ARCH: Good afternoon. 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 Day.

DAY: Senator Jen Day. I represent Legislative District 49, which is north-central Sarpy County, including the areas of Chalco, Gretna, and western Papillion-La Vista.

MURMAN: Senator Dave Murman from District 38, most of eight counties along the Kansas border in the middle part of the state.

WALZ: Lynne Walz. I represent Legislative District 15, which is all Dodge County and now part of Valley.

WILLIAMS: Matt Williams from Gothenburg, Legislative District 36.

ARCH: Also assisting the committee is one of the legal counsels, T.J. O'Neill, our committee clerk, Geri Williams, and our committee pages, Aleks and Rolf. A few notes about our policies and procedures. First, please turn off or silence your cell phones. This afternoon, we'll be hearing three bills. 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. Hand it to one of the pages when you come up to testify and this will help us keep an accurate record of the hearing. 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. 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. We will ask you to wrap up your final thoughts. If you wish to appear on the committee statement as having a position on one of the bills before us today, you must testify. If you simply want to be part of the official record of the hearing, you may submit written comments for the record online via the Chamber Viewer page for each

bill. Those comments must be submitted prior to noon on the work day before the hearing in order to be included in the official record, but 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. With that, we will begin today's hearing with LB976 and welcome Senator Wishart.

WISHART: Well, good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Anna Wishart, A-n-n-a W-i-s-h-a-r-t, and I represent the 27th Legislative District, which includes west Lincoln and parts of southwestern Lancaster County. I'm here today to introduce LB976, which enables the implementation of a game-changing delivery model for behavioral health services in Nebraska, known as the Certified Community Behavioral Health Clinic Act. Are you all able to hear me all right? OK. Over my years in the Legislature and my time on the Appropriations Committee, I have witnessed the struggle of those in need of access to mental health and substance use treatment care and the struggles of the providers that deliver those care. In fact, Senator Walz and I had the opportunity to tour around the state looking at long-term care for people with mental health needs and we saw the huge lack of adequate services for people in this state. The Legislature absolutely needs to step up in funding a system that has always been underfunded, building more capacity in our current system, especially in rural areas, and expanding the behavioral health workforce. The Division of Behavioral Health conducted a rate study in 2016, showing rates between 15 to 40 percent under the actual cost of providing services. That's what our providers have to contend with and yet they continue to deliver services to Nebraskans. That was the status of rates over five years ago and as you can imagine, as we've had budget cuts in the past when we came in with a significant revenue shortfall, that these providers are still contending with this disparity in terms of what they provide for services and the rates that we provide in our state. And then you add the pandemic on top of that and you can imagine what they're dealing with and what the people of-- Nebraskans are dealing with in terms of mental and behavioral health. The model in LB976 isn't new to this country. In 2017, this model was organized as a Medicaid demonstration project that included eight states in the federal Substance Abuse and Mental Health Services Administration. And they provided and continue to support the initial startup of these grants for facilities around the country during this pilot. Currently, there are actually now 430 CCBHCs in the United States across 42 states. The CCBHC model requires outpatient mental health and substance use treatment services, as well

as primary care coordination, including monitoring of key health indicators and risk-- and health risks, crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention and stabilization, screening assessment and diagnosis, including risk management, psychiatric rehabilitation, peer and family supports, and housing. And the way it's been described to me is it's a holistic rate of support for somebody who comes in and in particular in a crisis situation where they're, they're having an addiction issue, mental illness, they're out of corrections and needing to get certain services to fulfill their probation. It's a holistic support that allows the provider-- instead of having to bill administratively for every single type of service, it allows them to provide individualized care for that person that helps them get back on their feet and rejoin society in a way where they can live as independently as possible; have a family, have a career, give back to their community. For me, the most exciting part of the CCBHC model is working with community partners and law enforcement and in our school. When my husband was a police officer in Lincoln four or five years, he would oftentimes come home and talk about the fact that somebody who had a mental breakdown would be released from a hospital and would be called. He would be called to go and help that person find where they were needing to stay because there was nowhere for them to go. I mean, that's what law enforcement is dealing with right now. They're the front lines of mental health supports. And what's amazing about this model is it integrates them in our schools with these providers. So there is that sort of connectivity in providing a whole service for somebody. In addition, I know the chief of police of Lincoln, I briefed her on this. She's in Judiciary Committee hearing today, so she couldn't be here, but they will be sending a letter of support and they do support this. We have a leader from Missouri actually with us today-- he came here-- that is going to talk to you about how they've implemented this program and the savings that they've experienced by doing so. And then we also have representatives from two clinics in Nebraska; one that's already implemented this model so they'll be able to share with you how it has worked and then another in central Nebraska that plans to apply. To allow clinics in Nebraska to continue to provide these services and save our resources in other areas of government, LB976 establishes the financial foundation to expand access to care and improve coordination with community partners by requiring the state of Nebraska to file a state plan amendment to draw down additional Medicaid dollars for providers in the system to deliver this array of services. Colleagues, now is the time to invest in a modest increase in Medicaid matching dollars because this new delivery model has

really proven to be very effective and it will save in the long run for government entities across the country. And in particular, we are going to be talking about criminal justice reform. And one of the key items that has come up when I talk to any person from those who support the CJI work that's going on and those who have concerns with it is we can all share an understanding of needing to support mental health services. And so these are the type-- this is the type of bill-- and I've talked to Chairman Lathrop about it-- the type of bill that allows our state to build out the capacity and support system for people who are coming out of our criminal justice system or people who are in alternatives to correction, where judges and prosecutors need to have a place for them to get the necessary services for that person to lead a life of sobriety, for example. So these are the type of systems that work. So I'm really excited for you to hear from, from others. We did have a chance to talk with the Department of Health and Human Services yesterday. It was a very productive conversation. I do not believe they're coming in in opposition to this, but they do have some really good suggestions to improve the bill. We're going to expand the definition of mental health and substance use treatment center so that as many clinics as possible can apply and then also they discuss the timeline of implementation with me and that needs some tweaking. They, they, they convinced me, realistically, that this is going to take time to implement and so I'm definitely open to listening to them on that and working with them on that. So we'll provide an amendment to you and I'd be happy to answer any questions. And I have another thing I have to go to, but I will be-- try to be back for closing.

ARCH: Other questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and thank you, Senator. I think we've all, especially in this committee, heard lots of testimony on behavioral health and what we need to do. My question for you, but maybe more for those that would follow if they could address, we have a lacking of providers in this area. We have more, more of a lacking of providers in rural areas than we do in our urban areas. Does this model work and can it work well in our rural areas of the state also?

WISHART: Absolutely, it does. And the gentleman who is going to speak about Missouri will be able to speak to that as well. And, you know, I look at this issue from the appropriations side almost exclusively. I rarely come in in Health and Human Services because I understand the complexities of the issues you're dealing with and as a senator that doesn't sit on this committee, it can be intimidating. But the reality

is from the appropriations side, a lot of it has to do with just basic numbers. If we are asking people to provide a service where they cannot cover the cost of that service with what we are providing in terms of rates, then we will continue to see closures and, and restrictions of what services providers can provide. What's great about this is it, it provides a rate that allows those providers to have the flexibility to do holistic support for that person. And you'll see the, the benefits have reduced recidivism and a lot of other things that come from this type of holistic approach.

ARCH: OK. Other questions? Seeing none, thank you.

WISHART: Thank you.

ARCH: First proponent for LB976. The page will distribute those.

