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ARCH: Good morning and welcome to the Health and Human Services Committee. My name is John Arch. I represent the 14th Legislative District in Sarpy County and I serve as Chair of the HHS Committee. I'd like to invite the members of the committee to introduce themselves starting on my right with Senator Murman.

MURMAN: Hello, I'm Senator Dave Murman from District 38. I represent Clay, Webster, Nuckolls, Franklin, Kearney, Phelps, and southwest Buffalo County.

WALZ: Good morning. My name is Lynne Walz and I represent Legislative District 15, which is all of Dodge County.

WILLIAMS: Matt Williams from Gothenburg, Legislative District 36: Dawson, Custer, and the north portion of Buffalo Counties.

M. CAVANAUGH: Machaela Cavanaugh, District 6, west central Omaha, Douglas County.

ARCH: Also assisting the committee is one of our legal counsels, Paul Henderson, our committee clerk, Geri Williams, and our committee pages, Jordon and Sophie. A few notes about our policies and procedures. First, please turn off or silence your cell phones. This morning we'll be hearing two bills and we'll be taking them in the order listed on the agenda outside the room. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters of the bill, then from those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given the opportunity to make closing statements if they wish to do so. For those of you who are planning to testify, you'll be-- you will find green testifier sheets on the table near the entrance of the hearing room. Please fill one out, hand it to one of the pages when you come up to testify. This will help us keep an accurate record of the hearing. We use a light system for testifying. Each testifier will have five minutes to testify. When you begin, the light will be green. When the light turns yellow, that means you have one minute left. When the light turns red, it is time to end your testimony and we will ask you to wrap up your final thoughts. When you come up to testify, begin by stating your name clearly into the microphone and then please spell both your first

and last name. If you're not testifying at the microphone, but want to go on record as having a position on a bill being heard today, excuse me, being heard today, please see the new public hearing protocols on the HHS Committee's web page at Nebraskalegislature.gov. Additionally, there is a white sign-in sheet at the entrance where you may leave your name and position on the bills before us today. Due to social distancing requirements, seating in the hearing room is limited. We ask that you only enter the hearing room when it is necessary for you to attend the bill hearing in progress. The agenda posted outside the door will be updated after each hearing to identify which bill is currently being heard. The committee will pause between each bill to allow time for the public to move in and out of the hearing room. We request that you wear a face covering while in the hearing room. Testifiers may remove their face covering during testimony to assist committee members and Transcribers in clearly hearing and understanding the testimony. Pages will sanitize the front table and chair between testifiers. This committee has a strict no props policy. With that, we will begin today's hearing with LB570, which I am introducing, and I will turn the committee hearing to Senator Williams.

WILLIAMS: Welcome, Chairman Arch, and you are welcome to begin your opening on LB570.

ARCH: Good morning, Vice Chair Williams, members of the Health and Human Services Committee. My name is John Arch, J-o-h-n A-r-c-h, and I'm before you to open on LB570, which was introduced by the Health and Human Services Committee. LB570 would require the Legislature to complete an evaluation of the state's privatization of child welfare case management in the Eastern Service Area by December 31, 2021, and authorize the hiring of a private consultant to assist in completing the evaluation. As this committee is aware, Nebraska has a relatively short but complicated history with child welfare privatization. In 2009, Nebraska launched a statewide child welfare privatization initiative. Within a year, three of the five original private contractors lost or ended their contracts due to financial and management deficiencies. By early 2012, there was only one private contractor left, Nebraska Families Collaborative, covering only the Eastern Service Area. As we are very aware today, the Eastern Service Area, which consists of Douglas and Sarpy County, remains the only region of the state with privatized case management. Nebraska Families

Collaborative became PromiseShip, which we all know was replaced in late 2019 by Saint Francis Ministries. This committee is keenly aware of the difficulties Nebraska has recently experienced in its contract with Saint Francis. This bill, however, is not specifically related to our concerns over Saint Francis. Rather, its purpose is to step back and consider whether privatization has improved child welfare in the Eastern Service Area and whether or not we should continue down that path. I do want to acknowledge that a few different evaluations have been conducted over the past decade and clarify why this evaluation would not be redundant of those completed in the past. For example, in 2019, DHHS commissioned an evaluation by The Stephen Group to help it determine a path forward with privatization in the ESA. Notably, however, the Stephen report did not ask whether the state should continue with privatization; rather, it asked how the privatization model could be improved. The other reports I'm aware of were good reports. However, they need to be brought up to date due to the time that they were conducted. In 2012, LB1160 required the Department of Health and Human Services to engage a nationally recognized evaluator to provide an evaluation of privatization efforts, very similar to what I'm asking for here, what we are asking for as a committee bill. That evaluation by the consulting firm Hornby Zeller concluded that it's not at all clear that privatization improved outcome achievement, nor is it clear that it detracts from outcome achievement-- mixed results. In 2014, under LB660, the Legislature commissioned an evaluation by Hornby Zeller Associates which asked the question, should privatization continue? That report concluded that at that point in time, outcomes achieved under privatization were no better but no worse. In 2012 and 2014, reports by Hornby Zeller were good reports and they asked many of the right questions. However, we're now seven years later in this privatization project, and it is an appropriate time to conduct an impartial assessment of privatized child welfare services from a longitudinal perspective, that is, over the past decade, has privatization been a service or disservice to the citizens of Nebraska? We've engaged in a pilot project up to this point and it's time to evaluate it. Specifically, this study should consider quality, innovation, and cost. First, what impact has privatization had on the quality of childcare-- child welfare services? Second, what impact has privatization had on child welfare service innovation? And third, what impact has privatization had on the cost of child welfare services? LB570 would require the completion

of this evaluation by the end of this year, at which time I think this committee will be in a good position to act based upon those findings. There is a fiscal note which is associated with the cost of hiring a consultant to conduct the evaluation. I think the fiscal note is a modest amount when we consider the cost of the case management services we're-- we're talking about and the importance of getting our child welfare system on the right track. With that, I'm happy to answer any questions. I just want to add one other comment, and that is, we're really taking a look at a ten-year period. Again, I say this is not specific to the Saint Francis issue that we have in front of us, a more immediate issue, but rather it is that larger question of, do we, should we continue privatization in the state of Nebraska, even for the Eastern Service Area, for the case management of child welfare? So with that, I will stop and I'll answer any questions you might have.

WILLIAMS: Thank you, Chairman Arch. Are there questions?

WALZ: I have a--

WILLIAMS: Senator Walz.

WALZ: --quick question.

ARCH: Yeah.

WALZ: Just that, you know, we haven't really had any answers on whether or not it should continue, just it's no better, it's no worse. Do you expect that we'll have, you know, a little bit more clear answer if we hire another consultant to--

ARCH: I-- I anticipate that will have that we'll have-- that we'll have clear direction. The-- the-- the questions-- and if-- and if-- and-- and honestly, if-- if-- if it's a similar result to what-- to what the Hornby Zeller report showed in 2014, in addition to the-- the number of years now that we've had since that time, but if-- if that is the conclusion, we still have a decision here within this committee to make. Is this- is this something-- we have-- we have spent a great deal of time, angst, effort, not just-- not just this committee, not just the Legislature, the department itself, you know, and we've had discussions within our committee. How do you evaluate the cost that

the department has put into privatization while they may-- while they may contract out, they themselves, and more oversight and more issues keep-- keep arising? So, yeah, we have a-- we have a decision. I inquired as to what happened at the end of 2014 with that report from Hornby Zeller, and the answer was it went on the shelf. This-- this report's not going on the shelf.

WALZ: Can I follow up on that? And you and I have had the discussion when it comes to cost on, you know, have-- has it saved the state any money, how much more are we spending, you know, did-- was there elimination of-- of staff from DHHS when they took on privatization, which, you know, you would think that there might be. Will that be-- will we get answers on that?

ARCH: Yeah, the issue of cost-- the issue is cost-- of cost is yet to be defined, exactly what needs to be in that report, but that's very appropriate that that be included.

WALZ: OK. Thank you.

WILLIAMS: Additional questions? One of the questions I would have is that the-- the previous reports that were generated may not have asked the specific questions that we're asking this time. So I sense that with your leadership, we will be asking those very specific questions about cost, about the viability of this kind of model--

ARCH: Right.

WILLIAMS: --and asking for a recommendation directly on that.

ARCH: Right.

WILLIAMS: Is that correct?

ARCH: That's correct. Those are the questions that have to be asked and answered so that we as a Legislature, as a committee, can make a recommendation to the full body, should we continue, shouldn't we-- shouldn't we continue with privatization.

WILLIAMS: Thank you. Senator Walz.

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WALZ: I'm sorry. I just have one more question. Do you know if any of these reports or any of the past, I don't know, consultations or whatever, did they include interviews with families and kids--

ARCH: I don't know.

WALZ: --the consumers?

ARCH: I don't know. Now you go far-- you go as far back as 2011, the-- the-- the big report in 2011, I think that there was that. That was very, very comprehensive. And as a matter of fact, at the end of the 2011 report, it was recommended that we not continue privatization, but the will of the Legislature just wasn't there to stop it at that point.

WALZ: OK. All right, thanks. I'm done. Thank you.

WILLIAMS: Seeing no more questions, thank you. We will invite the first proponent, supporter of LB570. Seeing none, is there anyone here to speak in opposition? Welcome to HHS.

LYNN CASTRIANNO: Thank you. OK. Sorry, this whole cane thing is new to me, so I'm trying to figure out how to navigate. So good morning, Senator Arch and members of the Health and Human Services Committee. My name is Dr. Lynn Castrianno, L-y-n-n C-a-s-t-r-i-a-n-n-o, and I am representing myself. I served as the vice president of continuous quality improvement and data management at PromiseShip for seven years and was with two other lead agencies prior to that, beginning in 2009 when privatization began. I appreciate this committee taking an active interest in this issue and understand the desire for an evaluation, as Senator Arch just described. Since 2011, there have been at least 12 different reports that have focused on child welfare privatization, with 50 percent of these reports concluded in the past three years alone. I oppose LB570, as the information being sought through the evaluation already exists. We have the data. The most recent and comprehensive of these report was completed in 2019 by The Stephen Group, as Senator Arch referred to. The report provides extensive data about performance improvement costs, as well as summaries of the reports completed between 2011 and 2018. The summaries, which you have copies of, are critical to our understanding of what has already been done and can be used to help answer the questions posed by this bill.

As one of my last assignments at PromiseShip, I wrote a report that provides an overview of the accomplishments and successes achieved in the Eastern Service Area during the ten years PromiseShip served as a lead agency. The report, which you also have a copy of, complements the data from other evaluation. The focus on outcomes as a primary criteria for successful privatization is dependent on a well-functioning public-private partnership. Evaluations are based not only on outcomes, but is an assessment of the infrastructure and implementation of the project. The two go hand in hand. I suggest to the committee that the question that needs to be answered is not does privatization work in Nebraska. Instead, I recommend reframing the question to what needs to occur in order for there to be a functional privatization system in Nebraska. It goes without saying that part of the question needing to be answered is whether Nebraska wants a privatized child welfare system. That is a core element of a functional model. There is no evaluation or consultant that can answer that question for Nebraska. This has to be a considered decision with a comprehensive implementation plan and a clear understanding of what privatized model is best for Nebraska children and families. And many of the reports specific to evaluating Nebraska's privatization initiative during this past decade, the reports had two overarching themes which underlie my suggested reframing. Essentially, the reports concluded that the privatization initiative was not well developed or implemented, there's a lack of trust between the parties, and the contract was poorly managed. Secondly, better performance outcomes with PromiseShip did not do better or worse than the private sector. An additional evaluation would support the data we already have and would not answer the question of whether Nebraska should continue down this path. Nor would an evaluation shed light on the current circumstances with Saint Francis. An evaluation of the current outcomes of Saint Francis is not needed, as we all know what those struggles are. The question in this case is not whether privatization failed. That question goes squarely to the procurement process and, although not the point of this testimony, cannot be ignored because of the ramifications this decision has had on the privatized model. Saint Francis was not set up for success, and looking at their outcomes is not indicative of whether privatization in Nebraska works. This is an indication of what privatization model Nebraska chose, and it appears they chose poorly. Although I oppose LB570 as it is currently proposed, I would advocate for an understanding of what Nebraska would

need in order to have a fully functioning and supported privatized child welfare system. Thank you and I will be glad to answer any questions.

WILLIAMS: Thank you, Dr. Castrianno. Are there questions? Seeing none, thank you for your testimony.

LYNN CASTRIANNO: Thank you.

WILLIAMS: Are there any additional opponents? Seeing none, is there anyone here to testify in a neutral capacity? Seeing none-- oh, excuse me. Welcome.

MONIKA GROSS: Thank you. Senator Williams and members of the Health and Human Services Committee, my name is Monika Gross. That's spelled M-o-n-i-k-a, last name G-r-o-s-s. And I am representing myself today. I'm here to testify in a neutral capacity on LB570 and to give you some information about the lead agency model pilot project in the Eastern Service Area. I'm the former PromiseShip interim president and CEO and, before that, the general counsel at PromiseShip for over nine years. The original child welfare contract between DHHS and Nebraska Families Collaborative, later known as PromiseShip, in the Eastern Service Area terminated on June 30, 2014. At that point in time, no new competitive bidding process had been initiated. And within six months prior to the expiration of the contract, all of the staff at Nebraska Families Collaborative had no idea whether they had a job in six months or not. I was here in 2014, in this room, when Senator Krist introduced LB660, which permitted DHHS to extend the lead agency pilot project in the Eastern Service Area and required an evaluation of the pilot project to be completed by the end of 2014. So what ended up happening is that LB660 passed unanimously and Nebraska Families Collaborative was granted a one-year contract and a consulting group, Hornby Zeller Associates, completed an evaluation of privatization in Nebraska, and you've already heard the-- the results of that. Since that time, Nebraska Families Collaborative had a series of short-term contracts, one-year extensions and then a two-year contract from 2017 to 2019. And since 2014, at least six more evaluations or reports have been prepared on child welfare privatization in Nebraska, including the very comprehensive assessment of the outsource model in the Eastern Service Area by The Stephen Group in May 2019. The current issues in child welfare in the Eastern Service Area, however, have

their roots in a flawed and failed procurement and selection process. There have been a number of high-profile state government procurements that have failed in Nebraska in recent memory, and two of them involved PromiseShip. In 2017, DHHS awarded a five-year contract to PromiseShip to manage ongoing child welfare cases in the Eastern Service Area following a competitive bidding process. After a protest filed by the only other bidder, DHHS rejected both bids and withdrew the RFP, effectively canceling the procurement. Then DHHS entered into a two-year emergency deviation contract with PromiseShip, pending another procurement process. And I will tell you that that contract was for the exact amount that was bid in our proposal, no more, no less. The 2019 procurement process ended with DHHS awarding a five-year contract to Saint Francis Ministries of Salina, Kansas, based on an unreasonably low cost proposal that they have since admitted was improperly bid and a technical proposal that fell far short of the minimum requirements of Nebraska law. And so here we are. Those of you that were here in 2012, in 2013 and 2014, this may all sound familiar. This may all sound like déjà vu. An evaluation, assessment, or investigation will only be helpful in determining exactly what went wrong in the procurement and selection process and who's responsible for that. Beyond that, I don't think you can judge the success of privatization based on the performance of Saint Francis Ministries over the last 18 months for the reasons that I've already stated. Unless we fix the procurement and selection process, we'll never have a successful public-private partnership in child welfare case management in Nebraska. Thank you for your ongoing commitment to children and families, and I'd be happy to answer any questions.

WILLIAMS: Thank you, Ms. Gross. And one of the issues we are dealing with is there are none of us sitting at this table that were here in '12 and '13 and we're caught in this same dilemma that-- that you are bringing up. Are there questions from the committee? If we-- the focus that we are looking at, that Senator Arch is bringing with LB570, is not directly on the procurement process. It's on assisting the state, the legislative branch, the policy-making branch, with making a decision as to whether privatization works or whether this should be brought back under the umbrella of HHS. You have read and looked at all of the other reports that have come out through all those years and that. It would appear that we believe that is a fair question to--

to ask of a professional to help us-- guide us on that decision. I would be interested in your direct thoughts on that process.

MONIKA GROSS: On the-- the procurement process?

WILLIAMS: On the process-- no, not on the procurement process--

MONIKA GROSS: Oh.

WILLIAMS: --on a report that could be generated to help determine the direction that this state should take long term.

MONIKA GROSS: Well, I think the-- that the-- the thing that would be most important is, as Dr. Castrianno discussed, is what does the state of Nebraska want? I think the state of Nebraska needs to do some soul searching. And if you look at successful models of privatization, the structure began with the state legislatures, with legislation to authorize the-- the privatization effort and to set up the structure that would be followed. And so I would-- I would encourage the committee and the evaluators to look at the state of Florida and-- and to see how it was set up there. They-- the regions in Florida rolled it out. It was rolled out slowly. It wasn't rolled out statewide all at once. It was studied and it was tweaked as they went along to-- to make the process better. And it was all about community-based care. And if you look to the state of Texas right now, they are in a similar process, rolling this out region by region. I think that may be somewhere else you could look for inspiration or guidance on this.

WILLIAMS: Thank you. Are there additional questions? Seeing none, Ms. Gross, thank you for your testimony.

MONIKA GROSS: Thank you.

WILLIAMS: Is there any additional neutral testimony? Welcome to Health and Human Services.

LANA TEMPLE-PLOTZ: Good morning. Good morning, Chair-- Chairman Williams and members of the Health and Human Services Committee. My name is Lana Temple-Plotz, L-a-n-a T-e-m-p-l-e P-l-o-t-z, and I serve as CEO of Nebraska Children's Home Society, but I appear before you today as president of the Children and Family Coalition of Nebraska, also known as CAFCON. CAFCON is an association of ten child welfare

and family service provider agencies with a mission focused on turning forward thinking into action for the betterment of children, youth, and families in Nebraska. We are grateful for the attention paid by the legislative branch with regard to service contracts, specifically the Eastern Service Area case management contract, and we are neutral to LB7-- LB570 as it is written. LB570 calls for the Legislature to complete an evaluation of the pilot project prior to December 31, 2021. While we are-- while CAFCON is supportive of an evaluation of the ESA case management lead agency, we have concerns regarding LB570. And as previously has been discussed, there's been many evaluations that have occurred in regard to the question, should we as a state choose privatization or, as I like to say, public-private partnerships? And so we understand that, as I've testified in previous hearings, transitioning case management back to the department at this particular juncture would not be warranted and could cause, obviously, some damage in-- in that part of the state. And so we understand as an association that maintaining a lead agency contract provides opportunities for innovation by piloting well-being solutions in the ESA that have the potential to be replicated in other parts of the state. So I think the question that's been brought before the committee in regard to is privatization good for Nebraska, does-- should we be doing it, is a primary question that-- that we need to answer, as has been previously mentioned, as a state. Monika mentioned a couple of other states who've done it and done it well. And as she mentioned, it was a-- it was a slowly rolled-out process that was evaluated on an ongoing basis. And I think in regard to taking a look at what's been happening in our state, CAFCON supports the opportunity for public-private partnerships and, again, as I mentioned, because we understand that those opportunities lead to innovation. So PromiseShip, for example, worked with several CAFCON members to develop and pilot a model called family Finding, which successfully found caring connections for children and youth in foster care, thus decreasing their time in care and leading to lifelong connections necessary for adulthood. That was one example of a pilot that happened within PromiseShip that has now been successfully replicated statewide. Another example of innovation in the ESA is the Pathways to Permanency program, which I discuss in my report. in my testimony. And another example is our Professional Foster Care, which was also initiated in the ESA. So in regard to my testimony, as I mentioned, we testify as neutral, and these are just a few examples of the benefits

of having a lead agency contract. Public-private partnerships stimulate innovation and give root to major initiatives that were incubated in the ESA but extend statewide in ways that the state agency often cannot do due to financial and bureaucratic constraints. We would also suggest a better approach is to adjust the bid process and award determination in order to ensure competent lead agency is chosen. And I've included within my testimony our position paper which outlines five areas that CAFCON is recommending be closer look-- be taken a closer look at in regard to this issue. And I will end my testimony and take any questions.

WILLIAMS: Thank you, Ms. Temple-Plotz. Questions? Would it be a reasonable takeaway from your testimony to say that-- that you are supportive of an evaluation, but the evaluation should only center on privatization?

LANA TEMPLE-PLOTZ: I think, what I mentioned before in regard to the previous two individuals who have testified, we have lots of information and data about privatization and about the privatization that happened in the ESA. And so in my-- in CAFCON's position, what we want to do is look at not, is privatization good or bad or should it continue? We believe that privatization can lead to innovation and that ending privatization is not, as I mentioned, what I like to refer to as public-private partnerships, is not in the best interest of Nebraska. However, you have to have a strong and well-laid-out plan to implement privatization, and what has happened over the last ten years is that, as previous testimony has indicated, there has not been a strong implementation plan throughout this whole process. And so whether it has to do with the implementation plan that was implemented at the very beginning, whether it has to do with the back-and-forth between the department and PromiseShip regarding contractual pieces and extending contracts and whether it has to do with the procurement process that currently happened with Saint Francis Ministries, all of those pieces have been flawed, but there are states who do it and do it well. And if we can do it and do it well, privatization, there are many opportunities for innovation that can happen between that public-private partnership that can't happen at the state level due to financial constraints and other bureaucratic issues. So CAFCON would be in support of continuing to look at privatization in a thoughtful, meaningful, well-planned way, which has not happened up to this point in our state and unfortunately has led to some perceptions around

privatization as a-- as a whole, versus the way that we implemented it as a state.

WILLIAMS: Thank you for that. That's very helpful questions. Senator Walz.

WALZ: Thank you. Thanks for coming today.

LANA TEMPLE-PLOTZ: Yes, absolutely.

WALZ: Privatization can lead to innovation. You said that there are some great opportunities that can happen through privatization.

LANA TEMPLE-PLOTZ: Yes.

WALZ: Can you just maybe give us a couple examples?

LANA TEMPLE-PLOTZ: Sure. So a couple examples of privatization leading to innovation would be Pathways to Permanency, which is mentioned in your-- is mentioned in my testimony. So we-- a couple of CAFCON member agencies created this model, Pathways to Permanency. We approached PromiseShip at the time and said this family support and visitation services aren't working the way that they were designed and we feel like we can get better outcomes if we are able to look at a different way of doing business, look at a different way of working with children and families. And PromiseShip said, absolutely, let's have a meeting, let's have a discussion. We worked in partnership with PromiseShip to develop this model, called the Pathways to Permanency model, and it really looked at holistically helping families beyond just those two separate services. And the model was presented to PromiseShip and they implemented it. And after months of positive outcomes, as I mention here, which included decreased length of stay for families in care, they began to implement that across their whole agency and across their whole Eastern Service Area. So that's a great example, because two agencies within the Eastern Service Area went to PromiseShip and said, can we do this, and they said, yes, let's have a discussion, and we were able to pilot it in just a small way and see that we had positive outcomes and then do it in a broader way with other agencies. So that's an example where at the state level that's very difficult to do because in a-- in a state system, you have to do individual contracts, the procurement process, all those pieces, so

you don't have as much opportunity for that innovation. And they-- they have certain parameters that they just can't-- aren't-- don't allow them to do that kind of innovation.

WALZ: Good. That's good to know. Thank you.

LANA TEMPLE-PLOTZ: Yeah. So that's just one example.

WILLIAMS: Any additional questions? Seeing none, thank you for your testimony.

LANA TEMPLE-PLOTZ: Thank you.

WILLIAMS: Are there any additional neutral testifiers? Seeing none, we do not have any submitted testimony. We do have one opponent on-- it does say, written testimony on here. Is that right, Jerry, that it's written testimony, that we have-- we don't have any-- we have a letter.

