentimes being most costly, right? You mentioned NICU, you mentioned kind of the trauma patient. Wha-- what happens in the case of, like, a person who's just, like, incapacitated, right? So in other words, like a real severe trauma in the hospital? I-- is there a way for them to even be applying for, for Medicaid during that period of time?

MIKE DEWERFF: No. I mean, if it's long term, like a coma or something like that, it's-- you know, we'd probably try to work with a guardian or something like that. Otherwise, I suppose you wait until they are conscious.

FREDRICKSON: Right. So, so I'm-- thi-- this is obviously an extreme case, right? But I'm just kind of thinking hypothetically. Like, someone is-- comes in, hit by a bus or something, and maybe is not able to complete documentation or maybe even cognitively is not of, of sound mind to do that. So if this waiver were to be approved, a case like that, would that individual-- all that time before they were able to do that, they-- that would just be--

MIKE DEWERFF: Right. That is one of our challenges, is getting-- I think it was previous testimony that it's the date of a complete application. Sometimes that can take quite a while to get a complete application done.

FREDRICKSON: Right.

MIKE DEWERFF: Especially if it's in the second half of a month.

FREDRICKSON: Right.

MIKE DEWERFF: Yeah.

FREDRICKSON: OK. Thank you.

MIKE DEWERFF: Mm-hmm.

HARDIN: Other questions? Senator Quick.

QUICK: Yeah. Thank you, Chairman. I, I, I know you probably-- you heard my question before about more or less unfunded mandate and what-- how would that affect because-- you have several hospitals acro-- rural and urban hospitals, so. Do you see how that would affect you?

MIKE DEWERFF: Well, as far as, I mean, trying to promote Medicaid to patients before they need our services?

QUICK: Mm-hmm.

MIKE DEWERFF: Yeah, I would suggest that-- yeah, it'd be unfunded. It would cost us advertising dollars, I suppose, and things like that. But we, we do, do our best as well. I mean, we ask our patients if they come in for a clinic visit or something like that if they're applying for Medicaid. When the emergency declaration ended after the pandemic, we tried to proactively reach out to ask people to apply for Medicaid because they knew that their presumptive eligibility ur-- during the pandemic was going to end. And so we've done things like that unfunded. It's in our best interest as well to get people enrolled, and so I, I would offer that's nothing new for us. We've, we've already invested time and energy to try to do that.

QUICK: OK. All right. Thank you.

MIKE DEWERFF: Mm-hmm.

HARDIN: Senator Ballard.

BALLARD: Thank you, Chair. Thank you for being here. I just want to make sure I'm crystal clear on the, the financial impact. So $35 million, that is the combination of Medicaid, 340B, DSH, and state-directed payments. That's $35 million?

MIKE DEWERFF: Correct.

BALLARD: So with this change, can you kind of give me a ball-- what, what would that number be if we went to zero? Or would it be that--

MIKE DEWERFF: That is the number, yeah.

BALLARD: That is the number, 35?

MIKE DEWERFF: From the current status to--

BALLARD: OK. And then so-- and I, and I know we talked previously. They said a percentage would be able to qualify, but it's that roughly-- how many would be in that 48-hour window, which you'd strive to get people eligible-- or, strive to get people on Medicaid? So how much would that-- $35 million would you see to receive? Or would that be a total loss? Am I asking the question correctly?

MIKE DEWERFF: I think so. I think-- you know, I-- if you're going to assume that if the people that we can get the application in, they'd get their care in first half of the month--

BALLARD: Yes.

MIKE DEWERFF: --we can get the application complete, and then that runs through. Versus the second half of the month. Let's assume nobody gets through and doesn't qualify-- I suppose you could argue maybe half of that, but--

BALLARD: Half of that--

MIKE DEWERFF: --reality is--

BALLARD: --but still significant.

MIKE DEWERFF: --you know--

BALLARD: Yeah.

MIKE DEWERFF: --like I said, I think babies, easy enough to qualify. Other patients that are more difficult to get the paperwork done and it takes 65 days to get it approved, that just takes longer.

