HANSEN: All right. I will briefly mention a couple things here. Good afternoon and, and welcome to the Health and Human Services Committee. My name is Senator Ben Hansen. I represent the 16th Legislative District in Washington, Burt, Cuming, and part of Stanton Counties and I serve as Chair of the Health and Human Services Committee. I would like to invite the members of the committee to introduce themselves, starting on my right with Senator Day.

DAY: Good afternoon, I'm Senator Jen Day. I represent Legislative District 49 in Sarpy County.

HARDIN: Brian Hardin, District 48, the real west: Banner, Kimball, Scotts Bluff County.

RIEPE: Merv Riepe, Legislative District 12, which is part of the Omaha metro area.

HANSEN: Also assisting the committee is our legal counsel, legal counsel-- our research analyst Bryson Bartels and our committee clerk Payton Coulter. And our committee pages for today are Maggie and Molly. A few notes about our policy and procedures. We'll-- please turn off or silence your cell phones. We will be hearing 5-- 4, 4 bills today and will be taken in the order listed on the agenda outside of the room. On each of the tables near the doors to the hearing room, you'll find green testifier sheets. If you're planning to testify today, please fill one out and hand it to Payton when you come up to testify. This will help us keep an accurate record of the hearing. If you are not testifying at the microphone and want to go on record as having a position on a bill being heard today, there are yellow sign-in sheets at each entrance where you may leave your name and other pertinent information. Also, I would note if you are not testifying but have an online position comment to submit, the Legislature's policy is that all comments for the record must be received by the committee by 8 a.m. the day of the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. We would ask if you do have any handouts that you please bring 10 copies and give them to the page. We use a light system for testifying. Each testifier will have somewhere around 3 to 5 minutes to testify depending on the number of testifiers per bill. When you begin, the light will be green. When the light turns yellow, that means you have 1 minute left. When the light turns red, it is time to end your testimony and we'll ask that you 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. 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. On a side note, the reading of testimony that is not your own is not allowed unless previously approved. And we do have a strict no-prop policy in this committee. So with that, we'll begin today's hearing with LB1087 and welcome Senator Jacobson to open. Welcome.

JACOBSON: Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Senator Mike Jacobson, M-i-k-e J-a-c-o-b-s-o-n, and I represent the 42nd Legislative District. I'm thrilled to be here today to introduce LB1087, which I believe could be one of the most impactful pieces of legislation that we have the opportunity to pass this session. LB1087 will create the Hospital Quality Assurance and Access Assessment Act, which is a program to allow hospitals across our entire state to draw down appropriate Medicaid reimbursement costs and recoup the costs they incur when providing care to our constituents who are using Medicaid. If passed, this bill will increase and improve access to the quality care across the state and give us measurable results for all Nebraskans. As you know, I currently serve on the governing board of my local hospital, and I know from this experience how important this legislation could be. I have introduced and passed with this committee support bills to improve Medicaid access and eligibility and rebase certain rates. But those bills alone cannot touch the incredible hole our Medicaid providers find themselves in. This program allows our state to dramatically increase reimbursement rates without costing our state General Fund any money. It will have a dramatic impact on reimbursement rates, hospital services, and ultimately on the availability of healthcare across the state. I might just mention, along with that, if you look at this bill-- I've referred to this many times as a win, win, win. This is a huge win to the state of Nebraska. This is nearly $1 billion of federal dollars coming to the state. There are 43 other states that have already-- that are already accessing this program and have been accessing these dollars. This is net dollars coming to the state of Nebraska, and the hospitals across the state to participate would be required to be-- pay an access fee, if you will, to be part of this program. And they will also collectively, as a group of hospitals across the state, be held to increasing certain outcomes-- medical outcomes as one of the prerequisites for continuing to receive these funds. The benefit of

