[AGENCY 25]

The Committee on Appropriations met at 1:30 p.m. on Monday, January 23, 2012, in Room 1524 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on an agency budget, LB901, and LB952. Senators present: Lavon Heidemann, Chairperson; John Harms, Vice Chairperson; Tony Fulton; Tom Hansen; Heath Mello; John Nelson; Jeremy Nordquist; and John Wightman. Senators absent: Danielle Conrad.

SENATOR HEIDEMANN: I think we're going to go ahead and get started. Welcome to the Appropriations Committee. It looks like it's going to be an interesting and, hopefully, informative day. Looks like it's going to be a little bit longer day, so if we can all cooperate and we can get as much information to the committee as possible, that would be a good thing. We're going to start with self-introductions over to my right.

SENATOR NORDQUIST: Jeremy Nordquist, representative of District 7, which is downtown and south Omaha.

SENATOR HANSEN: I'm Tom Hansen, District 42, Lincoln County.

SENATOR WIGHTMAN: John Wightman, District 36, all of Dawson and Custer County, part of Buffalo County.

SENATOR HEIDEMANN: Right next to Senator Wightman is Senator Danielle Conrad from Lincoln. She will not be with us today. I am State Senator Lavon Heidemann, Elk Creek, Nebraska. To my right is fiscal analyst Liz Hruska. To my left is fiscal analyst Sandy Sostad, and to her left is...

SENATOR HARMS: John Harms. I represent the 48th Legislative District, Scotts Bluff County.

SENATOR NELSON: John Nelson, District 6 in Omaha, central Omaha.

SENATOR FULTON: Tony Fulton, District 29 here in Lincoln.

SENATOR MELLO: Heath Mello, District 5, south Omaha.

SENATOR HEIDEMANN: Right to Senator Mello's left is Anne Fargen, the committee clerk. Our pages for today are Christina and Alex. I just want to stress, we always stress they're great resources, but they are a great resource. Is it a busy day today. If you need anything and you think the pages can help, just ask them. They're always more than willing to help. At this time, I do want to say one other thing. We have a full committee today except for Senator Conrad, who's not going to be here. Some of the senators have bills in other committees and will be in and out all day long, but what we have before us is very important. I just want you to know that. At this time, as not to be disruptive later on, if you have cell phones either put them on silent or vibrate so they don't disrupt us later on. I also want to remind you that testifier sheets are on the table or near the back doors. You need to fill out completely and put them in the box on the table when you testify. At the beginning of your testimony, we ask that you would please state and spell your name. Nontestifier sheets near the back doors if you do not want to testify but would like to record your support or opposition, you only need to fill this out if you will not be publicly testifying. If you have printed materials to distribute, please give them to the page at the beginning of your testimony. We need 12 copies. We ask, in the matter of time, that you please keep your testimony concise and on topic. Looking today at what we have before us, we are actually going to use the light system. In an effort to be fair to all that want to testify, the Appropriations Committee will be using the light system. The principal introducer or the principal agency representative will not have a time limit. We do urge even those to keep their testimony concise and on topic. All testifiers following will be given three minutes. On the light system sitting on the testifier table, you will notice a green light when you start your testimony. When you have one

minute left, the yellow light will turn on. When the red light turns on, we ask that you conclude your testimony. Following the principal introducer on bill hearings, we take testimony first from proponents, then opponents, then neutral. For agency budget hearings, which we have first, we will take general comments, not in opposition, not for, general comments following the principal agency's representative. With that, we are going to open up the public hearing on Agency 25, the Department of Health and Human Services. Welcome.

KERRY WINTERER: (Exhibit 1) Thank you. Good afternoon. Good afternoon, Senator Heidemann and members of the Appropriations Committee. For the record, I am Kerry Winterer, that's spelled K-e-r-r-y, last name is W-i-n-t-e-r-e-r. I'm chief executive officer for the Department of Health and Human Services. I am joined today by Matt Clough, chief operating officer for the department; Dr. Joann Schaefer, director of the Division of Public Health and state's Chief Medical Officer; Scot Adams, who is the interim director of the Division of Children and Family Services and director of Behavioral Health; Vivianne Chaumont, who is director of the Division of Medicaid and Long-Term Care; Jodi Fenner, director of the Division of Developmental Disabilities; and John Hilgert, director of the Division of Veterans' Homes. I say I'm joined by them; I'm not quite sure exactly where they are but they are somewhere in the building and they would be available to the extent that you happen to have questions in their area of responsibility. I'm told they can be here within a matter of seconds. So if you have questions for them, they are available. Before we begin, we wish to thank you and your staff for your work and commitment to this process and consideration of our requests. We also thank you for including many of our requests in your preliminary recommendations. We will not address those requests unless you have additional questions for us. The budget adjustments proposed by Governor Heineman are intended to continue our initiatives to improve services for the most vulnerable Nebraskans. The recommendations reflect the realities of the current economic situation and enable us to implement operational efficiencies throughout the department, to redirect resources where necessary, and to adjust to changes in federal funding. The Governor's recommendation includes

$222,030 in General Funds--this is relative to our administration budget--$222,030 in General Funds; $229,029 in federal funds; $309,837 in personal service limitation for fiscal year 2012 requested by the department to retain social service workers to assist with ACCESSNebraska caseload increases resulting from the downturn to the economy. These funds will allow the department to continue to finance up to 40 social service worker positions through the end of FY 2012 that otherwise would be eliminated to meet previously adopted budget actions. The committee's preliminary recommendation does not include this amount and we ask that these funds be included. The Governor also recommends the transfer of $2,271,755 in General Funds and the same amount in federal funds from the department administrative program to public assistance for fiscal year 2013. This transfer of appropriation authority allows for the child welfare case management functions to remain with the private contractors. The department requests the committee to include this recommendation to continue transfer of funds to contract for case management. Medical assistance: Governor recommends reductions of $3,382,913 in General Funds and $4,302,032 in federal funds for the Medicaid Program for fiscal 2013, as well as reductions of $8,319 in General Funds and $18,681 in federal funds for the Children's Health Insurance Program for fiscal year 2013, to reflect savings from proposed changes to the Medicaid and CHIP Programs. These reductions are based on the department's December 1 letter to the Legislature and would have an implementation date of January 1, 2013. One recommendation increases copayments for physical, speech, and occupational therapy visits from $1 to $2 per visit. We currently have a $2 per visit copayment for practitioners, such as physicians and dentists, as well as for behavioral health therapy visits. This increase allows the program to be consistent with the application of copayments. The nonemergency use of emergency departments by Medicaid clients has long been recognized as a costly problem. Nonemergency issues and chronic conditions should be treated by a primary care provider, not by an expensive visit to a hospital emergency department. The copayment of $50 per nonemergency visit to the emergency department is a cost-effective way to discourage those, who do not need to visit an emergency department, from doing so. If the primary care provider determines the visit

was indeed an emergency, the copayment will not be required. We are proposing a reduction of home health services to 240 hours per year. As of 2008 data, 29 states have identified limits on home healthcare services, including 3 surrounding states with limits of 100, 120, and 240 visits per year. This limitation will impact less than 5 percent of current clients receiving home health services. The limitation mainly impacts clients who are authorized for a large amount of home health aide hours. There has been concern expressed that this will result in institutional care. This is not the case. We believe it is important for people to be able to stay at home and have, in fact, developed programs for that purpose. Appropriate care for clients can be provided through the Home and Community-Based Waivers and personal assistance services. The hourly rates of those services are about half of the hourly rate of home health aides, I'm sorry, home health services. The Home and Community-Based Waiver can currently serve these clients. I want to add, however, that we know out-of-home care is not always more costly. The Nurse Practice Act allows personal assistance services and waiver providers to be reimbursed by Medicaid for any task that an individual can be trained to do for a family member. These tasks include ostomy, wound, skin, and ventilator care such as suctioning; provision and application of medication; injections into veins, muscles or skin; insertion and care of catheters. The variety of these services along with home health services, up to 240 hours per year, provide options for people to continue to live in the community. The department recommends the elimination of private duty nursing, an optional service under federal law. According to 2008 data, 28 states do not cover this service, including 5 of the surrounding states. Those that do place limits on services. Clients receiving the private duty nursing services would be eligible for the more cost-effective community-based services, such as PAS or chore through the Home and Community-Based Waivers. Additionally, medical childcare and respite services through the Home and Community-Based Waiver could be used to maintain the care of children while parents go to school or work. Department proposes two changes to the Personal Assistance Service Program. The first is to require that clients meet the level of care necessary to be eligible for nursing facility care and Home and Community-Based Waiver in order to receive personal assistance services. This

requirement ensures that the service is provided to clients in lieu of the more expensive nursing home care. The second change is to limit the personal assistance services to 3.5 hours per day or not more than 60 hours per month per client. Using a combination of PAS, home health, and waiver services a client can still have the care necessary to remain in the community. Again, the change in these services will not necessarily result in institutional care. As of the 2008 date, 20 states do not offer PAS Programs; of the 6 surrounding states, 4 do not provide this service. We propose that Medicaid stop paying for oral nutritional supplements, such as formula and drinks such as Boost and Ensure. Nutrition taken via a tube or food mixtures given into the blood through an IV would still be covered. Medicaid is not a food program. Other programs, such as the Women, Infants and Children food program and SNAP are in place for nutritional needs. Medicare does not pay for nutritional supplements that are taken orally and this is not a benefit covered by private insurance. I repeat, nutrition taken via tube or IV would still be covered after implementation of the reductions identified in the December 1, 2011, letter. Department proposes to limit behavioral health services to 60 outpatient therapy visits per year. This limit would provide parity with the current limit of 60 outpatient physical health therapies per year. The vast majority of Medicaid clients do not currently exceed the number of 60 mental health therapy visits per year. Limits applied in other states vary from 12 to 52 visits per year. Of the 34 states where the Medicaid Program offers mental health therapy services, a majority limit those services to one time per week or less. Making the necessary changes to the Medicaid Program is difficult. Our goal has been to ensure that limited resources are used efficiently and effectively to provide safe and appropriate services. The Medicaid Program currently provides services to more than 237,000 clients. We propose these measure to ensure that it remains a viable program for meeting the basic health needs of needy Nebraskans. Regarding developmental disabilities, the Governor's recommendations includes $127,580 in General Funds, the same amount in federal funds, and $160,795 in personal service limitation for fiscal year 2013 for an additional disability service specialist as well as four additional service coordinators in the department's Developmental Disabilities Division. The addition of the disability service specialist

would allow for timely identification and referral to DD service coordinators from Children and Family Services intake staff for children who may be eligible for services through the Division of Developmental Disabilities, potentially avoiding the situation where a child has to enter state custody in order to access services. This is part of the department's efforts to coordinated services across our divisions. For this select population, the goal would be to put the most appropriate services in place quickly in an effort to avoid prolonged court involvement and to obtain permanency and normalcy in a more efficient and effective manner. The Governor proposes to finance the state's share for these additional staff through a reallocation of resources from the Developmental Disabilities Aid Program. The committee has included this item recommended by the Governor at an amount less than recommended by the Governor. Department urges the committee to include the Governor's recommendations as these funds are necessary for timely referrals. We appreciate the opportunity to discuss these budget adjustments and be happy to answer any questions you may have. [AGENCY 25]

SENATOR HEIDEMANN: Thank you. Are there any questions? Senator Nordquist. [AGENCY 25]

SENATOR NORDQUIST: Thank you, Mr. Chairman, and thank you, Director Winterer. Just a couple...there are couple questions here on your opening testimony. On the cap on the behavioral health visits, it's 60 per year. Is that adults and children that would be impacted by that? [AGENCY 25]

KERRY WINTERER: I believe that's true, yes. [AGENCY 25]

SENATOR NORDQUIST: Okay. And so we're capping, say, a child's behavioral health and it may only be a few hundred people a year but that is still a significant amount. Those services already have to be prior authorized by Magellan, is that right,... [AGENCY 25]

KERRY WINTERER: Yes. [AGENCY 25]

SENATOR NORDQUIST: ...and deemed to be medically necessary. So what we're capping here is we have the authorization from Magellan, who says, yes, these services are medically necessary and we're putting a cap on that. Is that correct? [AGENCY 25]

KERRY WINTERER: Yes, we're trying...yes, we're putting a cap on that to be consistent with what many other states provide in terms of these services. [AGENCY 25]

SENATOR NORDQUIST: Okay. On the emergency room utilization, you said it's certainly primary care is the best alternative. Are you confident that every Medicaid recipient in the state of Nebraska has access to timely primary care in their community? [AGENCY 25]

KERRY WINTERER: Well, we would hope that that would be the case and obviously we continue to work in that direction. Relative to the emergency room deductible, to the extent it was a true emergency and was required, then there would be no deductible for that. [AGENCY 25]

SENATOR NORDQUIST: Okay. Okay. And then just this idea of utilizing the waiver for some of these services, so the entire...the 5 percent you said that's affected, they would all be covered under waiver services? [AGENCY 25]

KERRY WINTERER: Yeah, that's something that when Director Chaumont is here... [AGENCY 25]

SENATOR NORDQUIST: Okay. [AGENCY 25]

KERRY WINTERER: ...you would probably be well-advised to ask her those questions. [AGENCY 25]

SENATOR NORDQUIST: Okay. Okay. That's all I have for right now. [AGENCY 25]

SENATOR HEIDEMANN: Senator Mello. [AGENCY 25]

SENATOR MELLO: Thank you, Chairman Heidemann. And thank you, Director Winterer, for joining us today and I have three questions, then I'll let other people, other senators, be able to have some of your time as well. The first is dealing with on your testimony regarding the administration under ACCESSNebraska. [AGENCY 25]

KERRY WINTERER: Yes. [AGENCY 25]

SENATOR MELLO: Could you provide the committee, I guess, a little bit more background or explanation of why the department needs these additional caseworkers when it was...it was your department who's come in front of us the last few years of explaining the need to reduce workers to implement the ACCESSNebraska Program? And we've had some reports that your department has provided us the budgeting process in regards to the number of caseloads within the existing ACCESSNebraska system and it's maybe more for explanation on our end of why you need to do this when your original intention and purpose as to why we needed to cut these workers were for streamlining and efficiency purposes. [AGENCY 25]

KERRY WINTERER: That's right. I think what we've discovered is that essentially the volume of cases in ACCESSNebraska continues at a high level and we need to continue to have on a temporary basis caseworkers available to continue to work on that caseload and probably enhance services offered at ACCESSNebraska. [AGENCY 25]

SENATOR MELLO: Well, by continuing...by essentially retaining or rehiring these caseworkers, what is the...does the department have any estimates in regards to the

number of caseloads or the wait time, so to speak, on the ACCESSNebraska call center, what that would be reduced by, by incorporating these employees into the process? [AGENCY 25]