BALLARD: OK. So you-- could be-- it's safe to say-- it's going to be in the eight-figure range, eight-figure range of losses, potentially, regardless of who you get on-- OK.

MIKE DEWERFF: Correct.

BALLARD: And it's for the $6.5 million in savings. OK. I appreciate it. Thank you.

MIKE DEWERFF: Yep.

HARDIN: I truly don't mean this as a gotcha question. I'm trying to pick your creative pocket.

MIKE DEWERFF: Mm-hmm.

HARDIN: OK? You're right. There are smarter, more responsible ways to solve the budget challenge than creating a problem twice the size of the solution. My question to you is, give us some ideas. Such as-- because you guys think about this and you, you drive home at night or you will open your eyes at 3:04 a.m. and you go, how come they don't do blank? What crosses your mind?

MIKE DEWERFF: Yeah, we do have this conversation with commercial payers. We, we are in successful programs with Medicare. I would suggest that to, to reimburse providers to keep people healthy and out of the hospital would be better than just simply cutting provider rates. We have successful programs called accountable care organization. I could-- we could talk for hours about that, but essentially we're reimbursed to keep people healthy and out of the hospital. The-- right now, the MCOs are required to have what's called value-based purchasing. It's similar to that, keep people out of the hospital. I would suggest that those programs are minimal or nonexistent almost.

HARDIN: OK. Can you give us an idea? You guys are-- as Senator Quick said, you guys are a large hospital organization, both rural and urban.

MIKE DEWERFF: Mm-hmm.

HARDIN: And how much does Bryan get from Medicaid on a per year or per biennium basis now? Can you kind of set that template for us?

MIKE DEWERFF: I'd have to ball-- I'd be ballparking. I'd have to guess a few hundred million.

HARDIN: OK.

MIKE DEWERFF: Yep.

HARDIN: Gotcha. And-- Senator Riepe.

RIEPE: Thank you, Chairman. You referenced a couple times, at least twice, first of the month, first half and the second half. I'm trying to-- that causes me to question. I-- why is that? Why, why, why is there a difference between a first half application and a second?

MIKE DEWERFF: The eligibility would be retroactive the date of a complete application. So if it takes--

RIEPE: So it's based on the month.

MIKE DEWERFF: Of-- that the application is complete and submitted. So if you're in-- if you're-- if the care is delivered in the second half of the month-- let's say they're incapacitated and they don't wake up till the next month, and then it takes another day-- or week or two to get the application complete and in, then it wou-- then it wouldn't be retro to the actual month that they received the care. It actually-- it'd only be retro to the first of the month that the completed application came in.

RIEPE: Oh, OK. So timing is everything.

MIKE DEWERFF: Mm-hmm.

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

HARDIN: Do you-- for your hospital-- and we had asked this of, of Mr. Johnson earlier. Ab-- about how long is an average time for filling out a Medicaid app? I mean, it-- do you know what that is in the context of Bryan? And I realize we're dealing with lots of locations here.

MIKE DEWERFF: Yeah. I'd say for a newborn where there's not a lot of documentation required, it's fairly quick and easy, a day or two.

HARDIN: OK.

MIKE DEWERFF: For someone else that needs more required documentation, maybe they're unorganized, maybe they can't get home because they're in the hospital, things like that, it can take a couple weeks at least.

HARDIN: OK. Very well. Other que-- yes, Senator Quick.

QUICK: Yeah. Thank you, Chairman. And I just-- you know, for the newborn then-- so most of your cost is at delivery, right?

MIKE DEWERFF: Mm-hmm.

QUICK: I mean-- and then that would just be whatever stay-- days of stay. So does it go back to the-- it goes from the application being filled out. Do you usually do this before-- like maybe when they're in labor or when they first come in or the-- is it after the baby's born?

MIKE DEWERFF: Usually it's right after the baby's born.

QUICK: OK. So it would-- they would have maybe-- but would-- do you think they include the delivery, or is it just then you pay after the delivery?