GERI WILLIAMS: Yeah.

WILLIAMS: Thank you. Senator Arch, you're welcome to close on LB570.

ARCH: Thank you. I appreciate the testimony this morning very much. We have a complicated decision in front of us as a committee. I think we-- we understand that. You know, we're-- after this bill we'll hear another bill and we'll have varied opinions as to the direction that we should proceed with here. And I-- and so I view this-- I view the report that we're requesting here to be a piece of the information that we need to make the decision that we must make. We've been at this 11 years with-- with our privatization effort and we can say, well, we should just do it better, we should try, and maybe that-- maybe that is the conclusion. Maybe that is what we should do. There would be other people that would say, no, no, we're-- we're done with privatization. But the only people that can make that decision is us, and we have to make that as a policy decision. And so this would be a piece of information that we would need to make that. The issue of procurement that Monika Gross brought up? Dead on, big issue. How all this happened, we have to-- we have to look at that. We have to understand how that happened, but not just how it happened, but how-- how do we-- how do we ensure that if we have other rounds, regardless of what the procurement issue is with-- with DHHS in particular, our--

our agency, that we-- that we set a different-- a different path if-- if that's needed, should there be legislation on a different procurement process. That needs to be one. That isn't the study-- that isn't this study, but that's another question that is absolutely out there. Other states have had some success with privatization. Other states have pulled back from privatization. And I think-- I think we'll see that in-- in any report that we do here. What I'm-- what I am most interested in is I am interested in a deliberative process in this decision. It's a big decision. It affects-- it affects children. It's a big decision. What-- but-- but we could go from crisis to crisis, from not doing it well to not doing it well to doing it better to not doing it well again. We have to have that deliberative process as a body and as a committee where we can come to our conclusion of policy as to what is best for the children under our care as a state, what's best-- what's best for our state. And so I see this-- I see this particular report as a piece of that deliberative process, not the end and the-- and the be-all that answers all questions, but a piece of that deliberative process. So with that, I would conclude my remarks and answer any-- any other questions you might have.

WILLIAMS: Thank you, Chairman Arch. Are there questions? Seeing none, that will close the hearing for LB570.

ARCH: We will now open the hearing for LB491. Welcome, Senator Cavanaugh.

M. CAVANAUGH: Thank you, Chairman Arch and members of the Health and Human Services Committee. My name is Machaela Cavanaugh, M-a-c-h-a-e-l-a C-a-v-a-n-a-u-g-h, and I represent District 6, west-central Omaha in Douglas County. I'm here today to introduce LB491. I introduce this bill in order for this committee to have options to deal with the Eastern Service Area Child Welfare contract. The current contract has yet to meet caseload requirements or any other quality metric in Child Welfare. Their performance is reported to have decreased the-- decrease the number of children being adopted and being properly cared for. They are embroiled in controversy over mismanagement, and their own CEO told this committee that their original application was fraudulent. So not going to read the rest of my remarks. I'm going to turn to the fiscal note. I have extra copies if anybody-- does anybody need a copy of the fiscal note? OK. So the fiscal note. So the fiscal note starts with our Fiscal Analyst, the

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Legislature's Fiscal Analyst detailing this bill. This bill eliminates the authority of the Department of Health and Human Services to contract for a case management lead agency pilot project in the Eastern Service Area. The bill also prohibits the department from reinstating a lead agency in the Eastern Service Area. Current state statute allows the department to designate a lead agency. The current contract with St. Francis Community Services is cost based-- is a cost-based contract with a cap set at 5 percent or less of the out-of-home cost per child in the area of the state outside of the Eastern Service Area. The financial provisions of the contract are summarized below. I'm going to skip those. I think everybody can look at that on their own. Based on this cap, eliminating the contract and returning case management to the state would either be equal to current costs or save costs, excluding transition costs. The department's fiscal note shows additional costs of $6,193,347. There would be transition costs, but the department's estimates-- estimates appear to be high for the following reasons. The department's fiscal note states that St. Francis Communities paid a premium on their administrative salaries. However, the department is required to pay the salaries in the state's personnel classification plan, except for discretionary nonclassified employees. The department is limited to the number of discretionary nonclassified positions with-- many of which are currently fill"sic-ed"ed. The department could request a review of classifications from the Personnel Division within the Department of Administrative Services. This would take time and would cover all employees in the state within those classifications, not just those in the Eastern Service Area. Those additional costs, if any, would not be attributed to this bill. The start-up costs allowed under the Amendment 3 of the contract with St. Francis Community Services for cases transitioned from PromiseShip was $1 million, $43, $43,904 [SIC]. It's unclear why the transition from St.. Francis Community Services to the state would be six times higher-- six times higher. The department's fiscal note shows $6.2 million in state personnel and related costs during the transition, but does not recognize any reduction in the costs paid to St. Francis Community Services. As it is a cost-based contract, the state would not be paying for children not under the care of St. Francis Community Services. Based on the prior amount that was allowed for start-up costs, it is estimated those one-time costs would be between $1 million and $1 million-- $1,500,000 thousand. Very grateful to the

Fiscal Office for their in-depth look at this. I spoke with Chairman Stinner of the Appropriations Committee this morning because of my remarks on the floor this morning about fiscal notes. And he told me, you know, the-- our Fiscal Office is working really hard, and they're getting these fiscal notes from departments, and they're trying to sort through them as quickly as they can. And it's really problematic. This is problematic. This is really problematic and it is disrespectful to this committee and to this legislative body to have a fiscal note like this. I encourage you all to look at it very closely as this proceeds. I sent an e-mail and I saw that the Fiscal Analyst from DHHS responded to the entire committee, so you all have it, because I questioned what this cost for a mobile crisis center would be. I thought, did I require a mobile crisis center? I didn't. Sounds like a great idea-- $500,000-- $506,000. So you all have that explanation in your e-mail. It's paying 40 staff for 60 days to come from across the state and stay in Omaha during the transition. I'm not sure why we wouldn't be hiring and training staff here during the transition time, but apparently this is the plan. I would also direct you to the department's fiscal note where it says DHHS will need to develop a mobile crisis response and transition plan to ensure families and children are supported during the transition and the continuity of services in-- is in place. That might be the most upsetting and disturbing part of this entire thing. They don't have one? They don't have one. This would require them to have one, and they don't have one. They currently do not have a crisis response and transition plan. That-- I lost sleep over that last night. Another question that this fiscal note brings is-- and, and I hope-- I see that the department is here-- I hope that they will speak to this part of it because it is confusing and I am very unclear as to how to interpret this. LB491 eliminates the ability of the Department of Health and Human Services to contract a third party to provide case management services in the ESA of Child Welfare program, Douglas and Sarpy Counties. It also prohibits the Division of Children and Family Services from reinstating a contract for a lead agency after October 1, 2021. This is the confusing part. DHHS would not be able to enter into a new contract with the current third-party contract in the ESA: St. Francis Ministries. The current contract runs through February 28, 2023. At the end of the current contract, DHHS would be required to assume all case management of the ESA under the administration of CFS. I don't know if they are intending to say that they intend to bring it

back in house after February 28, 2023, or that this would not allow them to continue the contract after February 2023, because this would now-- this would terminate the contract prior to 2023. So this is very confusing and I, I hope that an explanation will be given to this committee on what that is right now. I spoke with Kerry Winterer this morning. He's not able to join us. He is the former CEO of DHHS during the-- between August 2009 and December 2014. And it's unfortunate that he wasn't able to be here, but he was the head of DHHS under Governor Heineman, and he came and testified on LR29. And we spoke this morning, and he agreed that it would be best that I share his testimony from LR29 with the committee today. For those of you that did not hear it, this is what he had to say: Between August 2009 and December 2014, I served as CEO of the Nebraska Department of Health and Human Services. My service began as implementation of the contracts to implement the state's efforts to privatize Child Welfare services was just beginning. I am testifying in favor of LR29. Along with this written testimony, I am providing a copy of an opinion piece published in the Omaha World Herald I wrote shortly after the contract was awarded to Saint Francis, and I will forward that to all of you. I hope it provides a bit more background. I have two basic points regarding LR29 and the need for the special committee that resolution creates. The contract with St. Francis was fatally flawed from the beginning and should not have been awarded. On its face with those-- those with any experience with the state's earlier contracts for these services would have known that the contract was seriously underbid by St. Francis, and that it would be impossible for the required services to be provided for that amount. Under-- underfunding was the primary cause of the earlier failure of privatization in the state with all contractors except the Eastern Service Area, ending their contracts or going bankrupt. The Eastern Service Area was salvaged only through significant increases in the payments to the surviving contractors. Yet the accepted contract with St. Francis bid only 60 percent of the amount bid by the incumbent contractor, who had learned from its long experience to-- true cost of providing these services. Something is wrong with a process that results in this contracting being awarded, and this resolution provides a means to help understand that process. All has been well reported in the news media. St. Francis has done an abysmal job in performing its contract. By its own admission, it has failed to meet the obligations of the contract, including meeting the required caseworker ratios. The bad behavior of this leadership has

also been widely reported, as it-- as have its problems in delivering services in its home state of Kansas. With their record performance, how do we really know the quality of services they are providing to children in Douglas and Sarpy Counties without a thorough and independent investigation? This resolution would-- provides for that investigation. Nebraska has a less than stellar history in providing child welfare services for its people. It is time now for the Legislature to show its concern for Nebraska's children and ensure that we are doing the best possible job for them. This is a mess; it's just a mess. And this bill today is just another opportunity for us to have this conversation and to keep it at the front of our minds that this is a mess, that the state was defrauded, that we paid a ransom, and that we are continuing to prop up another-- an organization from another state. They aren't in compliance in just about every respect. It's negligent for us to not do something. If the department actually intends to end privatization on February 28, 2023, if that is what this means, it would have been great for them to come to me and say that, and I would have changed the date in the-- in my bill. But the department doesn't do that. The department doesn't communicate with me and, frankly, they don't communicate with this committee. With that, I'll take any questions.

ARCH: Are there any questions? Seeing none, thank you very much. I would welcome the first proponent for LB491. Good morning.

SARAH HELVEY: Good morning. My name is Sarah Helvey, that's S-a-r-a-h, last name H-e-l-v-e-y, and I am a staff attorney and director of the child welfare program at Nebraska Appleseed. I am here today to testify in support of LB491 on behalf of our client, Laura Virgl, L-a-u-r-a, last name V-i-r-g-l, who is the taxpayer plaintiff in Virgl v. Smith et. al., against the Department of Health and Human Services and St. Francis Ministries. I'm an attorney of record in this case, and I'm here today to speak publicly on this bill in relation to our pending litigation. On September 3, 2019, Miss Virgl filed this lawsuit. It alleges that Nebraska Revised Statute 68-1212(2), which LB491 seeks to strike, constitutes special legislation in violation of the Nebraska Constitution. Subsection 1 of 68-1212 sets the current default for our Child Welfare System, declaring that for all Child Welfare cases, case manager-- case managers, quote, shall be employees of the department, meaning that the department cannot contract out its Child Welfare case management responsibilities to a private agency

across the state. However, Subsection 2 carves out an exception for the Eastern Service Area, allowing the department to contract with a private agency for its child-- Child Welfare case management responsibilities there. Miss Virgl's lawsuit alleges that 68-1212(2) creates an unequal child welfare system in Nebraska and unjustifiably treats Douglas and Sarpy Counties differently from the rest of the state. This has created an equity and instability in the state's most fundamental responsibilities for the care and custody of children. LB941-- LB491 would strike 68-1212(2), eliminating this inconsistency that currently exists between Douglas and Sarpy Counties and the rest of the state. On behalf of Miss Virgl, we support LB491 because its passage would essentially have the same result as a successful resolution of her lawsuit: to void 68-1212(2); to cease the unconstitutional expenditure of taxpayer funds on an unequal system; to potentially terminate the current contract; and to prevent the department from entering into future contracts for Child Welfare case management services in the Eastern Service Area. For all of these reasons, on behalf of Miss Virgl, we respectfully request that you vote to advance LB491 out of committee.

ARCH: Thank you. Are there questions? Seeing none, thank you very much. The next proponent for LB491. Seeing none, the first opponent for LB491.

STEPHANIE BEASLEY: Good morning.

ARCH: Welcome.

STEPHANIE BEASLEY: Good morning, Chairperson Arch and members of the committee. My name is Stephanie L. Beasley, S-t-e-p-h-a-n-i-e L. B-e-a-s-l-e-y, and I'm the director of the Division of Children and Family Services, and I'm here to testify in opposition of LB491. Let me begin by saying that ensuring the safety and well-being of children and families in Nebraska is our highest priority. All of us share the goal of safety, permanency, and well-being for our children. The department is committed to providing child welfare services in the least intrusive and least restrictive manner. The continuum of services provided in Child Welfare includes prevention activities and coordination, as well as child protective and case management services that focus on safety, permanency, and well-being of the child. Child Welfare services are delivered in collaboration with the broader child

welfare community, including courts, law enforcement, schools, providers, and others, the focus again on safety, permanency, and well-being of children-- children and families is constant. LB491 will require DHHS to enter into contracts with St. Francis Ministries contracted providers to ensure the continuity of services for children and families. If a provider chooses not to contract with the DHHS, the family and child will be greatly impacted. There will be staff turnover within St. Francis, which will impact children and families having multiple caseworkers and directly-- and directly delay permanency. To fulfill the bill, DHHS would need to hire new staff and transfer all case management and activities in the ESA. Ideally, DHHS would allow for a six-month transition and implementation plan starting in September 202, where DHHS would need to continue paying the administration of St. Francis, as well as higher DHHS staff. DHHS will need to develop a mobile crisis unit and transition plan to ensure families and children are supported during the transition and that the continuity of services remains in place. This service includes bringing in staff from other areas of the state to provide coverage in the ESA. This will put a strain on the other service areas and may cause a delay or disruption in other areas of the state during the transition period. To facilitate the transition, DHHS estimates 40 staff would need to be stationed in the ESA for 60 days. Thank you for the opportunity to testify today. I'm happy to answer any questions you may have.

ARCH: Thank you. Are there questions from the committee? Senator Walz.

WALZ: I'm-- I'm just going to ask the question. Do you feel that DHHS would be prepared to do that?

STEPHANIE BEASLEY: To do a six-month transition?

WALZ: Yeah.

STEPHANIE BEASLEY: I do think that a six-month transition would be needed to move those cases over to DHHS, at a minimum.

WALZ: OK.

ARCH: Other questions? I have-- I have a couple. So if this were to occur and the department needed to take this back, isn't-- I mean,

having watched some of the other transitions, it-- it-- even the transition between PromiseShip and St. Francis, case managers, a lot of the-- a lot of the case managers were removed, right? They worked for PromiseShip, worked for St. Francis. It wasn't a one-to-one, but it wasn't a zero either. And there were-- there were a number of staff moved to St. Francis to continue the services which provided continuity of care of-- of the case management for some of the youth, trying to keep-- trying to keep the same cases that they were managing. Wouldn't you see that as something similar? I see you're talking about moving people into the ESA. Is that different than what-- what I just mentioned?

STEPHANIE BEASLEY: It is different, Senator. And-- and what you're referencing would be the ideal setting for us, is that-- that we-- if we were transitioning cases back to DHHS, there-- there are fantastic workers with St. Francis Ministries that we would love to hire. The assumption would be that we can't guarantee that. And so the fiscal note is really built on what would it like to create or replicate that structure on the off chance that they wouldn't want to come and be at DHHS.

ARCH: And so-- so your fiscal note is basically worst case.

STEPHANIE BEASLEY: Yes.

ARCH: Correct?

STEPHANIE BEASLEY: Yes, it is the conservative fiscal note so that if this bill were to advance and we were transitioning cases back, that we would not have a budget shortfall and have to come back, that we would clearly identify this is-- these are the potential costs should the St. Francis staff or any of the ESA staff not want to transition, because, of course, there are some really fantastic workers doing amazing jobs there, but whether or not they would choose to be DHHS employees has yet to be seen.

ARCH: OK.

STEPHANIE BEASLEY: And the--

ARCH: Next question: mobile crisis response. Help us understand what that is. That does not-- does the state not have something like that?

The state is managing currently the rest of the state, with the exception of the ESA for case management. Correct?

STEPHANIE BEASLEY: Yes.

ARCH: And so is-- is there not a mobile crisis response now?

STEPHANIE BEASLEY: We have continuity of operations planning. And so it's contingency planning, whether it's flooding or, you know, impact to-- we really refocused again after-- when COVID hit, on understanding, you know, pandemics. So the mobile response system is a plan that we have should anything-- we could deploy that. Ultimately, let's say there's flooding in an area like there was in 2019, and staff needed-- you know, our existing staff couldn't do their job, and so we needed to deploy staff. So as part of our continuity of operations, we have this mobile crisis team identified. So we-- we understand what the plan would be. We know we've-- we've done the deliberate process of saying: What would that look like for 60 days, you know, estimate costs for travel, estimate costs for housing? How would we identify those 40 staff? So we have a plan in place to do a mobile crisis unit. The intent for that is really just to ensure stability and ensure that kids are being seen. Should we start to see people leave a position or be unable, whether it's our-- you know, let's say it's our Western Service Area-- if we have staff who can't do their case management duties, we want to make sure kids are seen. And so we have a plan put together, whether it's ESA or Western or Northern, etcetera.

ARCH: So-- so as I hear you explain that, it doesn't sound as though it's directly tied to the ESA. But if the state takes over the whole state, then they feel they need a mobile crisis response team?

STEPHANIE BEASLEY: So the-- the concern, and what we've really talked about at length around this mobile crisis team for the 40 and that specific number where, once this bill was introduced, if-- if staff started to leave St. Francis and we needed kids to be seen, and to ensure continuity or services to continue, we-- we have this ability and we have this plan of continuity of operations to ensure kids are safe and seen whichever area it is. Eastern Service area is a bigger service-- you know, it's a larger number, and that's where the 40 number comes in.

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ARCH: OK. Further questions? Senator Walz.

WALZ: Yeah, I-- I just need to clarify this. So I'm just wondering what happens after February 28, 2023. Is the plan that you take it back after that or what-- what-- what happens after that date?

STEPHANIE BEASLEY: The way that this legislation was written, if this were to advance and become law, obviously we would not be able to contract after February 2023, the end of February '23. So the plan and the fiscal note was written for the six months leading up to that, what would that look like, because that's the contract end date for our current contract with St. Francis Ministries.

WALZ: OK. And was there a crisis? I'm just trying to-- just trying to understand this. Was there a crisis plan in place? Did-- was there a crisis plan in place prior to this? I mean, we know that, you know, there's-- we've had problems for a-- a long time. Is this the first time that we've put a crisis plan in place or was there something in place prior to this?

STEPHANIE BEASLEY: There was, to my understanding, prior to my arrival, so I-- I want to preface that-- a transition plan. The mobile crisis plan is more of our COOP plan around flooding, etcetera. This was-- we brought that back out and dusted it off and really looked to say: What would this look like if-- if we needed to send staff in? And how many staff do we estimate would be needed to make sure the kids are seen, families are getting services, that we're following, court orders, etcetera? So we had a transition plan. I believe the Stephens [SIC] Group helped develop that. But ultimately, this-- this is an extension of that, in that any time that there is a real crisis and our workers in an area are unable to provide case management services or we have, you know, significant vacancies, that would put us in a position where kids need to be seen and we need to ensure safety. This is what we would utilize, is this short-term 60 days, while we get people hired and up and running. It's a 14-week training regimen to be trained by CCFL. And so this gives us some flexibility and-- and just really our priority is safety for kids, so to make sure that we're bringing staff in who are trained, who can go out and see these kids, make sure they're safe, do the assessments that might be needed.

WALZ: Um-hum. All right. Thank you.

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STEPHANIE BEASLEY: Thank you, Senator.

ARCH: Other questions?. I have another question. The previous bill heard is a-- is a committee bill asking for the evaluation, at the end of the year, of 11 years, understanding-- and-- and you've made it clear and we understand much of this predates you. But-- but we collectively, as a state and as a committee, want to engage in that process of-- the deliberative process of evaluating: Should privatization continue? Should the state take it back and-- and manage the entire state case management? And so whether this bill, that bill, whatever bill passes, I think that this is-- this is the will of the committee that we-- we do that process. My question to you is: Is the department willing to collaborate with us, to cooperate with us in determining and coming to an answer to that question during this year, 2021?

STEPHANIE BEASLEY: Yes, Senator.

ARCH: Yes?

STEPHANIE BEASLEY: Yes.

ARCH: Thank you. Are there any other questions? Seeing none, thank you very much for your testimony.

STEPHANIE BEASLEY: Thank you, Senator.

ARCH: Next opponent-- excuse me-- next opponent to LB491? Welcome.

LANA TEMPLE-PLOTZ: Hello. Good morning, Chairman Arch and members of the Health and Human Services Committee. My name is Lana Temple-Plotz, L-a-n-a.T-e-m-p-l-e-P-l-o-t-z, and I serve as the CEO of Nebraska Children's Home Society, but I appear before you today as president of the Children and Family Coalition of Nebraska, also known as CAFCON. CAFCON is an association of ten child welfare and family service provider agencies with a mission focused on turning forward, thinking into action for the betterment of children, youth, and families in Nebraska. CAFCON is grateful for the attention paid by the legislative branch with regard to service contracts, specifically the Eastern Service Area case management contract. We are opposed to LB491 as written. LB491 calls for the Department of Health and Human Services to not reinstate a lead agency in the Eastern Service Area on or

before-- on or after October 1, 2021. We know, from testimony received before this committee by DHHS officials in the last few weeks, they are not prepared to take over case management services any time in the near future. Transitioning case management services to an ill-prepared DHHS would cause harm and irreparable damage to children, youth, and families served in the Eastern Service Area. While the recent concerns with the lead agency contract in the ESA warrant a comprehensive analysis of what went wrong and what must change, ending the opportunity for future lead agency pilot projects could be an overcorrection. Maintaining a lead agency contract provides opportunities for innovation by piloting well-being solutions in the ESA that have the potential to be replicated in other parts of the state. As I mentioned in my previous testimony, there are a couple of examples where-- where CAFCON member agencies worked with PromiseShip to develop and pilot different models, one being the Family Finding model which successfully found caring connections for children and youth in foster care, thus-- thus decreasing their time in care and leading to lifelong connections necessary for success in adulthood. The Family Finding model has been successfully replicated statewide. Another example of innovation in the ESA is, as I mentioned before, is the Pathways to Permanency program, which I previously described in previous testimony. Professional Foster Care was also initiated in the ESA by PromiseShip, to meet the complex and unique needs of children and youth in foster care. Today juvenile probation now uses this model, and the Foster Care Rate Reimbursement Committee recommends extending this beneficial service across the state through the specialized rate proposed in LB541 by Senator Walz. These are just a few of the examples of the benefits of having a lead agency contract. Put simply, public-private partnerships stimulate innovation and give root to major initiatives that were incubated in the ESA, but extend statewide in ways the state agency often cannot do, due to financial and bureaucratic constraints. Additionally, to provide clarity of CAFCON's position regarding legislation around the ESA case management contract, I've included a position paper we recently drafted as an exhibit to my testimony. It references and summarizes key historical documents, outlines concerns and recommendations, as well as new requests related to the ESA case management contract and contracts the state may enter into in the future. While we are opposed to LB491, CAFCON looks forward to working with Senator Cavanaugh in creating legislation that would ensure the safety and well-being of children,

youth, and families in the Eastern Service Area, as well as across the state of Nebraska. Thank you for your consideration, and we respectfully request you not advance LB491 from committee. With that, I'll take questions.

ARCH: Thank you. Are there any questions? Senator Walz.

WALZ: I don't really have a question. I just want to say thank you and how much we appreciate your work and the recommendations that you're making. It will help.