KERRY WINTERER: I think Director Adams can answer that question, if you'd care to have that...have him respond to that. [AGENCY 25]

SENATOR MELLO: Okay. Okay. Okay, I'll ask him then at a later point in time. A second question goes to the privatization effort. This committee did not include in our preliminary budget the $2.2 million that is needed to continue with the child welfare privatization effort. And part of the reason I think is, while the Health and Human Services Committee has been primarily been the focal point of exploring the Family Matters Initiative, can you provide this committee any more updates in regards to whether or not your department is negotiating contracts right now with the lead agencies that would increase the amount of their contracts? [AGENCY 25]

KERRY WINTERER: As you probably know, we are in the midst of discussions with the contractors centered around implementing a case rate. That's something we've tried to work toward and we continue to work toward. We don't have an agreement at this point. We are working, I would say diligently, to try to accomplish that. I think it's premature at this point to make a prediction in terms of what does that really mean and what is that case rate going to be. I mean it's like negotiations. We have our ideas about a case rate and they have theirs. In negotiation now is how do you come to some kind of an agreement that will be reasonably reflective of the costs to provide the services and something that we can move forward with. [AGENCY 25]

SENATOR MELLO: If you're in the process right now of negotiating, and we're discussing deficit appropriations, where would the department find additional funding then to renegotiate these contracts or extend these contracts to the lead agencies then? [AGENCY 25]

KERRY WINTERER: Well, in the first place, I'm not sure that it means that we are going to have to have additional funds. We won't know that until we really play through this process, so it's a little premature to make some prediction or some analysis of where funds may come from until we really finish the process that we're engaged in right now. [AGENCY 25]

SENATOR MELLO: Is that process, you think, will be completed before the end of this legislative session? [AGENCY 25]

KERRY WINTERER: Oh yes. [AGENCY 25]

SENATOR MELLO: So it would be possible that you would have to come back in front of our committee to request additional funds for these renegotiated contracts? [AGENCY 25]

KERRY WINTERER: Certainly that could be...that could be one of the possibilities, yes. [AGENCY 25]

SENATOR MELLO: Okay. Okay. My last question, real quick, deals a little bit more with the childcare subsidy issue. Your department provided a $9 million a year childcare deficit. The Governor put $12 million in his preliminary budget. We ultimately put $12 million in ours. Can you provide a little feedback to us? It's our understanding that the department has been able...that funding out of the childcare subsidy is not siloed, that money can be moved around within that department to sometimes meet the needs of other aspects of the department, whether that be child welfare or others. And it's an issue and a concern that was raised within...with our committee of looking to silo that money to ensure that this kind of deficit appropriation, essentially in the name of childcare, is not really...it's not really possibly needed for childcare because you're able to take that money and spend it on other priorities that you see within the department. If

we continue this $12 million appropriation, is that something you would be willing to agree or at least acknowledge that the need possibly would be for us to silo that money away from any other aspects of other programs in the department and keep it exclusively for childcare subsidy issues? [AGENCY 25]

KERRY WINTERER: Well, you're talking about Program 347,... [AGENCY 25]

SENATOR MELLO: Yeah. [AGENCY 25]

KERRY WINTERER: ...which generally is the public welfare program, if you will, which is the funding source for several different programs. And historically the department has been able then to utilize that pool of money to support all these programs and there has been some flexibility to move dollars from one program to another because it's essentially one program area. I would continue to argue for the need for that kind of flexibility because it does allow the department the ability, from one year to the next, to, if a budget...if the allocated amount for a particular program is higher or lower than may have been projected, or you have a population change or something that says our expenditures are actually going to be higher in this program than we might have anticipated, the use of 347 and the dollars in there to be able to make some adjustments inside that larger program has provided flexibility and the ability to fund those programs. [AGENCY 25]

SENATOR MELLO: I guess, I guess, Director, I think from the extensive audit by the Public Auditor of Accounts, as well as the Performance Audit Committee of this Legislature, has shown that Program 347 needs more transparency in regards to where funds currently go. And I guess my question is we have seen, through these now fairly well-documented financial audits, that your department has been able to use money in Program 347 and spend it on other aspects, primarily on the child welfare privatization effort. My question is, if we provide you this $12 million in Program 347, are you amenable for us to silo that $12 million so it goes for childcare and does not continue to

go for the child welfare privatization effort, which currently you could take this money, this $24 million,... [AGENCY 25]

KERRY WINTERER: Uh-huh. [AGENCY 25]

SENATOR MELLO: ...and spend it on that and not spend it on childcare one bit? [AGENCY 25]

KERRY WINTERER: Well, I understand what you're saying, Senator, and I guess the Legislature can appropriate and do what they will. I want to reiterate what I said before and that is that there is an advantage to being able to have those dollars in 347 that can be...can provide some flexibility. Now relative to childcare, we know that we've got about an $11.5 million deficit in childcare right now. So the appropriation is $12 million. I don't see that there's much available that can be used for any other purpose other than childcare and that's what we would anticipate through the next year as well. So those dollars are necessary for that childcare program so I don't see how it fits within some dollars that may be available for some other purpose. [AGENCY 25]

SENATOR MELLO: Okay. Thank you, Director. [AGENCY 25]

SENATOR HEIDEMANN: Senator Mello, did you have questions for Director Adams? [AGENCY 25]

SENATOR MELLO: Is...would now... [AGENCY 25]

SENATOR HEIDEMANN: Were they going to all testify or only as needed? [AGENCY 25]

KERRY WINTERER: No, they don't intend to testify, but they are available for questions and specifics that I may not necessarily adequately address. [AGENCY 25]

SENATOR HEIDEMANN: Did you have questions for Director Adams? [AGENCY 25]

KERRY WINTERER: They are...they are in an office next door so they could be here within 30 seconds. [AGENCY 25]

SENATOR MELLO: Yeah, I'll let other senators ask and I'll come back and try to get Director Adams. That would be great. [AGENCY 25]

SENATOR HEIDEMANN: So we have interest in getting Director Adams eventually in here. Is there anybody else wanting to talk with any... [AGENCY 25]

SENATOR NORDQUIST: (Inaudible)...address Director Chaumont too. [AGENCY 25]

SENATOR HEIDEMANN: And also Vivianne Chaumont. Anyone else? Are there any other questions for Kerry at this time? Senator Nordquist. [AGENCY 25]

SENATOR NORDQUIST: And you can tell me to direct this towards Director Chaumont if that's all right. So in the budget, we are taking $5 million, we're decreasing the base of Medicaid by $5 million and $1 million in CHIP for, it says, a year-to-date analysis of program funding requests based on...is that based on underutilization in the program versus previous projections? [AGENCY 25]

KERRY WINTERER: Well, yeah, it's based on looking forward to utilization and realizing that it's unlikely that money would be spent... [AGENCY 25]

SENATOR NORDQUIST: Okay. Do you... [AGENCY 25]

KERRY WINTERER: ...based on current utilization trends. [AGENCY 25]

SENATOR NORDQUIST: Okay. Do you know...Director Chaumont said at the LB826 hearing, I think it was, that we're going to see an increase of enrollment of over 4 percent. Why are we seeing the trend of enrollment going up 4 percent and services having that... [AGENCY 25]

KERRY WINTERER: Enrollment, 4 percent in what? [AGENCY 25]

SENATOR NORDQUIST: I believe it was Medicaid enrollment, but she can...she can correct that. [AGENCY 25]

KERRY WINTERER: I think you can ask her that question. [AGENCY 25]

SENATOR NORDQUIST: Okay. Okay. And then also could be for her, so we're cutting our base down in these two programs $6 million. And your department conducted a study related to the implementation of healthcare reform that said in the next biennium the estimated costs, maybe this all wasn't to the department, but the estimated cost was anywhere from...about $80 million over the biennium to $120 million over the biennium. Why are we reducing now knowing that we have this looming potential liability? [AGENCY 25]

KERRY WINTERER: Well, I think my answer to that is I think you kind of deal with that liability as it matures and look at that liability at that point in time. To the extent that we have those extra dollars in Medicaid at this point in time, I mean they could be available for something else in the short term. [AGENCY 25]

SENATOR NORDQUIST: Uh-huh. Is the department still estimating...using that estimate of the $80 million to $120 million as the best number we have right now for the next biennium? [AGENCY 25]

KERRY WINTERER: I have not seen anything that would call that into question at this

point. [AGENCY 25]

SENATOR NORDQUIST: Okay. So...okay. I just want to keep that in mind as we look at the Governor's proposed budget for the next biennium, which only has $300 million of new spending in it. And if your department is saying that we have $80 million to $120 million of that for healthcare, then that takes about half of his estimated spending growth. So I think that's important for the committee to keep in mind. Thank you. [AGENCY 25]

KERRY WINTERER: Okay. [AGENCY 25]

SENATOR HEIDEMANN: Are there any other questions for Kerry at this time? Seeing none, if you could identify yourself for the transcribers later on. [AGENCY 25]

VIVIANNE CHAUMONT: Sure. My name is Vivianne Chaumont, V-i-v-i-a-n-n-e C-h-a-u-m-o-n-t. I'm the director of the Division of Medicaid and Long-Term Care. [AGENCY 25]

SENATOR HEIDEMANN: Senator Fulton. [AGENCY 25]

SENATOR FULTON: Thank you, Mr. Chairman. Thank you for being here, Director Chaumont. The way I look at some of these proposed cuts, number one, we have to make a determination here in the Appropriations Committee and the Legislature as to whether indeed we believe there's adequate funding to accomplish a legitimate responsibility that government has to certain people. Another part of it has to do with whether indeed the policy of making a reduction here will indeed be good fiduciary fiscal policy going forward. And so I'd like to focus my questioning on the latter. Can you give me some insight as to how the department has concluded that the reductions...we can speak specifically to reductions within the home health services but I think there are other places where the philosophy is going to apply anyway, whether, for lack of a

better term, saving $5 here is going to indeed cost more dollars down the road? This is separate from the determination that we have to make as to whether indeed we're honoring our responsibility to individuals, but I'm asking you, the fiduciary, what was the rationale and can you speak to that? [AGENCY 25]

VIVIANNE CHAUMONT: That's right. We believe that there are other services available that could take the place. First of all, we have no interest in putting anybody in institutional care. As a general rule, institutional care is more expensive than community care but not always. We have many clients who in fact are more expensive in the community than they are...than they would be in a nursing facility. But what we believe we have is access to the home and community-based services which would allow the clients to be served at an even more efficient way in the community as opposed to going into an institution or as opposed to the way that we currently fund the programs now. For instance, home health aides, in the type of services that they do in the Home and Community-Based Services Waiver are about one-half of what they would cost as a home health aide. And so we believe that there are folks who can be served by...in the waiver and result in cost savings to the department while maintaining their ability to stay at home. We believe that because we have clients currently in the waiver who have the same kinds of needs as folks who are currently getting home health aide services. [AGENCY 25]

SENATOR FULTON: Well, going...I appreciate that. Going forward, that's, for others who will testify to follow, that's a question I'd like to have an answer from people publicly to the contrary; no offense, but I want to hear both sides of the... [AGENCY 25]

VIVIANNE CHAUMONT: Absolutely. Uh-huh. [AGENCY 25]

SENATOR FULTON: Thank you. [AGENCY 25]

SENATOR HEIDEMANN: Senator Mello. [AGENCY 25]

SENATOR MELLO: Thank you, Chairman Heidemann. And thank you, Director Chaumont and Director Adams, since you're both here. I'll start with Director Chaumont first. And I guess it's maybe more of a clarification on some of the communication this committee has received. Federal changes has required the department to update their state Medicaid plan in regards to pharmacy, essentially in regards to the drug costs that are paid to pharmacists. It's been laid out that the department was supposed to, in theory, have these updated Medicaid regulations by October 1, 2011, to change and update the drug costs that would be paid back to local pharmacists for Medicaid patients. That has not been done to date and the reality is that if those regulations are not adopted in the near future that more than likely those costs would continue to be...shift to the pharmacist to accept, at least through the first quarter of 2012. Can you give the committee an update at all of where you're at with the adoption of that regulation and if there's any soon-to-be adoption, so to speak, in the near future? [AGENCY 25]

VIVIANNE CHAUMONT: Right. It's my understanding that those regulations are ready to go to hearing, but I didn't check on that just before coming over here. The federal guidance came late, as it tends to, and we believe that once...that we will implement as soon as possible. [AGENCY 25]

SENATOR MELLO: Okay. Okay. [AGENCY 25]

VIVIANNE CHAUMONT: And I'm not aware of any cost shift to pharmacies as a result of that. [AGENCY 25]

SENATOR MELLO: Well, essentially, because of the...because...it would be a cost shift to the pharmacist because, in theory, if the regulation was not adopted by October 1, they're still operating off the old plan and old costs, and that means that they're not being...their increased payment has not come into effect for the last quarter of 2011.