MIKE DEWERFF: If it's-- if the timing is right, the delivery would be included.

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

HARDIN: Any other questions? Seeing none. Thank you.

MIKE DEWERFF: All right. Thank you.

HARDIN: Those in opposition, 1115. Welcome.

CHRIS LEE: Thank you. Good afternoon, Chair Hardin and the members of the Health and Human Services Committee. Good to see you again so soon. My name is Chris Lee, C-h-r-i-s L-e-e, COO of Madonna Rehabilitation Hospitals. And thank you for this opportunity to provide comments on DHHS's proposed submission of the 1115 waiver to eliminate Medicaid retroactive eligibility. Madonna operates four hospital-level facilities and one skilled nursing facility between our Lincoln and Omaha campuses. In the last five years, our hospitals have served patients from 88 counties in Nebraska, hundreds of whom are Medicaid beneficiaries. From a post-acute hospital perspective, retroactive Medicaid eligibility is essential to discharge planning, patient flow, and access to medically necessary aftercare. Our social work team is deeply involved in assisting patients with applying for Medicaid when the patient's ins-- insurance coverage changes during the course of their rehabilitation or when Medicaid eligibility is needed to facilitate discharge to a nursing facility or other long-term care setting. In practice, there's often a meaningful gap between when care begins and when a Medicaid application can realistically be submitted. Patients may be medically unstable, cognitively impaired, or reliant on family members to gather documentation. Financial screening takes time, and applications cannot

always be filed on the first day care is delivered. If retroactive eligibility is eliminated, medical ne-- medically necessary care provided before the month of application would not be covered even when a patient ultimately qualifies for Medicaid. This risk will complicate discharge planning and create delays in care transitions, particularly for patients awaiting placement in nursing facilities or other long-term care. Even under the existing policy, these delays have ripple effects across the health care continuum. Patients remain in higher cost settings longer than medically necessary, acute care beds remain occupied, post-acute capacity is constrained, and patient throughput slows. What begins as an eligibility policy change could quickly worsen hospital throughput, increase cost of care, and harm patient outcomes. Mission-oriented nonprofit providers like Madonna already serve a high proportion of Medicaid recipients and operate on very thin margins. Retroactive eligibility helps mitigate the financial risk of unavoidable process delays when patients need immediate post-acute care or placement in a long-term setting. Policies that reduce that protection increase uncompensated care and decrease the ability to place patients in the right setting at the right time. Madonna believes retroactive eligibility is not just an abstract policy issue, but an operational necessity that supports access to care, safe transitions, and efficient use of hospital resources. For these reasons, we have significant concerns about the proposed waiver and its impact on providers and the patients we serve. Thank you for the opportunity to testify. And I'm happy to answer any questions you might have.

HARDIN: Thank you. Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. I've seen your notation here that you receive patients from 88 counties in Nebraska. Do you also get any Medicaid patients out of Iowa or Missouri or other--

CHRIS LEE: Yes, we, we do see a few. The majority of our patients with Medicaid are from Nebraska, but we do get a few from surrounding states too.

RIEPE: Say-- just pick one state, whether it's Iowa or Missouri, how does it vary from the payment that you receive from Nebraska Medicaid?

CHRIS LEE: When it's out of state, it's typically single-case agreements or special contracts we have with that state to provide care that's not available in Iowa or not available in Missouri, say.

RIEPE: So they're open to negotiation.

CHRIS LEE: Yes.

RIEPE: OK. And I assume you're a good negotiator.

CHRIS LEE: We try.

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

HARDIN: Other questions? Seeing none. Thank you.

CHRIS LEE: Thank you.

HARDIN: Opponents, 1115 waiver. Welcome.