BRENT McGINTY: Good afternoon, Mr. Chairman, members of committee. My name is Brent McGinty, B-r-e-n-t M-c-G-i-n-t-y, and I'm the president/CEO of the Missouri Behavioral Health Council, which represents Missouri's behavioral health safety net providers, and I'm here to testify in support of LB976. As way of introduction, I spent nine years in the Missouri Senate working on appropriations, five years at the state department of mental health, and now nine years in my role with the council. As was mentioned earlier, Missouri was one of the original eight demonstration states for the Excellence in Mental Health Act that codified in federal law the Certified Community Behavioral Health Clinic model and we've been at it since state fiscal year '18. In all my years at the Missouri Senate, every lobbyist and every state department person said, if you spend money here, you're going to save money or earn more money elsewhere. I heard that all the time. I'm here to tell you this is true for this program. Missouri Senior-- Senator-- U.S. Senator Roy Blunt likes to say when he talks about this model-- he's a big advocate-- it's both morally and fiscally the right thing to do. Nobody wins, not the patients, families, or taxpayers when law enforcement and emergency rooms are the front line of mental healthcare in this country. So a few things about it that I've seen in-- firsthand in Missouri the past four years: it's a data-driven model. It has over 30 quality measures that are tracked by the state. Some of them are claims, some are out of EMRs, but things like hospital follow-ups, suicide screening, med adherence, getting initiation of SUD treatment. And there is a payment for quality and a lot of fee-for-service model is just volume based. This gets us starting to move away from that kind of model, which is very important. Expanded access to care. Just a little-- few features,

points on that infographic there: 23 percent increase in patient access to care, over 100 percent increase in medication-assisted treatment, 19 percent increase in services to veterans. And why is that? Well, it was made possible by some requirements of the law, so same-day access to care. It's not an appointment-driven model anymore. But a key one, like it was mentioned about rural, is workforce. You know, you're able to build into the cost report the cost of care. So our-- we've not been competitive in the behavioral health marketplace for community-based providers for a long, long time and this model has kind of changed that and let us be competitive. Just in the first year of the demonstration, just a few things that are not on there, our system was able to hire 29 new child and adult psychiatrists, over 160 new licensed clinicians, 14 new addiction professionals, and 64 new peer and family support specialists. Those are like 30 to 80 percent increases in our system among the participating providers. I'm also proud to say by the end of this fiscal year, our entire system will be shifted to the model that will be from 15 agencies with over 200 clinics to 22 agencies with almost 250 clinics across Missouri. So this will be the new standard of care across the entire state. Another key feature that was mentioned is law enforcement. This model really mandated that-- it allows the state to put in what is missing. So our liaison to law enforcement with the connect-- the connective piece between providers and law enforcement was something that needed to be addressed. The state has now added 80 liaisons, mental health professionals that's sole job is to work with law enforcement and the courts and those liaisons now have received 53,000 referrals from law enforcement officers over the time of the demonstration. We have CIT-trained officers across the state, more still who are mental health first-aid trained. The other cool thing we do that not a lot of people get as geeked out about as I do is we now provide post training for law enforcement officers free of charge on mental health, things like suicide, de-escalation, different things like that. Now cost: what is the fiscal? Let's get to that. So one of our requirements is an integrated care healthcare home model. For that population, the savings are in the E.R. visits and inpatient, so 28 percent reduction in E.R., 24 percent reduction in inpatient. That's for the sickest comorbidity patients we serve. But for overall performance, so anybody in CCBHC care with one or more E.R. or hospital encounter, a 36 percent decrease in E.R. visits and a 20 percent decrease in inpatient. So I-- that's really where the cost savings are driven and we have some data that backs that up where you can see through the Medicaid claims what I'm talking about there. But anyway, let me summarize just briefly. And so in Missouri, the model, as described by

the senator, has really allowed us to take those gaps that we've identified, take clinical initiatives, and then put it under this CCBHC prospective payment model. And it really lets you maximize federal dollars and, and extend your state dollars as far as you possibly can. So that's the-- where I'll leave it with and be happy to answer any questions. Thank you.

ARCH: Thank you, thank you. Are there questions? So I have a few. You are, you are under the pilot, so your state applied, correct? Are there other, are there other providers in your state that under the, the SAMHSA grant program?

BRENT McGINTY: Yes.

ARCH: And how-- like, how many of those? Do you have a--

BRENT McGINTY: So I think--

ARCH: --idea?

BRENT McGINTY: --we have about seven grantees now. I think three or four of them are CCBHCs identified by the state and the rest are the ones that are coming on at the end of this year.

ARCH: OK.

BRENT McGINTY: Yeah.

ARCH: And so, so under a pilot program, what's your timeline?

BRENT McGINTY: So we worked-- we had about a two-year lead up to implementation to try to get our folks ready. And I don't know what the timeline is here, but it does take some ramp-up of the provider level. It takes some ramp-up time at the state level. There's system work that has to be done, data reporting, all that kind of-- those things that go into it. And so, yeah, we had to do about a year's worth of planning to get that year's worth of implementation work before we started turning that switch to the payment methodology.

ARCH: And what's the, what's the timeline on commitment from the federal government to this pilot program?

BRENT McGINTY: So the pilot is through September of '23 and the plan is-- I know Senator Blunt and talking to him and Debbie Stabenow is in whatever new legislation, they'd like to add a five-year window to it.

But the ultimate goal is to codify it in law as a provider type so just like your federally qualified health centers. This will be a provider type under federal law permanently is the goal.

ARCH: So at, at the present time, though, you're looking at, you're looking at a sunset in '23 for the program. If they don't, if the federal government doesn't do anything, it will end in '23.

BRENT McGINTY: Well, we do have an approved state plan amendment that CMS has recognized our provider type in Missouri, so we do have a plan if the demonstration ends that we have a state plan amendment approved by CMS that the, the model stays. So we're, we're not throwing away the work we did. We are going to continue it under a state plan. What's happened is they keep extending the demo, so we had the state plan approved, but then they're like, well, hold on, the demo is now another two years, the demo is another year. And so they keep taking it further out.

ARCH: Right and the anticipation is that the Feds will, will codify this.

BRENT McGINTY: That's right, yeah. Yep.

ARCH: OK. All right. Other questions? Senator Murman.

MURMAN: I think you mentioned you work with education, so is that K-12 schools?

BRENT McGINTY: Yeah. The, the school-based care, there were-- two things happened that really have exploded care in our school population. Medicaid did a parity review and found that there was really no reason to not allow behavioral healthcare in a school, in, in a school. So that was switched right about the time this model happened. So school-based care has exploded because the kids and families, if they could arrange it, like it to happen there. It has to be planned right. School superintendents aren't happy to have people trying to bang at their door and interrupt the, the, the school day, but I can tell you, we've seen a lot of innovation. One thing, if you don't mind just a-- we have one provider, a CCBHC in rural Missouri and down the Bootheel, southeast Missouri, that has a program that they got DESE, our education folks, to approve the curriculum around behavioral health and life skills so they actually get school credit as well as some treatment therapy. So it's kind of a combination partnership that we think is going to really replicate out in rural

Missouri and urban Missouri. But yeah, school-based care is really trying to swim as far upstream as you can and this model really works for that.

MURMAN: So the offices of the, the psychiatrist or whoever it is, the office is right in the school?

BRENT McGINTY: Yeah. Typically they'll provide a space for a mental health worker or a therapist and often any kind of APRN or psychiatrist time would probably, in most cases, be telehealth if, if needed into the school setting.

MURMAN: Could you tell me how that referral works in the schools?

BRENT McGINTY: Yeah. Typically it's from the school counselors that identify a kid through whatever behaviors they're expressing, but might need a little bit more engagement by the behavioral health provider. And so they're referred and an appointment is set up. My daughter actually is in two rural schools right now for one of my CCBHCs and that's how she tells me they get the referrals most often.

MURMAN: So how are the families involved, parents if there is a referral?

BRENT McGINTY: Yeah. Typically that all has to be authorized and sign-offs done, etcetera. And then to be quite honest, typically the family does get involved in the care directly because that's often where some of the problems can be happening too. So that's the skills that are often-- these folks are training their staff on how to engage families and kids together.

MURMAN: Thank you.

BRENT McGINTY: Yeah.

ARCH: Thank you. Other questions? Another question for me, I guess. You obviously have other private providers outside of the CCBHC program. How do they, how, how-- what's been their reaction to the agencies that are providing services under this pilot?

BRENT McGINTY: Yeah. So just to be just straight up with you, I have 33 members, 15 of them are CCBHCs, 22 of them are going to be-- and that will probably be about the most that can reach the comprehensive nature of it. So they're all-- I'll just say they're jealous. They're living under a fee-for-service model that's pretty outdated and

antiquated. So the next step that the state is going to pursue is really, how do we take count of the lessons we've learned around getting away from fee for service and make that some sort of look-alike program that's not the full array that's required under CCBHC, but that gets out of fee for service and what does that model look like? But I can tell you trying to herd these cats for the past eight years, nine years on this issue, one of my biggest kind of saddest points has been trying to let that-- those other folks that aren't going to get there find a different alternative. And that's-- it's coming, but it's been a long time. So they've been on the sidelines looking in for a while.