And if it's not been adopted yet, it would probably be still the first quarter of 2012, which means it's a cost shift essentially of six months on Medicaid patients to local pharmacists. We can have the conversation off record if we want, that's fine, but that... [AGENCY 25]

VIVIANNE CHAUMONT: Right. That was my understanding... [AGENCY 25]

SENATOR MELLO: ...that was my understanding, so to speak, of it. [AGENCY 25]

VIVIANNE CHAUMONT: Right, and my understanding is that the rates will decrease rather than increase, so... [AGENCY 25]

SENATOR MELLO: Director Adams, just I guess as a point of clarification on the ACCESSNebraska issue, I asked Director Winterer, this committee, the past predecessor of the director of Children and Family Services has come before this committee explaining that ACCESSNebraska would save the state significant amounts of money in regards to the efficiency in operations of our public assistance programs. Your deficit appropriation bill or request comes in requesting additional funds for caseworkers. Can you provide a little...I guess a little bit more feedback to us in the sense there's multiple other bills that you know of that looks to address ACCESSNebraska to make it...to make it more user friendly, consumer friendly. And the question is with this $200,000 or $300,000 in General Funds to continue employing these caseworkers, what's the end result going to be? I mean this is a short-term fix, so to speak. It's not a long-term staffing issue. It's only six months, it looks like. And can you give us a little update of what do you expect to really get from this? [AGENCY 25]

SCOT ADAMS: Sure. [AGENCY 25]

SENATOR HEIDEMANN: Can you state and spell your name? Thank you. [AGENCY 25]

SCOT ADAMS: Great. I have my dad and my mom here. (Laughter) That's great. Thank you. My name is Scot Adams, S-c-o-t A-d-a-m-s, interim director for the Division of Children and Family Services in this capacity here. Thank you for the question. I appreciate that, Senator, very much. Frankly, the answer is that we are falling somewhat behind on some of the workloads that we have, and that really is the result of the unprecedented numbers of persons seeking public assistance. When ACCESSNebraska began a couple years ago no one was looking at a recession this long or this deep for many folks, and so that has affected benefits acquisition. So part of it is just an overwhelming workload and we think that we can begin to get on to it and get caught up here in the next six months or so with regard to that. As an example, the last of the call center staff came on-line in January last week in Lexington, Nebraska. And so we think that that part of the plan is good and we're getting better and better every time, all the time, but it's going to take a little bit more time to catch up with some of the past work orders that are part of this process. And so that's the reason for the short-term focus with regard to that. I do have some additional information regarding ACCESSNebraska that we have given to other committees that may be of benefit to this committee as well. [AGENCY 25]

SENATOR MELLO: Okay. Thank you. [AGENCY 25]

SCOT ADAMS: Yes, sir. [AGENCY 25]

SENATOR HEIDEMANN: Why aren't they on the waivers now? What's preventing them from being on the waivers, if it's cheaper? [AGENCY 25]

VIVIANNE CHAUMONT: Well, currently we have been advised that there are times when home health agencies advise clients to not go on the waiver because they tell them that they can get more home health off the waiver than through the waiver. In fact, there's also some...I think some misunderstanding about the caps on the waiver. There

is a cap on the waiver because the waiver requires that someone on the waiver not cost more than they would in the community. And so there is a general cap. However, if a client exceeds that cap because their needs are more extensive than they would be in a regular nursing home, than their case comes to central office and we actually compare what that person would cost in the...is costing in the community with what they would actually cost in an institution, and that's the cap for that individual, not the normal cap. So I think there's some misunderstanding about the waiver and I also think that providers want the more expensive services because the home health aide service is billed at about twice what a home health...what a waiver service provider would be. [AGENCY 25]

SENATOR HEIDEMANN: Senator Nordquist. [AGENCY 25]

SENATOR NORDQUIST: Thank you, Mr. Chairman. Thank you, Director. Following up on that, I've heard a lot of concern about the personal assistance services and possible, you know...well, one of the largest concerns is you have your own individual; if they're not there for you, you're out of luck. Can you address those concerns? [AGENCY 25]

VIVIANNE CHAUMONT: Uh-huh. Right. On personal, some folks use personal assistance services. We have people on the waiver currently. One of the examples that I have that I'll talk about in response to your bill is...and this isn't the only example, but they have personal assistance and, in case of emergency, they have home health set up as a backup through a home health aide. And so folks...that is one of the things that...that's one of the issues with personal assistance services. With the waiver services, the home health agency or an agency can provide the waiver services as much as they provide the home health aide services, and so there would be that backup there. [AGENCY 25]

SENATOR NORDQUIST: Uh-huh. And am I right, there are also...does the state do some case...they do case management on the waiver? [AGENCY 25]

VIVIANNE CHAUMONT: There's case management on the waiver and that case management...and I think that's also a benefit because a case manager can help a family, an individual to see what other services are available in the community and other options, and then you have a case manager that's managing the care for that client and looking at it, as opposed to a provider who has a financial interest managing the care of that client. [AGENCY 25]

SENATOR NORDQUIST: Do we have enough capacity right now with the case management to absorb this or would there be additional state workers brought on? [AGENCY 25]

VIVIANNE CHAUMONT: They...no, currently I think we have the capacity. The case management, the way we do it in the waiver, is fragmented right now, which I think is something that we should probably look at in the future. For children, the case management is done by workers within the department in Children and Family Services. With folks between, I guess, 18 and 65, it's done by the League of Human Dignity and other organizations, Independent Living, Centers for Independent Living, and they get a per person, per month rate so they could easily expand. That would be an additional...because they would get additional revenue. And then for folks 65 and above, the case management is done by the AAA. [AGENCY 25]

SENATOR NORDQUIST: Okay. [AGENCY 25]

VIVIANNE CHAUMONT: So where we might have a problem might be if we did have a problem with caseworkers, our own caseworkers, I think we could contract that out to the Centers for Independent Living or the League of Human Dignity as well. [AGENCY 25]

SENATOR NORDQUIST: So are you confident if we were to move forward with this that

we wouldn't see an increase in institutional care? [AGENCY 25]

VIVIANNE CHAUMONT: I think that I am comfortable that we would be able to manage the care of clients in the community. [AGENCY 25]

SENATOR NORDQUIST: Okay. On the letter you sent on December 1, there's two pages, the second page is the optional services and it said these would be restricted if the federal government made choices that adversely impacted the state. Has there been any movement to any changes since that letter was sent to make you think that we need to go down that road this year? [AGENCY 25]

VIVIANNE CHAUMONT: I don't. It doesn't look like we would definitely go down that road this year. What that was, was you all saw in the news the federal budget and they had the super committee that was supposed to take care of the federal budget and come up with solutions for balancing or reducing the budget. The super committee wasn't so super; it didn't do it. And so then there's supposed to be, you know, standard...I think it was 2 percent cuts across the board. The 2 percent cuts did not include Medicaid and did not include Medicare. But then after the super committee failed and then there was talk that, no, no one is going to stand for the cuts the way they are, and so everything is kind of back on the table. So it really is in the worst case scenario that something would happen to the Medicaid Program and I don't foresee that happening in the next fiscal year. [AGENCY 25]

SENATOR NORDQUIST: Okay. Okay. And then last question, I asked Director Winterer and he directed me towards you, the savings of $6 million between Medicaid and CHIP and I believe you said in LB826 we've seen an increase in enrollment of over 4 percent. [AGENCY 25]

VIVIANNE CHAUMONT: Uh-huh. [AGENCY 25]

SENATOR NORDQUIST: How do those numbers come together and where are...what part, I guess, of Medicaid, what services are we seeing the most dramatic costs, under projections I guess? [AGENCY 25]

VIVIANNE CHAUMONT: I don't think we're...well, I don't think we're seeing any particular service under costs. We did save money when we redid some nursing facility rates. We saw a goodly amount of money there as a result of that, and I'm not talking about the 2.5 percent, just when we revised rates to make them more accurate as to the acuity of each client. And I think managed care has made a big difference and continues to make a big difference and will make a big difference when we implement statewide July 1. [AGENCY 25]

SENATOR NORDQUIST: Okay. Thank you. [AGENCY 25]

SENATOR HEIDEMANN: Senator Hansen. [AGENCY 25]

SENATOR HANSEN: Thank you. Director Chaumont, I want to go back to what Senator Mello started on the drug cost increase. [AGENCY 25]

VIVIANNE CHAUMONT: Uh-huh. [AGENCY 25]

SENATOR HANSEN: And I've been contacted by pharmacies out in the western part of the state that said that there certainly is a cost shift because they only have two alternatives, either to rebill from last quarter the increases that they didn't get Medicaid payments for, and those are for Medicaid prescriptions, of course; but the other...the only other alternative is that they absorb that increased cost. So can they rebill from last quarter? [AGENCY 25]

VIVIANNE CHAUMONT: You know... [AGENCY 25]

SENATOR HANSEN: They've been told they couldn't, so... [AGENCY 25]

VIVIANNE CHAUMONT: I apologize but I am not at all familiar with this issue so I'd like to go back and talk to my pharmacy people and then send you a letter with additional information,... [AGENCY 25]

SENATOR HANSEN: Great. [AGENCY 25]

VIVIANNE CHAUMONT: ...because I just don't know, sir. I'm sorry. [AGENCY 25]

SENATOR HANSEN: Thank you. [AGENCY 25]

SENATOR HEIDEMANN: Senator Mello. [AGENCY 25]

SENATOR MELLO: Thank you, Senator Heidemann. And, Director Chaumont, I only have one other real follow-up question for you regarding what Senator Nordquist started to talk about, the December 1 letter. In that letter you indicated there was going to be some offsets to the savings gained by the proposed cuts. Can you give us more information on what those offsets are? [AGENCY 25]

VIVIANNE CHAUMONT: Sure. We, you know, what we say is that we're going to shift people from the home health. Let's take that as an example, the home health reduction to 240. The majority of clients that will be affected by that is to home health aides, so they're receiving home health aide services. Home health aide services would be provided under...can be provided as chore services or other services under the Home and Community-Based Services Waiver. So it isn't that we would stop paying for that service at all. It's that we would shift it to a different place at about half the cost. [AGENCY 25]

SENATOR MELLO: Do you think there's...are you confident that's not going to have any

increased costs then with nursing home costs? [AGENCY 25]

VIVIANNE CHAUMONT: Yeah, I am. [AGENCY 25]

SENATOR MELLO: Okay. That's all I have. [AGENCY 25]

SENATOR HEIDEMANN: Are there any other questions? [AGENCY 25]

SENATOR NELSON: Yeah, Lavon. [AGENCY 25]

SENATOR HEIDEMANN: Senator Nelson. [AGENCY 25]

SENATOR NELSON: Yeah, thank you very much. Thank you, Director Chaumont. Just a little follow-up on what, Senator Mello, you...in cutting 240 hours...to 240 hours per year, you talk about only 5 percent, will impact less than 5 percent. What type of person constitutes that 5 percent person, people that need physical therapy and other things of that sort? How does that work and how are they cared for, if you follow me? [AGENCY 25]

VIVIANNE CHAUMONT: The 5 percent are folks who are currently receiving home health services. We took...we looked at everyone that's currently receiving home health services and determined that only 5 percent of those people were...would be impacted by the reduction. Those are all kinds of people who are receiving care at home, quadriplegics, people on vents. [AGENCY 25]

SENATOR NELSON: That need 24-hour care or things of that sort that would... [AGENCY 25]

VIVIANNE CHAUMONT: No, actually... [AGENCY 25]

SENATOR NELSON: Well, okay. [AGENCY 25]

VIVIANNE CHAUMONT: ...most people do not, do not need the 24-hour care in the home health. In the private duty nursing, you have people that might need more of that care. [AGENCY 25]

SENATOR NELSON: All right. All right, thank you. [AGENCY 25]

VIVIANNE CHAUMONT: Uh-huh. [AGENCY 25]

SENATOR HEIDEMANN: Senator Mello. [AGENCY 25]

SENATOR MELLO: Thank you, Senator Heidemann. I apologize, Director Adams. I should have asked you about this when I first mentioned about the ACCESSNebraska, and hopefully maybe you can shed a little bit more light than what Director Winterer was able to do. If this committee does not transfer the $2.2 million General Funds to continue the privatization effort, child welfare privatization effort, according to your budget request, what ultimately will happen, what will ultimately happen within the department to meet that need? [AGENCY 25]

SCOT ADAMS: Well, you know, Senator, that's a good question. The Unicameral and the committee transferred that the first year and so we made motion in that, and I suspect that that was an attempt to keep an eye on the progress of things, and so... [AGENCY 25]

SENATOR MELLO: Correct. [AGENCY 25]

SCOT ADAMS: ...so there's a great conversation going on currently in a lot of different committees about the topic. [AGENCY 25]

SENATOR MELLO: Uh-huh. [AGENCY 25]

SCOT ADAMS: I certainly hope that there will be clear resolution to that. [AGENCY 25]

SENATOR MELLO: Uh-huh. [AGENCY 25]

SCOT ADAMS: And that your scenario, if simply straightforwardly comes to us, we'll have to figure that out one way or another. But right now we're hoping that as a result of the conversations going on in the various committees there will be clear resolution of that question. [AGENCY 25]

SENATOR MELLO: Okay. Thank you, Director Adams. [AGENCY 25]

SCOT ADAMS: Thank you. [AGENCY 25]

SENATOR HEIDEMANN: Senator Nordquist. [AGENCY 25]

SENATOR NORDQUIST: Thank you. And maybe both, start with I guess Director Chaumont. I guess I don't know who's leading the charge here on the implementation of the Affordable Care Act and the actions the department has taken so far to move us toward that seamless integration that's envisioned between the exchange and Medicaid and updating enrollment systems to handle the new capacity and the other changes that you foresee, either things you have worked on the last six months and things you foresee maybe in the next six months as we move down that road. [AGENCY 25]

VIVIANNE CHAUMONT: Well, we are planning. The Affordable Care Act requires many changes to the Medicaid system and we are planning and trying to determine. CMS has not...the federal government has not been particularly quick in giving out guidance or being very specific about the guidance. They keep saying, we'll get to that, it's coming. So based on the information that we have, we are planning but we will not be building

anything until the Supreme Court has ruled. [AGENCY 25]

SENATOR NORDQUIST: Okay. Are there any...do you know, are there any innovation state...any innovation or state grants that are out there that states have taken advantage of that we could potentially use a similar system? I know there had been talk of that. [AGENCY 25]

VIVIANNE CHAUMONT: Right. There's been some talk about early innovators... [AGENCY 25]

SENATOR NORDQUIST: Uh-huh. [AGENCY 25]

VIVIANNE CHAUMONT: ...and a lot of the early innovators have backed out. [AGENCY 25]

SENATOR NORDQUIST: Yeah. Okay. [AGENCY 25]

VIVIANNE CHAUMONT: And part of the issue even before they were, for instance Kansas, before they backed out,... [AGENCY 25]

SENATOR NORDQUIST: Uh-huh. [AGENCY 25]

VIVIANNE CHAUMONT: ...they were an early innovator and they were going to have something set up very close to the time that people would have to implement, so it really wouldn't have been particularly helpful to any other state. [AGENCY 25]

SENATOR NORDQUIST: As you're walking through your planning process, I guess, what are the...what are the decisions that need to be made, you know, and how soon do they need to be made, like in the next six months? [AGENCY 25]

VIVIANNE CHAUMONT: I don't see anything that needs to be made in the next six months. One of the things that we're working on is trying to figure out how current eligibility categories, except for the aged and disabled, will translate over to modified adjusted gross income; what kind of requirements or what kind of documentation we need to have, those types of issues. [AGENCY 25]

SENATOR NORDQUIST: Okay. And working with the Department of Insurance on all this as well? [AGENCY 25]

VIVIANNE CHAUMONT: Yes. [AGENCY 25]

SENATOR NORDQUIST: Great. Thank you. [AGENCY 25]

SENATOR HEIDEMANN: Senator Wightman. [AGENCY 25]

SENATOR WIGHTMAN: Thank you. I'll direct this question to Director Chaumont, and it's a follow-up question on what Senator Nelson asked a few minutes ago with regard to the 240 hours. I see that you're talking 240 hours per year, but the limits that have been set by other states are in terms of visits, at least the way it reads in this. [AGENCY 25]

VIVIANNE CHAUMONT: Uh-huh. [AGENCY 25]

SENATOR WIGHTMAN: Can you tell us how "hours" and "visits" would correspond? [AGENCY 25]

VIVIANNE CHAUMONT: I think that we are thinking 240 hours. [AGENCY 25]

SENATOR WIGHTMAN: Two hundred and forty hours is not visits. [AGENCY 25]

VIVIANNE CHAUMONT: Uh-huh. Uh-huh. Right. [AGENCY 25]

SENATOR WIGHTMAN: Is there a minimum charge of one hour per a visit or...? [AGENCY 25]