ROGER REAMER: Thank you. Good afternoon, committee members. My name is Roger Reamer. It's R-o-g-e-r R-e-a-m-e-r. I'm the chief executive officer at Memorial Health Care Systems in Seward, Nebraska. Memorial Health Care Systems consists of a critical access hospital and three rural health clinics. Those three rural health clinics are in Seward, Utica, and Milford. Today, I'm oppo-- proposing to you to align the coverage period with H.R. 1. I would like to share with you an example of why I recommend retro eligibility period to two months for a traditional Medicaid population and one month prior for the Medicaid expansion population. Just a couple months ago, we had this unfortunate scenario play out with one of our community members. A woman under the age of 65 living on a low-wage from a pension she's received from a job she no longer has and caring for her husband who is disabled had a fall at her home which resulted in a serious leg injury. This individual's not at Medicare age, thus was not qualified for that program. She presented to our hospital ER with a complicated break requiring specialty surgical care. Our hospital stabilized her and transferred her to a tertiary facility for the surgery. Our social services team started working with the patient to identify her possible eligibility for Medicaid coverage. In our initial intake and review, we determined that she wou-- should be eligible and we should start helping her with getting approved. Unfortunately, she was not ready to continue this effort since she had been transferred, had surgery, and was recovering. Due to the fact that she did not have insurance coverage, her plan after surgery-- which she determined-- was no rehab and to return to her home in fear of the financial consequences. Unfortunately, she did not do well at home and returned to our ER for further care. We admitted her to our facility and started the effort again of working on getting her approved for

Medicaid. Our team had determined that she could not take care of her health needs at home, and we started a rehab effort with her. We felt it was necessary to get her in some sort of rehab or recovery effort to try to find assurances that she would not go backwards in her recovery and return again to our ER for even more extensive care. As you can imagine, this individual was quite concerned and occupied with her health needs, worried about her financial condition on top of her medical condition, and depressed over the entire experience. We were sensitive to these concerns and gradually got her to complete the effort with us in regards to getting qualified for Medicare benefits. This scenario played out and took just over six weeks to get completed. Because we were able to educate the patient that she was eligible and that the care she is currently receiving could be covered through the program, it was one less worry for her. I feel this story would be much different in-- if there was not a retroactive coverage period. This individual may have continued to try and refuse certain care due to her financial situation, which in turn would have put her in an even more dire medical situation. Patients such as this does not-- done-- does not happen every day in our facility, but there are most likely many stories similar to this happening across our state in a variety of health care settings. The hospital's long-cerm-- long-term care facilities, clinics, et cetera, are sometimes the lead resource in rural settings for helping our community members who need this help due to limited resources. We take pride in caring for all members of our community and see the need for a good partnership with the state in an effort to help serve those most vulnerable when dealing with medical needs. We're able to help the patient learn about their eligibility, comfort them in knowing their cases-- their cares will be covered during their most difficult times, which in turn will get them on track for better care plans, which we hope will stabilize their health conditions in many cases. If someone is eligible for this very important program but have not for whatever reason got signed up, they should have the opportunity to get into the program when a medical situation presents itself with a retro eligibility, since they did qualify at the time of the service. Once we can get individuals who need to be and are eligible to be in the program, the providers of care have a much better opportunity to help these individuals get on a healthier plan going forward. In summary, it is our ask at this, at this time to just allow the retro period to align with H.R. 1, not eliminate it entirely. I appreciate the opportunity to testify. Thanks.

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

ROGER REAMER: Thank you. Appreciate it.

HARDIN: 1115 waiver, opponents. Welcome.