ARCH: So do the, do the private providers then experience that, that patients are actually shifting out of their private practice over to the CCBHC?

BRENT McGINTY: It's a lot of partnership, honestly. What, what the CCBHC in Missouri has is what's called a designated collaborative organization. So we have a lot of those partnerships. Instead of competition, it's like, how can we work with and have FQ to do some primary care work? How can we bring in this local psychologist group under some sort of contract arrangement to make sure we're having good care and increasing access? So there's been a lot of that. It doesn't happen always. I'm not saying I can make every provider cooperate and be happy, but the model does allow for a good partnership. It really encourages it.

ARCH: It sounds like it's-- that this program is more than just let's start a CCBHC, but it has, it has-- it, it is in process of completely changing your behavioral health system in Missouri.

BRENT McGINTY: Yeah, I think--

ARCH: It's not a, it's not an add-on program for a certain population.

BRENT McGINTY: That's exactly right. I, I describe it, it's, it's culture changing. It has brought in more integrated care. It's brought in what community mental health should have been all along before we started kind of chasing fee-for-service units. It really says, what does the community need and how can we fill that gap and then put it under a PPS model that gets Medicaid participation and, and how can you serve your community better? So yeah, to think about how far we've changed from where we used to care, is that person taking their meds and that's it? Do they have a house and that's it? But oh, by the way,

they're dying of diabetes. Well, that's not my problem. We're just mental health. It has changed that culturally to where we care for that whole person. And we got to arrange are they going to their doctor, are they taking their meds for their diabetes? Because it's doing no one any good if they're going to end up in the E.R. because of their physical healthcare conditions. So it really has culturally changed what our provider types look like.

ARCH: So would you say Missouri is, is out in front on this CCBHC?

BRENT McGINTY: On CCBHC, we are. We had the most-- we had-- for the original eight states, we had the most agencies, most clinics, and the most number of people served under the model of the eight original states. So we feel good about that, but yeah.

ARCH: Thank you.

BRENT McGINTY: Um-hum.

ARCH: Other questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and thank you for coming and helping us understand this. You mentioned that you have a large number of your members that are part of this group and some that aren't. And I think you used the term they just can't get there. Can you explain to me-- I'm not sure I'm understand that.

BRENT McGINTY: Yeah, sure. I should have explained that better. I apologize. So we-- I have some who are providers who might be SUD-only providers and really don't have the capacity or desire to move into maybe the mental health or the integrated care stuff as much. I have some who are maybe a real small clubhouse provider and that's a-- kind of a different model where they're members and not patients and so they just-- the model doesn't necessarily fit what the CCBHC requirements are.

WILLIAMS: OK.

BRENT McGINTY: And some of them just look at it as it's just too big of a lift. You got to serve youth and adults. Some are adult only and don't really want to get into kid stuff. So that's my challenge is how do I make--

WILLIAMS: So if you participate in this, you have to offer the whole umbrella?

BRENT McGINTY: That's right.

WILLIAMS: Yeah.

BRENT McGINTY: Yeah.

WILLIAMS: Gotcha.

BRENT McGINTY: We have a whole state certification that you have to go through and you've got to really serve a broad population and a lot of evidence-based practices, etcetera. Yeah, yeah.

ARCH: Senator Murman.

MURMAN: You said that it's not a fee-for-service model, so how does the fund-- funding work? Is it per patient?

BRENT McGINTY: Yeah, great question. So there's a couple of ways you can go at it. What we do in Missouri is a daily rate, so you basically-- behavioral health, at least in Missouri, we weren't really big on cost reports, so getting actuarial folks in to help all our providers figure out how to do their cost reports. It's very detailed. The state's very involved in reviewing it. But that's where you can figure out where are the gaps? What do we need to add? Sometimes the state-- what, what's beautiful about the method is the state can say, here's what we think is missing and we need to add that into the cost report so that you are going to bring in like, say, law enforcement liaisons. We want to make that a requirement. So maybe Topher's group would put, you know, so many thousand dollars in to hire one. You take all those costs and then you basically numerator/denominator. You take your cost divided by your visits and that's the daily rate you get paid. So what is good about that is it lets the care be the driver of the service array versus I got to do this many units of service in order to make my bottom-line budget. Whether that may be the exactly right thing to do, that's what we got to do to stay afloat, it changed that model completely to what does that individual need and we get that daily rate. And then the state-- I don't know. There's a lot of detail the state department will have to figure out, but then we rebase every so often. We do annual cost reports so the state and see how close we are to the PPS rates and, and they have accountability that way.

MURMAN: Thank you.

BRENT McGINTY: Yep.

ARCH: Senator Hansen.

B. HANSEN: Hi. Thank you. Sorry I missed your opening part of your testimony. Just have a couple of questions. Will you be working with public health entities, local public health entities?

BRENT McGINTY: Oh, absolutely. Yeah, that-- it depends on the issue, but there's a lot of good relationships from the local public health authorities that are county based and the CCBHCs, absolutely. In fact, we use-- in Missouri, they're-- they do it every three years, I think. It's their community needs assessment is really kind of the basis of some of the stuff that we include in our CCBHC application and some of the stuff we do for recertification.

B. HANSEN: OK. Would you be taking over some of the stuff that public health entities typically do now?

BRENT McGINTY: No.

B. HANSEN: They don't do all of behavioral health, I know, but I don't know.

BRENT McGINTY: Yeah.

B. HANSEN: Sometimes you say, well, they don't want to deal with it because there's nobody else around and so I didn't know-- then you'd be--

BRENT McGINTY: Yeah--

B. HANSEN: --take them?

BRENT McGINTY: --we do-- on the primary care side, we, we operated that integrated care model in cooperation with FQHCs and local health departments. We often contract with our primary care physician--

B. HANSEN: Sure.

BRENT McGINTY: --from one of those entities. So we have very much more of a coordination of care, being responsible to make sure that person is going to the local health department, is getting their shots, whatever they need--

B. HANSEN: Gotcha.

BRENT McGINTY: --versus trying to take that over--

B. HANSEN: OK.

BRENT McGINTY: --because that's not our, our lane, so to speak, but making sure that person is healthy is.

B. HANSEN: Yeah.

BRENT McGINTY: And so just getting them to the right space to get the care is where we're really driving towards.

B. HANSEN: Then you talked about primarily this would be-- this would include just behavioral health, right?

BRENT McGINTY: Yeah.

B. HANSEN: OK.

BRENT McGINTY: We do-- like I said, we operate a healthcare home because we found through studies, folks with mental illness, serious mental illness were dying 25 years earlier than the general population. And that's not because of their mental health; it's from diabetes, cardiovascular disease, heart attacks. So like I was saying, we, we were like, well, they're taking their meds. They have a house. That's us, that's-- our job is done while they're dying--

B. HANSEN: OK.

BRENT McGINTY: --of other issues. So part of this model is really making sure that their physical health is being addressed as well.

B. HANSEN: OK.

BRENT McGINTY: So I say we might not directly provide it, but we're trying to make sure they're getting healthy.

B. HANSEN: OK and I noticed in the bill it says that you try to make a collaborative effort with certain entities such as law enforcement and schools. Would you go into schools at all or have a--

BRENT McGINTY: Yep.

B. HANSEN: --have a setup in schools?

BRENT McGINTY: Yeah, absolutely. There's usually-- we found the schools love us. Behavioral health and behavioral-- just troubled

behavior is a huge issue for schools and administration so having-- they are usually always glad to provide us some space.

B. HANSEN: OK.

BRENT McGINTY: And we have a mental health worker there. I was saying earlier my daughter's doing that right now in a couple of rural schools in Missouri as her job and she loves it and the schools love it and the training these folks give, your providers give staff to deal with these families and kids is really important because usually it is-- it's a family issue often, not just the kid. Yeah.

B. HANSEN: OK. So would you be seeing kids or would you be seeing other people? Like, if you were in the school, would you see people besides children? Would you see like their parents or anything like that?