VIVIANNE CHAUMONT: I think that we reimburse per two hours. [AGENCY 25]

SENATOR WIGHTMAN: Two hours. [AGENCY 25]

VIVIANNE CHAUMONT: Right. [AGENCY 25]

SENATOR WIGHTMAN: So we'd be looking at about where 120 is in these surrounding states. Would that be true? [AGENCY 25]

VIVIANNE CHAUMONT: You know what, let me check on that... [AGENCY 25]

SENATOR WIGHTMAN: Okay. [AGENCY 25]

VIVIANNE CHAUMONT: ...because I think I may just have misspoken. While everyone else testifies, I will send an e-mail to my staff and come back and let you know the right answer. [AGENCY 25]

SENATOR WIGHTMAN: Thank you. That's all of my questions. [AGENCY 25]

SENATOR HEIDEMANN: Are there any other questions? Do any of the senators have any questions for any of the other directors? Seeing none, thank you. [AGENCY 25]

VIVIANNE CHAUMONT: Thank you. [AGENCY 25]

SCOT ADAMS: Thank you. [AGENCY 25]

SENATOR HEIDEMANN: At this time, we are going to take general comments on Agency 25's budget, general comments. We will be starting the light system at this time. You will have approximately three minutes of testimony time. For certain people that want to testify that we can see that they need a little additional time because of a disability or other reasons, we will try to accommodate that. Welcome. [AGENCY 25]

MARTY FATTIG: (Exhibit 2) Good day, Senator Heidemann. I have prepared comments and Bruce is getting them for you here. Senator Heidemann and members of the Appropriations Committee, my name is Marty Fattig, and that's spelled M-a-r-t-y F-a-t-t-i-g, and I'm the administrator and chief executive officer of Nemaha County Hospital in Auburn, Nebraska, and we're a 20-bed critical access hospital employing about 104 people. And I'm here to testify on behalf of the Nemaha County Hospital and the Nebraska Hospital Association in opposition to the proposed cuts in the Medicaid and CHIP Programs as required by the Governor's proposed biennium budget adjustments. I realize the nature of this hearing is to focus on the proposed budget and healthcare provider reimbursement reductions contained therein; however, I think it would serve the committee well to begin with a discussion of the macro financial pressures currently imposed on hospitals before addressing the specific cuts proposed by the Governor's biennium budget adjustments. On average, Nebraska's hospitals are currently reimbursed at 28 percent below their cost when providing care to Medicaid patients. The current margin for caring for Medicare patients is 13 percent below costs. In 2009, the unpaid cost of providing Medicaid services by Nebraska's hospitals exceeded $130 million, and the unpaid cost for providing Medicare services was nearly $350 million. That same year, Nebraska hospitals provided more than $168 million in traditional charity care and incurred more than $200 million in bad debt. Altogether, the unpaid costs of those services amounted to nearly $850 million in one year. For years increases in costs of providing care for Medicare and Medicaid patients has been far greater than any increases in corresponding provider rates. Recent year-to-date hospital rate increases for Medicaid have been 1.95 percent in 2008, 1.9 percent in 2009, 1.5 percent in 2010, and .5 percent in 2011. And for fiscal year 2012, our rates

were cut by 2.5 percent. The Patient Protection and Affordable Care Act will not only increase the...will not only provide decreases in Medicare and Medicaid rates but it will also increase the number of providers (sic) that will be eligible for Medicaid. In 2014, eligibility goes to 133 percent of the poverty level for nonelderly, which includes parents, children, and childless adults. Recently, headlines across the state have indicated other providers, especially physicians, dentists, are questioning how much longer they will be able to accept Medicaid patients and some are considering the same for Medicare. Most of the hospitals in Nebraska are located in rural communities so that residents of large geographic areas will have access to healthcare, and data shows that a larger percentage of these residents in rural areas rely on Medicare and Medicaid to pay for their care. Not only will the provider cuts jeopardize existence of these rural hospitals, which currently operate at very low margins anyway, but they will make it almost impossible to recruit doctors and dentists to these rural areas as the current providers retire. On behalf of the Nemaha County Hospital and the Nebraska Hospital Association and rural hospitals throughout the state, I appreciate your time and attention to this important issue. [AGENCY 25]

SENATOR HARMS: Thank you very much for your testimony. Do we have any questions? Seeing none, thank you very much. [AGENCY 25]

MARTY FATTIG: Thank you. [AGENCY 25]

GARY PERKINS: (Exhibit 3) Good afternoon, Mr. Chairman and members of the Appropriations Committee. My name is Gary Perkins, G-a-r-y P-e-r-k-i-n-s. I'm the president and CEO of Children's Hospital and Medical Center in Omaha. On behalf of the children and their families, I appreciate the opportunity to provide comments on the Division of Medicaid's budget proposal and its impact on our patients, families, and employees. Children's is the only speciality pediatric hospital in the region, with approximately 2,000 employees. When our doors first opened in 1948, we never turned away any patient because of an inability to pay; this stands true today. The number of

patient visits to Children's has grown to over 340,000 in 2001. Because we are the largest provider of pediatric care, Children's serves a disproportionate share of children from low-income families. We have seen the percentage of Medicaid patients grow steadily over the years. In 2011, 46 percent of the patients were covered by Medicaid. Children covered by Medicaid generally require more care, yet Medicaid payments cover less than 75 percent of the cost of providing that care. The cuts proposed in this year's Medicaid budget will impact Children's ability to serve our most vulnerable patients. However, when these cuts are coupled with the 2.5 percent provider payment reduction already in effect and the unknown costs of federal healthcare reform, our ability to provide necessary services is diminished even further. We fully recognize the efforts of the department to maintain a viable Medicaid Program. To that end, our hospital is focused on providing high quality, cost-effective care. For example, we have reduced the average length of stay from 5.4 to 4.6 days in 2011 in our hospital. This is an outstanding measure, given the complexity of care our patients receive. Also, I have included information on one of our cost-savings programs, Children's World. Children's World provides a cost-effective alternative to private duty nursing for working parents. I mention this to illustrate that Children's is a good steward of our financial resources. Two of the divisions' proposed cuts include private duty nursing and oral nutritional supplements, which we contend are shortsighted and detrimental to our patients. I understand the department is considering moving patients who receive private duty nursing services to waivers for coverage. Waivers do not cover private duty nursing for sleep, a critical component for parents to allow them to continue to work. This cut will not only have a dramatic impact on families but also 35 nursing positions will also be in jeopardy. In addition, the elimination of oral nutritional supplements is an immediate concern for Children's as many of our home-care patients who receive oral supplements are considered failure to thrive. These premature patients are simply not mature enough to digest off-the-shelf formulas and a majority of these patients are Medicaid recipients. These families will be unable to afford prescription nutritional supplements. My concern is these fragile children will not receive the nutrition they need and will require hospitalization to stabilize their condition. The unintended consequences of these cuts

will result in higher medical costs for both the families and the state. Lastly, I would like to draw your attention to four personal statements that families of patients have sent regarding their concerns of the proposed cuts. Our mission is so that all children may have a better chance to live. To this end, we will also be submitting testimony in support of Senator Nordquist's LB952. These proposed cuts are life changing for many of the smallest and most vulnerable children, and we appreciate his efforts to remove such cuts. Thank you for your time. I would be happy to answer any questions you might have. [AGENCY 25]

SENATOR HARMS: Gary, thank you for your testimony. Do we have any questions? Seeing none, thank you very much. [AGENCY 25]

GARY PERKINS: Thank you. [AGENCY 25]

SENATOR HARMS: Welcome. [AGENCY 25]

SCOTT WOOTEN: (Exhibit 4) Senators, good afternoon. Thank you for allowing me the opportunity to testify today. My name is Scott Wooten, S-c-o-t-t W-o-o-t-e-n. I am senior vice president and chief financial officer of Alegent Health. My comments today, we were asked also by BryanLGH to reflect their voice as well and so my voice will be speaking on behalf of both organizations. On behalf of our healthcare team, nearly 10,000 strong, Alegent Health is on a mission to provide high-quality care for the body, mind, and spirit of every person. We are the largest nonprofit, faith-based healthcare system in Nebraska. We, along with the entire healthcare community, provide an economic impact in both our Lincoln and Omaha communities in the several-billion-dollar range. I wanted to visit with you today about the critical ministry of behavioral health, the financial challenge of the Medicaid population, and request that you restore the 2.5 percent cut from last year and the necessary...make the necessary inflationary adjustments and future patient updates. Last year, Ann Oasen (phonetic), COO of Immanuel's Medical Center, came and testified and shared with you that we

serve over 21,000 individuals in behavioral health each day. Our services help different people, community members, neighbors of ours. Chad began drinking, using drugs by the age of 12; age of 19 he was diagnosed with schizophrenia and bipolar; in 1991 he attempted suicide for the first time by pouring gas on himself and lighting a match. In 2010 he was on the verge of attempting suicide again but he sought help at Alegent Health and he credits his 12-month recovery to the staff of Lasting Hope. He says that the caring staff helped him to see that a life of hope and change were possible. Connie was an attorney. It was only after disruption in the workplace that he finally sought help from Alegent Health. He had become a recluse. He credits the staff and his psychiatrist at Immanuel Medical Center for saving his life. And lastly, Maggie, a child, a happy child, became unhappy and depressed. She began self-medicating with drugs and alcohol, and after a DUI incident finally the court sent her to Immanuel Medical Center where she has been sober for the last two years, is productively in college, looking at a career in law enforcement and therapy. We have been a strong partner with the state with Lasting Hope. We were a strong partner with the state with safe haven crisis. It is becoming increasingly difficult to do so. Boards in behavioral health are evaluating this. Over 20 programs have closed in the recent months and last year Uta Halee the most specific. Medicaid funding is a challenge but shifting the burden to healthcare providers is not the answer. The 2.5 percent Medicaid cut costs state healthcare providers over $33 million last year, combining state and federal together. Last year we were representative of the average at Alegent Health. While we were paid $75 million for care, it cost us $96 million. Consider a physician visit: A physician visit we are paid $45 for, our direct cost is $126; that's a shortfall of $81. With healthcare reform and the pending increase in enrollment, it's very necessary for us to consider payment methodology. And providers are placed in a difficult situation. I submit to you lastly that decreasing reimbursement will not improve access to healthcare in the community. That said, we're very grateful to the committee for your work last year to reduce the cut from 5 percent to 2.5 percent. It's our great hope once again this year that you'll be able to restore that 2.5 percent cut and make appropriate inflationary modifications in future years' updates. And we just ask that you consider the importance that Medicare,

Medicaid plays in the health of our community and to our citizens. And before we pause for any dialogue, thank you for your service. [AGENCY 25]

SENATOR HARMS: Scott, thank you for your testimony. Senator Nordquist. [AGENCY 25]

SENATOR NORDQUIST: Thank you. Thank you, Scott. So we reimburse you $45 for a cost of $126. How do you keep your doors open? [AGENCY 25]

SCOTT WOOTEN: There are cross-subsidies in healthcare and, largely, those with insurance subsidize those with government payment. [AGENCY 25]

SENATOR NORDQUIST: Okay. Thank you. [AGENCY 25]

SENATOR HARMS: Any other questions? Senator Mello. [AGENCY 25]

SENATOR MELLO: Thank you, Senator Harms. And thank you, Scott, for testimony. And I probably should have asked it earlier to the representative on behalf of the Hospital Association but I'll ask you and probably some others along the way. As you might have heard, there's a proposal in front of this Legislature, LB970, that...put forward by the Governor that reduces taxes on the wealthiest 20 percent of Nebraskans by over 55 percent. A question I pose to you is with a tax-cut bill that...it's about $326 million, I believe, being in front of this Legislature, how do you think we can wrestle both with the Medicaid issues that we currently have in front of us as well as trying to provide a tax cut that overwhelmingly goes to the wealthiest Nebraskans? [AGENCY 25]

SCOTT WOOTEN: As a general statement of principle and philosophy, it's our perspective that the state should take responsible (sic) for the programs which it endorses for its citizens. [AGENCY 25]

SENATOR MELLO: Okay. Thank you. [AGENCY 25]

SENATOR HEIDEMANN: Are there any other questions? Seeing none, thank you. Welcome. [AGENCY 25]

ANDREA SKOLKIN: (Exhibit 5) Thank you. Good afternoon, committee members. Thank you for the opportunity to be here. My name is Andrea Skolkin, A-n-d-r-e-a S-k-o-l-k-i-n, and I am the chair of the Health Center Association of Nebraska. I am also the chief executive officer of OneWorld Community Health Centers in Omaha and I'm here today representing all of the health centers. As you know, Nebraska's federally qualified health centers are community-based organizations that provide comprehensive primary and preventive care, including medical, dental, behavioral health, pharmacy, and support services to persons of all ages, backgrounds according to their ability to pay. In 2010 the six health centers in Nebraska were the healthcare home for 63,330 patients; 93 percent had incomes under 200 percent of poverty, 57 percent of them were uninsured. We save valuable tax and private dollars by keeping people out of emergency rooms and helping the working poor and their families to be healthy and employed, preventing costly services that occur when people can't get the primary preventive services that drive down the high cost in our healthcare system. We welcome Medicaid and Medicare patients and those that often have difficulty finding providers because the practices do not have room for them. Your General Fund support and funding for minority populations through the Health Care Cash Fund has been core to our ability to serve people throughout the state. We are good stewards of state dollars, running efficient and effective clinics, and we are your experts in providing primary care for underserved patients with complex issues and needs. We ask for your consideration of four requests, kind of complicated four requests today, two regarding minority health funding and two regarding General Funds. First, regarding health center minority funding formula we want to thank you for your quick response last year providing a temporary fix due to changes in the census report that came out in April 2011. Today we express our unanimous support for changing the language from

requiring 75,000 minorities as a criteria for the allocation of funds to 150,000 minorities for the minority health funds directed to the Omaha area to reflect the current census numbers. This will keep funding at its current level, which is $1.4 million. Our two health centers in Omaha, Charles Drew and OneWorld, have more than doubled the number of minority low-income patients cared for during the last decade from 9,972 in 2002 to 23,343 in 2010. The funds have indeed achieved what they were intended to do to ramp up healthcare to underserved populations. Again, this requires no additional funding, just clarification of the number of minorities. Our second request regarding the minority health funding, and I can see I'm out of time. I haven't hit them all. As you are aware, Nebraska's racial and ethnic minority population has been growing over the past decade and we've been fortunate to increase the number of health centers across the state. Nebraska's four other health centers provide healthcare to 13,000 racial and ethnic minorities at 21 sites. Under current law, these four health centers have partnered with health departments for grants from the $1.8 million in the minority health cash fund. We are asking that $600,000 be set aside to be distributed directly to these health centers, as is done in the Omaha area. These centers are located in Norfolk, Columbus, Lincoln, and the Scottsbluff-Gering area. By providing a direct allocation, they'll be better able to plan and deliver the services in their respective communities. Our third request regarding our health center funding is about the General Fund appropriation. Federally qualified health centers receive $100,000 in base funding and the remainder is divided by the percentage of uninsured patients seen. This fluctuates year to year, but ends up being around $300,000 for each center. Rather than adjusting variations every year, the health centers request that each of them receive an even $300,000, again, no funding, just clarifying language. But fourth is our request for funding. We respectfully ask you to increase this General Fund appropriation to help us meet the ever-increasing numbers that you've heard about. At my health center alone, we turn away on average 500 patients per month because of lack of capacity and resources. All Nebraska health centers are facing similar problems and we need your partnership to continue to keep up with the patient volume. In five years, from 2005 to 2010, our centers across the state have gone from 133,000 patient visits to 242,000, a 55 percent increase. Our

centers have the highest percent of uninsured patients in the nation and increasingly seeing higher volume of patients. Particularly one of the reasons of recent is the loss of Medicaid coverage for the unborn. Today we ask you to consider a request for an additional $1.2 million to expand our services across the state. It would make a tremendous difference in the lives of the medically underserved, majority of whom are women and children. Thank you and I'd be happy to answer questions. [AGENCY 25]