LANA TEMPLE-PLOTZ: Thank you.

ARCH: I-- I did have a chance to read the white paper. Well done.

LANA TEMPLE-PLOTZ: Thank you.

ARCH: Well written. Thank you.

LANA TEMPLE-PLOTZ: Thank you.

ARCH: Any questions? Seeing none, thank you very much.

LANA TEMPLE-PLOTZ: Thank you.

ARCH: Next opponent for LB491? Seeing none, is there anybody who would like to testify in a neutral capacity for LB491? Good morning.

LYNN CASTRIANNO: Good morning. Good morning, Senator Arch and the committee. My name is Dr. Lynn, Castrianno, L-y-n-n C-a-s-t-r-i-a-n-n-o, and I am representing myself. I served as a vice president of continuous quality improvement and data management at PromiseShip for seven years. And I was with two other lead agencies prior to that, beginning in 2009, when privatization began. Those two agencies were Visinet and KVC. I have been, and continue to be, a proponent of privatized child welfare. On this bill, though, I am testifying as neutral, I firmly believe that in order for a privatized child welfare system to work, there needs to be a strong commitment to the success of a privatized system. This includes what the various evaluations of Nebraska's privatized system have recommended consistently: 1) having a strong vision of what the privatized system is intended to do, including with the focus is: Is it stability? Is it

innovative services? Or is it efficiency in cost? Quality of service delivery? I will say that over the course of the ten years, what was the original intent of the contract changed over the course of those ten years. A desire for collaboration with the private contractor-- I certainly believe, as Lana has said, that this would need to be a public-private partnership. I don't believe that the ten years showed us that we had a good public private partnership. Putting in place an infrastructure that sets the largest lead agency up for success, which includes contract monitoring and contract collaboration. Those two also go hand in hand, a procurement process that works. You've heard what Monika said. I'm probably going to repeat some of what she said. To remind the committee, the procurement in 2017 ended up being awarded to PromiseShip. The RFP was then terminated due to a protest by the other bidder, and we then went into a two-year deviation contract. The most recent procurement ended up going to a bidder with an unreasonable low bid, and the contract was subsequently terminated. And that contract is now in a 25-month emergency contract. In the ten years that I worked in the privatized system, I saw a lot of improvements in the Child Welfare system, including greatly improved statewide CQI processes. I will say that, when we started this process in 2009, the CQI process at the state was not well developed and was fairly immature. In the ten years that I have worked in the privatized system, the state system has extraordinarily improved, and I'm quite proud of what the state has accomplished with that. It-- in EDSA [PHONETIC], we had innovations in our practices which Lana attested to. In addition to what she said, we created specialized teams, we had complex case teams, we had judge-specific teams. One of the things that I'm most proud of is that we made this a community involvement agency. This was not a child welfare agency. This was about involving the community to be responsible for the outcomes for children and families. Throughout the ten years, I will say, I experienced a lot of uncertainty regarding whether our contract would be renewed, especially in the last five years of PromiseShip's contract. This resulted in a heightened sense of vulnerability and a feeling of having to prove that we deserve to exist. I believe that contributed to the lack of trust between the two parties. I am distressed by what is happening in the Eastern Service Area, knowing that the instability in the system not only could have been avoided, but should have been avoided. The emergency contract has me concerned it is-- as it is very difficult to recruit talent under these conditions while also trying

to improve outcomes. I have lived through these two-year emergency contracts. I know this-- what this does to staff and what this does to staff morale. I am very concerned that staff are going to be leaving, especially because they've been through this already. Given that we are in an uncertain moment and not knowing the support from DHHS in committing to a privatized system, I reluctantly am neutral on this proposal instead of opposed to it. I would like just to make a couple of other remarks, if I might. The opinion pieces by Kerry Winterer are in my PromiseShip final report, along with two other opinion pieces, one by Matt Wallen, who was the director at the time, and one by Ron Zychowski, who was the CEO of PromiseShip at the time. Those are included in that report, so you have those. I will also say that 42 percent of PromiseShip's staff did move over to St. Francis. And so we were very proud of that fact. I know more would have gone to St. Francis, had their cost proposal actually been reasonable. And I will also say that going back to 2009, given that folks here were not here in this capacity then, the costs for case management were not known. I sat in meetings where we asked, what are the costs? And we were told that there was a bucket of money that DHHS had, and they could not reasonably state how much money it cost for each service area. One of the things that I think that was critical, and what PromiseShip did, was to help identify what the costs were and what the cost should be in order to provide good care for children and services in the Eastern Service Area, as I believe, prior to this effort, the Eastern Service Area was likely underfunded, given the way the buckets of money were distributed across the state. I've gone off script. I'm going to end now, and I thank you. And I will be glad to answer any questions you might have.

ARCH: Thank you. Are there questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch. And thank you, Doctor, for being here and-- recognizing all the issues that have happened over these ten years and with this pilot program-- all these things-- today, if there were a pro-- procurement process instituted, is there a lead agency out there that would even be interested?

LYNN CASTRIANNO: That's an unknown. I-- I believe that there actually might be interested parties who would be interested in putting together a proposal to take this on. You won't know that until you issue an RFQ or an RFI to see what people's interests are and actually

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doing something like this. But I do believe that there would be some interest in-- in going forward with a lead agency concept by current providers here in Nebraska.

WILLIAMS: Thank you.

ARCH: Other questions? I-- I have one.

LYNN CASTRIANNO: Um-hum.

ARCH: It's probably a- the bigger question. You've had experience. I-- is as we look back over 11 years,--

LYNN CASTRIANNO: Yes.

ARCH: --we see a variety of players within the department.

LYNN CASTRIANNO: Yes.

ARCH: We're not just talking about today. We're-- history, right?

LYNN CASTRIANNO: Yes.

ARCH: Long history--

LYNN CASTRIANNO: Yes.

ARCH: --with, probably to be generous, mixed-- mixed success,--

LYNN CASTRIANNO: Yes.

ARCH: --which-- which leads me to the question of, is-- is this-- is the state, as an institution, capable of a public-private partnership? In other words, we could fix process.

LYNN CASTRIANNO: Right.

ARCH: We'll go over to procurement--

LYNN CASTRIANNO: Right.

ARCH: --and fix process and-- and have a better process. But at the end of the day, it's not paper. It's not-- it-- it is-- and so my-- my question to you is, having seen it--

LYNN CASTRIANNO: Um-hum.

ARCH: --firsthand, is it is it culture-- far more difficult to fix? Or is it process-- much easier to fix?

LYNN CASTRIANNO: That is a very complicated question, and not one that is easily answered. I will say it goes directly to the point I made in my previous testimony, which is: What does Nebraska want? And then the question then becomes: If you-- if you want this, how do you do this in such a way that you set it up for success? The 2009 initiative was not well thought out. It was not well implemented. You may not have been around for it, but you've read about it. You've seen it. And what has happened since then is everything has been on top of that poor implementation to begin with. My strong recommendation is following what Monika said. There are many models that work. But the first question that has to be answered is: Is there a commitment to do this? And what is the intention of the-- of this Legislature in moving forward to do this or deciding not to? So what is it that you want to see happen? One of the things that Lana testified to is that you can have great innovation in a public-private partnership. And I will say that PromiseShip was on the precipice of doing a lot of innovative work. It all had to be paused because of the two-year deviations contract and then the one-year emergency contract because it requires some external funding. And we lost our funders because they did not want to fund an agency that they didn't know was going to exist. So, you know, having that uncertainty, not having the commitment makes it very, very difficult. A five-year contract is actually not long enough. You need a long runway in order to achieve that innovation. And so again, it goes back to the commitment and what it is that you want to achieve. If you decide to do this, there are some models out there that work, and really taking a good, hard, long look at what model we want to emulate and then put together a good implementation plan. I am a firm believer in implementation and, without a good implementation plan-- and I said this from the beginning-- that this 2009 initiative did not have a good implementation plan and it went off way too fast and went off the rails very quickly.

ARCH: Thank you. Are there any other questions? Seeing none, thank you for coming today.

LYNN CASTRIANNO: Thank you.

ARCH: Is there anyone that would like to testify in the neutral capacity? Welcome.

MONIKA GROSS: Thank you. Good morning, Senator Arch and members of the Health and Human Services Committee. My name is Monika Gross, M-o-n-i-k-a G-r-o-s-s, and I'm representing myself today. I'm here to testify in a neutral capacity on LB491 and to give you some additional information about the lead agency model pilot project in the Eastern Service Area. I'm the former PromiseShip interim president and CEO and, before that, the general counsel at PromiseShip for over nine years. The lead agency case management model pilot project was created under LB961, introduced by the Health and Human Services Committee in 2012. PromiseShip, formerly known as Nebraska Families Collaborative, held a contract for child welfare service coordination, services, and case management in the Eastern Service Area for 10 years until December 31, 2019, and was the only surviving private contractor following the statewide privatization effort begun in 2009. The language creating the pilot project in LB961 allowed-- allowed the privatization of child welfare case management to continue in the Eastern Service Area when the rest of the state that-- that opportunity was prohibited, moving forward after the collapse, really, of all of the other private entities that were involved in those contracts. Having devoted over nine years of my life to trying to get the lead agency model right in the Eastern Service Area, I cannot support this nuclear option because to do so would be to dismantle the very system that I and many others, some of whom are in the room here today, worked so hard to help build. Neither can I unequivocally oppose this bill because the current circumstances run so counter to my sense of ethics, duty, and moral reasoning. Rather than bringing privatization to an abrupt end, Nebraska needs to decide what kind of child welfare system it wants. If Nebraska wants a public system, then let's get behind it and support it. If Nebraska wants a private system, then let's support that. If Nebraska wants a hybrid system as it currently has, then let's support that as well. No matter what kind of system Nebraska chooses, the commitment has to be all in. We can't waiver in our commitment, and we can't hobble along on one- or

two-year contracts. You already heard some about that. But the last five years at PromiseShip, it was one-year, one-year, one-year, two-years. Do you know what that does to the workforce right now? Do you know what this proceeding is potentially doing to the workforce? They've heard this before. They've been here before talking about evaluations, talking about whether or not the system should continue to exist. It's going to have ramifications. And with all due respect to Director Beasley, whom I-- I greatly admire, there's no such thing as a six-month transition; there's no such thing. Staff will start leaving. As soon as they know that a decision has been made, they'll start leaving, and it-- it'll be a crisis for more than 60 days. I wish I could tell you different but, based on past experience, that's-- that's the way it works. Even-- even minor blips can cause major disruption in the workforce. I continue to support privatized child welfare case management, but there are also other privatization strategies that should be considered as well, such as: outsourcing safety and in-home services-- that was previously done here in Nebraska for a short period of time; outsourcing network management; coordinating foster care services on a statewide basis. In order to create an ecosystem that supports a public-private partnership in child welfare, Nebraska must commit to the following: a common sense procurement process and state level cost principles; a sophisticated public agency that sees the value in partnering with the private sector and wants to see the private agency succeed; funding that covers the full cost of care, limits financial risk to all parties, and uses incentives to enhance performance; public sector flexibility that allows the private sector to innovate and flourish; and more than one adequately-resourced, financially-stable private organization in a mildly competitive environment that encourages collaboration and community engagement. The children and families deserve no less than the best we have to give. And the child welfare professionals that work in this field every day also deserve no less than the best we have to give. Thank you for your dedication to children and families, and I'd be happy to answer any questions.

ARCH: Thank you. Are there questions? Senator Walz.

WALZ: Thanks. Thanks for coming today. Just for a little history, can you give us, like, the reasons there were for the year-to-year extensions? What was the--

MONIKA GROSS: Well, yes. So the-- the original contract was for five years, roughly five years, from November 2009 through June 30, 2014. So by its terms, it ended at that point in time. There was no-- no formal RFP process implemented prior to the end of that contract. And so the Legislature took action to allow DHHS to-- to extend the contract. So DHHS offered PromiseShip a one-year contract-- deviation contract-- because this evaluation was going to be completed by the Hornby Zeller Group. And then at the end of that one year, there was another one-year extension of that same contract, just extended out the date on the same terms for another year. And then I don't know what was going on, why it wasn't put out to bid at that time. And maybe-- maybe it's just slipping my mind. But then there was another one-year extension from 2015 to 2016. And at-- at that-- I'm sorry, from 2016 to 2017. Again, I believe it was on the same terms. I think some of the documents that Dr. Castrianno shared with you have a complete timeline and have a list of every contract and every amendment and what was included in those. And then-- then they finally did a procurement process in late 2016, and there were two bidders. And in March 2017, the intent to award was announced, the intent to award a five-year contract to PromiseShip. And before a contract was signed, they withdrew the-- the RFP, they canceled the procurement. And so then in order to ensure continuity of service and stability in the system, because we were less than two months from our contract expiring at that point, the-- the department offered a two-year sole source deviation contract with PromiseShip on the terms, the financial terms that were included in our proposal that-- that was awarded, that the intent to award was based on. So that's kind of the history. And then there was an additional six-month extension of that two-year contract to-- to get us to the transition-- through the transition with St. Francis.

WALZ: So a lot of the-- the year-to-year was based on evaluations and recommendations that were made on how-- how well you performed? Or I'm just--

MONIKA GROSS: I think there was ambivalence. I mean, that's really my best explanation. I think there was ambivalence on the part of the-- well, I think one thing that happened, too, is we had a gubernatorial election in 2014. So I think part of it was, we're going to get through the election into the next-- and let the next Governor decide essentially how we proceed. And-- but I do think there was a lot of

ambivalence within state government about whether-- whether there was a commitment to the public-private partnership. There was never ambivalence on the part of-- on-- on the part of PromiseShip and-- and our member agencies.

WALZ: And I'm just going to go back to-- my gosh, what's his-- Senator Arch's-- sorry-- question regarding, do you think it is-- it's a process problem or is it a culture? I don't want to say problem, but--

MONIKA GROSS: I think again, just reflecting on-- on Dr. Castrianno's testimony, I think you have to go back to how-- how the privatization effort was implemented in the very beginning. And I think there were strong reactions among stakeholders, including, I would say, including the legislative body, because they were not consulted. They were not-- they were not included in the planning. It seemed it was a very rushed process, as I recall, you know, less than a year from start to finish for such a major statewide initiative. And so I think it just goes back to the beginning. I think there were a lot of hurt feelings and there was just-- change management did not occur in an optimal way. And so I think there was resistance to change, and that just carried forward. That-- that carried forward. And I don't know if that still exists today, but I think that that goes all the way back to 2008-2009.

WALZ: OK.

WILLIAMS: Any additional questions? Seeing none, Ms. Gross, thank you for your testimony.

MONIKA GROSS: Thank you.

WILLIAMS: Any additional neutral testifiers? Welcome, Miss Carter.

JENNIFER CARTER: Good morning. Good morning, Vice Chair Williams and members of the Health and Human Services Committee. For the record, my name is Jennifer Carter, J-e-n-n-i-f-e-r C-a-r-t-e-r, and I serve as your Inspector General of Child Welfare. We're here today in a neutral capacity just to offer some a little bit of history of privatization and really more, since some of that has been covered, to identify issues for your consideration as you deliberate on this bill. The Office of the Inspector General of Nebraska Child Welfare Act was

enacted in 2012, and it was part of all of the recommendations that came out of LR37, which was an extensive and thorough review of Nebraska's troubled attempt to privatize case management services. And our office was created to provide independent oversight and accountability in the child welfare system through investigations, identification of systemic issues, and hopefully attempts at system improvement through recommendations from our work. Since our office was actually created out of that effort and the challenges of privatization, we obviously pay careful attention to the privatization efforts in the Eastern Service Area as part of our work. The OIG has not taken a position on privatization in general because our duty is to monitor the provision of services to children and families in the Eastern Service Area and throughout the state, regardless of who is doing that work, and to ensure that the Department of Health and Human Services is meeting its statutory duties, whether through its own personnel or through other contractors. Some of the history has been given, and we have more detailed history in our written testimony about what happened in privatization. I just would note that a lot of the transitions there were-- were not long. So, you know-- well, this wasn't a transition, but one contractor walked away before the contracts were signed. Another walked-- had to walk away due to the money they were already losing a day after the implementation was supposed to be complete. A week later Visinet went bankrupt. That transition was a matter of days. I mean, my memory of being a part of that was-- that was like at midnight, suddenly the state was responsible for knowing where 2,000 children were and where they were going to be. And then over the course of the next year two other providers also left. And I don't believe those were six-month transitions either, so I just did want to note that. We also give a brief summary of some of the evaluations that have been done prior and-- and actually did include one from the University of Nebraska that was done to the Digital Commons group as part of the-- the Department of Psychology. And they also found-- it-- it's interesting. I think all of the evaluations did find, as we've heard, that right now there's no demonstrable benefit or improvement or, you know, a decrease in outcomes with privatization. All seem to agree implementation was flawed. In one Hornby Zeller report, they found a-- maybe a slight savings, but in the University report, they found a significant increase in costs, and that is even with the private providers putting in a lot of their own money. Where this leaves us is

just to say, I think the evaluations in the state experience with privatization highlight some really key issues to consider when thinking about this. And some of that is just the simple: What is the state gaining? If it is not cost savings-- and I don't know that it ever would be because this is just a resource-intensive obligation of the state. And so I would hope, as has been said, whoever is doing it, I hope they are properly resourced, and that would be our hope. But I think it's also important to remember that HHS cannot contract away its ultimate legal responsibility under the law to serve children and families. And as a result, I think that requires, at the very least, some robust contract management and monitoring. And I think that we're seeing more of that now. But it is fairly personnel-heavy. So that is a cost to think about. For our office, the very most important point, I think, is that the state always has to be prepared to take case management back when necessary, because we saw that happen in the last attempt at privatization. The termination of the contract is not always within the department's control. I know right now the new emergency contract extended the notification for termination. So if the department did decide to terminate the contract, they would have six months, under the contract, to continue to pay St. Francis in transition cases. But that, as we saw, is not always the case. If St. Francis, something were to happen to them, or they're significantly compromised in some way and not able to meet their duty to the children, that would accelerate a timeline for transition and for the state having to take that case management. And so-- so in either of those scenarios, and actually even just if there's just a consistent breach and the state feels the need to act on it, but-- but practically speaking, doesn't have somebody to answer that phone call, check on that child, the state needs to have existing resources in place to be able to do that. So-- and our-- we remain committed to monitoring these issues and working to ensure the best outcome for children and families in the Eastern Service Area. And we'd be happy to take any questions.

ARCH: Thank you. Are there questions? Senator Walz.

WALZ: Thank you, Senator Arch. Well, if there's one thing that we have heard loud and clear, it's implementation is important. The other thing that I'm curious about, you know, talking about the last 10 years or 12 years, is the relationship between the organization and the department. Like, do you know what that-- what that looks like? Is

there a lot of support? Is there a lot of collaboration? Is there a lot of communication? Has there been? And if not, how-- how can we make that better?

JENNIFER CARTER: And I probably can't fully answer that question because I would-- wouldn't know the details from sort of prior experiences. I know there's a-- my understanding, I should say, is from-- from my conversations with the department and with St. Francis in limited capacity for other reasons, is that there's a lot of communication right now. There's a lot of contract management. There's regular meetings and that type of monitoring. But I-- I just-- I don't know if that is productive or not. It's certainly-- we're-- from our oversight perspective, we're glad that there's contract monitoring. In terms of whether that actually enhances the relationship and helps innovation or create, you know, better services, that I-- I don't know. I think probably that St. Francis and the department would be better able to answer that. I don't know that we've seen that, but I haven't dug in really for that much. But-- but we know at least the contract is being well-monitored. I would say there's a lot of activity around that.

WALZ: Do you think that-- and I-- I'm just going to ask the question-- do you think when you say well-monitored, it is a case of, you know, here's a very strong recommendation and then it's hands off? Or do you think there's ongoing support and help and training or whatever it takes?

JENNIFER CARTER: I think that's the tricky balance here and again, without truly taking a position either way. But I just think the state has obligations it has to meet. So they have to make sure their contractor is meeting those obligations. So you have to have some of those things in place. So I don't-- I am less well versed in how you manage that in a way that still allows for innovation, if innovation is the benefit of privatization. I mean, I think there's a general question of: Is there inherent value to privatization or is it that there's something we get out of it, whether that's innovation or cost savings? And as I said, my-- the idea of cost savings when it comes to taking care of children and families, if that's the driving force that is concerning to me, unless we know for sure it can be done, because I think this is sometimes just a resource-intensive work. So balancing that, I think must be tricky to meet your obligations to-- under state

law, under federal law, and have a contractor doing that. So you have to be monitoring them and prescribing things--

WALZ: Sure.

JENNIFER CARTER: --to some extent. So how do you do that while still leaving some room for innovation? I think that balance has been tricky.

WALZ: Um-hum. All right. Thank you.

ARCH: Other questions? Thank you for your testimony.

JENNIFER CARTER: Thank you.

ARCH: Is there anyone else that would like to testify in a neutral capacity? Seeing none, Senator Cavanaugh, you're welcome to close. As you're coming up, I would mention that we had one submitted testimony this morning from Julie Erickson for Voices for Children. And we had two neutral letters that were submitted as well.

M. CAVANAUGH: Well, I think this has been a good conversation, one that we've probably needed to have for a long time about the Eastern Service Area. I'm thankful to everyone that came today to talk about it. I think that it is very constructive for us to start having these conversations. I want to make one point clear. I think that Director Beasley is doing a good job, and I think sometimes that gets lost in some of this because this is such a mess. And I just want to make sure that Director Beazsey knows that. I think that she's doing a good job. And I feel bad that she has to come in, sit in front of this committee, and talk about fiscal notes. But that is part of her job, so we'll just continue doing that. But I wanted to acknowledge that in the record. So I-- I take Ms. Gross's point very seriously, that the staff that have the caseworkers, the people that have been doing this work for all of these years, are traumatized. They've been calling me. They've been e-mailing me. I've had spouses, multiple spouses of staff caseworkers reach out to me and tell me how traumatized their spouse is. It's creating toxic stress, and it-- it's not good for anyone. And we need to work together to find a solution, whatever that solution is. And I am not saying that this is the solution. And I have already said I'm not going to push for us to move this out of committee any

time soon. But it's a good conversation for us to have. I think we got some really good input and information from the people that have been engaged in this work for a decade. And I know that we, as a committee, can move forward and continue to have this conversation. I remain concerned about what is the plan, what is it? Whatever it is, what is it? And I would like that to be communicated to us. We are government, and government should be transparent. There should be light on what the plan is. It shouldn't be secret; we should know what it is. We should know if they plan to transition or if they plan to continue to work on this. But what is the plan? And right now, all we know is February 28, 2023. And that just creates further instability for everyone, children's families and the workers. So with that, I'll take any questions.

ARCH: Are there any questions? Seeing none, thank you very much.

M. CAVANAUGH: Thank you.

ARCH: This will end the hearing for LB491, and we'll end the hearings for the morning for the committee.

ARCH: Good afternoon and welcome to the Health and Human Services Committee. My name is John Arch, J-o-h-n A-r-c-h. I represent the 14th Legislative District in Sarpy County and I serve as Chair of the HHS Committee. I'd like to invite the members of the committee to introduce themselves starting at my right with Senator Day.

DAY: Jen Day, District 49, northwestern Sarpy County.

MURMAN: Hello, I'm Senator Dave Murman from District 38 to the west, south, and east of Kearney and Hastings.

WALZ: Hi, I'm Lynn Walz from Legislative District 15 and I represent Dodge County.

WILLIAMS: Matt Williams from Gothenburg, Legislative District 36: Dawson, Custer, and the north portion of Buffalo Counties.