BRENT McGINTY: Yeah, usually-- sometimes if the parents are working, you try to do it after school, but obviously the parents sign off on the care and all that. But yeah, you can see them together at the school--

B. HANSEN: OK.

BRENT McGINTY: --or it can be you see the kid there and talk to them and then schedule something maybe after hours, the weekend. This model did change how we do business. We were kind of this clinic eight-to-five model where you come to us eight to five Monday through Friday and that's not the way this is anymore. So there are after hours, there's crisis services 24-7 in a lot of facilities. So it has changed the model of care and outreach at schools versus--

B. HANSEN: OK.

BRENT McGINTY: --making them come to us.

B. HANSEN: This sounds like a behavioral health clinic in a school that can see anybody.

BRENT McGINTY: Yeah, I mean, we don't-- like no one can come into the school and see us if they're not a student or member of the family.

B. HANSEN: OK.

BRENT McGINTY: So I don't mean to say we put a sign out and say--

B. HANSEN: Just wondering. Yeah.

BRENT McGINTY: Yeah, we don't.

B. HANSEN: The intricacies I'm just kind of curious about, so.

BRENT McGINTY: That's right.

B. HANSEN: And their family is primarily immediate family and not like--

BRENT McGINTY: Yeah, that's correct.

B. HANSEN: OK. Just kind of curious. I know it's maybe varied.

BRENT McGINTY: Yeah.

B. HANSEN: OK. And would you be dispensing psychiatric medications like in the school or would you refer them out to a psychiatrist?

BRENT McGINTY: Usually that's referred, yeah.

B. HANSEN: OK, curious about that.

BRENT McGINTY: Yeah, absolutely. But that's almost always the-- most of the telehealth we do is at our clinics. There may be an example or two at some of the bigger schools where there's an actual telehealth setup at the school, so you could conceivably do that with parents being there, etcetera.

B. HANSEN: OK.

BRENT McGINTY: But most of the time, that's done at, at the clinic location.

B. HANSEN: OK. And primarily behavioral health medication, nothing else?

BRENT McGINTY: Right, right.

B. HANSEN: OK. Just curious.

BRENT McGINTY: Yeah.

B. HANSEN: I know you get some of these questions, so.

BRENT McGINTY: Yeah.

B. HANSEN: OK, well, thank you very much. Appreciate it.

BRENT McGINTY: You bet.

ARCH: Other questions? I have another one. And so total budget for the state, did you see a decline in fee-for-service visits as your CCBHCs ramped up? Did you-- how did that-- is this a shift or is this an expansion?

BRENT McGINTY: So it is a shift. Obviously, the fee-for-service money was then used to make the PPS payments. And so that we can all-- I can give my friend Annette [PHONETIC] all that kind of data that we saw on the shift from the fee-for-service side to the, the PPS. And the state, in our side anyway, chose also to mandate that the MCOs participate as well, our managed care entities pay the PPS rate just like the state does for non-MCO lives, so that it was equal treatment across both, both payers because we have populations that are Medicaid fee for service outside of MCO--

ARCH: Right.

BRENT McGINTY: --and populations who are inside of MCO.

ARCH: OK.

BRENT McGINTY: So they made that-- everyone has to participate.

ARCH: OK.

BRENT McGINTY: But yeah, it was a shift from fee for service over to this PPS model.

ARCH: So has that financial analysis done-- been done for the state of Missouri, do you know?

BRENT McGINTY: Yes. It's-- I say this: we try to focus on utilization as much as we do the claims. The claims are incredibly nuanced because you can get a new drug that's introduced. You can have a rebate that changes the fiscal. So in every single year, there's maybe ten changes that are outside of the control of whatever policy you adopt and so trying to make sure that's all done and parsed out right. But we do have some of our integrated care stuff and some of our outreach where

the claims have been done prepost and I'll be happy to provide that to the committee. Yep.

ARCH: All right.

BRENT McGINTY: Thank you.

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

BRENT McGINTY: Uh-huh. Thank you very much

ARCH: --for coming today.

BRENT McGINTY: Appreciate it.

ARCH: You didn't even have to drive up in a snowstorm or anything.

BRENT McGINTY: Yeah, great.

ARCH: That's good.

BRENT McGINTY: Straight shot.

ARCH: Next proponent.

TOPHER HANSEN: Good afternoon, Senator Arch and members of the committee. My name is Topher Hansen, T-o-p-h-e-r H-a-n-s-e-n. I am president and CEO of CenterPointe and I'm here today representing CenterPointe and the Nebraska Association of Behavioral Health Organizations in support of LB976. Certified community behavioral health clinics-- and the test afterwards where you say CCBHC fast three times take some practice-- are not a new concept. Holistic, integrated care was a concept discussed by the Chinese 5,000 years ago and 4th Century Socrates said the part can never be well unless the whole is well. After all, we all are a system of systems that integrate every day and one system affects the other as we conduct our lives. Organs can get sick and affect other systems so treating with that in mind is important. CCBHCs are similar to federally qualified health centers in their promotion of holistic care and payment systems that allow for quality, not quantity, and that incorporate services that may not be billable under traditional models but are essential to quality care and positive outcomes for a population. The mental health of our communities is at a level of urgent concern. The inner-- indeterminacy, restricted activity, and isolation caused by the COVID-19 pandemic has skyrocketed anxiety, depression, substance use,

and increased the already high rate of suicide. CenterPointe received a grant to become a CCBHC in May of 2020. We hired 17 new positions in our outpatient programs. We focused on access, crisis response, suicide prevention, primary care, and youth and family care. Our crisis response team had 6,367 contacts in the last 16 months, a 50.9 percent increase from the prior 16 months. We did 90 field assessments initiated by the Lincoln Police Department. That is, they call us and say, we need your help. Can you come out? And we work with them in the field. The outcomes of those assessments are important; 80 percent of those people remained in their home, 97.8 percent avoided the need for further law enforcement involvement, like going to jail, 94.5 percent avoided the need for hospitalization. Our expanded crisis response was not possible without the CCBHC grant. Our team has intervened with two youth younger than 10 years old who were thinking of ending their life. Our team intervened and got the family into care as a result of that intervention. Same-day access is part of a CCBHC and what that means is that when you show up, you get served. We don't want people to wait for care if they are ready to receive care. If there is a crisis, we have crisis response available 24/7. In the 16 months since being certified as a CCBHC, we have seen 1,300 more people than in the 16 months before being certified, a 33.2 percent increase. Of the 5,320 we served in that time frame, 82 percent were within the federal poverty guideline and I can tell you 62 percent made less than $1,000 a year. Integrated interdisciplinary team works to provide the person coordinated services that will meet all their mental health, substance use, primary care, and basic needs. We wrap around the person. If you come in with four flat tires, we will attend to all four tires, we'll teach you good tire care, and help you get down the road. We had a person, in fact, who used our services come into our outpatient facility thinking he maybe experiencing a life-threatening medical event. Our primary care practitioner immediately addressed the concern, while community support, peer support, and therapy staff who are already connected to that individual began to support him and identify other ancillary issues. It was discovered that no critical physical health condition was at issue, but that other issues related to mental health were impacting him. The team worked with him to a successful resolution that day so he was able to comfortably return home. In primary care in the last 16 months, we started a primary care service serving from children to seniors. We've seen 372 people, with the number continuing to grow; 86.8 percent of those people did not have a connection to a primary care practitioner upon their first visit to us. We've served 322 youth and their families. Our team has formed relationships with Lincoln Public Schools, where we have

actually been providing them iPads to the social workers so they can contact our crisis team immediately if need be and are beginning to make other steps for other programing inside the schools. Child advocacy: the Malone, Bryan Health, and LPD are all involved with our crisis unit and our services. We've also done 2,615 suicide screenings, resulting in 687 high-risk individuals receiving a suicide care management plan, and none of those people with a care management plan have committed suicide. Good health is foundational for all else in life. Our problems with mental health and substance use are the pandemic less discussed. LB976 is the solution to lean on in these issues and help people achieve health and well-being. These are persistent problems that need stable funding for a permanent solution. Grants are not the answer here. Grants are to try things out, not to create a sustained state-of-the-art system to establish a healthy society. From the front lines, I can tell you this is the kind of solution we need. Please support LB976. Thank you.

ARCH: Thank you. Questions? I have one.

TOPHER HANSEN: OK.