SENATOR HEIDEMANN: Are there any questions? Senator Harms. [AGENCY 25]

SENATOR HARMS: Thank you for your testimony. Appreciate it. I would tell you that the center in Scottsbluff and Gering does a really great job. It helps tremendously for us. Question I have for you is you turn away 500 patients per month. Do you do an analysis on those patients? Do you know how seriously ill they are? I mean are you taking patients that are very ill? You're not just turning them away. [AGENCY 25]

ANDREA SKOLKIN: Thank you for the question, Senator Harms. We try, if someone is sick, to be able to fit them in somehow. A lot of these appointments are new patients, new patient appointments. We are struggling just because we don't have enough physicians at this point in time to see them all. [AGENCY 25]

SENATOR HARMS: How do you determine your costs? [AGENCY 25]

ANDREA SKOLKIN: We file an annual cost report, all the health centers do, with the Medicaid department. Also the Centers for Medicare and Medicaid we file cost reports and it's based on the services provided. [AGENCY 25]

SENATOR HARMS: As an average, what's your cost per FTE? [AGENCY 25]

ANDREA SKOLKIN: Oh, per FTE, Senator, I don't have that at hand. I would have to look that up and I can get that to you. [AGENCY 25]

SENATOR HARMS: I'd be curious of that. For the centers that we have, I'd be curious about their cost. Tells me a little bit about where the money is going and how much it's costing us for those programs. [AGENCY 25]

ANDREA SKOLKIN: I don't have the exact detail at my hands. I would be happy to e-mail that to you... [AGENCY 25]

SENATOR HARMS: That would be fine. [AGENCY 25]

ANDREA SKOLKIN: ...to you and the committee members. [AGENCY 25]

SENATOR HARMS: Yes. Thank you very much for your testimony. [AGENCY 25]

ANDREA SKOLKIN: Thank you. [AGENCY 25]

SENATOR HEIDEMANN: Senator Nordquist. [AGENCY 25]

SENATOR NORDQUIST: Thank you, Mr. Chairman, and thank you, Andrea. Senator Harms kind of hit on the issue of the 500 patients per month from certainly OneWorld in south Omaha but it's probably happening at all the centers in the state. I know for a while when we had the loss of universal prenatal care, Columbus certainly was turning away many patients as well. And we had Director Winterer in earlier and you may have heard, I asked about the access to primary cares; he said we need to move more towards that and away from the emergency room utilization. And he didn't say, yes, we have adequate primary care. I think he said we're making progress towards it. But do you think a number of these patients potentially are turning up in our emergency rooms, the 500 that you can't serve because you don't have the capacity to do that? [AGENCY 25]

ANDREA SKOLKIN: Senator Nordquist, I don't have exact data on it... [AGENCY 25]

SENATOR NORDQUIST: Uh-huh. [AGENCY 25]

ANDREA SKOLKIN: ...but I would assume many of them are turning up in emergency rooms, not just in Omaha but in other parts of the state. [AGENCY 25]

SENATOR NORDQUIST: Okay. Thank you. [AGENCY 25]

SENATOR HEIDEMANN: Are there any other questions? Seeing none, thank you. [AGENCY 25]

ANDREA SKOLKIN: Thank you. [AGENCY 25]

SENATOR HEIDEMANN: Welcome. [AGENCY 25]

TOPHER HANSEN: (Exhibits 6-7) Senator Heidemann, thank you very much. Chairman Heidemann and members of the Appropriations Committee, my name is Topher Hansen. I'm the executive director of CenterPointe in Lincoln, here today representing the Nebraska Association of Behavioral Health Organizations. NABHO is made up of 49 behavioral health facilities across the state representing a vast majority of all behavioral health providers, including consumer groups, all six regional program administrators, providers ranging from individual private practice groups to major hospitals across our state. I'm also submitting written testimony on behalf of the Nebraska Speech and Language Hearing Association, Friends of Public Health in Nebraska, Public Health Association of Nebraska, the Nebraska Psychological Association, Building Bright Futures, and the Nebraska Child Healthcare Alliance. NABHO members strongly support reinvesting in the services of providers across the state by putting back in the budget the 2.5 percent provider rate cut made last year. In the behavioral health arena, that cut lost just under $3 million in state funds and an additional $5 million in federal

funds. This is a loss out of a healthcare system that was ranked 36th nationally in per capita spending several years ago, prior to the time we faced the most recent cuts. We do not, however, support the Medicaid cuts contained in the second year of the proposed biennium budget. With respect to behavioral health services, reducing access by capping behavioral health visits is shortsighted. Ask an expert in managed care systems whether capping outpatient visits is where money is saved and they will tell you no. The decision to cut these behavioral health services for a modest savings of $191,000 shows a lack of understanding of mental health and substance treatment services. Director Chaumont states in her December 1 letter that she intends to match limits on mental health and substance treatment services at the same rate as physical health limits. The problem with that philosophy is that the people who require a higher number of therapy visits annually are those most in need of services. Group therapy and medication management would be lumped together with one-on-one therapy so the cap would be reached very quickly for consumers with high needs. The reality is that these services work together to keep the high-utilizing, high-cost Medicaid consumer out of even more costly hospitalization. Spending $191,000 is much less costly than having countless consumers who are high utilizers of services get sick and require high levels of service. Restricting access to services in order to save money is an archaic concept in behavioral health system management. Intuitively, it seems like a good idea to control the cost, but the metrics will tell you differently. It is much like squeezing the bottom of a water balloon, seeing the water move toward the top. There's no savings, no better results, just shifted costs. Instead of finding creative ways to fund services through waivers and other means, paying for early intervention or managing our money better by leveraging federal dollars, this budget proposes to continue to cut past the bone. Our child welfare debacle tells us very clearly about the consequences of undercutting a service system. We urge you to restore the 2.5 percent rate cut from last year and not support the proposed cuts in this year's budget. I do have one additional paragraph that I skipped in the interest of time, and so it's there for your reading. [AGENCY 25]

SENATOR HEIDEMANN: And I noticed that. Thank you very much, in a matter of time, as we see what's before us. Are there any questions for Topher? Senator Harms. [AGENCY 25]

SENATOR HARMS: First of all, thank you very much for your testimony. [AGENCY 25]

TOPHER HANSEN: You're welcome. [AGENCY 25]

SENATOR HARMS: How many providers, (inaudible) the budget a year ago, how many providers in Nebraska have we lost? [AGENCY 25]

TOPHER HANSEN: I have a sheet here I'll give to you, how about, and I can't tell you the exact number off the top of my head, but we've compiled a sheet that itemizes the closings that we've seen in Nebraska. [AGENCY 25]

SENATOR HARMS: Can you isolate those geographically for us? Where... [AGENCY 25]

TOPHER HANSEN: They're all... [AGENCY 25]

SENATOR HARMS: Good. Good, thank you. [AGENCY 25]

TOPHER HANSEN: ...right there. [AGENCY 25]

SENATOR HARMS: How many patients, that by cutting back, losing our providers, how many patients have gone unserved? [AGENCY 25]

TOPHER HANSEN: Gone unserved? [AGENCY 25]

SENATOR HARMS: Yes. [AGENCY 25]

TOPHER HANSEN: Well, to estimate how many statewide is not a number I have. All I could say is the number that stand in line of those that are not able to get in the doors because of the waiting lines are what we see, and that is program by program. I don't have the number off the top of my head but I can tell you the evidence, that there are waiting lines that exist in almost every public service program, indicates that access is limited. [AGENCY 25]

SENATOR HARMS: Well, when we look at the level...different levels of mental illness, what's happening in regard to the treatment of folks who are really truly needing that assistance immediately? Have we lost this or what's really happening to the people who really absolutely have to have this? They all need it, but I'm just trying to build into my thinking how severe this is, of who are we losing and who are we not treating and at what level. [AGENCY 25]

TOPHER HANSEN: Uh-huh. Well, and one of the ways to look at that is look at the crisis system and see how many people are in crisis centers and hospitals from...that may be an overflow from a crisis center and so on. The fact of the matter is, if you have a system that's operating well at all levels, you can minimize the number of people in a crisis center. If you don't serve people when they need it in the manner they need it, then it can cause the illness to accelerate or exacerbate and then people end up in higher levels of service. So one of the things we see is a busy crisis component and that tells me we don't have an adequate service component to meet the needs of folks. [AGENCY 25]

SENATOR HARMS: Does your data show us that? Do you have the data to show us that and also geographically where that's located, where the biggest needs are? [AGENCY 25]

TOPHER HANSEN: What I could provide personally, I'd refer to our regional program

administrator, C.J. Johnson, who manages the crisis system in this region, in Region 5, and he keeps close track of that regional information. Then I would defer to other regional administrators for that information. [AGENCY 25]

SENATOR HARMS: It would really be very helpful for me to have a better understanding about this. We've had a lot of discussion about provider rates and that sort of thing, and to get a handle on this in my own mind that this would really be helpful... [AGENCY 25]

TOPHER HANSEN: Sure. [AGENCY 25]

SENATOR HARMS: ...seeing this, what really truly is happening to us. Thank you for your testimony. [AGENCY 25]

TOPHER HANSEN: I will follow up and ask that that occur. [AGENCY 25]

SENATOR HARMS: Thank you. [AGENCY 25]

TOPHER HANSEN: You're welcome. [AGENCY 25]

SENATOR HEIDEMANN: Are there any other questions? Seeing none, thank you. [AGENCY 25]

TOPHER HANSEN: Thank you. [AGENCY 25]

SENATOR HEIDEMANN: Welcome. [AGENCY 25]

DAVID HOLMQUIST: Good afternoon, Chairman Heidemann, members of the committee. My name is David Holmquist, D-a-v-i-d H-o-l-m-q-u-i-s-t, and I am director of state legislative government relations for the American Cancer Society. First, let me say

that I am in agreement with those individuals who have testified that we need not cut Medicaid Programs that might jeopardize those most in need. The most vulnerable of our citizens, whether they be cancer patients or behavioral health patients, need the services that are offered through the Medicaid Program. But I'm really here today to simply bring up a slightly new topic for you. I'll be fairly brief. Often in conversations with senators we're told that the Tobacco Prevention and Control Program within HHS, which we call Tobacco Free Nebraska, doesn't need funding it already receives because, quote, they can't spend what we give them, and I wanted to clear that up. The reality is quite different. In addition to the challenge of having a roller coaster ride in terms of funding historically, managers of the program must also deal with being able to spend what you as legislators give them the authority to spend, and statutorily the State Treasurer is required to transfer $3 million each year into the Tobacco Prevention and Control Cash Fund. So for example, in the current budget cycle it will look like the program isn't spending $1.4 million over the two-year biennium. Does the phrase "they can't spend what they're given now" sound familiar? Additionally, the program works with subgrantees at the community level. Program was designed and has always shown great success in working with agencies within local communities, but as a result of working with those community health groups, from all outward appearances, it looks like managers aren't spending about a fourth of the allotted dollars? Why? Because subgrantees and contractors are on a funding cycle consistent with the fiscal year, so they're doing business through June 30 and the subtgrantees then submit invoices for payment for the fourth quarter--April, May, June--to the department by July 30. Since invoices aren't submitted until after the fiscal year closes, the expenditures aren't recorded to that particular budget year until a later time, even though the expenses were incurred during the current fiscal year. The naysayers are dead wrong. The program has shown numerous successes during its history and will continue to do so, but successes can only continue with additional sustained funding. Over the past dozen years the youth smoking rate in Nebraska has shrunk from 39 percent to just under 18 percent, and adult smoking rates have declined from over 22 percent to less than 18 percent. These figures and others demonstrate the efficacy of the program even as the

tobacco industry pumps about $65 million a year into efforts to keep people hooked on smoking and chewing. We simply ask the committee to advance a budget that gives Tobacco Free Nebraska the authority to spend the $3 million which the State Treasurer will transfer by July 15 of each year. That's my testimony. [AGENCY 25]

SENATOR HEIDEMANN: Thank you. Are there any questions? Seeing none, thank you. [AGENCY 25]

DAVID HOLMQUIST: Thank you. [AGENCY 25]

SENATOR HEIDEMANN: Welcome. [AGENCY 25]

JESSICA MEESKE: (Exhibit 8) Welcome. Good afternoon. My name is Jessica, J-e-s-s-i-c-a, Meeske, M-e-e-s-k-e, and I'm a pediatric dentist from Hastings. I also want to disclose that I'm on the state's Medicaid Reform Council. However, today I'm here on behalf of my patients with special healthcare needs and as my role as chair of the medicaid committee for the Nebraska Dental Association. I'm in opposition to the proposed Medicaid cuts, but I would also like to go on record I'm speaking in favor of LB952. Our practice cares for over 300 adults and many, many more kids in rural central Nebraska with developmental disabilities, and while some will have the opportunity to have gainful employment, others will not, due to their disability, and many will never have any chance whatsoever of ever getting employer-based dental insurance. These individuals need dental care for several reasons. And I want you to look at the children right now that are with us today because all of these kids will eventually turn 21. They're going to be at greater risk for tooth decay and gum disease. Many can't brush their teeth and maintain their oral health. Having untreated dental disease is going to exacerbate their existing medical condition and the results of prolonged dental treatment lead to pain, infection, inability to eat, missed work or school, and expensive emergency room visits. In fact, we know from other states that have eliminated their dental Medicaid adult programs, the costs simply get shifted to the

medical side as they use more expensive routes for care, such as hospital emergency rooms. Several of you have visited our annual Mission of Mercy dental clinics so you've seen firsthand the long lines of families camping out overnight waiting to be seen for a dental visit. I want you to think about the kids in this room being adults, trying to camp out overnight waiting to be seen by a dentist. It's simply just not a possible thing and in their best interests. Keep in mind, Mission of Mercy is not a system of care; it's just a one-shot deal. In my written testimony, you'll see several statistics. In the interest of time I won't go through those, but it's about 8 to 10 percent of our dental students' clinical experiences in dental school. Now I also sympathize with you because I, too, am an elected official. I'm the president of a local school board and so I know firsthand that budgets have to balance. I think there's many things we can do with the dental Medicaid Program to make it more efficient. And I just want to let you know that last spring we met with the Health and Human Services Committee and we proactively talked about cuts we were willing to endure that we thought wouldn't cause any harm to patients. So there's many creative solutions to reach this goal. The problem when you cut out entire programs, like adult dental, or continually erode provider rates is you just simply push the costs off to the medical side. And in conclusion, I just want to note that adult has not been cut yet but it is on the top of the list in those optional services at the end of the session, and any cuts to optional services ultimately cost us in the long run. The dentists are more than ready and willing to sit down and work with you on creative solutions. Thank you. [AGENCY 25]