M. CAVANAUGH: Machaela Cavanaugh, District 6, west central Omaha, Douglas County.

ARCH: Also assisting the committee is our legal counsel, T.J. O'Neill, and our committee clerk, Geri Williams. And our committee pages, Kate and Rebecca. A few notes about our policies and procedures. First, please turn off or silence your cell phones. This afternoon we will be hearing three bills and we'll be taking them in the order listed on the agenda outside the room. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters of the bill, then from those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given the opportunity to make closing statements if they wish to do so. For those of you who are planning to testify, you will find green testifier sheets on the table near the entrance of the hearing room. Please fill one out and hand it to one of the pages when you come up to testify. This will help us keep an accurate record of the hearing. We use a light system for testifying. Each testifier will have five minutes to testify. When you begin, the light will be green. When the light turns yellow, that means you have one minute left. When the light turns red, it is time to end your testimony and we will ask you to wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone and then please spell both your first and last name. If you are not testifying at the microphone but want to go on record as having a position on a bill being heard today, please see the new public hearing protocols on the HHS Committee's web page at nebraskalegislature.gov. Additionally, there is a white sign-in sheet at the entrance where you may leave your name and position on the bills before us today. Due to social distancing requirement, seating in the hearing room is limited. We ask that you only enter the hearing room when it is necessary for you to attend the bill hearing in progress. The agenda posted outside the door will be updated after each hearing to identify which bill is currently being heard. The committee will pause between each bill to allow time for the public to move in and out of the hearing room. We request that you wear a face covering while in the hearing room. Testifiers may remove their face covering during testimony to assist committee members and transcribers in clearly hearing and understanding the testimony. Pages will sanitize the front table and chair between testifiers. This committee has a strict no props policy. And with that, we will begin today's hearing with LB129 and welcome Senator McCollister.

McCOLLISTER: Good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is John, J-o-h-n, McCollister, M-c-C-o-l-l-i-s-t-e-r, and I represent the 20th Legislative District in Omaha. Today, I'm introducing LB129 to provide a 12-month continuous eligibility period for Medicaid eligible children under the age of 19. Currently, Nebraska provides continuous eligibility for pregnant women, newborns up to age one, and six months of continuous eligibility for children from the date of their initial application. Most other Medicaid individuals must complete a redetermination of eligibility every 12 months. However, at any time during the year, enrolled individuals must report a change in circumstances such as income, family size, employment status within, within ten days. LB129 would extend continuous eligibility to all children for 12 months. Currently, 33 states, 33 states have adopted continuous eligibility for children enrolled in the Medicaid or CHIP, and two states have expanded continuous eligibility to adults. Continuous eligibility would ensure more children, enhance continual continuity of care, reduce administrative burden for patients and providers, and redirect spending from administration toward actual services. Having access to continuous Medicaid coverage reduces churn, people moving in, in and out of Medicaid coverage because of temporary fluctuations and factors that influence eligibility, including income. Lower income individuals are more likely to experience shifts in income from month to month due to factors like changes in hours or seasonal employment. Under our current requirements, these changes can result in an individual moving in and out of coverage multiple times throughout the year. Adapting 12-month continuous eligibility would ensure more children are covered and have access to healthcare. Experiences in 12 other states shows that 12-month continuous eligibility increases the monthly Medicaid rolls. Historically, adopting this policy reduce the number of children with coverage gap by nearly one-fifth. Churning on and off Medicaid can have a profound effect on overall health. As you'll hear from the testifiers after me, disruptions in coverage result in increase in emergency room use, decreased access to preventative care, and the reduced likelihood of chronic disease remain in control. Children in 12 states with 12-month continuous eligibility are more likely to have preventative and needed specialist visits in the year and decrease amounts of unmet needs for specialty care. Uninterrupted coverage for children can reduce the avoidable hospitalizations by as much as 25 percent. The administrative burden associated with

Does not include written testimony submitted prior to the public hearing per our COVID-19 response protocol

additional paperwork and reporting requirements can also cause individuals to churn off of Medicaid. Colorado recently reported that 15 percent of letters mailed to public assistance recipients are returned as undeliverable each year, and that's approximately 131,000 households. Officials estimate that as many as 33,000 individuals lose access to benefits due to this issue. Reducing the number of times an individual must report changes alleviates some of these administrative burdens. From a purely financial perspective, 12-month continuous eligibility will reduce the administrative costs within DHHS. The administrative cost of just one individual churning off and on coverage is estimated between $400 and $600, roughly the same cost as one month of Medicaid coverage. For states that have implemented continuous eligibility, cost increases have been minimal. Might-- just 2 percent, just 2 percent. For states that implement continuous eligibility, cost increases have been minimal, around 2 percent. Those costs, however, are related to the provision of healthcare services and are offset by administrative cost savings and lower spending per patient because of the greater coverage stability. Doesn't it make more sense to make our-- make sure our Medicaid dollars are being spent on preventative, continuous healthcare instead of bureaucratic red tape? Does to me. Colleagues, our Medicaid program is intended to serve individuals who otherwise cannot access healthcare coverage. We have a duty to ensure that the program is administered-- administrated in a way that does not hinder access to care. LB129 would provide the opportunity to encourage continuity in healthcare coverage and reduce undue administrative expense. Finally, I know exceedingly high fiscal notes on bills are a common occurrence with current administration to deter the Legislature from taking action. I know that to be true. This will be-- there will be a testifier today that will call into question the, the authenticity of the department's fiscal impact if LB129 were implemented and encourage another review of fiscal impact of this bill of this important change that 33 other states have already implemented. I encourage your support and would be happy to answer any questions that you may have.

ARCH: Thank you. Are there any questions? Senator Walz.

WALZ: I'm talkative today. I'm sorry, Senator Arch. Did you bring this bill before?

McCOLLISTER: No, not this particular bill. But every year it seems I, I come in with a bill to, to expand the food stamp program.

WALZ: Right.

McCOLLISTER: SNAP benefits. In previous years, I've been here often, that's for sure.

WALZ: OK, so right now they reapply every year. And the thing that you're-- we're trying to eliminate is the fact that they have to report every month?

McCOLLISTER: Well, there's, there's some categories that you don't have to do that. And I mentioned that in the first part of my testimony. But, you know, otherwise you have to, you know, report when there's changes in your status: income, family members, anything like that, you have to report.

WALZ: OK, and then the last question I had is, and you answered it, how much does it cost the state to churn on and off? Four hundred to six hundred dollars every time. Do you know approximately how many, and maybe you said this in your testimony, but approximately how many times that happens per year?

McCOLLISTER: No, but I think the HHS officials are going to testify behind me. But that's a good question you need to ask. And I think, you know, the premise of this bill is it's better to provide continuous coverage rather than pay for the continual churn that seems to occur with families in this particular income bracket. So, you know, that-- that's a better use for the money, I think, than paying administrative costs to, to deal with the churn.

WALZ: All right. Thank you.

ARCH: Thank you. Other questions? Seeing none, thank you very much. You'll stay to close?

McCOLLISTER: I will. Thank you.

ARCH: OK. Thank you. First proponent for LB129. Welcome.

KRISTINE McVEA: Thank you. Good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Dr. Kristine McVea, K-r-i-s-t-i-n-e M-c-V-e-a, and I'm the chief medical officer at OneWorld Community Health Centers. I'm also a pediatrician. I'm here on behalf of the Health Center Association of Nebraska, representing the 7 federally qualified health centers in Nebraska, serving over 115,000 patients statewide. The Health Center Association of Nebraska stands in strong support of LB129, which would have Nebraska Medicaid provide 12-month continuous eligibility for children. Twelve-month continuous eligibility is a proven method to increase enrollment in Medicaid, ensure continuity of coverage and care, and limit administrative burden and eliminate red tape. As you have heard, often, individuals will churn off and on Medicaid coverage throughout the year, and roughly 2 percent of children churn off and on the Nebraska Medicaid program in just 12 months. Among low-income workers, seasonal or monthly variations in income are very common and can cause interruptions in insurance status. Although coverage for Medicaid is intended to last for 12 months, additional income reviews can be requested by the state at any time during this coverage. For example, the state may get an alert that a 16-year-old Medicaid recipient just got a part time job at McDonald's over the summer. Or a mother may pick up employment to get extra hours right before Christmas and trigger a review. These people are not hitting the lottery. They have minor variations in their income that trigger a cumbersome income verification process. Providing income verification is not easy for many low-income families, especially those that have low literacy or limited access to technology. A common barrier is getting proof of income if you have direct deposit. So many employers will not give employees pay stubs and they need to figure out a way to create an email account and then register and negotiate an electronic payroll system and then find access to a printer just in order to be able to provide the documentation for these income reviews. Another challenge occurs for people who change jobs. If you work for Target, for example, and then switch jobs and work for Walmart, the state may still have your previous job in the system. In order to maintain your Medicaid coverage, you would have to go back to Target and ask them for a letter verifying you no longer work there. This can be hard to do, especially if you quit or were fired. In the end, many families get stuck in the process and then children lose their insurance coverage. Although the state has a hotline to help people, it is very

cumbersome to access. The burden of helping people to respond to income verification requests often falls to hospitals or clinics like OneWorld. It takes our staff about 20 minutes or more to walk someone through this process and help them to maintain coverage. We would love to get rid of that wasteful overhead. The cost of a single person churning off and on Medicaid has been estimated to cost the state as much as $400 to $600. Believe me, it costs us more as well. Unnecessary government paperwork is bad for everybody. We should be using our resources to help children get the care they need. And losing insurance coverage due to red tape happens far too often to children living in poverty. In 2019, 12,445 children were disenrolled from Medicaid, from the Medicaid program due to these checks. However, according to data submitted by the department to CMS, 72 percent of the children disenrolled by Nebraska are disenrolled because they did not fill out the paperwork properly, not because they did not qualify. Paperwork should not cause children to lose their insurance coverage because it puts their health at risk. Continuity of Medicaid coverage is essential for continuity of healthcare. Children with gaps in coverage are more likely to skip well-child visits. They're more likely to be unable to afford medications or access to specialty and behavioral healthcare. Children's with-- children with gaps in coverage are nearly 25 percent more likely to have preventable hospitalizations. Currently, 33 other states provide 12-month continuous eligibility to children, including neighboring states such as Kansas, Iowa, Colorado, and Wyoming. Adopting 12-month continuous eligibility will help more low-income Nebraska children keep their Medicaid coverage in order to stay healthy. I would like to thank Senator McCollister for introducing this bill. I would also like to thank the committee for their time and encourage you to advance LB129 to General File. I would be happy to answer any questions.

ARCH: Thank you. Are there any questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thanks for being here. So we-- I didn't realize that we did this eligibility review every six months.

KRISTINE McVEA: It isn't necessarily every six months. It can be triggered kind of randomly. I-- honestly, we are not always aware of what triggers a review, but it can happen at any time. It can happen after three months, six months or whatever. It typically happens after about six months, though.

M. CAVANAUGH: And but we could just have it every 12 months.

KRISTINE McVEA: Yes. Because the coverage was-- is intended to last for 12 months, these check-ins, you know, cause people to lose it prematurely. It's intended to be a 12-month program.

M. CAVANAUGH: OK. Thank you.

ARCH: Other questions?

B. HANSEN: I got a--

ARCH: Seeing none-- oh, Senator Hansen.

B. HANSEN: Did you say 12-- 2 percent of children churn on and off Nebraska Medicaid program in 12 months on average?

KRISTINE McVEA: That's my understanding, yes.

B. HANSEN: OK. Is that-- do you think it's a lot or a little bit? You say often, often individuals, and then you say 2 percent.

KRISTINE McVEA: I mean, it's-- what happens is that it takes an extraordinary amount of effort to keep people on it. We actually get a reminder or a notification so that we actually try to reach out proactively to make sure that this doesn't happen. And so these reviews and this, this process happen a lot. And a lot of times we can't-- because it's so cumbersome, we can't rescue the case, so to speak. We can't get the paperwork done in time or whatever. I think it is-- overall, my bottom line is it's just a waste. And even though some people would churn off without a tremendous amount of effort by partners and other people trying to keep them back on, it really doesn't serve any good purpose.

B. HANSEN: Have, have you seen, like, over time, the department, has it gotten a little bit easier to do some paperwork or harder? I thinking with, with things becoming electronic now, have they switched to that very much? I'm not familiar, so I really don't know.

KRISTINE McVEA: That's a really good question. I will say that during COVID they have kind of suspended this for regular Medicaid, but it is still in place for those people covered by CHIP. I think that in

general, the, the burden of paperwork is almost-- it's almost harder sometimes for low-income people to be able to do things electronically because, you know, over half of our patients don't have any Internet access. So if you have systems that require you to get pay stubs or get things like that, for you and I would be super easy. But for many of our patients, that's just one more barrier to them not being able to get a pay stub or get the proof that they need in order to submit that to the state.

B. HANSEN: OK, thanks.

ARCH: Other questions? Seeing none, thank you very much for your testimony.

KRISTINE McVEA: Thank you.

ARCH: Next proponent for LB129.

AMY BEHNKE: Good afternoon.

ARCH: Good afternoon.

AMY BEHNKE: Good afternoon, Chairman Arch, members of the committee. My name is Amy Behnke, A-m-y B-e-h-n-k-e, and I'm the CEO of the Health Center Association of Nebraska. We stand in strong support of LB129. We believe that this will help make the system easier to navigate and help improve continuity of coverage. I'd like to take some time to talk about the fiscal note for this bill. The Medicaid and CHIP program in Nebraska provides low-income children with health insurance in partnership with the federal government. The federal government pays between 56 and 70 percent of the total cost, depending on the level of eligibility and the state funds the remainder. According to the most recently published Medicaid annual report, in 2019 Medicaid and CHIP served an average of 162,207 children a month, at a cost of just over $609 million and that's state and federal combined. The department's analysis in the fiscal note claims that adopting LB129 will increase the total spending by $211 million, roughly a 33 percent increase in total Medicaid spending for children. Given the experiences in states that have already enacted continuous eligibility, this estimate seems inflated and fails to account for administrative savings. We believe just in doing some back of the

envelope math, that the, the true cost of LB29-- 129 would be closer to about $14 million a year, with about $5.5 million in General Fund spending. As has been previously, previously stated, continuous eligibility has been adopted in some form in 33 states and so far none have seen a jump in costs comparable to the department's estimates. After the CHIP Reauthorization Act of 2009 made it easier to adopt continuous eligibility, seven states, including Iowa, adopted the policy. On average, their child enrollment numbers grew by 2.2 percent more than other states that did not adopt continuous eligibility. Based on this 2.2 percent increase in enrollment, one would expect only a roughly $14 million increase in federal and state spending, as opposed to the department's $211 million estimate. And this doesn't take into account other potential savings. We know that people drop off Medicaid for a variety of reasons. Parent may have a new job with health insurance, so they no longer need Medicaid. A child ages out of the program. The family moves out of the state. The policy of 12-month continuous eligibility likely only impacts a small subset of these drop-offs, specifically those who are found to be ineligible through eligibility redeterminations throughout the year. All states submit data to the federal government regarding their CHIP and Medicaid enrollment in redeterminations. According to the most recent publicly available data, in 2019 Nebraska disenrolled 12,445 children from its program through the redetermination process. Even under generous assumptions that all of these individuals would no longer be disenrolled and that each child would gain six months of eligibility, that would be about $18.6 million. The department in the fiscal note claims that they assume all children in the Medicaid program will be enrolled in the program for the full 12 months. However, we know from experience in other states that this assumption is faulty. Looking at states such as Iowa and Washington who have adopted 12-month continuous eligibility, we see that individuals still drop out of the program before 12 months. Neighboring Iowa reports about a 9.5 percent of individuals drop out of the program by 12 months. Washington State sees nearly as many as 16 percent drop out. This indicates that the assumptions on which the department is making their fiscal are flawed. In their fiscal note, the department also does not include any administrative savings. By adopting 12- month continuous eligibility, there should be a dramatic reduction in both the amount and frequency of the redetermination processes, as well as the number of individuals churning on and off coverage. And we-- we've talked about the cost of

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churn. In 2019, the Medicaid program, we had about 2 percent of children churning on and off Medicaid. And this doesn't count kids who had moved between the Medicaid and CHIP programs, but they were back on the program by 12 months. So if we're looking at about 4,000 kids churning on and off the program and using that $400 to $600 estimate, that could be about $2 million in savings. Not to mention this doesn't take into account the large number of redeterminations that would be conducted on a less frequent basis or not conducted at all. We know that decreasing gaps in coverage improve continuity of care and lower usage of high cost services such as ER, ER and hospitalization visits. More importantly, however, we know that when individuals have a lapse in coverage, they tend to ration and delay care until they have insurance. When those with gaps in coverage are reenrolled, that delay can be-- can result in more serious needs and a higher cost of care. Again, we'd like to thank Senator McCollister for introducing this bill. I'd also like to thank the committee for the time and encourage the advancement of LB129 to General File. And with that, I'd be happy to answer any questions you may have.

ARCH: Thank you. Are there any questions? Senator Hansen.

B. HANSEN: Hi, thank you. Just a couple of questions about the child enrollment numbers you say grew up on average 2.2 percent.

AMY BEHNKE: Um-hum.

B. HANSEN: Was that just like a, a new child enrolling or is that, like, they grew--

AMY BEHNKE: That was like total enrollment.

B. HANSEN: OK, so like instead of a child being on it for six months out of the year, would that, would that count going from six months to a year now, if this got enacted? Like, that grew, or is this like--

AMY BEHNKE: Right.

B. HANSEN: --like a new child-- brand new child who was never on Medicaid joined? Is that part of the 2.2 percent?

AMY BEHNKE: That would be both.

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B. HANSEN: OK. All right. That's what I was wondering. OK.

AMY BEHNKE: Yeah.

B. HANSEN: And so-- and you, and you mentioned the cost to churn a single individual is between $400 and $600 on average. Do you know how much the state saves by churning them on and off on average?

AMY BEHNKE: I, I don't know what-- I mean, obviously, whatever the cost of that child would be for the months that they're not enrolled in coverage.

B. HANSEN: That's all-- OK.

AMY BEHNKE: But I, I don't have that number, no.

B. HANSEN: I don't either so maybe they might know that one. So I'm just trying to figure--

AMY BEHNKE: Right.

B. HANSEN: --what the benefit, you know, ratio is there. So OK.

AMY BEHNKE: Right.

B. HANSEN: All right, thanks.

AMY BEHNKE: You're welcome.

ARCH: Thank you. Are there other questions? Seeing none, thank you very much--

AMY BEHNKE: Thank you.

ARCH: --for your testimony. Next proponent for LB129. Seeing none, is there anyone that would like to speak in opposition to LB129? Welcome.

KEVIN BAGLEY: Thank you. Good afternoon, Chairman Arch, members of the Health and Human Services Committee. My name is Kevin Bagley, K-e-v-i-n B-a-g-l-e-y, and I'm the director for the Division of Medicaid and Long-Term Care within the Department of Health and Human Services. I'm here to testify in opposition to LB129, which would change the period of continuous eligibility for children on Medicaid

from 6 months to 12 months with some exceptions, as noted in the bill. Currently, Nebraska Medicaid provides a 6-month period of continuous eligibility at initial application from the date we find someone under the age of 19 eligible for Medicaid or CHIP. In addition, as has been discussed in previous testimonies, babies who are born to Medicaid-eligible mothers currently remain eligible for Medicaid until their first birthday. In 2019, Medicaid and CHIP provided health coverage for a third of all Nebraskans under the age of 19 and paid for 36 percent of all births in the state. The average length of time a child remains eligible for Medicaid in a given 12-month period is roughly 9 months. This bill would provide coverage for those additional 3 months at a cost of roughly $425 per child per month in total funds. This adds up quickly when spent across the 130,000 children served in the state each year. And as has been discussed in other testimony, that's where the source of our fiscal analysis comes from. In addition, a Medicaid individual's eligibility can change from month to month based on life circumstances. For example, at the start of new employment or an increase in income can impact their eligibility. This can also mean changing from one eligibility category to another. The prime example of this would be moving from Medicaid to CHIP as a family's income increases. CHIP and Medicaid cover the same age groups and include the same healthcare service benefits, but there are differences in income limits associated with eligibility and there are differences in the federal match associated with both of those programs. It's fairly common, for example, as has been noted, for children to move from Medicaid to CHIP or from CHIP to Medicaid more than one time in a year. LB129 would prevent the department from moving a child from Medicaid into CHIP during that time period, allowing us in today's environment to actually capture the benefit of those additional federal funds. Whereas if we were unable to do that, we would not be able to capture those funds. I'd like to move off my prepared remarks for just a second and address a couple of the items that have come up in discussion in previous testimony surrounding the process by which we reevaluate eligibility on a periodic basis throughout the year. There's a requirement that we look at those annually and this bill wouldn't change that requirement. We would still be required to do an annual review of income-based eligibility. We do periodically receive notifications from the Department of Labor when individuals in our programs move into a new job or have changes in employment. Those notifications allow us to keep track of what's going on and, and

what's going on in the lives of, of the people we're serving. It also helps us address those eligibility questions. We work hard to ensure that we make that process as least burdensome as possible. However, there are requirements to make sure that we're meeting the statutory requirements as set out. And so while we try to balance those two things, I, I want to point out that is-- we hope to make that as least burdensome as possible. One last item to note, as we look at administrative savings, we would still need to do those periodic reviews of income even if we weren't making a decision, because when that 12- month period comes around, we still need to know what the current status of those families is. Most of those 12-month reviews are done as a desk review and require very little interaction with the client. And that's because of those notification systems that are in place. That reduces the burden to the client and makes it more straightforward for everyone. I'd like to point out to as my time is up. Would it be OK if I took an extra minute?

ARCH: Please.

KEVIN BAGLEY: I'd like to point out as well as we talk about the fiscal note, looking at a, a $14 million or an $18 million fiscal note, as we look at those additional 3 months of coverage across the 130,000 children served in the state, that works out to about $36 per child per month. And that to us just doesn't seem like a realistic number in terms of the healthcare service costs that we administer. So I'll end my testimony there and say thank you. I'd, I'd be willing to answer any questions the committee has.

ARCH: I, I have a question on-- back to the fiscal-- well, a couple of questions.

KEVIN BAGLEY: Sure.

ARCH: I thought we heard previously that it wasn't just when you were notified of a change, but that you're also doing a 6-month review. You must do a 12 month, but you're also doing a 6-month routine review.

KEVIN BAGLEY: I believe that's correct. We, we will need to do that with that six-month continuous eligibility. But again, most of those will end up being desk reviews.

ARCH: OK. So you do a six month. OK. The-- you may have not seen the legislative office fiscal note, but there's quite a difference between the department's fiscal note and the legislative office. And I just put down some numbers. The legislative fiscal note indicates as far as General Fund impact, $22 to $30 million. The department says $88 to $100 million. All large numbers. But do you have any comments about the legislative fiscal note?

KEVIN BAGLEY: You know, I've-- I haven't had the time to review it as thoroughly as I would like to have coming into the discussion today. I will note, in previous years, there has been bills that related to continuous eligibility for a broader range of Medicaid recipients. And as we looked back on those as a department, we felt like the estimates that would have been pulled out of that were probably understated for a couple of reasons. One, we didn't take into account the assumption of individuals who are no longer eligible in the period of time we pulled numbers who would have otherwise been. And so that was an oversight, I think, on the department's part that would have understated those numbers. And in addition, when we look at the rate of churn in eligibility, children do tend to have higher churn than any of our other categories. And so if we were to take a broader number that included adults and children for continuous eligibility and just proportionally allocate that out, it would significantly understate the cost for children because we're paying for more months. Our aged blind disabled groups do not have the level of churn. And so despite the fact that they're costlier, there'd be very few months that would cover in a, a continuous eligibility. Whereas children, we're talking about roughly three months on average.

ARCH: Thank you. Other questions? Senator Walz.