ARCH: So you and I have had a conversation about CCBHCs and so just so that the committee understands, you're operating under a SAMHSA grant--

TOPHER HANSEN: Yes.

ARCH: --currently.

TOPHER HANSEN: Correct.

ARCH: Refresh my memory on you-- on the timing of, of your grant. And, and is it renewable? Help me with that.

TOPHER HANSEN: So they are issued as two-year grants, but you have to apply on the second year so they want to see how you're doing. As Brent said, these are data driven and so our program officer at SAMHSA is really looking-- are we hitting the marks on the data? Can we gather this information? Can we report on how we're doing and so on? And so they really look at you the first year and see if you're doing it. And if so, then they'll let you do a second year. So that second year ends for us on April 30, 2022, and we're expecting that there's going to be an FOA or funding opportunity announcement coming up shortly and that we will reapply to extend out further, again, so this whole thing doesn't hit, hit the ground. We were fortunate that when

the pandemic started, that's when we got the grant was right when everybody was starting to go into lockdown and so on. But while we were changing the system, we were doing, doing that, we were also hiring 17 new people and then saw-- in the 12 months timeframe, we saw 4,200-plus people. So our-- which is almost 1,000 more than we saw the year before. So we just got a flood in the door, but we had hired more people that helped us address that. And again then with the ancillary services that aren't billable kinds of services, it allows us to then wrap around that whole person in the ways that they need that.

ARCH: What's, what's the size of your grant annual?

TOPHER HANSEN: $2 million each year for two years.

ARCH: And that's just your organization?

TOPHER HANSEN: Yes.

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

TOPHER HANSEN: Thank you.

ARCH: Next proponent for LB976. Welcome.

BOB SHUEEY: Hi. Good afternoon, Senator Arch and committee members. My name is Bob Shueey, B-o-b S-h-u-e-e-y. I'm the director of operations and corporate compliance officer at South Central Behavioral Services in Hastings and Kearney. I'm testifying today in support of LB976 on behalf of the Nebraska Association of Behavioral Health Organizations, NABHO, and I thank you for the opportunity to testify. At South Central Behavioral Services, we provide our rural communities a wide range of behavioral health services, including outpatient treatment for mental health and substance use disorders, 24-hour crisis services, as well as a variety of rehabilitative services for the population diagnosed with severe and persistent mental illness. We are excited by this opportunity to expand the Certified Community Behavioral Health Clinic model of care permanently into Nebraska. At our facility, we intend to apply for a federal CCBHC expansion grant in the next few weeks. We believe this grant will allow us to shore up the finances of some of our service lines that we are at risk of losing in central Nebraska, expand access to care, and help us move the behavioral health care system in our state forward. LB976 will help us make this forward progress permanent by moving the state from an old-fashioned fee-for-service model that incentivizes quantity over quality to a modern prospective payment system that rewards us for

early intervention, effective treatment, and addressing the whole health needs of the individuals we serve. Bringing the CCBHC model to Nebraska will help us accomplish several important objectives. At the heart of the CCBHC model is robust coordination of care. The model formalizes and strengthens the coordination with primary care, hospital partners, law enforcement, veterans services, the educational system, and other providers in our communities. This will help us improve access to care at all levels and make sure that Nebraskans are able to access the level of care or the specialized services they need when they need it and without facing multiple barriers of entry or funding source issues. The model will also help us expand the use of evidence-based practices to improve the quality of care, along with robust data and outcome reporting requirements to help measure the effectiveness of that care. Measuring behavioral health outcomes has been an ongoing challenge faced by our organization and others around the state. The CCBHC framework will provide us with the tools to make tracking those outcomes a reality. We are hopeful that the CCBHC model will help us break down the silos created by rigid service definitions and payer pre-authorization requirements by giving us the flexibility to enroll Nebraskans in the exact type of services they need when they actually need it for the length of time they need it and move them through our continuum of care in a fluid and sophisticated manner, a manner which should help us improve the quality of care we can provide and minimize the costs associated with the current system's admission, discharge, and readmission cycle. It is our belief that the CCBHC model represents the future of behavioral health care in Nebraska. It vastly improved access to care, while at the same time improving the quality of care, producing measurable outcomes, and controlling costs by aligning the motivations of providers with that of the state. Without this bill, which makes the model sustainable, the forward-looking agencies that embrace the CCBHC design will be put into the undesirable position of needing to roll back the progress they have made once their grant funding runs out. Please support this important and timely piece of legislation. Thank you.

ARCH: Thank you for your testimony. Questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and, and thank you. The question that I asked earlier was about this model working in rural areas. I might adjust that question a little bit. It would seem to me that this type of business model could give a rural provider more access to recruiting additional providers. Can you respond to that kind of comment?

BOB SHUEEY: Yeah. I believe that you're correct, Senator Williams. The, the hope with the prospective payment system is that you'll be reimbursed at a rate which would allow us to recruit the type of providers we need. The rates have been too low to allow that for too long and that's why we've seen providers moving away from rural areas. We, we can't produce the amount of volume necessary in rural, in rural communities under the current fee-for-service model.

WILLIAMS: Thank you.

ARCH: Thank you. Other questions? Seeing none, thank you very much for your testimony. Next proponent for LB976. Seeing no other testifiers-- excuse me if I saw somebody stand up-- no other testifiers as a proponent, are there any opponents to LB976? Seeing no opponents, anyone want to testify in a neutral capacity? Seeing none, Senator Wishart is waiving close. Let me just read into the record we received seven letters in-- as proponents: Beth Ann Brooks from Nebraska Psychiatric Society; Carmen Skare from Nebraska Psychological Association; Monica Meier, Nebraska Chapter National Association of Social Workers; Andy Hale from Nebraska Hospital Association; Jina Ragland, AARP Nebraska; Cheryl Logan, Omaha Public Schools; Dexter Schrodt, Nebraska Medical Association; Dexter-- oh, twice-- Bryson Bartels-- oh, that's a different bill, excuse me. Dexter Schrodt was the last one on that. So with that, we will close our hearing on LB976 and we will now open our hearing for LB697. I don't know how we got LB976 and LB697 on the same day, but we did, not to be confused. Yeah. Senator Kolterman, please.

KOLTERMAN: Good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Senator Mark Kolterman, M-a-r-k K-o-l-t-e-r-m-a-n. I represent the 24th District in the State of Nebraska Legislature. I'm here today to introduce LB697 on behalf of the Nebraska Hospital Association. LB697 is a bill to provide licensure of rural emergency hospital services. In December of 2020, unites-- United States Congress passed the Consolidated Appropriations Act of 2021, which has since been signed into law. This legislation established a new Medicare provider type, rural emergency hospital, or REH. This new REH model will allow-- will offer the opportunity for current critical access hospitals and rural prospective payment system hospitals with fewer than 50 beds to convert to REH status to furnish certain outpatient hospital services in rural areas. LB697 enables Nebraska to create this new provider type and license rural emergency hospitals under the guidance of CMS rules and regulations. A REH is defined as a facility that is enrolled in Medicare on or after January

1, 2023, and it does not provide any acute care inpatient services. They have to have a transfer agreement in effect with a level I or II trauma center, which meets certain licensure requirements. It has to meet the requirement to be a staffed emergency department, meet the staff training and certification requirements established by the secretary, and meet certain conditions of participation applicable to hospital emergency departments and CAHs, which respect to emergency services. CAHs and small rural hospitals that convert to REHs may furnish rural emergency hospital service beginning in 2023. Rural hospital closures are at a crisis level with over 135 rural hospitals, hospitals closing since 2010 and more than 450 identified as vulnerable to close based on performance levels. In Nebraska, in our state, we have two rural hospitals that have closed since 2014, including MercyOne Oakland Medical Center that was in Senator Hansen's district that closed last summer. As many as five Nebraska critical access hospitals are strong candidates to convert to the REH model, with an additional 12 critical access hospitals financially in the red that might consider this REH model. Those of us who live in rural areas of the country make up about 20 percent of the population. We experience shorter life expectancy, higher all case-- all-cause mortality, higher rates of poverty. We have fewer local physicians and drive greater distances to travel to see healthcare providers. The healthcare inequities that many rural Americans face raise concerns that the trend for poor healthcare access and worse outcomes in rural areas will continue to increase unless potential causes such healthcare inequities are addressed. Rural hospitals are essential to providing healthcare to their communities and the closure of these hospitals limits access to care for the communities they serve and it also reduces employment opportunities, further impacting local economies. Barriers to estab-- to accessing healthcare services can lead to unmet healthcare needs, delays in receiving appropriate care, inability to receive preventive services, financial burdens, and preventable hospitalizations. Healthcare workforce shortages can also impact healthcare access in rural communities. It is imperative that our rural communities that we-- to our rural communities that we pass this legislation to ensure that more critical access hospitals do not close their doors to the community in which they serve. Andy Hale with the Nebraska Hospital Association is here to provide more information on the REH model in just a few moments. Last, upon the introduction of the bill, there was some concern with page 2, Section 3 (4) that the transfer agreement is exclusive to trauma I or trauma II hospitals. I've also passed out an amendment that would require a REH transfer agreement to include trauma I and II hospitals that is a requirement