SARAH MARESH: Hello. Chair Hardin and members of the Health and Human Service Committee, I'm Sarah Maresh, S-a-r-a-h M-a-r-e-s-h. And I'm the program director for the Health Care Access Program at Nebraska Appleseed. Testifying in opposition to the waiver today. Because retroactive coverage is critical to Nebraska families and our health system and because DHHS's proposed waiver is entirely optional and will cause harm, we oppose this waiver. Per the proposed 1115 maiver-- waiver made public this week, DHHS has made clear they intend to be even more restrictive for retroactive coverage than H.R. 1 requires. And to be clear, this is not required or permitted by federal or state law, and DHHS has to seek a special waiver to actually eliminate retroactive coverage contrary to federal law. Eliminating retroactive coverage would be harmful to Nebraskans and our health care system, and retroactive coverage can be very harmful for individuals who have experienced a medical emergency, a pregnancy, or newborn patients, and people who need nursing home or long-term care. Retroactive coverage prevents crushing medical debt for families and supports for our health care providers and systems. I would say that even when people can't pay their bills they still receive them and they still feel the results of the medical debt. Medical debt has ripple effects. It can cause people to have their wages garnished and have other downstream effects on their credit score and other elements of their life. So it does balloon and it does extend beyond impact to the hospital. I also wanna speak really specifically to an example that has been shared a lot. One of the more troubling examples of how this would be implemented is that the elimination of retroactive coverage would apply for babies in the NICU. And this example is deeply personal to me because I know the extreme fear and stress that comes with having your baby in the NICU, because I have been there. Two years ago today, I was in the NICU with my daughter at Children's Hospital. Because of the timing of our NICU stay-- which started on February 24 and lasted into March-- if we would have needed Medicaid, we would have easily fallen into the gap that this retroactive waiver creates. I would have had to get all my paperwork together in just a few days to apply or else I would've ended up paying tens of thousands of dollars out of my pocket for the care. To give you an idea of the NICU lifestyle, it is not for the faint of heart. It is challenging mentally, physically, and emotionally, especially for a new mom. And it took me several days to even go home and send a simple email to my work letting them know what happened to me. And even if I had to apply for presumptive

eligibility, it still requires paperwork. It still requires an applicant to sign something saying, I promise everything is accurate. It asks things like, what is your gross income? What's your countable income? And when you're a new mom facing all of that challenge in the NICU and trying to understand what's happening to your daughter, that's the last thing that we should have families focus on. I was laser-focused on caring for my daughter, and that's what we should want. And so if we really care about supporting moms and babies-- which I know we all do-- then we shouldn't add a needless paperwork deadline that will just make one of the most challenging experiences in moms' lives even more painful and challenging. With that personal story, I also just wanted to refocus back and say that one of the other things that I think the department and the state has been sharing is that this will incentivize hospitals in particular to make sure people are applying for Medicaid. I want to just share that of course it's more than the hospital. It applies--

HARDIN: Ms. Maresh, we're in the red.

SARAH MARESH: Oh. Sorry. Yes. OK. I would also just challenge you to think about nursing home as well. And I know Senator Riepe asked in the past about how other states have done retroactive coverage, and I share some information in my testimony about that. But sorry for the red light. I will respect that.

HARDIN: That's all right.

SARAH MARESH: Thank you.

HARDIN: Thank you. Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here and for your testimony. You were beginning to say something about the, the hospitals and the-- I-- but you were-- yeah.

SARAH MARESH: Sure, sure. Yeah. So-- yeah, I was just trying to say I think, like, the, the state has been talking about there is an incentive for hospitals then to quickly get people to apply. And just-- I think that it's been shared by a lot of the hospital staff that it's not just about making sure that the hospitals can quickly do it, because people still have to figure out how to get all their finances and make sure they're submitting accurate information. And then I would also say on the nursing home side of things, a, a frequent challenge when people are entering into nursing homes and

long-term care is that a lot of people have to spend down their assets. So a lot of us who end up in nursing homes eventually will need Medicaid coverage, and that's why it's so critical to their operation. Three in five nursing home residents across our state have Medicaid coverage, but it's really hard for nursing homes to understand when their patient is at that threshold because they don't have a perfect picture of what that person's finances look like, what status, you know, of their asset sell-offs they're at, and how long that spend down period or the-- like, the band that Medicaid has if you sell off expensive assets. So I would just say in the nursing home context that, you know, incentive isn't there because they-- it can't operate that way, which is the nature of how spend down happens and qualified when you're an elder adult.

FREDRICKSON: Understood. Thank you.

HARDIN: Other questions? Senator Riepe.

RIEPE: Thank you, Chairman. You started to say something about other states.

SARAH MARESH: Yes, yes. So other--

RIEPE: Would you expand on that?