WALZ: Thank you. Thanks for coming today. I just want to make sure I understand the six-month review. Is that a requirement or is that something that is the department's decision, the six month?

KEVIN BAGLEY: Senator, I may have to get back to you on that. That's something I'll need to dive a little bit more into. The six-month continuous eligibility is in statute, I believe. And so that's-- we wouldn't remove someone within that six-month period. However, I'm not exactly certain what the process looks like, so I'd be happy to get back with you on that.

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WALZ: OK, that'd be great. And I just have one more quick question. When the Department of Labor contacts you, how long does it usually take once they contact you for you to turn off that eligibility or--

KEVIN BAGLEY: You know, it, it will vary pretty widely depending on the nature of, of what that notification is. As I mentioned, a lot of these are done as desk reviews. So if, if we're seeing a, a job change, for example, and there's not a dramatic change in income, we may be able to resolve that fairly quickly. And it may not even require involvement from the client. But if we're seeing, you know, some really strange things that we don't understand, we may have to reach out to the client. And, and that can obviously take more time.

WALZ: OK, thank you.

KEVIN BAGLEY: You're welcome.

ARCH: Senator Cavanaugh.

M. CAVANAUGH: Thank you. It's nice to see you, Director Bagley.

KEVIN BAGLEY: Thank you.

M. CAVANAUGH: One thing that struck me about this fiscal note from others that we've seen in this committee is there are no FTEs on here. And I wondered how many FTEs do you currently have dedicated to the redeterminations that you're doing?

KEVIN BAGLEY: That's a, that's a great question, Senator. And the best answer I might be able to give right now is several. That being said, several is quite a few.

M. CAVANAUGH: OK, well, I would appreciate the department getting us an exact number and a breakdown of the salaries and benefits that we would receive with an FTE of adding those, because that would impact-- that would have fiscal impact if we didn't have to have as many of those FTEs. If we eliminated this, this extra redeterminations, I think that would be really helpful to have a more clear view of the fiscal note, so.

KEVIN BAGLEY: Certainly would be happy to provide that. I, I guess I'll note on the fiscal note, we did not believe that there would be a

significant change in the level of work required for that staff, as they would still need to monitor those changes over time.

M. CAVANAUGH: But they wouldn't be processing those changes every single month.

KEVIN BAGLEY: That's correct in the sense that eligibility may not change, but we would still need to record the outcome of those changes. So that at a 12-month review that would still need to take place, we'd have all the information in place to make a decision quickly and efficiently.

M. CAVANAUGH: So if this bill were enacted, you still would require individuals that are covered under CHIP and Medicaid to submit monthly documentation?

KEVIN BAGLEY: I, I don't know that that would be clear. But the, the notifications we get from the Department of Labor, we would continue to process and review. That being said, if we had a 12-month continuous eligibility requirement, if we noted an increase in income, that would move someone off of Medicaid during that time, we wouldn't take action at that point on their eligibility, but we would still need to record that in our system so that at the end of the 12-month period, we had that information already available.

M. CAVANAUGH: So you don't think it would be less-- there would be less staff time needed?

KEVIN BAGLEY: We don't believe that there would be a significant change in the level of work from an administrative standpoint.

M. CAVANAUGH: Huh. Well, that seems odd. OK. And I just wanted to say that I am looking at the language in the bill about the six-month review. It does not appear to be in statute that you do a six-month review because it's not striking that from, from statute. So unless it's somewhere else in statute that isn't in this bill, this bill does not strike a six-month review, which to me indicates that that's not actually in statute. But it does put into statute that we promulgate rules in accordance with U.S. statute, so.

KEVIN BAGLEY: So, Senator, you may well be correct on that. I-- I'm-- I may be confused in terms of how that six-month continuous eligibility is currently established.

M. CAVANAUGH: I won't hold it against you or myself if either one of us is confused.

KEVIN BAGLEY: Thank you.

M. CAVANAUGH: Thank you.

ARCH: Other questions? Senator Hansen.

B. HANSEN: Hope you can clarify just a couple of questions that I had previously in the other testimony as other testifiers had. How are you doing with making verification for the client easier? Like, are you doing more like electronic versions because some of the concerns we had is that, you know, they have to find a printer or they have to go to a computer, other kind of things, are there certain things [INAUDIBLE] they can do something from their phone or to verify certain things? Have we, have we been moving towards that over the course of time?

KEVIN BAGLEY: We certainly have as we move toward implementation of systems that allow for more electronic interaction. That's certainly a helpful item. I, I can certainly understand where we have clients with limited access to the Internet and other areas. That's something that can be problematic. One of the things, for example, that, that we've put in place is when there is a change in employment and they're no longer employed at a certain-- so the example that was shared was, you know, going working at Target. Now you're working at Walmart. But our system doesn't indicate that they are no longer employed at Target. So we may think that they have two incomes now. In those cases, we actually have a form that their employer can fill out and return to us so that there doesn't have to be a tremendous burden of detail and paperwork that goes into that.

B. HANSEN: And do you contact them or does the, the recipient contact the employer, typically? Do you know?

KEVIN BAGLEY: I'm not certain on that, Senator. That's a good question.

B. HANSEN: Just curious, because that might be a burden, too, you know, if they're doing it or somebody-- because one of them mentioned if they're getting fired, then, yeah, it's kind of a little awkward to go back there and ask-- let them know-- tell you that they're not working there anymore. So I was curious who, who, who does that? And have you noticed, has there been an increase or a decrease in the amount of complaints or appeals of the department from recipients saying, gosh, you know, I'm, I'm, I'm getting, you know, this is too burdensome or, you know, I'm getting denied too often for, you know, for the wrong reasons? Has, has there been much of a change in that or is there a lot of it?

KEVIN BAGLEY: You know, one of the, one of the roles that I have is to review any of our administrative hearing decisions that come through. And, and to this point, I've seen few, if any, in the few months that I've been here in this role that are related to that.

B. HANSEN: OK. Because I'm wondering-- I wonder, I wonder if the, the people are speaking to this, and that's usually the one way you can tell if there are appeals or complaints directly to the department. Even though they may not be doing it, you know, because they don't have the ability or some other reason. And the answer to my question about the how much would the state be saving, it looks like, you know, because the three months you're adding on that's better than the $1,300 per child for the year versus the $400, $600 they'll be saving by churning them in and out, so. Obviously, the state would save-- still save somewhere between $700 looks like.

KEVIN BAGLEY: We believe so.

B. HANSEN: And then the answer to the 2.2 percent-- on average, child enrollment numbers grew 2.2 percent that other states versus the ones that did not adopt continuous eligibility. Do you know a whole lot about that? Is that--

KEVIN BAGLEY: You know, I have, I have not seen a study on that front. I'd certainly love to look through that information and, and try to understand where those numbers come from. But our-- as we looked at the data and the actual enrollment data we have, we believe we'd be paying for roughly 33 percent more member months than we do currently when it comes to children.

B. HANSEN: That's good, just wanted to get your perspective on it. So thank you.

KEVIN BAGLEY: Yep.

ARCH: Other questions? Seeing none, thank you very much.

KEVIN BAGLEY: Thank you.

ARCH: Next opponent for LB129. Seeing none, is there anybody who would like to speak in a neutral capacity for LB129? Seeing none, Senator McCollister, you're welcome to close. As you're coming up, I would indicate that we received six letters in support as proponent for LB129. We also received four written testimonies this morning, all proponents: ACLU, Nebraska Child Health and Education Alliance, Voices for Children, Children's Hospital and Medical Center. You're welcome to close.

McCOLLISTER: Thank you, Mr. Chairman, members of the committee. The statistic that we should really look at first is the 33 states that do, in fact, cover this kind of situation. In fact, many of the states right around Nebraska cover this particular situation. And it's unfortunate Nebraska doesn't do the same. We all know what it means, death by fiscal note. Many of the bills that I bring to HHS come with that particular situation. It's unfortunate. And in this particular case, it's just not hundreds of thousands of dollars, it's hundreds of millions of dollars. So, you know, we need to do a better job with these fiscal notes. And I think we need to obligate HHS to be more accurate with the fiscal notes that they, they bring this particular committee. We're talking about churn, wouldn't it be better, better to provide coverage for people instead of administrative fees? And I think that's something we really need to consider. The mission statement of HHS is helping people live better lives and the fact that they come in opposed to this bill is-- I find unconscionable. They should do a better job providing care for the people we have in this state. And this is a good example of a bill that, you know, we can provide coverage and save administrative fees. We need to, we need to change that particular situation. It's simply a pennywise, pound foolish kind of situation. So with that, I'm willing to take questions, Mr. Chairman.

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ARCH: Thank you. Are there questions for Senator McCollister? Seeing none, thank you very much.

McCOLLISTER: Thank you.

ARCH: This will close the hearing for LB129. We will now open the hearing for LB376. Senator Cavanaugh, you're welcome to open.

M. CAVANAUGH: Thank you, Chairman Arch and members of the Health and Human Services Committee. My name is Machaela Cavanaugh, M-a-c-h-a-e-l-a C-a-v-a-n-a-u-g-h, representing District 6, west central Omaha in Douglas County here today to introduce LB376. Sorry. Right now, the pages are passing out a white copy amendment and I will be blunt. I'm not entirely sure what all is in here because it came together quickly. And I am grateful to the work of Mr. McDonald behind me and the Mr.-- Director Tony Green. I know that they have been collaborating. I'm not sure that this entirely takes care of some of the concerns of the agency. But we are determined to work through whatever we have to to get something moving forward for the developmentally disabled waiver. With that, I, I think I will let Mr. McDonald, who is much more versed in what this has to say, talk. And so if you have any questions for me, I will take them happily, but I would suggest saving them for the next testifier.

ARCH: Do we have any hard questions for Senator Cavanaugh?

M. CAVANAUGH: Oh, hard questions. I didn't say I'd happily take hard questions. Softballs, please.

ARCH: Seeing none, thank you.

M. CAVANAUGH: Thank you.

ARCH: First proponent for LB376. Welcome.

EDISON McDONALD: Hi. Hello, my name is Edison McDonald, E-d-i-s-o-n M-c-D-o-n-a-l-d. I'm the executive director for the Arc of Nebraska. We advocate for people with intellectual and developmental disabilities. We're here in support of LB376, the family support waiver, because this bill helps to fill the gap in our waiver system that allows many children with disabilities to fall through the cracks, helps to fix our waiting list that is radically increased from

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2,300 to over 2,900 people with disabilities in a fiscally responsible fashion. To start, I'll point you out to the pictures I've passed out of children who can't safely be here. I know that most of you have heard the stories over the last few years. They are nothing short of heartbreaking. Families that are forced into bankruptcy, state-forced divorce, lack of access to medical care and more. I hope these faces and stories stay with you as we work through this bill. In the summer of 2019, we had 3 significant systematic issues, the DD waiver waiting list that was about 2,300 people. The vocational rehabilitation waiting list of over 3,000 people. However, that has significantly been alleviated. And the third being, a discovery about really the, the gaps in our services around the aged and disabled waiver is a number of children were deemed ineligible. In order to understand these issues, we dug down, had town halls, worked with stakeholders, collected data, researched other states, and created a report to deal with some of these issues. Some of these recommendations have been implemented. However, this one has not yet. The key proposal is the family support waiver that Senator Cavanaugh has led on here today. While other states have been expanding their Medicaid waiver programs, we have shrunk ours in a way that has raised costs, cut children from disability services, and made it hard for those with conditions like autism or a rare condition, something that may present like Down syndrome to access services. Last year, I told you in this hearing that unless we took action, we would see an increase to the waiting list and an increase in the unmet need. And we have, unfortunately. Currently, the only guidance that we have is the state's Olmstead Plan that fails to keep up with inflation. If we don't act now, we'll continue to see this crisis grow. Waiting list probably would cost us about $200 million to go and just say, hey, we're going to just toss down the cash for this. We're trying to say, how can we fix this in a little more fiscally sound manner? So this bill helps to keep family caregivers in the workforce, keeps children with disabilities in their family home, supplements their family health insurance coverage, provides supports for therapies and medical needs not covered by health insurance, and also offers access to long-term services and support such as specialized childcare, respite, and home and vehicle modifications. The next handout I have breaks down how services are offered with the breakdown between Medicaid and capped LTSS services. That orange sheet. And it basically shows which, which services are covered under which portion. So we have things like PT, Behavioral

Health, Applied Behavioral Analysis, OT, Specialty Medical Care and Durable Medical Equipment that's covered under Medicaid side. And then you have the Long-Term Support and Services side that would cover Home Modifications, Specialized Childcare, Respite, Vehicle Modifications, and Independent Living Skills Training. You know, this, this is not meant for everyone. It's not going to be a perfect fit. Currently, our system is really designed to pretty much just serve adults with Down syndrome who want to be in a traditional agency setting. This helps to provide services in more of a family-based setting. And so it's got to have a bit of a different structure. It's serving a different need, but that's the difference between a state plan amendment and a waiver. A waiver is supposed to hit those targeted populations in ways that will decrease your service-- or your-- decrease your costs and increase your focus on your ability to provide proper services. So as you can see, overall, we're looking to significantly lower the cost array of services at a cap of $12,000 in comparison to the average of about $63,000 per individual per year that our DD services waiver covers. We're working on providing those services at a much lower cost that will be preventative, decrease those costs overall so we don't get into the high end. And you can see from the next chart that I have that really the high end gets up all the way to $134,000 per year. And that's those emergency situations that we're trying to avoid with this waiver. So this handout walks you through our current waiver system. I think of it like a Venn diagram. We've got kind of our two main waivers, the DD waiver and the A&D waiver. And the DD waiver really, you know, again, it's, it's designed mostly for people with typically presenting Down syndrome. And then you have the A&D waiver that doesn't really overlap. So we're trying to figure out how do we fix this. So if you look through in slide 5, we have kind of the breakdown of the costs. The high end, again, is going to be about $134,000. The low end is going to be about $33,000. And we're looking at how do we go and provide these services in a way that's going to be more consistent, make sure that we're providing more person-centered services, those preventative services. So, yeah, so that's kind of the overall ideas. We want to figure out how-- oh, I'm over time.

ARCH: Your red light has come. I'm sorry, but I'm sure there'll be questions.

EDISON McDONALD: Can I get a question?

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ARCH: I'm sure there will be questions.

EDISON McDONALD: OK.

ARCH: Questions from the senators? Senator Hansen.

B. HANSEN: All right, so basically what you're trying to do is you're trying to fund the DD waiver partially. So basically the ones who are on the waitlist--

EDISON McDONALD: Yeah.

B. HANSEN: --will get $12,000.

EDISON McDONALD: Yes and no. So overall, we want to go and make sure that we're working-- there's about 1,000 kids out of the 2,900 who are on the DD waitlist.

B. HANSEN: Um-hum.

EDISON McDONALD: So the amendment actually specifically is limited in targeting those kids. The original bill, however, is a much broader focus. We wanted to do those kids. We also wanted to do kids with autism, rare conditions who were being served on the A&D waiver until they were kicked off. And then there's some that have never been eligible for either, which is why that Venn diagram mentality is kind of important. We need to add another waiver that'll be the proper tool to kind of serve those needs. So we're not going to serve, you know, the folks who don't fit within our current system definitions, with the amendment. With the amendment, we're only focused on the DD waiver portion of it. With the original bill, it would serve a bunch of other folks and a lot of the stories that I know you've heard a lot of.

B. HANSEN: Yeah. And, and you know and I know Senator Cavanaugh knows my passion for the DD waiver and how we need to fund it. And because I'm, most people know, I think our taxpayer money should be spent specifically, and I think we have priorities I think we're spending money as taxpayers when it comes to healthcare, more than Medicaid expansion, more than expanding SNAP benefits as this first, this is the one where your community and your church can't really help you out, you know,--

EDISON McDONALD: Yeah.

B. HANSEN: --with stuff like this because this is where government kind of play a role. And so I, I appreciate the work that Senator Cavanaugh and you are trying to do with this--

EDISON McDONALD: Um-hum.

B. HANSEN: --and maybe taking a kind of more, you know, smaller step approach instead of eating the whole apple.

EDISON McDONALD: Um-hum.

B. HANSEN: So thanks for bringing it. And so I'll have some more questions probably--

EDISON McDONALD: OK.

B. HANSEN: --for Senator Cavanaugh maybe at later on about, about this bill. So thanks.

EDISON McDONALD: OK.

ARCH: Other questions? Senator Walz.

WALZ: Thanks, Edison, for coming. Is, is there anything else that you would like to explain regarding this handout?

EDISON McDONALD: Yeah, I think the, the biggest concern is, you know, kind of typically when folks say, oh, you want to create a new waiver, is that last slide 8, that they're afraid that we're just going to be taking people who are on the DD waitlist and put them on another new waitlist. But again, because the cost of services is capped at $12,000, you're going to be serving more people because you don't have to spend as much money on them. And so hopefully what you'll end up doing is spreading out how they're served. So really, we're not looking at the waiting list. We're looking at total unmet need. And our unmet need is both the waiting list and it's all the kids with disabilities out there who aren't being served, who don't have access to services, because unlike other states, instead of using a 1915(b), a 1915(i) waiver, an 1115 waiver, all these other options that are available to us in our federal system, we're saying now we're really

going to skinny down, just focus on our 1915(c) system. People have different needs. And so one of the stories that I included a little bit about in here talks about a mom who, you know, her daughter transferred from the A&D waiver to the DD waiver and she has a, a budget that's huge. But basically the only service she can use is respite because it's designed for adults, it's not designed for children. It's not designed for people with rare conditions. So we're really trying to make sure that we're serving them with tools that make the most sense for them.

WALZ: OK. And then can we talk about the amendment a little bit more because--

EDISON McDONALD: Yeah, yeah, so, so the amendment, you know, we've been in conversations with the department and trying to figure out how we can do this? How does this make the most sense? Because I think, you know, this is, this is an unknown territory for us. We're going and we're creating new waivers that we haven't had. Other states have, Tennessee, you know, has done it well, but we're still trying to figure out how to do this. And this isn't the complete process. This is just step one. So the amendment solely focuses on cost efficiencies and providing those preventative services for those 1,000 or so children who are on the DD waiver waiting list, sorry. And so then our hope is that we would then use this as a first step and then the next step would be saying, OK, we know the family support waiver works, it's going to save us money. But then we'll take that next step into expanding eligibility to cover kids with autism, kids with rare conditions. And really, we need to look at a waiver around dual diagnosis between behavioral health and developmental disabilities, because those are the hardest and most expensive cases. And that's where we burn through the most unnecessary capital by not spending on preventative services.

WALZ: So right now, the families don't really have any other options as far as--

EDISON McDONALD: Yeah, no, they've got, they've got nowhere else to go. If a family comes to Nebraska and they've got a kid with a disability, they call me up a lot of times, say, can we move here? And I said, well, if, if you want DD waiver services, you're going to be on a waitlist for eight to ten years. So unless you can wait that long

without services, you can't move here. For families who are here, it's, you know, how do we get eligibility? And, you know, they don't need everything. Nebraskans are hard working. They're trying to make it by themselves. And what they're trying to figure out how to do is just survive. But when you've got like $12,000 worth of formula that you have to buy a year when on average your kid costs like the folks on our service array an extra $63,000 a year. I mean, until you get into a six-figure income, it doesn't really matter because the Medicaid bubble all of a sudden for those families is so significantly bigger. You can't go and, you know, it doesn't matter if you're making like $90,000 would be a decent income. That wouldn't matter because ultimately you're not going to be able to cover all those medical services and your regular bills. So the amendment, I think, looks to take the first step within this and hopefully we can keep on moving that along. Unfortunately, there are a lot of the families that I know we've been working with and you all have been talking that this isn't going to cover the original bill with-- would, but at least it helps us to start moving into this process. So the ideal would be piece by piece, we're going to, you know, start with that decrease DD services costs, show the family support waiver model works. Then the next step is expand eligibility and start to see how we can kind of fill in those other bubbles so that we can actually cover our full needed service array.

WALZ: All right.

EDISON McDONALD: Does that make sense?

WALZ: Yeah, no, that helps a lot.

EDISON McDONALD: The other thing with that amendment, and I know in the, the fiscal note, there's some confusion and it's based around the original bill. But also, we don't know how, how many people are going to need this. We don't know if the family support waiver would ever end up even needing a waitlist. But what we do know is that statistically, only 20 percent of people with intellectual or developmental disabilities are known or served by the state. Eighty percent of families are kind of in this big unknown bubble. And I know its director Green's biggest nightmare is just, well, what happens if all of a sudden all of that 80 percent went and said, hey, we're going to apply for services? What happens when their caretaker passes away?

What happens, you know, with all sorts of conditions? What happens if they're going to lose those services, the or the natural family and community supports? What do we do when we lose those? And it makes it really hard to, to estimate exactly what this population will be. The amendment, though, is just targeted much more around about 1,000 kids. And so it's a much more focused population.

WALZ: Can I ask another question?

ARCH: Sure.

WALZ: Thanks. Thank you, Senator Arch. So if the kids aren't on any type of waiver right now,--

EDISON McDONALD: Um-hum.

WALZ: --there's no case management,--

EDISON McDONALD: Nope.

WALZ: --there's no planning.

EDISON McDONALD: I mean, well, if they do apply for the DD waiver, they are supposed to have case management, but that's not really been how it's functionally worked.

WALZ: OK.

EDISON McDONALD: But yeah, in terms of that cost, I don't know. Honestly, it-- earlier you all were talking about the, the cost of how of FTEs. And I can tell you just solely from the time that I take up of staff attorneys and staff at DHHS, you're going to have a lot of cost that increases whenever you have those decreased eligibility requirements just because you're going to go through all of those questions, all of those issues, all of those appeals, and then you're going to get them, you know, not when you can go and provide the preventative services. You're going to get them when, you know, it's a kid who's 16 with a disability and schizophrenia, who ends up attacking their parents. And at 16, they're, you know, not going to hit that higher age for transition services. So you're really left in kind of a huge gap there in families who have to say, do I give my kid up to foster care, which a lot of times is forced, or do I go and, you

know, divorce my husband and say, OK, great. Well, now one of us can at least be on Medicaid, but it just sets families in these horrendous conditions that we don't want to do. We want to find those preventative services that are directed towards that individual.

WALZ: And OK, so just to clarify, if somebody were to receive the family support waiver, they could receive up to $12,000.

EDISON McDONALD: Of LTSS services. So you've got the, the Medicaid side of things and then the LTSS side is the capped portion. So if you go back to this handout it breaks down, the LTSS is Home Modification, Specialized Childcare, Respite, Vehicle Modifications, Independent Living Skills Training. That's the capped portion.

WALZ: OK. But as they're-- as if they, if they would receive this waiver--

EDISON McDONALD: Um-hum.

WALZ: --at that point, a case manager would be involved and they would-- this money would be spent according to their individual plan.

EDISON McDONALD: So that's the other part of this that's a little bit interesting is that we're working on shifting towards self-direction, which, you know, allows for a lot more direction from what the family, what they actually want. What we find a lot of times with traditional agency settings is it's more of a cookie cutter. It's going to be-- we're going to serve you in how our structure is set up. This is set up to be, you know, what do you need? Is that specialized formulas? Is that respite? That's going to be different for each family. And that was one of the things we really saw with the transition from the aged and disabled waiver to the DD waiver. It's just really, you know, there's some confusion and, and differences in terms of how services were offered that left a lot of families in some really difficult situations and also left a lot of families not getting the same service array because it's a different waiver. This is a waiver designed more for kids and for, and for families so that people can live at home with their family in a setting that works for them.

WALZ: Got it. Thank you, Edison.

EDISON McDONALD: Yeah.