of CMS, but this change would also allow the REH to enter into transfer agreements with other hospitals that are necessary for patient care. So in other words, if you want to transfer, it doesn't necessarily just have to be to a, to a I or II trauma hospital. We could also transfer to critical access hospitals, which already exist. I would ask that the committee advance this bill and the amendment and I would be happy to try and answer any questions that you might have at this point in time.

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

KOLTERMAN: Thank you.

ARCH: First proponent for LB697.

JED HANSEN: Good afternoon, senators. My name is Jed Hansen. I'm the executive director with the Nebraska Rural Health Association and Jed Hansen, J-e-d H-a-n-s-e-n. The NeRHA represents Nebraska-- over 300 Nebraska-- rural health organizations across the state, including our 63 critical access hospitals, seven PPS hospitals, and roughly 140 rural health clinics and we're here in support of this bill. LB697, as proposed, will help align Nebraska's state statute with its federal analog for the designation of the new payment model beginning in 2023. The bill is considered budget neutral for the state. However, it is my understanding that there is some FTE allocation that is potentially associated with it. The intent of the rural emergency hospital designation is to help our most financially vulnerable rural hospitals in the state. Those most likely to convert are the facilities that have less than $20 million in revenue, an average of fewer than three patients per day inpatient, and a trend of three years with a negative operating margin. A late 2021 analysis, as the senator mentioned, identified that there are roughly-- that there are five Nebraska hospitals that this model will likely directly impact over the coming years. Yesterday, I had a correspondence with nearly a dozen of our critical access hospital CEOs and all were in favor of this bill. And I asked them if there are any nuances that should be considered and, and none presented to me at that time. Interestingly enough, I did have an opportunity to chat with, with the former CEO at Tilden, who's currently at, at Osmond, and he unequivocally supports this bill. And to quote him, he said it would have been a huge benefit to the Tilden community had this bill been available at the time. And without knowing any specifics, it was mentioned that, that Oakland did close last year and my educated assumption would be that this would have

been a model that would have helped them remain open as well. And while it's difficult to know what specifics, you know, are, are going to be required beyond just making this general change, essentially, it's a language change for these community-- for these hospitals. This is a good first step that the, that the state really does need to consider to align our state statute with, with federal policy. I'd be happy to try to answer any questions that any of you have regarding what, what this amendment is intended to do, so to speak. So I thank you.

ARCH: Are there any questions?

B. HANSEN: I got one.

ARCH: Senator Hansen.

B. HANSEN: Thank you for-- you, you mentioned, mentioned, you mentioned Oakland in my district and Tilden, which is kind of like my second home. That's like where all my family grew up and where I-- they're all at right now, so--.

JED HANSEN: Yeah.

B. HANSEN: --it's pretty awesome. Just one quick question. Would this bill, in your opinion, negative-- negatively affect current rural emergency hospitals that do not fall under this? Like, would that--

JED HANSEN: Yeah.

B. HANSEN: --restrict them from being able to do certain things? Because it sounds like this only provides, you know, federal funding in a way, you know, Medicare coverage for the ones that are eligible.

JED HANSEN: Correct, so the criteria is that a hospital is a-- has a rural designation, has fewer than 50 hosp--certified beds, or is currently designated as a critical access hospital. The, the statute, what it does is it's just aligns-- or it allows those facilities that are financially vulnerable to, to make that conversion. So let's say that West Point, you know, they're a pretty-- they're a very vibrant, viable critical access hospital. Will that affect them? The answer is no. This really is designed to help those communities that-- and those hospitals that are serving smaller communities to provide a new model for them to, to stay open. It doesn't create any kind of financial advantage for, for a converting hospital versus one that isn't. Is--

B. HANSEN: OK.

JED HANSEN: Did that--

B. HANSEN: Yes. I guess-- and I'm just always a little gun shy when I hear the licensure part of it. So if we're licensing certain-- other hospitals based on these factors, right-- like, say, there's one that doesn't have 50 beds in a really rural area-- part of Nebraska and only 20 beds, that doesn't affect them at all, does it? Like, they don't, like, have-- since they're not licensed or it's-- that shouldn't have any effect on them, right?

JED HANSEN: So all, all of our rural hospitals in the state are designated as critical access hospitals. There are 63 of those.

B. HANSEN: OK.

JED HANSEN: And they're able to, to maintain that that designation as a critical access hospital without having to convert over to this. And the way that the federal statute is aligned, they could, they, they could make a conversion to a rural emergency hospital. And let's say that there's-- the economy improves or there's a-- you know, maybe there's some kind of a robust scenario that happens where they would have an increase in, in the community. They would be able to convert back to a critical access hospital as well.

B. HANSEN: Ok and they're not required--- the ones who are eligible are-- they don't have-- they're not required to be a part of this. right?

JED HANSEN: Correct.

B. HANSEN: OK.

JED HANSEN: No, no. This really just provides a different avenue for, for the smaller hospitals to, to have a different, viable model. In essence, what it does is it removes the inpatient component of that hospital. So current hospitals, in order to be eligible for CMS reimbursement, are required to have inpatient components to, to their health system. This provides a model for those facilities where an inpatient system maybe isn't, isn't financially viable for them, but it allows them to keep emergency services in their community.

B. HANSEN: OK.

JED HANSEN: They're also able to maintain any type of a skilled nursing facility that they're currently under, all outpatient services. They're-- they just get away from that inpatient component.

B. HANSEN: OK, because-- so-- I'm sorry for asking so many questions here.

JED HANSEN: Yeah.

B. HANSEN: Just-- I'm a chiropractor and so we are eligible for Medicare as well and so there are some chiropractors who choose not to be a participating member, yet-- but they start to fill out forms. They have to do all this other kind of stuff so they still have some kind of form of control the federal government has on them. And so I'm-- that's my only concern here. So if you do have-- a rural emergency hospital for some reason chooses not to apply for this, now, since Medicare covers the other ones who are in their same field, I didn't know that now they, they're-- if Medicare people will be ineligible to go to nonparticipating hospital or anything like that. I know you haven't written all the rules and regulations yet I don't think. They haven't yet for this yet?

JED HANSEN: Correct.

B. HANSEN: I'm not sure if you could maybe-- if--

JED HANSEN: Yeah. If I'm understanding correctly, there won't be any additional inclusion or exclusion criteria administratively for current critical access hospitals. And from a patient standpoint, at the-- at least at the federal level, so with Medicare patients, there's going to need to be some additional language change that allows for that transportation to and from this newly designated rural emergency hospital, but really just becomes more semantic at the federal level at this point beginning in 2023.

B. HANSEN: OK. So is-- if a Medicare patient goes to a rural emergency hospital who has not participated in this, they're not taking federal dollars--

JED HANSEN: Correct.

B. HANSEN: --they-- the Medicare person should still be able to go to that hospital. They're not going to say well, you have to transfer them now to one that is participating because we're covering it under Medicare. I mean--

JED HANSEN: Correct. Yes, yes. So there, there, there isn't any change in, in Medicare coverage at the patient level.

B. HANSEN: OK. That's what's I was kind of wondering.

JED HANSEN: Yep.

B. HANSEN: Thanks. So sorry for--

JED HANSEN: Yeah. No, no, sorry, sorry if I wasn't, wasn't answering that correctly.

B. HANSEN: Thanks.

JED HANSEN: Yeah. Thank you.