SARAH MARESH: Yeah, absolutely. So there's a little bit of information in here, but, in the past, other states have tried to eliminate retroactive coverage in part. I know the state shared that there isn't a current proposal for folks to completely eliminate it. But in the past, almost ten years ago now, there was kind of a series of attempts to limit retroactive coverage. Arkansas attempted a waiver that would limit it to just 30 days for some enrollees, which we know were going to be forced upon us by H.R. 1 anyway. That was blocked by an appellate court. Iowa eliminated retroactive coverage and then scrambled to allow nursing homes to have an exemption because of how much basically finances nursing homes were seen, and they were having real talks of closure in a lot of the rural areas, which means that residents would have to move really far from their homes. Kentucky, Indiana, New Mexico all intended to implement or partially implemented it but ultimately abandoned those plans. So there's a lot of examples. None of them have gone well, so I would just keep that in mind too as we're thinking about this.

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

HARDIN: Senator Ballard.

BALLARD: Thank you, Chair. Thank you, Ms. [INAUDIBLE], for being here. Can you describe-- i-- if we were to pass some legislative version of a 30-day retroactive Medicaid, is D-- can DHHS still submit this waiver?

SARAH MARESH: So it's a waiver of federal law, not state. So they-- I mean, they could submit it. It'd be illegal. That mean it'd violate state law then.

BALLARD: OK.

SARAH MARESH: If they were to do that, yeah.

BALLARD: OK. I appreciate it. Thank you.

SARAH MARESH: Yep.

HARDIN: Other questions? Seeing none. Thank you.

SARAH MARESH: Thank you.

HARDIN: 1115, those in opposition. Welcome.

CHELSEA RUSSELL: Hello. Good afternoon, Chairman Hardin and members of HHS Committee. My name is Chelsea Russell, C-h-e-l-s-e-a R-u-s-s-e-l-l. And I serve as a director of nursing at Saunders Medical Center in Wahoo. I am testifying on behalf of the Nebraska Hospital Association in opposition to the state's submission of the 1115 waiver, eliminating the retroactive eligibility period. Saunders Medical Center is a 16-bed critical access hospital with a 6-bed emergency department, a 60-bed long-term care facility, and a rural health clinic all under one roof. We are often the only access point for health care in our community, and we see the importance of retroactive eligibility every day. Recently, we admitted a patient after a fall that resulted in multiple broken ribs. It quickly became clear she could not safely return home. We began discharge planning on day one and were able to transition her to our long-term care facility with-- and she could remain in her community close to her family. When she sought care in our emergency department, she was not enrolled in Medicaid. There was no power of attorney in place, and her family struggled to access financial records. She could not even locate her Social Security card. And these are common realities when patients present unexpectedly in crisis. Our team did exactly what they were

supposed to do. We provided excellent care and began the Medicaid process immediately. However, even when we start this process on day one, much of that timeline is outside of our control as families continue to try to track down these financial records. Today, long-term care facilities can accept patients with Medicaid pending because retroactive eligibility ensures coverage once approved. That assurance allows hospitals to discharge patients safely to the most appropriate level of care. If retroactive eligibility is eliminated, long-term care facilities will be far less able to accept Medicaid-pending patients. Without that certainty, the financial risk is too great. And on the other side of the coin, hospital beds filled with individuals who no longer require acute care but have nowhere else to go, creating discharge backlogs across Nebraska, delaying care throughout the health care system, and forcing patients to drive farther to find an available bed. And you can only imagine how difficult this will be, especially those seeking specialized care such as behavioral health or OB. Critical access hospitals operate on thin margins, and unreinforced days of care would be significant and destabilizing to rural providers like ours. Eliminating retroactive eligibility does not remove unexpected emergencies or paperwork bur-- barriers. It shifts financial risk to hospitals that are already fragile. We respectfully urge the state not to move forward with this 1115 waiver. Thank you for your time. And I'm happy to answer any questions.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. Do you find because of reimbursement that you would meet the EMTALA requirements but then refer a patient on down the road?

CHELSEA RUSSELL: Can you repeat that?