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ARCH: Any other questions? I, I, I have one and, and it's probably way too simplified. You mentioned that there are 1,000 kids out of 2,900 total. Our waitlist, our waitlist is about 2,900 and about--

EDISON McDONALD: Yeah.

ARCH: --1,000 of those are, are, are children, adolescents.

EDISON McDONALD: Yeah.

ARCH: OK. So if, if, if this were in the, in the amendment were to pass, are you saying that we could knock 1,000 off that waitlist?

EDISON McDONALD: No.

ARCH: No, I didn't think so.

EDISON McDONALD: So--

ARCH: That was way, that was way too simplified.

EDISON McDONALD: Yeah. And I hear Tony laughing back there.

ARCH: Yeah.

EDISON McDONALD: I'm sure he'll dig more into this.

ARCH: Yeah.

EDISON McDONALD: But it's targeted so it would take about those 1,000 kids. It would provide some of them, not possibly all of them. A lot of this is really going to be based upon the waiver application and what it looks like there. You also see probably some differences based upon how our aged and disabled waiver application goes through. But basically it'd be targeted at that group as kind of more of our focus trial pilot group and so it would help them. The other thing that Tony is going to say is that, well, you know, they're still going to be on the waitlist, which, which is important. Officially, they'd still probably like to get more of the Cadillac of services that is our DD waiver. And this is where it gets really confusing is how do you break down those numbers? And the department always will, always will contest that this isn't the best way to look at how we serve who we

serve. But for decades, the waitlist has been the main metric that we've looked at to kind of count that. And I think the other thing we need to shift our mind from is not just looking at the waitlist, but look again at that unmet need. Those families who are out there who aren't eligible for DD services, who have, you know, conditions that aren't typically presenting, who aren't eligible, you know, and, and that's where it starts to get really, really fuzzy and complex. And so I think, you know, sometimes we oversimplify to kind of say this, this is the number to just kind of give us a it's the best, it's the best kind of radar that we have that we'll use of that waiting list. But there are other pieces within that. We're looking to go and make sure that we've at least got kind of something and something that's going to be a lower cost and probably not the Cadillac of services that DD services is. Does that makes sense?

ARCH: It does. That's helpful. Thank you.

EDISON McDONALD: Yeah.

ARCH: Any other questions? Seeing none, thank you very much for your testimony. Next proponent for LB376. Welcome.

SHERRI HARNISCH: Hi, I'm Sherri Harnisch, S-h-e-r-r-i H-a-r-n-i-s-c-h, and thank you for having me today. Thank you, Chairperson Arch. I ask you to support LB376, a meaningful piece of legislation that would provide a fraction of funding to help provide a very basic need to working families like ours. As the parent of a young child with Down syndrome, I'm an active member of the Down Syndrome Alliance of the Midlands. I serve as a Nebraska ambassador for the National Down Syndrome Society, and I'm a member of the National Down Syndrome Congress Advocacy Coalition. Mostly, I stand before you today as a mom. Eleven years ago we fell unconditionally in love with our daughter. And at that moment she was born, despite our initial fears, due to unknowns regarding her diagnosis, we promised Macy that we would always unapologetically advocate for her rights. And that is why I'm here today. Our state should, like so many others, be putting forth more appropriate efforts to preserve family units like ours to ensure families that have a child with disabilities have reasonable access to services that promote independent living, family- centered care, and community integration. While navigating this new world of special needs can be overwhelming at times, you must know it is not my

child's disability that has me overwhelmed. It is the very thought of finding our way through Nebraska's complicated and confusing systems of winding roads. This system of accessing and qualifying for adult services is especially daunting, to say the least. And I think everyone here can can collectively agree that our system could improve. I don't have a dramatically heart-wrenching story to share with you. Ours is rather quite common and representative of so many others. We began investing in our daughter's future early on in the form of school-based and private therapies to ensure that she has as bright and productive a future as possible. Macy is in fifth grade and because of proper supports, she is doing well alongside typical developing peers in the general education classroom. Macy is active in our local community. She enjoys dance classes and competes on an inclusive cheer team. She participates in Special Olympics and she's part of our weekly education classes at our church. I know that these enrichment opportunities are helping to shape a more promising future for her. But the only, and the reason I showed up here today, the only way she has been able to participate in typical everyday activities like these in our community is because of costly PT, OT, and speech therapy services that her dad and I have been fortunate enough to provide for her from an early age. It is only with these supports that she will continue to develop skills and build connections to achieve and maintain employment. Macy, just like the next person, deserves to work and earn a fair wage. But she can't do it alone, and she will need programs that help teach her independent living skills, academics and social activities. I recognize this process of getting Macy to and through the system will be challenging. And again, not because of her cognitive disability, but because of the lack of funding and support for complicated and involved processes of accessing services that will help her transition from being a student to a productive, contributing, working, taxpaying adult. Our daughter Macy has a lifelong intellectual disability, and yet in the eyes of this Legislature, she's not disabled enough. Our daughter Macy has a lifelong physical disability, and yet in the eyes of this Legislature, she's not disabled enough. Macy struggles day to day with tasks that her typical developing peers take for granted, and yet in the eyes of this Legislature, she's not disabled enough. As she grows, disability gap will continue to widen. And the pace I've witnessed lately, especially amid this current global pandemic, it scares me to death. And this ability gap is what keeps me up at night and the reason I am

here today. Macy and her friends like her, however, do not fit in the extremely stringent bubble of criteria that our Nebraska lawmakers would consider her to be eligible for any sort of assistance program. If passage of LB76 [SIC] is Macy's slim chance to finally get a much deserved, albeit small, piece of the pie, then I'm all for it. Something is better than nothing, and anything will go a long way in helping to ensure that Macy and her friends have independent as a future as possible. And I'm also sure that you're well aware that Nebraska is light years behind so many other states who are already doing the right thing by providing supplemental services to families in situations similar to ours. LB376, it's a commonsense, public health approach that helps to ensure children with disabilities have access to, to resources and supports that would help them develop living skills, increase the likelihood that they will be self-sufficient, or in the very least have less dependency on government services, which would in turn be much less costly to our state in the long run. So I want to do the math. Our daughter is 11 and she has never qualified for assistance, but she has, still has 10 years before she can even become eligible to get on the waitlist for services that currently sits at a minimum of 7 years. At that point, she will be 28 years old. And you don't need to be an expert in common core to see that my husband and I will be nearing retirement age before our daughter will have received a single penny of waiver support from our state. I know that our-- Nebraska's current tourism motto is "Honestly, it's not for everyone." But I do wish and I hope that our Nebraska State Legislature would agree that honestly, equity before the law is for everyone. Thank you.

ARCH: Thank you. Questions? Senator Hansen.

B. HANSEN: You testified here last year, didn't you?

SHERRI HARNISCH: I did. I'm back.

B. HANSEN: I remember that because I remember when you said something about it last year, I felt like I got scolded.

SHERRI HARNISCH: Thank you. That was the point. No offense.

B. HANSEN: But I appreciate you coming here and fighting for, for your kid.

SHERRI HARNISCH: Thank you.

B. HANSEN: And I think you're right. I think, like I said, when there's certain priorities, us as legislators should use taxpayer money for, this is probably one of the most prioritized things we should be looking at.

SHERRI HARNISCH: Thank you.

B. HANSEN: Somehow we lose our-- we lose that I think sometimes and when we get 650 bills introduced in front of us and all of this money gets spent everywhere else, we kind of lose that important aspect, so.

SHERRI HARNISCH: Right.

B. HANSEN: Thanks.

SHERRI HARNISCH: All right. Thank you.

ARCH: Thank you. Other questions? Senator Walz.

WALZ: Thank you, Senator Arch. Thank you for coming today. Not only are you an active member of the Down Syndrome Alliance in Midlands, you are an active mom and advocate for all kids, and we appreciate that. Now I forgot my question. I'll get it. OK. I was just going to ask you about your case management. Do you have any right now? Nothing.

SHERRI HARNISCH: What is that?

WALZ: OK. It was just something I was curious about. So, you know, if Macy did qualify for the family support waiver, at least that was something that you could count on as some case management and--

SHERRI HARNISCH: Yeah.

WALZ: --develop a plan for her future or begin to develop a plan for her future.

SHERRI HARNISCH: That would be helpful to begin having that conversation and dialog, because I think I would remiss to assume-- be remiss to assume that, you know, she's fine, she's good. She wakes up,

she does all the things a typical kid does. She's just a kid doing typical kid things. Well, she is right now. But that ability gap is growing and it's important for us to begin having this dialog and conversation now while she's young so that we can educate ourselves on what our options are for her so that she can just have less struggles so that she doesn't fall off that cliff of services when she turns 21, so that we can have this continuous model just pre-created for her.

WALZ: Right. A lifelong plan starting early.

SHERRI HARNISCH: Right.

WALZ: And it would put you, I'm sure, more at ease as well.

SHERRI HARNISCH: Because who knows what could happen to us tomorrow.

WALZ: Right.

SHERRI HARNISCH: Um-hum.

WALZ: Thanks for coming and thanks for being an advocate.

SHERRI HARNISCH: Thanks.

ARCH: Any other questions? Seeing none, thank you very much.

SHERRI HARNISCH: Thank you.

ARCH: Next proponent for LB376.

LEAH JANKE: Good afternoon. My name is Leah Janke, L-e-a-h J-a-n-k-e, and I also testified last year. So some of you may have, may have heard our story. I'm here today to testify in support of LB376, the family support waiver. I'm the mother of three children and my youngest, Clay, has Down syndrome. I'm also the executive director of the Down Syndrome Alliance of the Midlands. And here to represent more than the 500 families we support. I often encounter people who assume that children born with Down syndrome qualify for some sort of state assistance. But this is not the case in Nebraska. Unless your family falls below the income threshold and most two-income households do not, or your child requires nursing level of care in several categories, things like a feeding tube or supplemental oxygen, having

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Down syndrome alone does not qualify a child for any of the current programs in Nebraska. My son required open heart surgery when he was six years-- six weeks old. We were able to bring him home from the NICU before his surgery and with frequent cardiology appointments, we were told that we would know when he was in heart failure because he would start to turn blue and would not be able to eat. Both of these things happened, and I was told by nurses and early intervention workers to apply for Medicaid, given his complex medical needs, only to get a denial letter stating that he was too healthy to qualify because he did not need any at-home medical devices to keep him alive. Clay has continued to have surgeries every year of his life, and every year we pay our $7,000 out-of-pocket deductible. As a single mom who works for a nonprofit, that's a lot of money. We pay our $60 deductible at his frequent appointments and multiple times a week to cover his speech, occupational, and physical therapies that allow him to be a thriving third grader. Unfortunately, our health insurance plan recently changed, and now he is limited to only 20 therapies per year. Private health insurance is just not designed to cater to individuals with intellectual disabilities or developmental disabilities. They want to know what the problem is and how quickly and efficiently it can be fixed. And that is just not the way our world works with Clay. His Down syndrome isn't going to go away. He isn't going to stop needing services. I'm not here to gain sympathy or give a sob story. Like Sherri, I actually feel pretty lucky with our situation in comparison to other families who have a child with an intellectual or developmental disability. I have known families who have been forced to surrender their parenting rights, quit jobs, become single-parent homes, or uproot their families and move to another state. Iowa, one-- being one of those. If you were not aware, individuals with Down syndrome do qualify for services in Iowa. So we have lots of families who move over the bridge just to qualify. This bill will keep parents like me in the workforce, keep children like Clay in their homes, and supplement family health insurance coverage and provide supports for therapies and medical needs not covered by health insurance. Thank you for your consideration. I urge you to please move this bill out of committee. And I'm happy to answer any questions related to my personal story or the Down Syndrome Alliance as well, our families. I provided a written testimony in support on behalf of our organization, and I apologize for getting emotional.

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ARCH: Thank you. Any questions? Seeing none-- oh, Senator Day.

DAY: Thank you, Chairman Arch. I was just going to ask you on a personal note, do you live in District 49 or do you-- what legislative district do you live in? Do you know by chance?

LEAH JANKE: I'm in Elkhorn, whatever that is.

DAY: Oh, you are. OK. OK. For some reason, you and I have interacted,--

LEAH JANKE: Yes.

DAY: --I believe, and this is the first time we're--

LEAH JANKE: Yep.

DAY: --meeting face to face.

LEAH JANKE: Yes, nice to meet you.

DAY: So I just, I just wanted to clarify. I thought you lived in my district.

LEAH JANKE: Sure.

DAY: But I appreciate you being here and sharing your story with us today. So thank you so much.

ARCH: Seeing no other questions, thank you very much.

LEAH JANKE: OK. Thank you.

ARCH: Next proponent for LB376. Welcome.

KRISTEN LARSEN: Hi, good afternoon, Senators. My name is Kristen Larsen, K-r-i-s-t-e-n L-a-r-s-e-n, and I am here on behalf of the Nebraska Council on Developmental Disabilities to testify in support for LB376. Although the Council is appointed by the Governor and administrated by DHHS, the Council operates independently and our comments do not necessarily reflect the views of the Governor's administration or the department. We are a federally-mandated independent Council comprised of 25 individuals and families of

persons with developmental disabilities, community providers, and agency representatives who advocate for systems change and quality services. The Council serves as a source of information and advice for state policymakers and senators. And when necessary, we take a nonpartisan approach to provide education and information on legislation that will impact individuals with developmental disabilities. Council members support LB376, which requires DHHS to apply for a HCBS, either a 1915(c) or 1115 demonstration waiver from CMS to administer a pilot family support program. It acknowledges a gap in the system that has existed for many years. The Council and other disability advocates are aware that the lack of family supports is a barrier in Nebraska, and we support a solution to stretch state appropriations by securing federal matching Medicaid funds. To stay focused on our mission, every five years the Council completes a needs assessment in order to identify ways to make a positive difference in the lives of individuals with DD and their families. In October 2020, the Council's contractor, Munroe-Meyer Institute, published the needs assessment findings from surveys and interviews with over 500 family members, self-advocates, providers, and others. Respondents rated informal and formal services and supports as their top priority area. Specific needs identified as important, included issues related to waiting lists and the availability of services, unmet behavioral health needs, and the needs to bolster families supports. People are being missed and kids are falling through the gaps. Families need more avenues to obtain services. While other states are expanding waivers to secure matching federal dollars to support families, our waiver options remain stagnant. LB376 demonstrates an innovative approach to support children with disabilities and their families. It would help keep family caregivers together and allow them to contribute to Nebraska's workforce. Without it, Nebraska experiences unintentional consequences, such as families resorting to divorce to secure Medicaid coverage, family caregivers dropping out of the workforce, students entering the juvenile justice school-to-prison pipeline and costly out-of-home placements. LB376 provides a pathway for working families to gain Medicaid access for their children with disabilities and provides the guardrails to protect them from the unintentional consequences. The Council supports the amendment and I really like the amendment that Edison proposed, LB250 [SIC], that we saw today. But it's great. It narrows the disability criteria to children who meet institutional level of care. Having this amendment will make it

possible to serve those children who are currently waiting for services on the DD waitlist. Providing family supports to these qualifying families is proactive measure and avoids potential priority comprehensive waitlist offers when a child or family is in crisis. The waiver would provide access to Medicaid for needed early intervention therapies and behavioral medical supports. The amount is almost a third the cost of the comprehensive waiver and would demonstrate financial stewardship. Roughly, 4,900 Nebraskans are currently being served on the DD waivers. However, only 4 percent of those are children, and there are still 1,132 children who are on that waitlist. The department must really reduce that waitlist in a cost effective manner. In addition to LB376, the Council offers another suggestion for legislative or department consideration to expand family access to Medicaid coverage through an amendment to Nebraska's current Medicaid state plan. This is in addition to what we're talking about today. There are 430 minors on the DD waitlist who do not have Medicaid coverage because their parents are over income. Under the Tax Equity and Fiscal Responsibility Act, or TEFRA, optional Medicaid coverage with the Medicaid category, category of covered states can cover children under age 19 who are disabled while living at home and who would be eligible for Medicaid if they were in an institution by basing eligibility solely on the child's income. Nebraska has elected to cover the TEFRA optional category for children who meet hospital level meeting-- care needs. The Council recommends that the state also apply for an amendment to add ICF or DD or institutional level of care to the Medicaid state plan. Last year, the-- we wanted to just encourage another proposed amendment before I saw LB250 [SIC] today, because I think LB250-- that AM250 is really robust. But there was some language we worked on when we had a collaborative effort in early March 2020 with leadership from within the DD Division, disability advocates, and Senator Cavanaugh's office in regards to LB1240 [SIC] then and I included that amendment language in the testimony. But I think what you provided is excellent. So we're just hopeful that the LB7-- or 376 with the amended language will move forward to help meet the unmet needs of families. Thank you for your consideration.

ARCH: Thank you. Are there questions? Seeing none, thank you very much for your testimony. Next proponent for LB376. Seeing none, is there anyone like to speak in opposition to LB376? Welcome.

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TONY GREEN: Good afternoon, Chairperson Arch and members of the Health and Human Services Committee. My name is Tony Green, T-o-n-y G-r-e-e-n, and I am the director of the Division of Developmental Disabilities within the Department of Health and Human Services. I am here to testify in opposition of LB376, which mandates the Division apply for a Medicaid family support waiver. I want to preface my written comments. I am aware of the amendment and did shortly before this receive a copy of the amendment. But my comments today will be to the bill, which is the green copy as written. So the department has three major areas of concern with the bill as, as introduced. First, would be Medicaid eligibility. LB376 would require the pilot program offer a pathway for participating children to enroll in Medicaid based on the child's income and assets, disregarding the parental income. States have two options available to specifically cover children with disabilities receiving services in the community. Both options require the child to be disabled according to the Social Security Administration definition of disability. But only one allows for the disregard of parental income. Under the Tax Equity and Fiscal Responsibility Act, or you've heard TEFRA, optional Medicaid category of coverage, states can cover children under age 19 who are disabled while living at home and would be eligible for Medicaid if they were in an institution. You would find that referenced at Section 1902(e) of the Social Security Act. TEFRA, or also known as the Katie Beckett Option after the child whose plight inspired Congress to enact this option into Medicaid law, allows children with disabilities whose family has income that is too high to qualify for Medicaid, to gain Medicaid eligibility based on the income and resources of the child, but the child must be determined disabled and meet criteria for institutional level of care. The other Family Opportunity Act allows children with disabilities and family incomes below 300 percent of the federal poverty level to buy into Medicaid. Again, referenced in the, in the Social Security Act. Contrary to the options for Medicaid eligibility listed above, many of the children in LB376, as written, would not qualify for Medicaid due to exceeding the financial criteria and may not meet the institutional level of care set forth in state regulations under 471 Nebraska Administrative Code. As a result, parental income would not be allowed to be disregarded. The bill does not specify the Family Opportunity Act as a pathway to eligibility. Therefore, a state plan amendment is not likely to be approved by the Centers for Medicare and Medicaid Services to serve these children

under the Medical Assistance Act. Second concern would be related to the department's requirement to submit a waiver application administering the, the pilot, family support and community-based program. Again, Nebraska currently does serve children through TEFRA, which allows us to disregard that parental income who require nursing facility level of care or intermediate care facility for the intellectual-- for folks with intellectual and developmental disabilities through those 1915(c) waiver authorities. The 1915(c) authority requires that a child have a disability and requires the institutional level of care before the parental income can be disregarded and only the child's income and assets considered. As written, the bill does not identify a specific level of care, either nursing facility or intermediate care facility. Therefore, a 1915(c) waiver could not be submitted as the bill is written. Another waiver authority is available to states under Section 1115 of the Social Security Act. The U.S. Secretary of Health and Human Services can waive certain federal guidelines on Medicaid to allow states to pilot and evaluate innovative approaches to serving beneficiaries. LB376, as written, would pose some unintended consequences for families, creating a temporary eligibility for children that would create a cliff effect. It would serve children who do not meet an institutional, meaning nursing facility or ICF level of care, and would therefore not be eligible for the existing 1915(c) waivers after the pilot. This would leave those children without services once they reach the age of majority. Finally, the, the last concern would be that the bill mandates the department to apply for a Medicaid family support waiver. However, if the program were to become law without that approved waiver from CMS, we would have to fund the program with 100 percent state General Funds. In summary, LB376, as written, would create a solely state-funded program that would divert General Funds not accounted for in the Governor's budget away from adults currently on the waitlist for DD waiver services. Again, these comments are, are to the introduced bill. I'm also aware of discrepancies in the fiscal notes between what the department submitted and Legislative Fiscal Office. And I'm happy to, to clarify some of those discrepancies during questions. I would respectfully request that the committee not advance the legislation as written, and thank you for the opportunity to testify and happy to answer any questions I can.

ARCH: Are there questions? Senator Walz.

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WALZ: Thanks for coming.

TONY GREEN: Thank you.

WALZ: Welcome to our committee.

TONY GREEN: Thank you.

WALZ: So you said in your testimony this would leave those children without services once the pilot program expires. Why can't-- I mean, wouldn't, wouldn't there be a way to change that? So they're no longer eligible for this if once it expires, but-- oh, it expires. OK, sorry. I was thinking that they would automatically then just go on to another type of program.

TONY GREEN: Yeah, so my testimony is that the, the way the bill is written, the population that it would serve is not really defined as a, a group of children that meet ICF or nursing facility level care. So there's an assumption that you could serve folks that don't meet that level of care. So when they aged out at 18, the existing waivers in place in Nebraska only serve child-- adults or children that meet nursing facility or, or ICF level of care. And so if there was a child in the pilot program that didn't qualify under a level of care for institution, they would be out of the pilot program and not move into any of the adult waiver programs because that, that eligibility requirement for those existing waivers is the institutional level of care--

WALZ: Um-hum.

TONY GREEN: --of how we're able to, to use the TEFRA, disregard the income.

WALZ: Right. I mean, I see what you're saying, but I guess I also think that it's still a benefit for families and children even though, you know, that, that may expire or at least they've had a head start on planning and, you know, some type of, of help and supports. The other question I have is how many-- what's the caseload for service coordinators right now?

TONY GREEN: So we have in developmental disabilities caseloads that we, we like to keep around 25. They generally range today between 25,

sometimes 30, obviously with vacancies and coverage, but we do 1 to 25.

WALZ: Does that number include kids like, like Macy for example? Is that part of that caseload who aren't receiving, you know, waiver services, but are still supposed to be getting some type of-- do you understand the question I'm trying to ask?

TONY GREEN: I, I do, Senator.

WALZ: OK.

TONY GREEN: So it does include folks that, that we call service coordination only. So those are folks that are eligible for the waivers, but they haven't received a funding offer yet. So there's about 400 and some folks on what we call SC only, meaning they're on the waiting list, but they're getting case management from the state. So we have a service coordinator that's assigned to them. So our service coordinators have mixed caseloads, some on the waiver, maybe a few, because, again, this-- that 5-- 400 number is statewide that, that access service coordination only.

WALZ: OK. And then I just had one other question that I wrote down. I think that this waiver transitions from a pilot to a permanent waiver once it expires. Once-- does that-- so you're not just ending services, it continues on, it transitions into another.

TONY GREEN: My understanding of the introdu-- the way the wording is in the introduced bill, is that it would end when they reached age of majority at 19.

WALZ: OK. All right.

ARCH: Senator Murman.

MURMAN: Thank you, Senator Arch. Again, thank you for testifying. You said you testified to the green copy. Are you familiar with the amendment? Because my question is, how does the amendment change eligibility?

TONY GREEN: Unfortunately, Senator, so-- I am aware of it, yes. And, and to the earlier comments, yes, I have been working with Edison and

giving him technical assistance as they worked on crafting language around what are the requirements of CMS. I am not in a position today. I just saw the copy this morning, so I haven't had a chance to officially look at it and would probably make that opinion once you formally adopt the amendment and we're able to see exactly the language that will go into the amendment.

MURMAN: OK, thank you.