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

JED HANSEN: Yeah, thank you.

ARCH: Next proponent for LB697.

ANDY HALE: Good afternoon, Senator Arch, members of the HHS Committee. My name is Andy Hale, A-n-d-y H-a-l-e, and I am vice president of the Nebraska Hospital Association and I'm here to testify in support of LB697. Fifty-three percent of our critical access hospitals-- and there's 63 of those, as the previous testifier mentioned-- are facing financial stress. Nebraska hospitals lost more than $640 million to shortfalls in Medicare, Medicaid, and other public health program payments. Nebraska hospitals employ over 49,000 Nebraskans, creating a demand for an additional 51,000 jobs in Nebraska due to hospitals buying goods and services from local businesses. That's nearly 10 percent of Nebraska's entire workforce either works in or is supported by hospitals. Nebraska hospitals were directly responsible for nearly $7.4 billion in hospital expenditures, including over $3.5 billion in salaries and benefits. Every dollar spent by a hospital in Nebraska produces another $1.91 of economic activity. We mentioned the hospitals closing in Tilden in 2013 and unfortunately in Senator Hansen's district with Oakland last year. When a hospital closes, the physicians, the nurses, the administrators, the entire staff are gone, along with the local healthcare infrastructure. Local businesses would presumably be next. The schools would suffer. The whole town would suffer. The idea of this bill is to give the hospitals a welcome alternative to closing. And that's really what this is about. Again,

Jed, the previous testifier, mentioned Lon Knievel, who was unfortunately the CEO of Tilden when it had to close. He is now in Osmond and we did reach out to him and he essentially said that this would have saved Tilden and, in his opinion, would have been able to save Oakland if we can do this. Kansas passed similar legislation last year and as Senator Kolterman noted, the federal government has passed this and I think if not, all states will pass this. The reason Nebraska is doing it so soon is because of the rural part of our state with our-- so many critical access hospitals, we want to get this on the books right now. I want to thank Senator Kolterman and his staff for introducing this bill and essentially what we're doing-- and, and trying to get to Senator Hansen's questions a little bit. We're not bringing in any new hospitals. These would be those that would convert. And there's-- our critical access hospitals would be qualified for this, as well as one of our PPS hospitals, our larger hospitals. This would be for the ones that are having trouble. And how are they having trouble? A lot of that has to do with patients coming through their door, especially in the emergency department. So this would have emergency department and you would still have your outpatient services. You would get rid of your inpatient. So you could still do your scopes, your knees, those sorts of things that make revenue. Just as an aside, a lot of those had to shut those down during the DHMs because of that and that really is what a hospital can generate revenue on too. So you would still have your emergency department, they would treat you, stabilize you, and then send you on to another hospital. The amendment that Senator Kolterman referenced, we brought or asked them to bring because it does clarify that it would have to go to a level I or level II. If you had a hospital maybe 30 miles down the road, a critical access hospital, you should be able to send this individual there and not send them up to just a bigger hospital. So the whole again idea of this is to give an alternative to shutting your doors. We don't anticipate right now any of our members-- and we represent 94 hospitals, against 63 of them critical access hospitals-- would convert to this model, but it is something that we would like to have in case we have to go that route. And I will take any questions from the committee.

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

B. HANSEN: Thanks for clarifying some of those answers. Are there a lot of hospitals currently, like especially rural hospitals that have outpatient and inpatient beds, that would maybe apply for this? And then they would have to get rid of their inpatient--

ANDY HALE: Correct, yeah.

B. HANSEN: --capacity, right? Do you expect a lot of that? And I'm curious about what happens with-- what, what would happen with their inpatients. Like, they just-- they transfer them to a--

ANDY HALE: Yeah.

B. HANSEN: --facility?

ANDY HALE: They would be transferred to another facility, so whether that's a critical access hospital or to a PPS hospital, so yeah. So the inpatient would eventually be closed and then those patients would be moved and they would not be allowed to have inpatient after that based on this model.

B. HANSEN: OK. Do you think a lot of rural hospitals would end up doing that?

ANDY HALE: I-- for in Nebraska, I'm not so sure. As we mentioned, we probably have five right now that probably will, in the next two to four years, consider that. We're very fortunate and very appreciative of the federal money that has come into the state and gotten to those hospitals. It has really allowed them to keep their doors open. And so our concern is what happens when that money runs out? Then we're back to facing these tough decisions. So right now, Senator Hansen, I do not think we would. I think other states will. We've been fortunate again. We have-- our hospitals are doing pretty well, but overall, I mean, there's 53 percent of our critical access hospitals that are-- have below a 2 percent operating margin so that's a concern.

B. HANSEN: Yeah. I know sometimes we get stuck and you have no other choice. But yeah, this, this is another viable option. I think it's--

ANDY HALE: Yeah.

B. HANSEN: --great that with these providers-- another other option besides shutting down, so.

ANDY HALE: Yeah. Thank you. And that's the whole idea of this is, is to provide them an alternative. You know, we may have some hospitals nationwide and even here in Nebraska down the road that might think that this works out best for them, but really, we're seeing this as of now as, as facing the alternative of shuttering the entire hospital.

B. HANSEN: And I don't mean to kind of expound too much. My only concern that-- eventually is if, if a rural hospital, which might only be one within 50 miles maybe, and they do have inpatient and outpatient that can serve both of those needs for people within that vicinity, they see that they can I don't want to say make more money, but it might be more financially viable for them to follow this kind of program and they get rid of all their inpatient beds just because now it's more financially prudent for them to do this. They don't have to close down. They could still be, you know, open, but-- and then what happens to those inpatient beds? Now we have patients with a-- who have drive or-- you know, hours away to stay in an inpatient bed--

ANDY HALE: Yeah.

B. HANSEN: --but that's not my concern. Maybe it would happen, maybe it might not happen, but--

ANDY HALE: Yeah, I could-- I can

B. HANSEN: --trying to read the tea leaves a little bit there.

ANDY HALE: Sure. I can see where you're coming from. Again, they would be able to treat, treat you, stabilize you, make sure that you're well enough to transfer, and then go down the road. So yeah, I mean, that would be a concern, but it, it's a concern now in our rural parts of the state, you know, having to travel long distances for that care. So ideally when you're, when you're looking at heart attacks and strokes and TBI injuries, those sorts of things, every second counts. And so if we can have these hospitals, just with their emergency departments, be able to treat and stabilize, that would be key.

B. HANSEN: Thank you.

ANDY HALE: Um-hum. Thank you.

ARCH: Other questions? Senator Murman.

MURMAN: So these hospitals would be able to do outpatient surgeries and also have a skilled nursing home connected. Is that--

ANDY HALE: That's correct, yep.

MURMAN: OK.

ANDY HALE: Yeah and that, that is still a pretty big revenue generator for our facilities and so they would still be able to provide that care in the community.

MURMAN: And, and need for the communities quite often also.

ANDY HALE: Yeah, absolutely. There's a huge need throughout the entire state.

MURMAN: Sounds great. Thanks.

ANDY HALE: Thank you, Senator.

ARCH: Other questions? I just have one final one. I just want to confirm Section 5. The way I read Section 5, you must, first of all, be a licensed hospital before you can become one of these, right?

ANDY HALE: That is correct.

ARCH: OK.

ANDY HALE: That is our interpretation.

ARCH: So people can't come into the state and open one of these up in Kearney.

ANDY HALE: Correct.

ARCH: They-- if Kearney decides to step down, that'd be one thing, but you, you have to be a hospital first.

ANDY HALE: Correct. Yeah, you already have to have a license within the state.

ARCH: OK.

ANDY HALE: And you'd be able to convert that license. So there would be no new hospitals. There would only be hospitals switching their licensure under this new agreement.

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

ANDY HALE: Thank you, senators.

ARCH: Next proponent for LB697. Any opponents for LB697? Anybody wish to testify in a neutral capacity? Seeing none, Senator Kolterman. And while you're coming up, we did receive two letters in support; one was for that-- from Dexter Schrodt from the Nebraska Medical Association and Bryson Bartels representing DHHS and no opponents.