RIEPE: Given the fact that you would meet all of the qualifications required under EMTALA to see the patient, stabilize them, do you at times-- does your hospital refer them then on down the road?

CHELSEA RUSSELL: Yeah. So as a critical access hospital, there are times that patients will come into our emergency department and the care that is required to be provided to them is outside of what we can do. So it is not uncommon for an individual to come into our emergency department and then we will need to ship them out to a higher level of care.

RIEPE: But would it be based on their medical needs or on their financial ability?

CHELSEA RUSSELL: Medical needs.

RIEPE: OK. Not on financial.

CHELSEA RUSSELL: No.

RIEPE: OK. Thank you, Chairman.

HARDIN: Other questions? Seeing none. Thank you. 1115 waiver, those in opposition. Welcome.

AMY BEHNKE: Thank you. Good afternoon. Apologies in advance for my voice. It's been gone this week. Good afternoon, Chairman Hardin, members of the committee. My name is Amy Behnke, and I'm the CEO-- A-m-y B-e-h-n-k-e. I'm the CEO of the Health Center Association of Nebraska. Our organization supports the work of Nebraska's seven federally qualified health centers and the 123,000 patients they serve each year. I'm here today in opposition of the proposed 1115 waiver that would eliminate retroactive eligibility. Medicaid is a critical lifeline for our patients. Health center patients are hardworking Nebraskans, but many work in occupations that do not offer health insurance. Statewide, 38% of our patients are enrolled in Medicaid, including 66% of the children we serve. In fact, one out of every seven Medicaid enrollees receives their care at a community health center. Medicaid coverage means our patients don't have to choose between buying groceries or going to the doctor. It means they can access specialty services when, when needed. And it means their children can receive all of their well child visits. Every health center has staff who assist eligible individuals with enrolling in health insurance coverage. When an individual comes into the health center for care and they are uninsured, financial services staff will refer them to these outreach and enrollment assisters to determine whether they may be eligible for Medicaid, Medicare, or marketplace coverage. In those instances, it's highly likely that they will not have all of the necessary paperwork and will need a follow-up appointment to complete the application process. If this happens at the end of the month, retroactive eligibility protects that individual from incurring a cost. It also protects the health center by ensuring health centers can bill for the services provided. Enrolling in Medicaid can be complex, and many people may not know they are even eligible for coverage. The assertion that eliminating retroa--

retroactive coverage will lead to more people enrolling earlier relies on the assumption that retroactive eligibility is an option that's widely known among potential enrollees. However, studies of other proposed waiver programs indicate that awareness of the specific provisions in Medicaid is extremely low even among those enrolled in the program. Health centers provide care to uninsured patients on a sliding fee scale based on income and household size. In 2024, health centers provided $30 million in sliding fee discounts and wrote off almost $7 million in bad debt expense. Helping eligible individuals enroll in coverage is a priority not only for the well-being of the patient, but for the financial stability of the health center as well. At a time when health care providers are already facing negative margins, preparing for the impact of Medicaid changes in H.R. 1, the elimination of retroactive eligibility only adds to that financial strain. Every provider who accepts Medicaid is affected by this change, and the assertion that the hospital provider tax will somehow mitigate the impact of that loss of retroactive eligibility is simply not accurate I would assume even for our hospital partners. As providers grapple with the impact of changes to H.R. 1 and patients work to understand how those changes will impact their coverage, making additional changes to retroactive eligible beyond what is outlined in H.R. 1 only adds to that burden and confusion. Thank you. And I'd be happy to answer any questions.

HARDIN: Ms. Behnke, I genuinely appreciate your ability to stay in your notes. And you're constantly watching that [INAUDIBLE].

AMY BEHNKE: I'm on it.

HARDIN: Se-- Senator Riepe.

RIEPE: Thank you, Chairman. You're kind of in a unique position because you're a federally-- health care provider.

AMY BEHNKE: Mm-hmm.

RIEPE: So if you lose money from the state from the 1115 waiver lookback, then does your formula with the feds, does that-- do you get any-- they don't make up the difference for you.