ARCH: Other questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch. One, one of the awkward situations is when we do have a, a substantial change like, like this amendment. Will you be able to have an opportunity to respond back to the committee after you have fully reviewed the amendment to see what your testimony would look like so that we can see what your testimony would look like when you're directing it just at the amendment?

TONY GREEN: Would we be able to give you a position on, on the amendment? Yes.

WILLIAMS: Thank you.

ARCH: Other questions? Seeing none, thank you very much.

TONY GREEN: Thank you.

ARCH: Next opposition for LB376. Seeing none, is there anybody who would like to testify in a neutral position?

AMBER PARKER: Excuse me.

ARCH: Welcome.

AMBER PARKER: That's a heavy chair.

ARCH: Yeah.

AMBER PARKER: Hi, my name is Amber Parker, A-m-b-e-r, last name Parker, P-a-r-k-e-r. There's so many bills to keep track of them, but the ones that are robbing freedom or things like that, I usually come and testify because I believe that if we-- the watchfulness of the

citizen is the salvation of the state. And I do believe that it's important that we are a voice for those who cannot speak for themselves and the families that have been through heartache. I don't know much about LB376, but hearing what I had today by Mr. Edison [SIC] from the Arc sharing that there are families that have gotten divorced to make sure that they could receive the funds of Medicaid to help their children get the therapies that they need or to meet their health needs. I've heard, I've heard more stories like that in the state, and it greatly disheartens me to see that a state policy to-- is, is going to break up families and then to say, well, we'll give you money. The part that I want to talk about is some solutions. I believe that we could work together as a state and we could encourage, perhaps introduce a bill, if a senator would be bold to come forward and introduce a bill, to help these families in a way of giving a tax break to the occupational therapy, physical therapy, just the special therapies that these children need. Some way that we could work together with these, like small businesses even or big businesses to encourage these therapies, because that's really the core and the foundation of these children's-- all these children and their development. So that's what I really want to come forward and advocate for. Like I said, I can't really speak to LB376, but I do believe as a state it is important to stand up for those who do not have a voice, can't defend themselves. And it, it just-- it grieves my heart. I personally have someone I'm very close to in my life who their children had become autistic after receiving some vaccinations. And if it was not for the love of this family to encourage their children, their developmental abilities would not be where they are today. So I believe that we can think outside the box and set a precedent and be a blueprint to the rest of the states near us and just the United States of America in general by working with a policy. Sad to say, but some businesses will come forward on the tax write-offs. And I, I do believe as our public-- excuse me, as our private sector has been suffering through COVID, a lot of people didn't come in through therapies and stuff because they were concerned of being sick. So I just think there's some avenues that haven't been discovered and we need to think outside the box.

ARCH: Thank you. Are there any questions? Seeing none, thank you very much. Anyone else wish to testify in a neutral capacity on LB376? Seeing none, Senator Cavanaugh, you're welcome to close. As you're

coming up, I would mention that we received four letters as proponent, no opponent, no neutral. In written testimony, we received three written testimonies, all proponent: ACLU; Angelie Willey-- Angela Willey, herself; and Disability Rights Nebraska also submitted written testimony as a proponent. You're welcome to close.

M. CAVANAUGH: Thank you, Chairman Arch and members of the committee. I, I think it's pretty clear that I'm passionate about doing something for our families that have individuals with developmental disabilities. And I appreciate the joint passion that Senator Hansen has with me. This is something that we've talked about quite a bit over our two years serving together. And it's an area where we both align very much that this is-- this should be a priority in the state. And I know that Senator Day is new to this committee and the rest of us have been on it for the past two years together. This would have looked very different if this were two years ago, Senator Day. I'm, I'm grateful to the parents that came today, Sherri and Leah and Kristen, to talk about their family, their experience. It's kind of become a community of families that have come here that we've gotten to know. And if it weren't for the pandemic, we, we would have certainly seen more, more of the faces that we than today. But I am so grateful to those that came and I'm grateful to those who have come in years past and shared their stories with us, because it's important that we remember that these are actual families with beautiful children that deserve every opportunity in life to thrive. Thank you to Director Green for being here today, and I look forward to continuing to work with him and his office on the amendment. I think we have a really great opportunity here to do something. This isn't the answer to the wait-- to the waiting list. I don't know what the answer is, but we, we need to start doing something to help these families and this helps families. And I think that we can find-- if we have the will, we can find the money. I'm going to quote Senator, Senator Anna Wishart, who has said multiple times on the floor that the budget is a moral document and this is a moral imperative and should be part of that budget. So with that, I will take any questions that the committee has.

ARCH: Are there any questions? Seeing none,--

M. CAVANAUGH: Thank you.

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ARCH: --thank you very much. This will close the hearing for LB376. The committee's going to take a ten minute break before opening the next hearing on LB67. We'll, we'll, we'll reconvene about 3:35.

[BREAK]

ARCH: We will now open the hearing for LB67. And Senator Day, you're welcome to open.

DAY: Thank you, Chairman Arch. Good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Jen Day, J-e-n D-a-y, and I represent Legislative District 49, which covers northwestern Sarpy County, including the areas of Gretna, Millard, and western Papillion and La Vista. School-based health centers are an important tool in improving access to healthcare for all students. They limit educational disruption and support academic success. When healthcare is accessed in schools, students benefit because they don't have to leave school to see a physician or therapist or a dentist. Schools benefit because students spend more time in the classroom. Parents benefit because they don't have to take a day off work to take their child to see a healthcare provider. Employers benefit because parents don't have to miss a day of work. School-based health centers are basically like a doctor's office in a school building. They essentially function as satellite clinics of an established healthcare provider intended to meet the healthcare needs of students in a way that is highly accessible. They remove significant barriers that would keep kids from getting the care they need and subsequently keep kids in the classroom for longer periods of time. More specifically, school-based healthcare is a powerful tool for achieving health equity among families who experience disparities in health outcomes. For example, parent-- perhaps a parent works long or unconventional hours and is unable to take a child to see a doctor during regular clinic hours. Perhaps a family lacks dependable transportation and struggles to get to a clinic. The goal of school-based health centers is to make healthcare more accessible for kids and families that may face additional barriers to accessing such care in a timely manner. This bill specifically removes unnecessary restrictions on the provision of healthcare in school-based settings to allow them to function just like any other clinic. By removing these unnecessary laws, we are working to dismantle a system that provides comprehensive healthcare services to those who can afford to

get to an outside clinic while providing a more limited range of healthcare for those who can't. Essentially, as it currently stands, a student who has access to a doctor's office in west Omaha is being provided more comprehensive healthcare than a low-income student who needs to utilize the school-based health center for their medical care. It is my assertion that regardless of zip code, income level, or transportation issues, all children should be able to access comprehensive quality medical care. LB67 seeks to establish just that. At this time, the only Nebraska school-based health centers that exist are in Omaha Public Schools. There are eight school-based health centers, five in elementary schools, one in a middle school, and two and high schools. Excuse me. The sponsoring facilities of these clinics are the local federally qualified health centers, Charles Drew and OneWorld. I want to be clear that this bill only applies to these eight centers, not all school health offices. LB67 seeks to allow these school-based health clinics to function as any other medical clinic subject to existing state and federal laws and regulations like HIPAA and parental consent, for example. It removes unnecessary barriers to the provision of healthcare in school-based settings. With the passage of LB67, school districts in partnership with healthcare providers and parents can determine what kinds of healthcare services are most appropriate to be offered in their own community, as well as when and to whom those healthcare services can be delivered. I've heard concerns about parental consent related to LB67, and as a mother of two myself, I certainly don't want to remove the role that we play in our kids' health services. When the Legislature authorized school-based, school-based health centers in 2013, comprehensive parental consent requirements were placed into the regulatory framework. I'd like to highlight what this looks like in practice, so in the packet of items you have is the Omaha parental consent form that students must bring in order to use a school-based health center. As you can see, parents have to opt-in on a service-by-service basis to allow their child to access services from school-based health centers. As a parent, I support this kind of involvement. And LB67 does not change any of this. Here are some of the limitations in the current statutory framework, framework that LB67 actually seeks to address. Under current law, school-based health centers are limited to only providing care during school hours. For many working parents, this may pose a barrier to engaging with healthcare providers. Additionally, it does not allow for care in more acute situations like

a mental health crisis, for example. School-based health centers are limited by law to only providing health services to children and adolescents. This means they cannot see school staff, their families, and the families of the students. As the clinics build relationships with the students, parents and family members may also be more likely to utilize the clinics for their own healthcare needs. Unfortunately, this is currently prohibited by law. Statute explicitly precludes school-based health centers from being a medical or dental home, but in OPS most students are already connected to the sponsoring facilities as their provider of primary care. Lastly, the current laws are unnecessarily prescriptive as to the type of healthcare services that can be offered, referencing medical health, behavioral and mental health, preventative health, and oral health. The reference list does not include vision services, PT or OT as examples. It is unnecessarily limiting and does not allow the school and sponsoring facility to meet the specific needs of their students and their community. LB67 seeks to remove the unnecessary restrictions that differentiate school-based health centers from other clinics. The passage of LB67 will allow healthcare providers to meet the needs of patients and school districts to meet the needs of their students and their families all while, all while maintaining the primary and important role of parents in meeting the healthcare needs of their children. The testifiers that will come after me are much more well-versed in the technical aspects of these centers, but I'm happy to attempt to answer any questions you may have for me at this time.

ARCH: Thank you. Are there questions for Senator Day? Seeing none, thank you very much. First proponent for LB67. Good afternoon.

ANDREA SKOLKIN: Good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Andrea Skolkin, A-n-d-r-e-a S-k-o-l-k-i-n, and I am the chief executive officer of OneWorld Community Health Centers. And today I'm here on behalf of the Health Center Association of Nebraska, representing the seven federally qualified health centers in Nebraska and pleased to support LB67. We thank Senator Day for introducing this important legislation. Nebraska's health centers care for more than 115,000 patients annually, providing medical, dental, behavioral healthcare, as well as enabling our support services such as transportation, interpretation. And we do this regardless of insurance status or ability to pay. Nearly half of health centers' patients are uninsured and/or

underserved patients, but they do contribute to the cost of their care based on a sliding fee scale. OneWorld Community Health Centers and Charles Drew Health Center operate the eight school-based health centers in partnership with Omaha Public Schools. These school-based health centers serve students and their siblings, providing convenient and safe places to access care. For families who may face barriers to accessing care, school-based health centers are a lifeline and can play a role in ensuring equitable access to healthcare. It's well established that health plays a key role in educational success. Children with access to healthcare perform better in school, have fewer missed days, and are more likely to complete high school. That success in school is directly related to breaking cycles of poverty and closing disparity gaps. The individuals served by our health centers and our school-based health centers face greater obstacles when it comes to accessing healthcare. Lack of adequate transportation or jobs where time off isn't an option, make it very difficult to schedule appointments. Language barriers and lack of health insurance make navigating healthcare daunting. School-based health centers alleviate these burdens bringing healthcare directly to students. Children and youth in our country are facing more stress and anxiety than ever before. COVID-19 has only magnified the mental health needs of our youth. School-based clinics are playing a key role in addressing mental health needs, providing a safe space for students to seek the help they need. Much like each community, health centers are tailored to meet the specific needs of the communities they serve. A school-based health center is responsive to the needs of the school in which they are located. The changes proposed to LB67 reflect current practice, standards of care, and ensure that school-based clinics are optimized to meet the needs of the students they serve. Again, our sincere thanks to Senator Day for introducing this legislation and to each of you for your continued engagement. We welcome the opportunity to work together to continue to innovate how healthcare is delivered to Nebraskans. And thank you again for the opportunity to be here and happy to answer questions.

ARCH: Thank you. Are there questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here. So this would expand it so that families could be treated at the health centers?

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ANDREA SKOLKIN: The concept behind updating the language, the language now is more restrictive, as Senator Day reported, but to allow more access and so that it would depend upon the school district whether or not families could be included.

M. CAVANAUGH: But this would allow them--

ANDREA SKOLKIN: This would allow for that.

M. CAVANAUGH: But it's still up to the school district.

ANDREA SKOLKIN: Yes.

M. CAVANAUGH: Right. OK. And-- yeah, OK. Thank you.

ANDREA SKOLKIN: Um-hum.

ARCH: I have, I have a question. How are the, how are the school-- how are these school centers currently funded?

ANDREA SKOLKIN: Oh, that's a great question, Senator Arch. It is a mix of private funding as well as reimbursed services. For instance, billing Medicaid or third-party insurance in the rare occasion someone might have third-party insurance.

ARCH: OK. Thank you.

ANDREA SKOLKIN: Um-hum.

ARCH: And I would just one, one other question.

ANDREA SKOLKIN: Sure.

ARCH: Staffed by primarily nurse practitioners?

ANDREA SKOLKIN: Yes, correct, that the provider is most often a nurse practitioner and then they have support staff as well.

ARCH: Thank you. Senator Murman.

MURMAN: Thank you, Senator Arch. And thanks for testifying. So the space and the facilities for the, the health center would be provided by the school?

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ANDREA SKOLKIN: Senator Murman, it depends. For us in Omaha Public Schools, they do provide the facilities and the utilities for the schools. Should there be other school-based health centers in other parts of the state, that would be up to the school district. I know in Norfolk that the school district provides space for mental health services.

MURMAN: Thank you.

ARCH: Seeing-- oh, Senator Williams.

WILLIAMS: Thank you, Chairman Arch. And thank you for being here. There's a lot to like about this bill, in my judgment. There's also some issues that are controversial in this bill. On page 2, starting at line 29 is where the elimination of right now is the portion concerning dispensed, prescribed counsel for contraceptive drugs and devices. So that prohibition is taken out. Do you know if there is anything, and I have not been able to spot it, but in the parental consent form, that would allow a parent to opt in or out of that particular dispensing, prescribing, or counseling for contraceptive drugs?

ANDREA SKOLKIN: The-- all the current forms that are used don't specifically talk about reproductive health. And the idea, again, behind this cleanup legislation is to allow a discussion between the school district and the health provider about what services are provided in that school. And certainly we, 100 percent of the time encourage parental involvement in that-- in those kinds of decisions.

WILLIAMS: But we don't know if that would be required.

ANDREA SKOLKIN: An opt out. No, not at this point.

WILLIAMS: At this point.

ANDREA SKOLKIN: That would be a discussion with the school district.

WILLIAMS: Thank you.

ANDREA SKOLKIN: Um-hum.

ARCH: Thank you. Any other questions? Senator Cavanaugh.

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M. CAVANAUGH: Thank you. That actually spurred a question for me. And I'm looking at this, I, I don't see an opt out because it's not allowed right now on the form. I see, like, an opt out of dental and vision, but obviously that's not allowed. But I do have a question about if a young woman is experiencing complications with her menstruation and the medication to help her is prohibited from being prescribed?

ANDREA SKOLKIN: Currently, the school-based health centers are not allowed to prescribe birth control, which often helps with those kinds of symptoms as well as skin issues. I'm not a clinician. I'm sure there's more.

M. CAVANAUGH: So then what, what do those young women do? Do you know?

ANDREA SKOLKIN: Either they go without or they have to make a trip with their parents to another clinic, meaning parent take time off--

M. CAVANAUGH: Wow.

ANDREA SKOLKIN: --and get there.

M. CAVANAUGH: I had a friend in high school who had such severe symptoms that she would black out in staircase. Like, she fell down a staircase. And the only thing that would fix it was for her to go on contraception. She was not sexually active. It had nothing to do with that.

ANDREA SKOLKIN: That, that is true. Birth-- or contraception is used for other purposes besides contraception.

M. CAVANAUGH: That's-- wow. Thank you.

ANDREA SKOLKIN: Um-hum.

ARCH: Other questions? Seeing none, thank you very much for your testimony.

ANDREA SKOLKIN: All right, thank you.

ARCH: Next proponent for LB67. Welcome.

KELSEY WALDRON: Thank you. Thank you, Chairperson Arch, members of committee. My name is Kelsey Waldron, K-e-l-s-e-y W-a-l-d-r-o-n, and I'm the policy associate with the Women's Fund of Omaha. The Women's Fund testifies in full support of LB67 to create a statutory framework for school-based health centers that allow medical providers and school districts to meet the needs of their community. Due to the direct access to students, school-based, school-based health centers can address the health needs of youth and promote, and promote preventative healthcare, all without extended disruption to learning. School-based health centers hold a unique opportunity to provide medical assessments, treatment for chronic and acute illness, prescriptive services, lab testing, vision and hearing screenings, sports physicals, nutrition counseling, safety and education promotion, and insurance enrollment assistance. In reaching otherwise medically underserved students, these centers can decrease school dropout rates among adolescents by reducing hospitalizations, managing illness or injury, and preventing unintended pregnancies that may otherwise pose additional barriers to school attendance. LB67 is intended to reduce barriers in accessing healthcare for students and families. It is intended to level the playing field so that students who seek healthcare in a school-based health center receive the same kind of care as those who receive care elsewhere. There are families who experience barriers to healthcare for a variety of reasons: lack of paid leave, irregular work hours, lack of insurance, lack of dependable transportation, and more. School-based health centers meet family needs where they are at a place where they trust. However, due to current statute that LB67 hopes to amend, we have essentially created a system of tiered healthcare services that create more limited tier of care available at clinics based in schools. It is important to remember that, that school-based health centers are bound by the same laws and rules and standards of practice as any other healthcare clinic in Nebraska with additional unnecessary regulations that would be removed by LB67. These additional laws and regulations potentially limit the care provided to patients in these settings in the following ways: School-based health centers cannot provide primary care related services as the student's medical or dental home. School-based health centers cannot operate outside of school hours. So for a student experiencing mental health crisis during a after school program, they would be denied services from the clinic. Faculty at schools with school-based health centers would also be denied services

as well as any family members if the school district opted to-- wanted to extend services beyond students that currently are not able to. A patient can present at a school-based health center with a positive STI test or request a pregnancy test. And currently under law, a medical professional cannot advise the student on how to avoid sexually transmitted infections in the future or how to avoid-- how to prevent unintended pregnancies. School-based health centers have a unique opportunity to address struggling students and an opportunity to intervene in mental health treatment and care. But current law governing school-based health centers limits providers' ability to meet the mental health needs of their patients to only on site during school hours. Research has shown that the mental health services of school-based health centers are most utilized by students with the greatest level of mental health challenges, such as thoughts of suicide or loss of sleep to depression. Additionally, students with access to school-based health centers receive more mental health service than students attending schools without such a center. The care school-based health centers provide to their patients should be guided by the same laws, rules and regulations and other standards of care that are present at other clinic settings, including parental consent. And this bill would not change that. Current Nebraska law imposes unnecessary regulations on school-based health centers, making it more difficult for centers, centers to respond to the needs of students and limiting the care they can provide. LB7 [SIC] would alleviate this burden and allow medical providers in practice with the school districts to serve patients as they would in other clinic settings. So with that, the Women's Fund urges your support of LB67, and I'd be happy to answer any questions. Thank you.

ARCH: Thank you. Are there any questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here. So we have sitting up here a letter of opposition to this from Planned Parenthood, but also have been receiving emails about this. Is this turning school-based health centers into a Planned Parenthood clinic?

KELSEY WALDRON: No. So thank you for that question, Senator. And to clarify, so you'll see on-- in the bill language on page 3, I believe it begins at line 12, there's a definition of providers that would be eligible to operate in school-based health centers, and Planned Parenthood does not meet that eligibility. So even under LB67, they

still statutorily would not be able to operate and, and meet those qualifications of those, those providers. And then I think it's important to note that, that we really value the healthcare that, that Planned Parenthood provides and view that as an important-- but, but that they do not pertain to this bill specifically.

M. CAVANAUGH: Thank you.

KELSEY WALDRON: And I know that their opposition speaks specifically to the abortion piece, that they-- that the school-based health centers are not allowed to provide or counsel--

M. CAVANAUGH: Right.

KELSEY WALDRON: --on abortion.

M. CAVANAUGH: Yeah.

KELSEY WALDRON: And that remains under LB67.

M. CAVANAUGH: It does. And I just wanted to make that clarification because we-- at least my office has received correspondence about that. And I appreciate you being here to offer that clarification.

ARCH: Other questions? Senator Hansen.

B. HANSEN: Thank you, Chairperson Arch. Mental health services. What does that mean when a, when a health, when a-- when the school-based health center provides mental health services? Does that mean prescribing, like, medication or is it more like talk therapy or--

KELSEY WALDRON: So it could be a whole host of services, and that would be up to the school district, as well as the healthcare providers in the clinic to determine and, and limited to the types of practitioners within those services. They would determine what services they're providing. But that could extend to talk therapy, that could extend to prescription services.

B. HANSEN: Like, they wouldn't be doing it themselves, but they would refer to somebody who would do that, probably.

KELSEY WALDRON: So it, yeah, it depends. I would say that, you know, if most of them are currently staffed by nurse practitioners, that would often result in referral, I would guess. But, but that would be up to the, the school and the practitioners to, to kind of determine how they would do that.

B. HANSEN: OK, that's what I was wondering, like, who, who exactly is in the school-based health centers, medical doctors and nurse practitioner. Like, typically, there's a nurse practitioner.

KELSEY WALDRON: Sure. Yeah. And, and so we heard from the previous testifier at OneWorld that currently the, the practitioners are registered nurses.

B. HANSEN: OK.

KELSEY WALDRON: And so--

B. HANSEN: Well, that's my fault, I, I was out--

KELSEY WALDRON: Oh, no that's--

B. HANSEN: --that's my fault. So it's-- I'm sorry for being redundant. And so do we know if nurse practitioners can prescribe, like you mentioned here about mental health needs of students and depression, thoughts of suicide, are they able-- I don't think they are, are they able to prescribe like, kind of like antipsychotics or antidepressants at all?

KELSEY WALDRON: Yes, it's my, my understanding--

B. HANSEN: They are. OK.

KELSEY WALDRON: --that they are.

B. HANSEN: OK. Just wondered. Thanks.

ARCH: Other questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. I don't-- I'm not sure if you'll know the answer to this or not, but do you know what currently happens in, in the type of instance that I was discussing previously about having

complications with menstruation? Do they prefer if they can't prescribe contraceptions to help with that?

KELSEY WALDRON: So, no, under current statute, the medical providers are prohibited from even referencing contraceptives and as well as referring too. So they would not be able to under this scenario that you're describing, they would be statutorily bound to remaining silent on that currently.

M. CAVANAUGH: So if you're having migraines and blacking out from menstruation, they aren't allowed to even counsel you on how you can go about addressing that?

KELSEY WALDRON: That's correct. Yeah. And I referenced earlier, but currently, so they can provide STI testing, sexually transmitted infection testing. They could have a student come in, request that testing, test positive to sexually transmitted infections. Currently, they can treat the STI, but they cannot cancel because of the prohibition currently that LB67 hopes to remove. They can't counsel a, a student on how to prevent sexually transmitted infections in the future. So they could continue to see that same student for, for STI testing and never be able to refer them or counsel them on how to prevent that in the future.

M. CAVANAUGH: So frankly, I'm shocked that we haven't been sued. I can't imagine that you can't tell a young woman how to stop a severe medical condition. Wow. OK, thank you.

KELSEY WALDRON: Um-hum.

ARCH: Senator Hansen.

B. HANSEN: I going to piggyback off what she-- I don't need to be hammering a whole bunch of stuff here. But I'm assuming if somebody is coming in with, like, a hormonal issue, they can say, look, this may be a hormonal issue. We have to refer you to a medical doctor outside of the clinic to address some of the issues. I mean, they can't say, I can't give you a, you know, a contraceptive that might help with, you know, your hormonal imbalance. But they can still-- it's like they can't say, well, I don't know what it is. I'm assuming. Right? They can still at least address hormonal issues. And there may be some

treatment out there, which could include a type of medication, but they don't say contraceptive, you know, and so then they can refer them out to get that kind of treatment. Right?