SENATOR HEIDEMANN: Any of those cuts that you proposed, anything that we're seeing today? [AGENCY 25]

JESSICA MEESKE: No. Any that I've brought with me? [AGENCY 25]

SENATOR HEIDEMANN: No, any of those cuts that you proposed to Health and Human Services Committee, they didn't look at any of those? [AGENCY 25]

JESSICA MEESKE: No, they have not sat down with the dental community and talked about things. And let me just give you one example that's very simple. If you look at things like bitewing x-rays, we don't have to take x-rays on every single patient every six months. What the evidence tells us is that you can do it based on their risk for disease. So if you have patients that are very low-risk disease, you can take x-rays once a year and be just fine, and that alone would have saved closed to $1 million. But, no, we have not had a good dialogue about how we could make some of those cuts. [AGENCY 25]

SENATOR HEIDEMANN: Because of why? [AGENCY 25]

JESSICA MEESKE: Well, we proposed the cuts to the committee, it was in the spring of last year, and we also copied the department on them. And then what we heard back is just that we were going to have the 2.5 percent cuts across the board. [AGENCY 25]

SENATOR HEIDEMANN: Okay. Are there...Senator Fulton. [AGENCY 25]

SENATOR FULTON: Thank you, Mr. Chairman. Do we have...is that in a concretized form? I mean is there something formal that you could provide this committee expressing... [AGENCY 25]

JESSICA MEESKE: Sure. I can send the committee...it was just a one-page summary of different kind of cuts that we thought would save the dental Medicaid Program money but would not cause patients harm, things like x-rays. [AGENCY 25]

SENATOR FULTON: And none of those have been incorporated into that... [AGENCY 25]

JESSICA MEESKE: No, they have not. [AGENCY 25]

SENATOR FULTON: Okay. Thank you. [AGENCY 25]

SENATOR HEIDEMANN: Are there any other questions? Seeing none, thank you. [AGENCY 25]

JESSICA MEESKE: Thank you. [AGENCY 25]

SENATOR HEIDEMANN: Welcome. [AGENCY 25]

JOYCE EBMEIER: (Exhibit 9) Thank you. Good afternoon. My name is Joyce Ebmeier, it's J-o-y-c-e E-b-m-e-i-e-r. I am senior vice president of strategic planning for Tabitha elder care services. I'm here on behalf of the members of LeadingAge Nebraska and the Nebraska Health Care Association. Most importantly, I am here in service to the residents, families, and dedicated staff in Nebraska's over 400 nursing homes and assisted-living facilities that provide Home and Community-Based Medicaid Waiver services. We are asking the committee to restore the 2.5 percent nursing home payment cut contained in the Agency 25 budget for the 2012-2013 fiscal year. By telling you Tabitha's story, I hope to shed a little bit of light on the hardships being faced by long-term care providers across the state. Fifty percent of individuals residing in Tabitha's two skilled nursing facilities rely on Medicaid for their care. Over the past five years, losses for Tabitha and all Medicaid providers have grown exponentially due to appropriation levels far below inflation. After cuts implemented last year, these losses have exploded. As illustrated in an attached table to this testimony, the impact of the July 1 Medicaid cut results to an annual loss to Tabitha of over $500,000. Effective October 1, 2011, an 11 percent Medicare cut by the federal government resulted in an additional loss of revenue that will amount to nearly $1 million by the end of fiscal year 2012. In the past, Tabitha has been able to continue to serve a very high percentage of Medicaid clients through careful management of direct expense, rate increases in line with inflationary factors, and fund-raising. In October 2011, response to cuts...in response to cuts and to maintain continued service to Medicaid clients, Tabitha was forced to cut direct care, support, and administrative staff. Although every effort is being

made to assure continued delivery of exceptional service to our clients, it's unrealistic to think that Tabitha and other Medicaid providers can continue to maintain the same high level of services when payment for Medicaid is so far below the cost of care. Seniors in your own districts will inevitably suffer due to these cuts, and realistically, that is if they're lucky to find Medicaid placement in the first place. Providers whose business limits the number of Medicaid clients to a low percent of their census will be able to employ a price increase to offset Medicaid revenue. For providers like Tabitha, this strategy is not a viable solution. If Tabitha raised private pay rates to offset the entirety of the Medicaid and Medicare cuts, we would add an average of $63 a day to current private pay rates. Doing so would not only exhaust the personal savings of our residents at an unconscionable rate, it would raise...it would price services out of the market. Tabitha considers the opportunity to provide long-term care to Medicaid clients a privilege. We come before you today to ask for funding that will allow us to continue this work responsibly. Your serious consideration of restoring the 2.5 percent nursing home payment cut would be deeply appreciated. [AGENCY 25]

SENATOR HEIDEMANN: Senator Fulton. [AGENCY 25]

SENATOR FULTON: Thank you, Mr. Chairman. I don't know if you got to hear the line of questioning that I had for the director, of Director Chaumont earlier, but I'll put it before you. [AGENCY 25]

JOYCE EBMEIER: I did. [AGENCY 25]

SENATOR FULTON: What happens to these individuals for whom you can no longer provide care? [AGENCY 25]

JOYCE EBMEIER: These individuals, well, we have not turned anyone away and it's our mission not to. And, however, as I consider what would happen to an individual who would not have access to Medicaid care when...Medicaid services when it's needed

would be either the spouse or other caregiver would do their very best to maintain them at home. I would say also that our healthcare continuum works very hard to coordinate the care so it's delivered in the most cost-effective setting. What will happen to people who don't get care will be a decline. There will be outcomes that are negative to their well-being and it will be...they'll go without service and perhaps not even know to be needing that service. [AGENCY 25]

SENATOR FULTON: Okay. Okay, thank you. [AGENCY 25]

SENATOR HEIDEMANN: Any other questions? Seeing none, thank you. [AGENCY 25]

TIMOTHY CUDDIGAN: (Exhibit 10) Senator Heidemann, members of the Appropriations Committee, my name is Timothy Cuddigan, T-i-m-o-t-h-y C-u-d-d-i-g-a-n. I'm appearing on behalf of the National Alliance on Mental Illness-Nebraska. We represent individuals and families affected by serious mental illness, as well as their friends and supporters. I appear in opposition to the proposed Medicaid budget cuts. We ask that in reviewing the budget issues that you consider the following. Nebraska behavioral health system is already in crisis. The provider cuts last year caused many providers and facilities to close their doors. The proposed additional 2.5 percent provider cut will continue the closing of mental health and substance abuse facilities across Nebraska. The budget proposal will further reduce access to physical and behavioral health for Nebraska consumers. Medicaid services that keep low-income families healthy, working, and going to school are an important investment by our state government. Budget cuts are devastating to individuals, families, and our communities. Mental illness affects one in five Nebraskans. There is an extreme lack of availability of services in rural communities. Continued budget cuts will make the recruitment of providers to Nebraska's rural communities even more difficult, as an earlier witness from Nemaha County said today. Treatment works but only if you can get it. Mental health costs end up costing us even more in lost jobs and careers, broken families, more homelessness, higher insurance costs, more welfare, and more expensive costs for

hospital emergency rooms, hospitalizations, nursing homes, schools, police, courts, jails, and prisons. This is a hidden cost shift to all of our economy, especially to providers, hospitals, cities, and counties. I would like to especially ask you to consider the cut in how the federal match dollars are affected because of the cut in the Medicaid Program. These have a compound negative effect of loss of state funding and loss of revenue for our economy. Behavioral health agencies already operate with inadequate resources and have worked hard to cut administrative expenses as well as imposed hiring freezes. More cuts can only mean deeper cuts in treatments and services. Provider cuts cannot be justified as a way to provide tax cuts. Instead, the Legislature should be looking at a way to roll back and restore last year's cuts. Thank you for your consideration. [AGENCY 25]

SENATOR HEIDEMANN: Thank you for coming in and testifying today. Are there any questions? Seeing none, thank you. Welcome. [AGENCY 25]

MARY FRASER MEINTS: Hello. I'm Mary Fraser Meints, M-a-r-y F-r-a-s-e-r M-e-i-n-t-s. I'm representing CAFCON, the Child (sic) and Family Coalition of Nebraska, and I'm the president of Uta Halee Girls Village. First, I'd like to thank you for your support last year from reducing the 5 percent cuts to 2.5, and I'd like to ask that as we look at the HHS budget we look at the big picture and restore those 2.5 percent cuts. You've heard people talk about closing services. Well, I've closed services in Nebraska because of the lack of money available to provide services to kids. First we closed Cooper Village, which provided services to boys. In 2010 we served 101 boys in a residential program in Omaha. Those were kids from across the state. That was closed in May of 2010. This 2011 we closed all of Uta Halee services. We had served 124 girls residentially in 2010 and we served 707 kids in the community, so we served a wide variety of services, mental health and substance abuse services. The 700 kids stayed at home or foster care or group home, and we served them there or on our campus, mental health treatment for substance abuse and we also provided services for juvenile offenders so that they could be with their families. That service is gone and I receive probably

information every week about families who are not getting the services that they need because the system didn't absorb that. That's 700 to 800 kids that didn't get what they need. So we've heard people talk about the potential impact. I'm here to tell you that it had a devastating impact on Uta Halee. We provided services for 60 years. So our safety net for Nebraska is threatened and Nebraska needs to rebuild the services, not continue to dismantle them, and the 2.5 percent cut that was done last year should be restored to provide services for kids and families. I'd be glad to answer any questions that you might have. [AGENCY 25]

SENATOR HEIDEMANN: Thank you for coming in and testifying today. Senator Nordquist. [AGENCY 25]

SENATOR NORDQUIST: Thank you, Mr. Chairman. Mary, you have great experience in this area and just...I've heard, as we talk about all the entire Medicaid system, the services we provide including some of the other services we'll talk about later, there's a perception that we have a generous Medicaid system and that folks from other states may be flocking here to receive services. And from the time...from all the time you've spent working in these services, can you just give us your experience and how you see us compared to other states and anything along those lines? [AGENCY 25]

MARY FRASER MEINTS: I think we're in the bottom, toward the bottom 30-some percent in terms of reimbursement for care. We figured we got 20 percent of the cost, we had to fund-raise 20 percent of the cost of care, so that's a lot of money for the private funders and the foundations and the philanthropists to put in. And we're not for profit so the money goes into the mission and, no, we didn't get even the cost of providing care. [AGENCY 25]

SENATOR NORDQUIST: Yeah. Sure. [AGENCY 25]

MARY FRASER MEINTS: Even the outpatient services you don't get the cost of

providing the care. [AGENCY 25]

SENATOR NORDQUIST: Uh-huh. Uh-huh. Right. Thank you. [AGENCY 25]

SENATOR HEIDEMANN: Any other questions? Seeing none, thank you. [AGENCY 25]

MARY FRASER MEINTS: Thank you. [AGENCY 25]

SENATOR HEIDEMANN: Welcome. [AGENCY 25]

DEE FRITZ: (Exhibit 11) Hi. Good afternoon. My name is Dee Fritz, D-e-e F-r-i-t-z. First of all, I want to thank you for the opportunity to testify on behalf of Nebraska Health Care Association, the Nebraska Assisted Living Association, and LeadingAge Nebraska. Combined, our associations represent over 275 assisted-living facilities in our state. I am the administrator of the Evergreen Assisted Living in O'Neill. We are a privately owned facilities with 33 apartments which remain full...which have remained full for the majority of our ten years of operation. I have 20 employees, 13 of which are full-time. I am here to respectfully ask the Appropriations Committee to restore the 2.5 percent assisted-living payment cut contained in the budget for the 2012-2013 fiscal year. I have been a nurse in long-term care for the past 30 years and have witnessed many changes in this industry. Providing excellent resident care for our seniors is my passion. I want you to know that we understand the need to cut expenses and reduce costs, however, it is unfair to keep asking us to do more for less pay. Many waiver clients require the highest level of care, and yet we are compensated less for them. It does not seem fair for the private-pay residents to cover their own costs as well as the losses from Medicaid waiver. In the past five years the Evergreen has averaged a 4 percent yearly private-pay rate increase due to the rise in costs that our facilities have incurred. We had an 11 percent increase in food costs last year alone, which is not covered in this rate increase or decrease in our waiver payments. We work hard to stay within budget in our facility. Unfortunately, it is our front-line staff that suffers the

consequences of budgetary constraints. This is reflected in not being able to give them the raises that they deserve. Upon admission, waiver residents have the same or higher level of acuity as the lowest care residents at a nursing home. We provide a private apartment versus a semiprivate room that many nursing homes provide. When extra care becomes necessary with age and illness, we do not have the option to charge for any extra services like a nursing home. What effectively happens is Medicaid waiver residents have the highest care levels at the lowest payment rates in the system. All businesses have to adjust to survive. We are here for our residents. Because of this, we will not compromise their care. We are willing to incur some extra costs in order to make sure that they receive the highest quality of life. However, we cannot risk the financial stability of our organization. We do not want to become a private-pay only facility; however, it seems that the system is pushing us in this direction. We currently have seven residents that are on Medicaid waiver in our program and have not asked them to move out when we could fill an apartment with a private-pay person. Consequently, this year's losses to our facility varied from $23,436 to as much as $36,036 if assessment points were charged on the average basis. Our industry has done an excellent job of proactive self-regulation. We want to continue to do so. Please allow facilities to add assessments for proven additional care, and please return the funding to 2011 levels. Thank you again for this opportunity to help all of our residents retain the highest possible quality of life for as long as possible. [AGENCY 25]

SENATOR HEIDEMANN: Thank you. Are there any questions? Senator Fulton. [AGENCY 25]

SENATOR FULTON: Thank you, Mr. Chairman. The folks who are on Medicaid, what happens to them if they... [AGENCY 25]