AMY BEHNKE: No. So the, the federal grant that each of the health centers receives, on average it's about 17% of their total revenue. That is specifically related to the uninsured patients who, who they

serve. And in fact, they're federally prohibited from using those dollars to supplant Medicaid dollars.

RIEPE: So it's uninsured versus Medicaid?

AMY BEHNKE: Correct.

RIEPE: OK.

AMY BEHNKE: Right. So we don't get an increase in federal grant dollars just because Medicaid--

RIEPE: Seemed like a good idea, but OK.

AMY BEHNKE: Yeah.

RIEPE: Thank you, Chairman.

AMY BEHNKE: Happy to take that back.

HARDIN: Other questions? Seeing none. Thank you. Those in opposition, 1115 waiver. Welcome.

CLEO ZAGURSKI: Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. Thank you for the opportunity to testify today. My name is Cleo Zagurski, C-l-e-o Z-a-g-u-r-s-k-i. And I'm the policy fellow and lobbyist for Reproductive Health Collaborative Nebraska. We are here in strong opposition to the proposed 1115 Medicaid waiver that will eliminate retroactive coverage. Reproductive Health Collaborate Nebraska works with a statewide network of ten health care agencies supporting 30 clinics across 22 counties to advance ha-- access to high-quality reproductive health care for roughly 25,000 patients across Nebraska annually. As the sole Title X grantee for Nebraska, we know that changes to Medicaid will significantly harm our clinic's capacity to serve Nebraska's most vulnerable populations. Title X is meant to be the safety net to the safety net that is Medicaid. Due to the currently uncertain reproductive health national funding landscape, many clinics across our network are facing challenging financial conditions. Completely eliminating retroactive coverage would remove one of the last stabilizing forces allowing these clinics to keep their doors open. In rural Nebraska, patients are more likely to experience coverage gaps due to administrative delays or limited access to enrollment assistance. Retroactive coverage ensures that when someone walks into a clinic for urgent care, whether that's STI treatment,

pregnancy confirmation, or contraception, providers can deliver that care immediately, trusting they will be reimbursed once eligibility is processed. Without retroactive coverage, clinics face an impossible choice: either delay time-sensitive health care until paperwork is complete or provide care and absorb the financial loss. For small rural health providers, even a modest increase in uncompensated care can be devastating. These clinics operate on thin margins, rely heavily on Medicaid reimbursement, and do not always have a large hospital system to offset losses. Title X funding cannot replace Medicaid revenue. If retroactive coverage is eliminated, clinics face increased uncompensated care, worsening cash low un-- cash flow instability, leading to the need to increase service fees, likely staffing cuts, and potentially clinic closures to address the gap. And in rural communities, when one clinic closes, clients face the reality of additional care deserts. Currently, 51.6% of counties in Nebraska are defined as maternity care deserts, according to the March for Dimes. 19 rural Nebraska counties already have no provider able to prescribe contraception. Patients will have to travel hours for basic health services. This waiver shafes-- shifts financial risk from the state onto the smallest providers and lowest income patients. It will create gaps in care, destabilize rural health infrastructure, and deepen existing in-- inequities. We urge you to reject this waiver and protect retroactive coverage. Thank you for your time.

HARDIN: Questions? Senator Riepe.

RIEPE: Thank you, Chairman. I have a question about-- do you have a other source of funding? I assume that you're not associated with any of the big hospitals or any of the big medical groups. What is your funding? Because you, you could probably be more exposed than some if you're small.

CLEO ZAGURSKI: Yes. So we are a-- we fund ten agencies. Our funding is about one-third from Title X, and then the rest are-- is made up in private philanthropy dollars.

RIEPE: OK. So you don't participate in United Way or any of those?

CLEO ZAGURSKI: No.

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

HARDIN: Other questions? Seeing none. Thank you.

CLEO ZAGURSKI: Thank you.

HARDIN: Those in opposition, 1115 waiver. Those in the neutral, 1115. Seeing none. This concludes our time today on the 1115 waiver on retroactive eligibility period. Thank you.