KOLTERMAN: Well, thank you again, Senator Arch and members of the committee. I just have a couple of things in closing. You know, I, I've been here seven years now, starting my eighth year and serve-- had the fortunate privilege of serving on this committee for four of those years. It is imperative to our rural communities that we pass this legislation. I felt somewhat honored that they would ask me to carry this because we've been strong advocates for our rural hospitals and our rural healthcare arenas, our medical practitioners. Over the last seven or eight years, we've passed a lot of legislation that's dealt with telehealth, with licensure changes. The goal for me in passing this legislation is we stop things-- we need to provide medical care for the Tildens and the Oaklands, just like we do for every place else in the state. If this is one opportunity to be proactive in allowing hospitals to stay open in some fashion, it's very positive for those communities that we serve. And so with that, I would hope that you could see your way to pass this on to the floor. If we need to move it into another bill that's more convenient for you, I'm open to that, but I'd appreciate a positive outcome and look forward to working with you as we move this bill forward. Thank you.

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

KOLTERMAN: Thank you.

ARCH: This will close the hearing on LB697 and we will now open the hearing on LB555-- I'm sorry, LB855. The numbers are swirling,

WILLIAMS: They all look alike.

ARCH: They're swirling.

M. CAVANAUGH: We have one more day.

ARCH: Yeah. Welcome.

DAY: Thank you. Good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Jen Day. That's J-e-n D-a-y and I represent Legislative District 49, which covers part of

north-central Sarpy County, including the areas of Chalco and portions of Gretna and western Papillion and La Vista. I'm here today to introduce LB855, which adds federally qualified health centers and rural health clinics under the state's Medicaid statute outlining required health services in our Medicaid plan. The healthcare sector is complex with intricate layers of providers and subcontractors. Ensuring Nebraska's laws reflect and match the language of the federal statutes ensures efficiency within the bureaucracy and that-- within that bureaucracy and that Nebraskans are receiving the medical care they deserve, which are guaranteed under current federal laws. The bill completes the list of mandatory services outlined by the Centers for Medicare and Medicaid and all states' Medicaid programs. As you know, Medicaid is a partnership between the federal and state to cover healthcare for vulnerable populations. Those vulnerable populations are regularly served by both federally qualified health centers and rural health clinics and it is important that our state statute reflects what is required by the federal government to participate. Nebraska's seven federally qualified health centers are nonprofit, community-based organizations that provide high-quality medical, dental, behavioral, pharmacy, and support services to persons of all ages, regardless of their economic or insurance status. To this end, Nebraska's community health centers provide comprehensive, culturally appropriate primary care to over 107,000 patients in Nebraska at 70 different service locations. Nebraska federally qualified health centers are a critical component to the healthcare safety net in the state. Nearly 47 percent of healthcare patients are uninsured and 93 percent are low income. Likewise, rural health clinics provide access to primary care services at over 140 locations in underserved communities in rural Nebraska. Because the health services provided by these two entities are required by CMS, the state of Nebraska already provides reimbursement for these services. Therefore, there are no additional costs associated with this legislation. LB855 is a necessary cleanup to bring our statutes better into line with federal statutes in a program that provides critical health services to Nebraskans, especially in rural areas of the state. And with that, I am open to answer any questions, but is probably best reserved for Dr. Andrea Skolkin, who is going to be testifying right after me.

ARCH: OK. Do we have any hard questions for Senator Day? All right, thank you very much.

DAY: Thank you.

ARCH: First proponent for LB855. Welcome.

ANDREA SKOLKIN: Thank you. 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, but I'm here today representing Nebraska's seven health centers in the Health Center Association of Nebraska. We are in strong support of LB855 and would like to thank Senator Day for introducing the bill. LB855 would codify federally qualified health centers and rural health clinics as a required service under the Medicaid statute. FQHCs and RHCs are required services under federal law and paid as such by a Nebraska Medicaid, but not included in statute. This bill simply cleans up the language with existing Nebraska Medicaid statutes and brings it into alignment with federal law. Because Nebraska already pays for these services, there's no financial or operational cost or impact to this state. Federally qualified health centers are unique and a critical element of the safety net in Nebraska and, as you heard, provide comprehensive primary care services to over 107,000 individuals, regardless of their insurance status. About one-fourth of our patients are Medicaid, though it varies from health center to a health center. Nearly 45 percent of our patients, though, are uninsured and we use a sliding scale based on their ability to pay. That is, 48,000 uninsured patients that sought care at a federally qualified health center in 2020, which is 31 percent of Nebraska's total uninsured population. The systemic barriers to achieving equitable access to health care have only been magnified, as you know, through COVID-19 and the pandemic. Because we largely serve low-income and minority populations, we have seen this impact firsthand. Over the course of the pandemic, health centers have tested, treated, and vaccinated thousands of Nebraskans. We are reaching the community not only inside our doors, but outside our doors during door-to-door vaccine education and vaccination and we continue to stretch our resources to address the cultural, linguistic, and systemic barriers to access care and treatment for COVID-19. FQHCs are integral to the communities that they serve, providing high-quality care to populations in areas in the state which would otherwise lack options. We provide stable, good-paying jobs and promote the economic well-being of the community. We provide about $208 million in overall economic impact and create 1,657 jobs, including the ripple effect to over 600 additional community jobs, not at the health center. This demonstrates immense value that the health centers have to our Nebraska communities. Thank you again, Senator Day, for introducing this bill and Chairman Arch and all of you members of the committee. We encourage and appreciate your support throughout all the years for federally qualified health

centers and LB855 and I'm available for questions. Thank you very much.

ARCH: Thank you and thank you as well for the work you've done, especially during this pandemic.

ANDREA SKOLKIN: Thank you.

ARCH: Very important work. Questions? Senator Murman.

MURMAN: Yeah. I also want to thank you for what you do, especially during the pandemic. The, the federally, federally qualified health centers are-- how much of the funding comes from the federal government?

ANDREA SKOLKIN: Of the seven, each one is individual that way. With some of the American Rescue funds, just our health center as an example going into '22, it's about 23 percent of our total budget and then 52 percent we-- is Medicare, Medicaid, and what patients pay.

MURMAN: So that funding is after the-- including the pandemic funding?

ANDREA SKOLKIN: Yes, that includes pandemic funding.

MURMAN: So before the pandemic, about how much came from federal funding?

ANDREA SKOLKIN: About 15 percent.

MURMAN: Fift-- 1-5?

ANDREA SKOLKIN: Um-hum, but every health center is a-- you know, every health center budget, like most nonprofits, varies and it's a patchwork of resources.

MURMAN: So with the, the pandemic funding, I thought that would increase, a higher percentage would come from federal funding.

ANDREA SKOLKIN: It has increased, but it hasn't increased to cover all the costs.

MURMAN: OK. So if we would codify this in state statutes and the federal funding would go away, how-- the, the state would have to pick up the difference or, or what is the risk that-- I guess I'm asking.

ANDREA SKOLKIN: From a federally qualified health center's viewpoint, we don't see any risk. What we're trying to do, I think, is assure that Nebraska continues to pay Medicaid to the federally qualified health centers and putting that in statute does that for us. In different administrations, quite honestly, differing opinions can exist as to payment to federally qualified health centers. And so by putting it in statute, that just gives us a comfort level and our patients a comfort level that Medicaid will be there.

MURMAN: Thank you.

ARCH: Other questions? Honestly, that raised kind of another question in my mind. If the federal government decides not to cover federally qualified health centers in their Medicaid services, by putting it into our statute, we wouldn't be able to either since it's federal-- since it's a federal program. My-- maybe that's something we can discuss later, but I, I guess that, that raises the question. Since this is in the statute that talks about Title 19 of the federal Social Security Act, if they suddenly decided to not include that, we wouldn't be able to do that at a state level. Now if the state decides not to participate and you-- and have this as a covered service, then-- but anyway, we can-- we'll, we'll-- we can discuss that offline, but we'll, we'll have that conversation. All right.

ANDREA SKOLKIN: Thank you, Senator.

ARCH: Any other questions? Seeing none, thank you--

ANDREA SKOLKIN: Thank you.

ARCH: --very much for your testimony. Next proponent for LB855. Is there anyone that would like to speak in opposition to LB855 or in a neutral capacity? Seeing none, Senator Day is waiving closing. So this will end our hearing on LB855. There were no letters we received and this will end the hearings-- the hearing of the committee for the day.