DEE FRITZ: This is Medicaid waiver. We do not take Medicaid. This is the waiver. [AGENCY 25]

SENATOR FULTON: Okay. [AGENCY 25]

DEE FRITZ: The Medicaid waiver people are qualified to go into a nursing home in order to be a waiver client, and that's how we accept them. So your question again? [AGENCY 25]

SENATOR FULTON: So what...if there's...if these cuts become...if these cuts are effectuated, then there will be more pressure on your budget. I'm asking when it comes to a point where you have to decide that you can no longer serve, when you have to become 100 percent private pay, what happens to...? [AGENCY 25]

DEE FRITZ: Uh-huh. They meet nursing home criteria so they would have to move into a nursing home and not be in an assisted-living facility. [AGENCY 25]

SENATOR FULTON: Okay. Thank you. [AGENCY 25]

DEE FRITZ: Thank you. [AGENCY 25]

SENATOR HEIDEMANN: Welcome. [AGENCY 25]

DAVE SORENSEN: Thank you. My name is Dave Sorensen, D-a-v-e S-o-r-e-n-s-e-n. I wanted to speak today on the fact that what your money goes to as far as the Medicaid and Medicare. I am a member of the mental health program through Nebraska that...and I have been helped through Medicare and Medicaid. As of the end of December, I will be off disability and I will be working full-time as a peer support specialist for South Central Behavioral Services. And if it wasn't for these programs, I wouldn't be leaving disability today. I would not be taking those steps to help others that want to accomplish this goal to do that. And when we keep these...when we keep the funding to be able to do that, we're helping people reach out to their future so they can have a better quality of life now and become more successful and independent as we

go along into the future, which in my opinion is going to help us out down the road even more with not having to fund these people once they get back to the way that they can hold their own job, and that's what we want to do. We don't want to sit here and soak up Medicaid and Medicare. We don't want to suck up the disability. We don't want to be looked down upon. We want to be able to sit and say this is the best I'm doing today, I can do even better tomorrow. And I'm a perfect example of that. Thank you for your time and please consider that when you do your voting. [AGENCY 25]

SENATOR HEIDEMANN: Thank you for coming to testify today. Are there any questions? Seeing none, thank you. Welcome. [AGENCY 25]

MARK INTERMILL: (Exhibit 12) Thank you. Thank you, Senator and members of the committee. My name is Mark Intermill, M-a-r-k I-n-t-e-r-m-i-l-l, and I am here today representing AARP to comment on the Agency 25 budget. There is a prepared statement that's circulating, I'm not going to read it to you, but there is also a chart and a graph that's the third page of the handout and that's what I really want to focus on. What you will see on that chart and graph is that Medicaid growth over the last eight years has averaged 2.4 percent. We don't have a problem with excessive growth in the Medicaid Program. As I look at the proposals that are being presented today of cutting a lot of the long-term care services that people with disabilities rely on, it seems like a high-risk, low-reward type of proposition. We heard from the Assisted Living Association just now what would happen if they can no longer provide...participate in Medicaid. I think you will probably hear from people who, if they were to lose the nutritional supplements and the private duty nursing or have a cutback on the personal assistance services or the home health, there's a risk that those individuals could go to a nursing home. And the reason that we've been able to keep Medicaid growth at 2.4 percent on average over the last eight years is because we have shifted a strategy from institutional care to in-home long-term care services. That goes back to 1997 when there was a long-term care plan that was developed. That led to the expansion of the Medicaid waiver. We went from the services coordination being provided within the

Department of Health and Human Services to being contracted out, as Director Chaumont noted, to independent living centers and area agencies on aging. That allowed more people to be served at a lower cost, and that has helped to control the cost. One of the things that you'll see on the right-hand column of the chart is that we have consistently been under budget in the Medicaid Program, and if you total up how much we've been under budget for the last eight years it almost totals $1 billion. That's $1 billion that we planned for, that our revenue structure was set up to collect that we didn't spend. That contributed to the fiscal situation that helped us and tide us over in this latest fiscal downturn. So I think Medicaid has been a real contributor, not only to the well-being of a lot of people who needed services but it has helped the state budget get through several crises here in the last few years. And with that, I will end and be happy to answer questions. [AGENCY 25]

SENATOR HEIDEMANN: Senator Nordquist. [AGENCY 25]

SENATOR NORDQUIST: Thank you, Mark. Kind of along the lines of the question I asked Mary Fraser Meints about the perception of our Medicaid Program being overly generous, maybe more specifically on the benefits we provide, and that maybe being perceived as a magnet for people coming in from out of state. And the fact of the data you provide that we're nearly $1 billion under would show that at least we're not having this huge influx. And I don't know if you have any experience or thoughts on that from your years of being involved in these issues. [AGENCY 25]

MARK INTERMILL: Well, I think the fact that we've kept the growth and spending at 2.4 percent on average for the last eight years would belie that contention. [AGENCY 25]

SENATOR NORDQUIST: Yeah. [AGENCY 25]

MARK INTERMILL: I don't...I think people do move from state to state, but it's not because...I don't think people are analyzing the Medicaid Programs in various states

and trying to figure out where they can get the best deal. It usually has to do with family... [AGENCY 25]

SENATOR NORDQUIST: Sure. [AGENCY 25]

MARK INTERMILL: ...and in my own parents' situation, that's what the issue was. [AGENCY 25]

SENATOR NORDQUIST: Uh-huh. I think that...yeah. Thank you. [AGENCY 25]

MARK INTERMILL: Sure. [AGENCY 25]

SENATOR HEIDEMANN: Are there any other questions? Seeing none, thank you. [AGENCY 25]

MARK INTERMILL: Thank you. [AGENCY 25]

SENATOR HEIDEMANN: Welcome. [AGENCY 25]

BECKY GOULD: (Exhibit 13) Good afternoon, Senator Heidemann, members of the committee. My name is Becky Gould, B-e-c-k-y G-o-u-l-d. I'm the executive director at the Nebraska Appleseed Center. Nebraska Appleseed is a nonpartisan, nonprofit, public interest law firm that works for equal justice and full opportunity for all Nebraskans, and I'm here today to testify on a number of issues that are wrapped up in the Agency 25 appropriations request. Certainly echo a lot of the concerns that have been raised related to the Medicaid Program and the challenges that would be presented to folks who are served by the Medicaid Program and the providers if the cuts that are proposed move forward and if the provider rates remain as they are. But I also want to touch on some of the other issues that were brought up earlier related to ACCESSNebraska, so I'm going to start with ACCESSNebraska. Our organization has

done a lot of work, as ACCESSNebraska implementation has moved forward in the state, to try to monitor what's been happening, and unfortunately there's a lot of challenges that have been presented. And it's great to see that the department is acknowledging those challenges and is taking steps forward to try to address them, and so we support their request for additional resources related to caseworkers. But we also want to highlight that there's three other pieces of legislation that, put together, would actually solve so many of the problems that have been presented with ACCESSNebraska: LB825, LB1016, and LB1041. And while certainly providing more caseworkers in the short term would help with some of the challenges, really we need to take more steps to not only serve people better in the state but also to protect the state from potential legal liability. If we don't maintain processing times at a certain level, the state becomes liable. If we don't serve folks with limited English proficiency, effectively the state is liable. And if we aren't able to serve people with disabilities effectively, there's liability for the state. So this is a really important problem to address, not just to make sure we're serving people effectively but also to make sure that the state is fulfilling its legal obligations. I also wanted to touch on the question that Senator Mello raised about transparency and the childcare funding, and we would wholeheartedly support providing more transparency to the funding that's in that program. It's very difficult to tell, as money is being shifted, whether that lines up with our priorities. The last thing I wanted to touch on, and there's lots of other things addressed in the written comments, but is related to child welfare and the mention of providing additional workers to help coordinate between developmental disability services and Medicaid. And the one thing I want to highlight is just that providing a coordinator is not going to solve that problem. Part of the reason that families are being faced with the difficult question about relinquishing services (sic) is because the services don't exist under Medicaid. Providing a coordinator is not going to solve that problem. Over the last several years we've eroded the Medicaid infrastructure in our state and we simply don't have all the levels of care that we need to provide services effectively to children, and until we address that problem we won't be able to stop the unnecessary relinquishment of children in the child welfare system. With that, I'm happy to answer any questions.

[AGENCY 25]

SENATOR HEIDEMANN: Are there any questions? Senator Mello. [AGENCY 25]

SENATOR MELLO: Thank you, Senator Heidemann. And thank you, Ms. Gould, for your testimony. Just something that I guess you had to leave out of your testimony due to the time limits was the proposed reduction, it says here in your testimony, the second to the last paragraph: A number of the proposed reductions in the optional services are services that are mandatory under the Patient Protection and Affordable Care Act and will require the state to offer those benefits again in 2014. I guess the question I have is that's something that no one else I guess has brought up today in the sense of a majority of the services that have been proposed by the department ultimately have to be reinstituted if we would so move forward on their proposal. I guess I appreciate you bringing that forward, but probably a bigger question is what real cost savings do you think, or has there been any conversations with your organization and the department of really what cost savings would occur if we were only doing this for a year, knowing that we get rid of these services and ultimately have to reinstitute them in another year? [AGENCY 25]

BECKY GOULD: Uh-huh. I think, you know, certainly it does seem shortsighted to be making some changes that we would ultimately have to undo in a very short period of time. I think some of the optional services that we were including in that also were if...the scenario that Director Chaumont had mentioned in terms of the federal funding had played out and we had to cut additional optional services. A number of those services are required to exist under the Affordable Care Act. And so because that step isn't going forward, some of those optional services, you know, will remain in place in Nebraska and we won't have that situation. [AGENCY 25]

SENATOR MELLO: Okay. [AGENCY 25]

BECKY GOULD: But I'd be happy to provide the senators with more information about what those services are and how that would play out. [AGENCY 25]

SENATOR MELLO: Okay. Thank you. [AGENCY 25]

SENATOR HEIDEMANN: Any other questions for Becky? Seeing none, thank you. [AGENCY 25]

BECKY GOULD: Thank you. [AGENCY 25]

SENATOR HEIDEMANN: Welcome. [AGENCY 25]

AMITY BISHOP: Hi. My name is Amity Bishop, A-m-i-t-y B-i-s-h-o-p. I am diagnosed with bipolar II and PTSD. I depend on Medicaid to pay for my services, like going to do rehab where I can get the help I need for my mental illness. These services have helped me by the following: They help me get my SSI benefits, they get to me to appointments because I cannot drive because of my medications, they have taught me to use coping skills and a WRAP plan that keeps me focused and keep me from relapsing. Uniwork (phonetic) offers me structure and gives me a reason not to just sit at home all day. Residential services have helped me a great deal. They keep me on a routine with my meds, help me to keep clean and pick up after myself. They also helped me speak up and be assertive and communicate my needs and wishes in an assertive way. I am also on my way to being out on my own again and I have overcome a lot of obstacles, and if it wasn't for the services I had I wouldn't know where I would be. [AGENCY 25]

SENATOR HEIDEMANN: Thank you for coming in and testifying today. Are there any questions? Seeing none, thank you. Welcome. [AGENCY 25]

JODY FALTYS: Hi. How are you? [AGENCY 25]

SENATOR HEIDEMANN: Good. [AGENCY 25]

JODY FALTYS: My name is Jody Faltys, J-o-d-y F-a-l-t-y-s, and I'm here today...I first of all want to thank all of you for letting us talk with you today about these life-altering recommendations made by DHHS mostly in relation to the home health providers. As I said, my name is Jody and I've been a quadriplegic for 37 of my 41 years of life and in that time I've never had a pressure sore or had a lengthy hospital stay, due to the high quality of care I've received and the consistency of that care that I've received through my home health agency, who I've been with, like I said, for 20 years with the same exact home health aides. I live on my own and ever since I came to college and my home health aides come in four times a day to help me get out of bed and then help me with lunch at the lunch hour and take me to the bathroom and then come back at supper, again take me to the bathroom, and then at bed. So it's four visits a day that they provide me that keeps me living my life in the same way as any able-bodied person. Just the fact that I can't walk like any other person doesn't mean that I don't have the right to live like anyone else. I am someone's daughter, someone's sister, and someone's best friend. I am more than just a dollar sign. I know Ms. Chaumont said that my home health agency refers to me as a dollar sign, but they do not. They actually do have my well-being in mind. The only time I felt like a dollar sign and a number was in my dealings with the Department of Health and Human Services. I'm a human being with hopes and dreams like anyone else. The recommendations made by DHHS will have a profoundly negative effect on my life. By allotting such a ridiculously minute amount of hours to home health--it works out to be basically less than 20 minutes a day--I will basically be forced into having to choose only one visit a day. So which should that be? Should I get up in the morning and then stay up for 24 hours? Should I stay in bed all day and have one meal and one bathroom visit? It's quite a quandary that I don't think anyone would want to have. The answer to this does not lie in such an inhumane cut to the budget, as she proposes, nor does it lie in people like myself having to rely on state workers through the PAS program or the Medicaid waiver program. Those workers are untrained. The same people that take care of your cleaning

are the same people that will take care of you in your home. It will lead to bigger problems in the future. I will have breakdowns. I will have more infections. No money will be saved that I can see. Vastly more harm than good will come of this change. So I implore you to remember that at any time you could become disabled yourself and you would be forced to live your life according to the recommendations of the DHHS. And please disregard any changes they have made in relation to the home health services. [AGENCY 25]

SENATOR HEIDEMANN: Thank you for coming in and it's good for us to hear your personal stories. So thank you for coming in today, Jody. Are there any questions? [AGENCY 25]

JODY FALTYS: I've been in the program a long time really. [AGENCY 25]

SENATOR HEIDEMANN: Thank you very much. [AGENCY 25]

JODY FALTYS: Thank you very much. [AGENCY 25]

SENATOR HEIDEMANN: Is there anyone else wishing to testify on Agency 25? Welcome. [AGENCY 25]