KELSEY WALDRON: So currently, so they could refer to other medical providers, they could not do so specifically in the context of saying that they're referring for contraception--

B. HANSEN: Yes.

KELSEY WALDRON: --or discuss it in that, in that type of way. I think that really what we're hoping to do here with this bill is address that equity issue for students who may not have access to a healthcare provider outside of the school-based center and for families, particularly low-income families, that have significant barriers to accessing that, trying to remove that current step of referral and allow for services to be provided on campus the same way that they would be at, at a pediatrician, for example. So under all of the same rules and regulations, but allowing that to happen at these school-based health centers.

B. HANSEN: If they were lower income, they'd probably, they'd probably be eligible for Medicaid at some point so they could be referred to the appropriate practitioner where they would have coverage under Medicaid, probably. Wouldn't they?

KELSEY WALDRON: Potentially. I think it's also important to note that, like, there are a whole host of reasons why someone may have barriers to healthcare. So, yes, Medicaid insurance could be one of them and some of those families may be eligible for Medicaid. I also think really tangible barriers is what this bill is hoping to address. So, for example, seven in ten low-income parents will, will lack access to paid sick time or time away from work in order to take their child to a medical provider during, during normal workday hours. And so for those families, they're often forced to forego medical care or delay medical treatment. I think we see about 2.5 times more likely for-- it's about 2.5 times more likely for a parent to bring their child to an ER when they lack access to paid sick and safe time for basic medical concerns that could be addressed through a primary care because of those problems of taking time off work during the normal workday. So that's kind of part of the issue that this bill--

B. HANSEN: That makes sense that you're, that you're trying to put into context this bill that they would have better access here--

KELSEY WALDRON: Um-hum.

B. HANSEN: --as opposed to going somewhere else.

KELSEY WALDRON: Exactly, yes, Senator.

B. HANSEN: OK. All right. Thanks.

KELSEY WALDRON: Yeah, thank you.

ARCH: I have a question and I-- I'm, I'm trying to recall the discussion when these-- when the healthcare in school clinics were established. I remember one of the, one of the discussions was this is going to be so much better because it reduces absenteeism. It, it, it provides, it provides care in there, which, which indicates to me episodic care, acute care, viral infection, bacterial, something Amoxicillin here, take this ten days, keeps the child in school and, and keeps that. This, this concept seems to be moving these health clinics into more of a medical home, into more of, more of broader primary care for, for a more comprehensive care, I guess, is what I'm saying versus, versus what was originally considered as an episodic care. Would, would you agree with that statement?

KELSEY WALDRON: So I think that-- and I, I appreciate that. I think that this bill is an intent to kind of respond to some of the tangible barriers to access that we're currently seeing. And I believe that it's still within the original intent of school-based health centers in the federal statute to expand these beyond. I would note that in the-- in our current statute-- state statute, some of these restrictions were created at a time when I would say that the school-based health center statute in Nebraska was created in order to ensure medical-- Medicaid reimbursement. And so when it was-- when the Affordable Care Act was passed at the federal level, including more prescribed definitions and requirements of these school-based health centers, it was a response to that. And during that time, we included multiple other restrictions on school-based health centers that were not required federally and were not required in other states. And so this bill is really attempting to strip out some of those additional

requirements that we had that went beyond other states and, and the federal regulations.

ARCH: All right. Thank you. That's helpful.

KELSEY WALDRON: Yeah. Thank you.

ARCH: Seeing no other questions, thank you for your testimony.

KELSEY WALDRON: Great. Thank you.

ARCH: Is there another proponent for LB67? Seeing none, are there opponents that would like to speak?

AMBER PARKER: Hi, my name is Amber, A-m-b-e-r, last name Parker, P-a-r-k-e-r. Wow, I have to tell you, it's kind of like deja vu, Senator Day. I don't know how long you've been here. I understand you're a new senator, but Senator Howard introduced similar legislation. But what she wanted to strike from the record was-- here, I'm just going to go to your bill a little bit here. Oh, that's right. I have a different bill pulled up, so my time's a ticking here, but it was to open the door to allow our health clinics in these schools to be able to do abortions. And she really couldn't answer why she wanted to strike that language. So, you know, I got to tell you, as a second house, we the people, you really craftily worked this legislation in what you drafted. So I'm here to expose truth. First of all, correct me if I'm wrong, but the learning community receives about a few million dollars a couple sessions ago. I've lost track of years from the Buffett Early Childhood Institute. Correct me if I'm wrong, Women's Fund, do, do they have connections to Susie Buffett? Buffett family, I don't know, money. About a billion dollars towards abortion. And I'm going to set the record straight. Omaha Public Schools, Karen Spencer may ring a bell, a bell. Excuse me. But she was one who was trying to impose sexual orientation, gender identity, and Planned Parenthood-- I don't even want to call it sexual education curriculum. Quite frankly, I was so embarrassed what I had to look at. So I'm just going to expose this because I believe there's a lot of deceit in here. And one, what's really interesting is you want to strike out the language is contraception. So many times a ticking. Here we go. I was on birth control. Senator Cavanaugh, you talk about being sued. Well, you know what, if I would of continued just being fed birth control,

something in my body could have exploded because what someone wouldn't have seen from the surface other than hearing of pain and debilitating pain. And I, I went to emergency rooms. I have quite a history. So I-- you're looking at a woman. You're, you're talking secondhand. You're looking at a woman who's firsthand experienced. I got doctors' reports to prove it. What I'm going to tell you is if you go forward, and Senator Day, let's just be real. You want to open the door. Planned Parenthood is already working with these OneWorld health community. We can get in these areas of terminology wars. You just hop in, Cavanaugh, and correct me if I'm wrong saying Planned Parenthood is against this legislation. Well planned, bravo. You know, we just need to speak truth here. And the truth is parental rights. And as a parent, Senator Day, you should know that parental rights should be expected. OneWorld health organization should know. The schools-- these children do not belong to the schools. They do not belong to the health clinics. And I am one sitting before you that if someone would have just handed me birth control, I wouldn't be here because something in my body exploded because scar tissue wrapped around it. See, my junior year in high school, I was hit by a drunk driver. I had a gastric rupture. So when I was about five and a half, six years old, I had a ruptured appendix and then an abscess. So I had quite a bit of surgeries and I could suspect that that scar tissue had happened. But as a woman in those female areas, absolutely. But let's be real. Birth control has effects. If, if the right amount of hormones are not given to a woman, we could be talking cancer. The last thing we need is our schools to try to become health clinics, cutting off the parents, giving them all parental authority. That's a nanny state mentality. Let's be real. Planned Parenthood is involved. I am not going to be silent and saying this, Planned Parenthood has disrespected parents, opt in or opt out position. In the Omaha Public Schools, I witnessed them lie to us. And I talked to a lady firsthand who said, oh, no, Planned Parenthood was always involved. So I'm telling you, it's interesting to me, Senator Day, the way and the deception of what you wrote your bill, you talk about accessibility, but what it really is, is accessibility to contraception and Planned Parenthood. And I refuse as a citizen of the state to remain quiet and allow this deception to take place. I have connections across this nation. Nebraska is being exposed. I will not remain silent. These children belong to their parents. Good parents love their children. And virtuous living is going to protect from STDs and STIs. But you guys are working together

with groups that just want to push fornication, masturbation to young, young children. I had to listen to those songs.

ARCH: I'm sorry, the, the red light house has, has turned on. I, I will leave time if there are any--

AMBER PARKER: Thank you.

ARCH: --questions for the senator-- from the senators. Seeing none, thank you very much for your testimony.

AMBER PARKER: Thank you.

ARCH: Next person, next individual in opposition. Good afternoon.

MARION MINER: Good afternoon. Excuse me. Good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Marion Miner, M-a-r-i-o-n M-i-n-e-r, and I'm here on behalf of the Nebraska Catholic Conference, which advocates for the public policy interests of the Catholic Church and advances the gospel of life by engaging, educating, and empowering public officials, Catholic laity, and the general public. And I'm here today to express the Conference's opposition to LB67. So LB67 would amend portions of the Medical Assistance Act dealing with school-based health centers, which are institutions created by the Legislature to extend some of the broadly agreed upon benefits of Medicaid into schools. Among other things, LB67 would strike from state law the provision that school-based health centers cannot be prescribers, dispensers, or counselors for contraception. The Church has been consistently opposed to contraception since the first century. Famously, the Church reiterated its position in 1968 with the encyclical Humanae Vitae by Pope Paul the VI, among other things, because of its social costs, including the encouragement of sexual exploitation of women by men, the temptation of men to make women objects of pleasure rather than equal partners, the fact that it undermines marriage, and the fact that men and women withhold the most intimate thing from each other in what is supposed to be a unitive act in the act of using contraception. So when it comes to the practical consequences, though, of LB67, as related to school-based health centers, there are at least three notable consequences. First, it would allow school-based health centers to counsel for, prescribe, and/or dispense contraception to children at

school. Second, because it must be read in tandem with the rest of the MAA, it would require that these Medicaid reimbursed contraceptives be advertised to school children at the beginning of each year. And you can find the citation there in Chapter 68-913(1). A third and most importantly, because of overlapping federal law related to Title X. And this is what I really want to draw attention to. School-based health centers in Nebraska would be allowed to offer contraception services to children without informing parents or obtaining their consent. Most of Nebraska's, as we've heard actually today, all of Nebraska's school-based health centers are also Title X providers. Where Title X providers offer contraception services, they are required by federal law to do so without regard to age, including to adolescent children and confidentially. In other words, without notifying parents unless written consent is given by the child. So when we're, when we're imagining the scenario in which this might play out, you can imagine a scenario whereby the school-based health center sends home a form to parents to say, do you want to opt in or opt out of the care that we might provide at the SBHC and the parent may say yes or no. Now, if it's not-- if contraception isn't listed on there, they may not know what they're opting in or out of first of all. And second of all, even if they do know because contraception is listed, right, it's still once they opt in and that service becomes available to children at school, the rule, the federal regs, according to Title X say when it comes to the provision of contraception or the prescription of contraception or counseling and referral in individual circumstances, the child, him or herself, has control over whether the parent ever finds out about it. So if the child does not sign off and consent, the parent never finds out. Those are the rules of Title X. And that's why I think it's very important to point out that when asked, Miss Skolkin said that they always encourage family involvement. They always encourage parental involvement. That's also required by Title X. But Title X makes very clear that the confidentiality requirement is ironclad, meaning parents do not find out in individual circumstances unless the child signs off. So once you allow these services to come into the schools, right, in individual cases, parents do not find out. I'm, I'm running out of time, so I'll, I'll, I'll note that state and local governments have tried to fight that federal requirement with parental consent laws for years. And they have lost in court each time, including in the Eighth Circuit over which-- under which Nebraska sits. I also have a great

number of studies that I've referenced in a fairly long paragraph towards the end of my testimony regarding findings about the ineffectiveness of these programs to achieve their stated goals. But I believe I'm out of time, out of time, so.

ARCH: You can, you can wrap up your comments.

MARION MINER: Yeah. So I'll, I'll stop there and I'll be happy to take any questions.

ARCH: Thank you. Are there questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. It's nice to see you, Mr. Miner. If the language that is struck-- if you happen to have a copy of it with you.

MARION MINER: The bill?

M. CAVANAUGH: Yeah.

MARION MINER: I should, but I don't think I do.

M. CAVANAUGH: That's OK. I, I just was going to reference it for you. So if, if the language that is struck about the contraceptions was not struck, do you have problems with the other parts of the bill? Because it, it-- it's-- really looks like it's trying to expand access to healthcare.

MARION MINER: Sure. I think that's something that we would definitely be open to listening to. We don't have a position on the rest of it.

M. CAVANAUGH: OK, so like the-- they can only provide services during school hours is striked--

MARION MINER: Right.

M. CAVANAUGH: --so that they can provide services outside of school.

MARION MINER: Right. I don't believe we have-- you know, we, we don't know, we don't know sort of what the pros and cons of that are on the ground. But, but we certainly don't have any position against it.

M. CAVANAUGH: OK.

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MARION MINER: And if, and if folks would like to bring us into the conversation to see if, if they can garner support for it, we'd be happy to have those conversations.

M. CAVANAUGH: I, I am just curious about some of the other, because you're only speaking to us a very specific point.

MARION MINER: Right.

M. CAVANAUGH: So I wanted to see about the other points in the bill about how those aligned with your position.

MARION MINER: Sure.

M. CAVANAUGH: So thank you.

MARION MINER: Yeah, thank you.

ARCH: Other questions? Senator Hansen.

B. HANSEN: I could probably ask Senator Day about this, too, but Senator Cavanaugh kind of made me think of something so if-- so are-- and what you-- and with your testimony.

MARION MINER: Sure.

B. HANSEN: So if a-- if the nurse practitioner prescribes an antidepressant to the child, they wouldn't have to tell their parent they're on it?

MARION MINER: I'm, I'm not sure about that. I don't want to make any representations about that.

B. HANSEN: That's what I was trying to figure out, like, the--

MARION MINER: So--

B. HANSEN: --when you're, when you're talking about, like, prescribe a contraceptive, don't tell the parent, whatever.

MARION MINER: Right.

B. HANSEN: Would that also go to other kinds of treatment [INAUDIBLE]?

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MARION MINER: So I, I don't, I don't know. This is specific to Title X.

B. HANSEN: OK.

MARION MINER: Title X is specific to family planning. So I don't believe that there would actually be that situation occurring in--

B. HANSEN: That's probably separate then. OK.

MARION MINER: Under that circumstance. Yeah.

B. HANSEN: All right. Thanks.

ARCH: Other questions? Senator Murman.

MURMAN: Thank you, Senator Arch. And you may have just answered my question, but on page 2, I know you don't have the bill available, but language is struck concerning dispensing, prescribing, and counseling for contraceptive drugs or devices. And then ahead of that on line 23, page 2, it adds language "Does not perform abortion services or refer or counsel for abortion services." So you're saying, according to Title X federal law, the part that's struck on the bottom of page 2 would not apply because federal law would overrule state law?

MARION MINER: I'm sorry, what, what-- the, the part on the bottom of page 2. I'm sorry, I should have a copy with me, but I don't.

MURMAN: OK, on the bottom, on the bottom of page 2, it says-- the language is struck that it "Does not perform abortion services or refer or counsel for abortion services and does not dispense, prescribe, or counsel for contraceptive drugs or devices."

MARION MINER: And then I think it add-- it adds the-- it adds, adds the prohibition on abortion provision back in, I think. And, and--

MURMAN: Yeah.

MARION MINER: --and-- yeah, that's my understanding. So, so what, what I'm, what I'm-- the point I'm trying to make is that when you allow for contraception services, whether, whether that's going to be dispensing them or whether it's prescribing them or simply counseling

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and referring them. When you allow for that to happen in the context of a school-based health center, if that entity, if that school-based health center is a Title X clinic, is a Title X provider, and the school-based health centers in Nebraska are Title X providers, there are certain rules that they have to abide by, they-- federal rules, and they trump whatever state rules might be in effect or local, for example, if the local school district wants to, to make rules about parental consent. When it comes to individual provision of services, when the child receives these services from a Title X clinic, federal law says you cannot tell the parents unless the child signs off on it in a written consent. That-- that's, that's what I'm trying to get, to get across.

MURMAN: OK, you answered my question perfectly.

MARION MINER: OK, good, thank you.

ARCH: Other questions? Senator Cavanaugh.

M. CAVANAUGH: Sorry, one more. I-- I'm confused about the Title X, and I know you have it in here, but this isn't-- is this turning this into Title X funding?

MARION MINER: No. So, so it's-- so Title X providers in Nebraska just happened to also be the, the people who run the school-based health centers. So the fact that they are sort of partnering with the schools to run the school-based health centers doesn't change the fact that they are still Title X providers. And as Title X providers, they have to abide by certain rules. And that-- that's what I was getting at.

M. CAVANAUGH: OK, thank you.

MARION MINER: Um-hum.

ARCH: Other questions? Seeing none, thank you very much for your testimony.

MARION MINER: Thank you.

ARCH: Next opponent for LB67. Seeing none, is there anyone who'd like to testify in a neutral capacity? Seeing none, Senator Day, you're welcome to close. As you come up, I would mention that we received

letters in opposition. We received 42 letters in opposition, no proponents, and no neutral. And we received two written testimonies this morning, one from the Nebraska Family Alliance, one from Planned Parenthood North Central States, both in opposition. You may close.

DAY: OK. So, again, 42 letters of opposition. I'm sure that we've all had our email inboxes flooded with opposition to this solely based on the contraception piece, and I have spent the last two days replying to emails about what this bill does and what it does not do because it-- unfortunately, I, I don't want to say deliberately people have been deliberately misled, I, I think maybe misunder-- misunderstanding what the bill does and at best and maybe deliberately misleading people about what this bill does. There is certainly no hidden agenda here. I, I mean, I think we all know that. I think it's unfortunate that this has to come down to solely the contraceptive piece. I think it's also important to recognize that these clinics are supposed to function just like a regular doctor's office. And that's what we're trying to do here. Like Miss Waldron said from the Women's Fund, what we've essentially done is we've created two tiers of care. And I mentioned this in my intro. If I live in west Omaha and I take my kids to a pediatrician, you know, in Village Pointe, I had a-- access to a different level of care than students who utilize these school-based health clinics as their primary care providers. And many of these students do because it's their only option. And so I-- that's what we're trying to rectify here is the fact that we've created two, two different tiers of care based on income and then based on whether or not you have access, transportation and those types of things to a, to a medical care provider outside of the school. If you don't, then you're kind of just the child. Remember, these are kids. The kids are essentially out of luck. And so, again, I think it's unfortunate that this has to come down to the piece about contraception. I will also mention that the age of majority in Nebraska is 19. The only exception to that when it comes to medical care is mental health services and the age is 18. So we're not-- this bill does not change parental consent in any way. And to reference what Mr Miner was saying about Title X, it-- it's confusing in that, because if it was true and the, the federal supremacy of Title X that supersedes state law, if that was true, then these centers could provide these services already. Right? And so it's kind of a misleading argument about what's going on here. And I, I, I think at the, the-- you know, we added the abortion

piece back into it because it was important to us to make sure that people knew that this is not what we're trying to do here. Realistically, if we genuinely-- I mean, I think the majority of the people on this committee would consider themselves to be pro-life. And if we genuinely want to consider ourselves pro-life, we have to understand the peace and the role that contraceptives play in preventing abortions, because we know through a, a, a wide variety of research that contraceptives are effective in preventing teen pregnancy and they are also effective in preventing sexually transmitted diseases. We know that at various points in the last few years, Douglas County, where all of these centers are at various points in the last few years, Douglas County has been the highest in the country for rates of sexually transmitted diseases. There is a real need for access to contraceptives. Whether we want to talk about that or not, I-- it's frustrating to me that, you know, again, I'm a Catholic woman by choice. I became Catholic as an adult. It was a choice that I made for myself. And, and I think that it's fine if the Church wants to oppose the use of contraceptives. But I'm not sure that school-based health centers is the right place for them to be imposing that belief system. So I think that's, that's it for me. If you guys have any questions, I'm happy to answer them.

ARCH: Are there any questions for Senator Day? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Senator Day. I-- yeah, the Title X thing kind of threw me off--

DAY: Right.

M. CAVANAUGH: --because I have two daughters and they're young, seven and five. And I would never, ever, ever want them to be getting access to contraception without me knowing it.

DAY: Right.

M. CAVANAUGH: That is-- like, that would be bad in my mind as a parent, as a mother, as a mother of daughters. I mean, I have a son as well. And I, I also wouldn't want him having access to contraception either without me knowing about it.

DAY: Right.

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M. CAVANAUGH: But for my girls, like, wow, that would be problematic, but--

DAY: Right.

M. CAVANAUGH: --if these are Title X providers already and they're not doing this because of the statute, then I don't, I don't know that that, that that would change,--

DAY: Right.

M. CAVANAUGH: --because they still aren't allowed to perform abortions or counsel for abortion services. And so I think that that's something that we probably will have to get a, a firm answer on. But I appreciate so much that you brought this bill because increasing access outside of the school hours and for families is just such a great thing. And so thank you.

DAY: Yep, thank you. And I think any parent would be cautious. Again, I'm a mother of two. Any parent would be cautious about providing their child with unfettered access to contraceptives without their consent. I think we have to make it clear that is not what this bill does and it's not what this bill is about. Ultimately, it is up to the district and the providers on how they would-- if, if we were to pass this bill, how they would handle that contraceptive piece, if that would include putting that on that list. The, the consent form that we passed around, obviously, like we said, it's not already on there because these services do not apply to these centers currently as it stands. Whether or not that would happen, I'm, I'm not sure. But--

ARCH: Any of the questions? Senator Hansen.

B. HANSEN: I've got a couple of questions. Something you kind of mentioned brought up a question about, you said you went to a, a different clinic outside of a school and you noticed there was a different level of care--

DAY: Correct.

B. HANSEN: --as opposed to a school.

DAY: Right.

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B. HANSEN: Do you think they should be the same?

DAY: I think that-- yes. I think that if a student-- if my kid can have access to comprehensive healthcare in a, in a, in a doctor's clinic, right, I know that I can take them there or when they're 16, they can drive themselves there and get healthcare. However that, however that best meets their needs, depending on what the, the doctor or the provider thinks. But there's a student who goes to school at King Science who use that school-based health center and they can't get that same level of care. That's a really big problem, I think. So, yes, I do think that they should be.

B. HANSEN: OK.

DAY: Yep.

B. HANSEN: And I think that's kind of maybe where we differ a little bit because I think when we're talking about a private clinic versus a clinic instead of a school, I think then we're talking about two different things because then we have taxpayer money and it's a tax-run institution.

DAY: Well, I will--

B. HANSEN: I mean, I think that-- I think that's where we maybe have a say as a Legislature to determine what we want in there and we don't want in there.

DAY: Sure, but it would be the same as if I were-- so I don't have health insurance. I utilize the OneWorld Health Center. Right? And I don't think that if I were to take my children there at that center versus a student who's utilizing the centers, again at King Science or wherever that might be, I don't see why, simply because the student doesn't have an available parent to take them outside of school or whatever that might be-- you know, transportation issues like Miss Waldron had mentioned earlier, I don't see why one center can provide a more comprehensive level of care and the other one cannot, right?

B. HANSEN: OK.

DAY: Yeah. I mean, I understand that, that it involves taxpayer dollars, but it doesn't make sense to me that simply because someone

is low income, that they shouldn't be provided quality healthcare, because essentially we know that that improves health outcomes for people. Right? So in the long run, we talk about saving money if we're preventing those pregnancies or if we're, we're treating things earlier.

B. HANSEN: OK. I, I got one, one other question.

DAY: Sure.

B. HANSEN: And it's probably just a ridiculous question, but it is about prescribed medications. Do you know, like, so if-- like, so if somebody had to prescribe medication to a student that the parent would still have to sign off on that?

DAY: I'm not sure.

B. HANSEN: OK, because--

DAY: So that would be-- I, I think Miss Skolkin could answer that question,--

B. HANSEN: I, I might ask it. Yeah.

DAY: --and, and I can get, I can get those answers for you.

B. HANSEN: Yeah, it's not a huge deal, just--

DAY: Sure. Yeah.

B. HANSEN: --kind of curious off the top of my head, so.

DAY: Well, before-- we can talk about it later.

B. HANSEN: Thank you.

DAY: Yep.

B. HANSEN: Appreciate it.

DAY: Um-hum.

ARCH: Any other questions? Seeing none, thank you very much.

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DAY: Thank you.

ARCH: This will close the hearing for LB67, and the hearings for the committee for the day.