LESLIE SPRY: (Exhibit 14) Good afternoon. Mr. Chairman, members and guests, thank you. My name is Leslie Spry. I'm a kidney specialist here in Lincoln, Nebraska and I am coming to testify against the Agency 25, I think it's called Agency 25 bill, and a proponent for LB952. I am the past-president of the Nebraska Medical Association. I'm currently the senior delegate for Nebraska to the American Medical Association and I act frequently as a spokesperson for the National Kidney Foundation. I appear before you today to predominantly talk about the nutritional support portion of...in LB952 and also in opposition to cutting the benefits associated with oral nutritional support for patients in the Medicaid Program. In my practice, I see many patients who are on

dialysis as a result of chronic kidney disease or who develop acute kidney injury and require dialysis until kidney function returns. These groups of patients commonly have many other illnesses that complicate their medical treatment. We refer to these complicating illnesses as comordibities. The most common comordibity that I encounter in dialysis patients is malnutrition. Many of these individuals suffer from other illnesses, such as hypertension, diabetes, and heart disease. Many of these patients are elderly and have the nutritional deficits associated with the elderly. Many of these patients have been in and out of hospitals numerous times and have suffered complications, such as infections, surgery, gastrointestinal illness, which lead to malnutrition. This malnutrition manifests as fatigue, weakness, poor wound healing, weight loss, loss of muscle mass, and ultimately delay in recovery from acute illness. The most common clinical laboratory measure that is used to assess this malnutrition is a serum albumin. In-hospital mortality and morbidity can be directly correlated with serum albumin of any individual in the hospital. This is a well-researched and described clinical measure that has been known for decades. In patients who suffer acute kidney injury and require acute dialysis, there is a recovery of kidney function that may occur; however, malnutrition is almost always present. It can be measured both by low serum albumin and other more sensitive measures known as the pre-albumin. Over my career, spanning more than 30 years, I have seen reports of many clinical trials that try to either hasten recovery or improve recovery from acute kidney injury, and despite those many fine trials of drugs and hormones to improve recovery of kidney function the only proven treatment to hasten recovery of acute kidney injury is nutrition. We commonly measure daily nutritional intake in our patients recovering from acute kidney injury, and if it is inadequate then low serum albumin...and the serum albumin is low, we recommend oral nutritional supplements. Now does that mean my time is up or...? [AGENCY 25]

SENATOR HEIDEMANN: If you could kind of condense what you have that's left, that would be great. [AGENCY 25]

LESLIE SPRY: Well, basically I would just point out two...the two things I wanted to

point out was, number one, the cost of a single dialysis treatment is $600. So I can buy a lot of nutritional supplements for $600. And if I can hasten that recovery of acute renal failure by even one or two dialysis, I can dramatically save a lot of money for that patient or whoever is the payer, and in many cases those are the Medicaid beneficiaries. Point number two is many of my chronic dialysis patients have as a distinct measure their serum albumin. In fact the federal government requires that I report serum albumin to them on a monthly basis, and they actually judge my dialysis unit on a Web site known as Dialysis Compare. If I'm forced to not make available oral nutritional supplements for my chronic dialysis patients, then I'm going to be at a disadvantage for other dialysis units across the nation that have access to oral nutritional supplements that I don't have access to. And so that puts me at a disadvantage. In fact, it gets published on a Web site which I've put on to my testimony. So those two things and then there are many other patients who use oral nutritional supplements. It's just that I have two distinct areas where I use these nutritional supplements. They are to patients' benefits and I think they save you money. [AGENCY 25]

SENATOR HEIDEMANN: So you're saying this is cost savings and not a cost. [AGENCY 25]

LESLIE SPRY: I'm saying this is cost savings. Again, the only thing that has ever been shown in all the research, I've been doing kidney medicine for 30 years, the only thing that has ever been shown to hasten recovery of acute kidney injury is nutrition. [AGENCY 25]

SENATOR HEIDEMANN: Are there any other questions? Seeing none, thank you. Is anyone else wishing to testify on Agency 25? Welcome. [AGENCY 25]

LAUREN NELSON: Hi. My name is Lauren Nelson. I am a physician and a mother of Peter. Peter was born extremely premature, which caused him to have severe lung disease. He spent ten months in the hospital and has been home with us for about a

year now. We have been so fortunate to receive home healthcare for Peter via an RN and Peter wouldn't be in the spot he is now without it. He was able to come home after ten months in the hospital only because we could have nurses at home. And I say that and my husband is also a physician too. Peter gets Medicaid because of the Katie Beckett Waiver. If he wouldn't have been able to come home, he would have cost the state of Nebraska hundreds of thousands of dollars continuously as he stayed in the hospital, and that doesn't include his increased morbidity, his increased infection risk, and it doesn't include just the fact that he doesn't have the same life at home or in the hospital. He's been home chasing after my four-year-old son, learning, getting physical therapy, seeing what kids do at home. Now I know that there's a question of allowing Peter to have a non-RN at home and I will say that I would not leave my child with anyone other than a physician or an RN. Peter's trache can obstruct at any moment. His ventilator, and this is only one part of the piece of equipment that I've brought up here, requires a lot of understanding, a lot of maintenance. There's been times where my nurses and/or my husband or I have had to react emergently as Peter is blue and floppy. That's not something, as a physician or a mother, I would ever trust to a nurse's aide. Since Peter has been home, in one year we've had no unexpected hospital admissions; only has been anticipated surgeries. He's had no hospital-acquired infections. You know, I know as a physician that there needs to be something done with the medical system as it is, but cutting these kids or anyone, not just the children, the most needy part, it doesn't make sense. It's going to cost more money in the system in the long run, whether or not people are institutionalized, whether or not people spend more time in the hospital. If they don't get as good of care, they're going to be back in the ER even more frequently. I'm not an accountant; I'm a mother and I'm a physician. And as a mother and a doctor, I think this is a really bad idea. I'll let the accountants testify to the money stuff. [AGENCY 25]

SENATOR HEIDEMANN: How many hours a day do you get help? [AGENCY 25]

LAUREN NELSON: We get, via the Katie Beckett Waiver, we get eight hours at night

and that's so we can sleep, because Peter needs constant suctioning, monitoring, meds; he gets continuous feeds, he's tube fed. So we get eight hours at night so we can sleep. Otherwise, my husband and I would have lost our sanity. We also get 12 hours a week of respite care which I can say that we never actually get our full 12 hours a week of respite care. And we get nursing hours for me working. And up until this...up until Wednesday, I've not been back to work full-time because I don't just want to yet. But we can get up to, I believe, 50 hours of working a week, which actually doesn't cover my working hours. I work more than that, but... [AGENCY 25]

SENATOR HEIDEMANN: So how many hours out of the day do you estimate that it's just you or your husband at home? [AGENCY 25]

LAUREN NELSON: Oh, the majority, most days a week. We get nursing about two days a week and then eight hours at night so... [AGENCY 25]

SENATOR HEIDEMANN: So it's the majority, the eight hours at night, that's helping you out so that you can sleep. [AGENCY 25]

LAUREN NELSON: So we can sleep, yeah. I mean the times when we don't have night nursing are the times where I'm afraid that I'm going to incorrectly suction him or the time that I've given him an incorrect dose of medicine. I mean the times where I've messed up something with his ventilator, those are the times when, you know...and my husband is an anesthesiologist and so he needs to be on and alert and wake and not up all night every night or, you know, every other night. What we would do is switch off. So Peter would not have come home if we would not have gotten this nursing. There is...he's stable enough now for me to like travel to Lincoln, because we're from Omaha, but that would not have happened. He would probably still be in the NICU or been transferred to the PICU. [AGENCY 25]

SENATOR HEIDEMANN: How old right now at the present time? [AGENCY 25]

LAUREN NELSON: Peter is 20 months old. He's been home a year next week. He was born 4 months early so he's just at about 16 months. [AGENCY 25]

SENATOR HEIDEMANN: Are there any other questions? Seeing none, thank you for coming in today. [AGENCY 25]

LAUREN NELSON: Thank you. [AGENCY 25]

SENATOR HEIDEMANN: Welcome. [AGENCY 25]

BRENDA DeLANCEY: Hello. My name is Brenda DeLancey, B-r-e-n-d-a D-e-L-a-n-c-e-y. First of all, I'd just like to thank you guys for hearing my concerns proposing the Medicaid cuts, more specifically the private duty nursing. I am a single mother of a ten-year-old boy who's actually here with me today. His name is Jackson. Jackson was born with a nonprogressive neuromuscular disorder called nemaline myopathy. He has the more severe form of it which has virtually left him unable to move or even breathe on his own. He is completely ventilator dependent. He has a G-button to allow him to feed, as he is unable to swallow his own saliva or any food supplements. Jackson requires 24-hour care which is obtained between our private duty nurses and myself. We are authorized for 122 hours a week. That's for eight hours a night to sleep. I get 48 hours a week for work. That allows me to work full-time and also for travel time to and from work. And then I get 16 hours a week of respite. What those hours allow, like I said, for me to work and Jackson to go to school. He is cognitively just like you and I. He is completely mainstreamed in a 5th grade classroom and he maintains all A's and B's. Without the care that he receives, I fear that he would not be able to stay in our home. Like I said, I'm a single parent. While my family and friends love Jackson dearly, not one member of my family feels comfortable to watch him, so I rely on private duty nursing to help me with that. This is a huge liability for somebody with nonmedical experience to come in and watch somebody who is completely ventilator dependent.

His life depends on one mistake. He, too, gets trache plugs. He needs constant repositioning. I'm proud to say in the ten years that we have been home, he has been hospitalized three times for illness and that is the care...because of the care that he receives in our home. And when he is admitted, he is admitted directly to the pediatric ICU, so the care that he receives in the hospital is no different than what he receives at home. And I'd just like to leave you with this thought. If you had a loved one who is completely vent dependent, would you want a nonmedical professional taking care of them? Thank you. [AGENCY 25]

SENATOR HEIDEMANN: Are there any questions? Thank you very much. Is anyone else wishing to testify on Agency 25, the Department of Health and Human Services? [AGENCY 25]

WALT ANTON: Thank you. [AGENCY 25]

SENATOR HEIDEMANN: Thank you for coming in today. [AGENCY 25]

WALT ANTON: My name is Walt Anton, W-a-l-t A-n-t-o-n. I'm here to testify. I have a son, he's 23 now. He was...he attended a year of college. He's doing fine. He's affected by Hunter syndrome, which is he's one of four, possibly five in the state of Nebraska with that. He had to have a surgery for...on the base of his skull for decompression of his spinal cord. It was decided that a trache would be the best way to go because he had some airway issues, so a trache was put in. That turned into a two-week hospital stay. A month later he had the surgery on his neck; turned into a five-week hospital stay. He still has the trache. We have home healthcare. We have a nurse that comes in every day for eight hours a day so me and my wife can both go to work. Without having the dedicated nurses that we have, either I or my wife would have to stay home, which then would put one of us on unemployment, which I know the state doesn't want that statistic either, but one of us would have to stay home. This affords us both at the same time to go to work. Basically, imagine being home with your child all day long. You hear

the pump going over here, somebody is needing suction. He always needs suction. If my wife can't go to work then I'm going to have to stay at work later. It's hard for one person to put up for all day long to be cooped up in the house. And believe me, it's our son and we don't have a problem doing it, but it does get to you. A lot of people need a break. We do get respite care. We don't always use it. Basically, we kind of take it on. He's our son, he's our responsibility, so we do as much as we can with him. So I just wanted to say that without that, one of us would be at home all day. [AGENCY 25]

SENATOR HEIDEMANN: Thank you for coming in and telling your story. Are there any questions? Seeing none, thank you. [AGENCY 25]

WALT ANTON: Thank you. [AGENCY 25]

SHIRLEANE LANGE: I'm bringing a helper with me just in case I (inaudible). My name is Shirleane Lange, it's S-h-i-r-l-e-a-n-e, Lange, L-a-n-g-e, and I fear that I'm speaking out of turn and I apologize for that, but my daughter can't wait anymore in her wheelchair. My daughter, Shelby, is sitting over there. She was born two months premature with the cord wrapped around her neck five times. During her initial hospital stay, which lasted from May 5 to June 29 in 1991, she coded multiple times a day. One day the doctor said she would never survive a normal life and the hard decision was made to let her go. After that decision was made, Shelby made a miraculous recovery and was taken off the ventilators to breathe on her own again. We were still told that she would never survive to see the age of one. Shelby subsequently has cerebral palsy, tracheomalacia, bronchopulmonary dysplasia, and a severe seizure disorder, is oxygen dependent, now ventilator dependent, and is fed through a G-button. She is currently a DNR. Shelby is dependent on someone for all of her daily cares. She spent the first five years of her life in and out of Children's Hospital in Omaha, Nebraska. She did not go into the hospital for a week or two; she went for months at a time. Shelby was trached at the age of three and came home on a BiPAP machine which we ran as a ventilator when she was five. Shelby takes a multitude of medications 11 times a day and

survives on nutritional formula called Peptamen Prebio. She has not been in the hospital since the age of seven. She is now 20. Most doctors who know Shelby cannot believe that she is still alive, yet alone not hospitalized for so long. Shelby is cared for by private duty nursing in our home. Many of Shelby's nurses have taken care of her since she was a small child. It is because of the excellent care and love that she receives at home that she has exceeded her prognosis. Shelby does not adjust well to change and I do not believe she would survive the move to an institution. Regardless, she most certainly would spend more time in the hospital ICU unit, which would raise the overall costs associated with her care. Despite all of these issues, Shelby is the most beautiful soul I have ever met. Her radiating smile can light up the darkest of days and she has taught me more as a mother than I have taught her as a daughter. She has taught me to appreciate the small things in life and be thankful for every moment that we have with those we love. She has taught me to love unconditionally. She appreciates and accepts everyone. She has taught me that sometimes we do not have all the answers. As her parent, I want her to be safe, happy, and healthy. If she has to be placed in an institution and all that she has known taken from her, I fear she will not be safe and know she will not be happy or healthy. I am a divorced, single parent who works full-time as an office manager, corporate administrator for a radiology group in Omaha, Nebraska. I have been employed with them for over 20 years. The private duty nursing has allowed me to remain an active and functional part of society while knowing Shelby is safe, happy, and healthy, and giving Shelby the ability to be an active part of our community in Blair, Nebraska. If we as a society expect the medical community to continue to push the envelope on the viability of premature babies, we will continue to have children with Shelby's disabilities in our society who will need to be cared for. I remember asking Shelby's doctors once, why did everything medically...why did we do everything medically possible for Shelby if we knew the outcome may not be favorable, and the response was that unfortunately they do not know who will be okay and who will not. With that said, I believe it our responsibility to support the most vulnerable souls in our society. They have every right to live a happy, healthy, and safe life, just like you and me. I understand that times are tough and budgets are out of balance, but we still

live in the United States of America, one of the richest countries in the world. I do not believe the weakest and most innocent of us should be the ones to pay the price to bring the budget under control. I believe it is our duty and our privilege to take care of those who cannot care for themselves. Thank you for your consideration. [AGENCY 25]

SENATOR HEIDEMANN: Thank you for coming in today. [AGENCY 25]

SHIRLEANE LANGE: Thank you. [AGENCY 25]

SENATOR HEIDEMANN: Are there any questions? Seeing none, thank you. [AGENCY 25]

SHIRLEANE LANGE: Thank you. [AGENCY 25]

SENATOR HEIDEMANN: Is anyone else wishing to testify on Agency 25, the Department of Health and Human Services? (See also Exhibits 15-17) Seeing none, we are going to close the public hearing on Agency 25, Department of Health and Human Services, and open up the public hearing on LB901. Senator Lathrop. [AGENCY 25]