this, of course, is, as I mentioned with the rebasing, is rebasing rates would be a way to be able to try to get a better reimbursement for our, our Medicaid, Medicare, and particularly this, Medicaid providers across the state. But that would come right out of the state's General Fund, which is the only option we've had. By bringing these dollars in-- the federal dollars in, this goes to DHHS. They then are able to increase the Medicaid reimbursement rates significantly. And let me just say for a minute on this: Medicaid reimbursement rates-- and I know-- remember first going on the hospital board, I was trying to understand their business model. And they explained it a couple of times and I said I'm trying to figure out what we're doing here and why you're in business. Because with Medicare and Medicaid, you're being reimbursed at rates far below your costs. I mean, we could be as low as 38% of your cost, maybe as high as 80%, but you're still doing services below your cost. How does that-- how is that sustainable? Well, the only way it's sustainable is that's how you get $25 for an aspirin and, and that's how you end up with insured providers-- or insured patients having to pick up that additional cost in order to make the numbers work. That, of course, then gets passed through to the-- insurance companies are going to eat some of that cost. They're going to pass that on to, to premium payers in, in the form of higher premiums. And the vicious cycle continues. This is going to be a win for insurance companies, health insurance providers. It's going to be a win for hospitals. It's going to be a win for the state. And, most importantly, it's going to create additional access for Medicaid patients, as we will find that more providers will likely be providing services to these Medicaid patients where they can't afford to today because those rates are so low. As I said in the beginning, I think this can be one of the most impactful pieces of legislation we could pass this session. And I encourage you to, to consider it strongly. There will be a number of testifiers behind me that actually know the guts of this bill, but I'd be happy to take any questions you may have.

HANSEN: All right. Thank you. Are there any questions from the committee? Seeing none, see you at close.

JACOBSON: Yes. Thank you. I do plan to stick around.

HANSEN: All right.

JACOBSON: Thank you.

HANSEN: All right. We'll take our first testifier in support of LB1087.

JEREMY NORDQUIST: Good afternoon, Chairman Hansen, members of the Health and Human Services Committee. I am Jeremy Nordquist, J-e-r-e-m-y N-o-r-d-q-u-i-s-t, and I'm the president of the Nebraska Hospital Association, here today to offer our support on LB1087 on behalf of our 92 member hospitals and 50,000 healthcare professionals they employ. Nebraska's hospitals are facing significant financial challenges. Much like Nebraskans are feeling throughout our economy, member-- our members are combating inflationary pressures and workforce shortages. From the middle of 2022 through today, the average cost to provide care at our hospitals is up 32-- 33.2% on average. Some hospitals have reported cost growth during this period as high as 48%. During the same time period, however, Medicaid rates have only increased an average of 2.25% per year. Due to the inflation-forced expense growth and insufficient rate, rate increases from public payers, a majority of Nebraska hospitals are now losing money on operations, 51%. This includes 59% of our small rural critical access hospitals. These financial dynamics have forced Nebraska hospitals to make difficult decisions. In the past 18 months, 3 of our rural hospitals have closed their labor and delivery units. Two more hospitals, in addition to several in the years prior, had closed their hospital and nursing homes. Hospitals have closed behavioral health, hospice, home health, all services that their communities needed but could no longer be sustained by our nonprofit hospitals with current reimbursement rates. LB1087 is a lifeline to our hospitals and, more importantly, to the Nebraskans they serve. We're grateful to Senator Jacobson for bringing this forward and for his continued leadership in advocating for rural healthcare. In short, LB1087 allows us to leverage additional federal funds to support Medicaid rate increases for inpatient and outpatient hospital services. This is carried out through a partnership between the state and hospital providers. Under this proposal, hospitals would pay an assessment to the state up to 6% of revenue that would then be matched by CMS. For every dollar in the program, whether that's a state dollar or, in this case, our dollars through the assessment, the federal match would be $2.19. Then these Medicaid directed payments, as they're called, would be distributed through the MCOs out to the hospitals based on the share of Medicaid inpatient and outpatient services they provide. The concept of a provider assessment to match federal funds and enhanced rates goes all the way back to the 1990s. Nebraska, we currently have 2 programs already, 1 for nursing homes that was enacted in 2011, and 1 for intermediate care facilities for individuals with developmental disabilities that goes back to the late '90s. I handed out a sheet in the folder that shows all the state programs for-- that, that have a provider assessment across the

country. As Senator Jacobson said, 43 states and the District of Columbia right now have a program in place. New Mexico has passed theirs and is implementing. And then we're in the same boat right now with, I know, Nevada and Delaware have pending legislation. So the only states that would be remaining would be South Dakota, North Dakota, and Alaska. I'd like to take a second and thank Governor Pillen's administration for working with us on this. DHHS has been a good partner and we feel that we can establish a program that focuses and improves the well-being of the Medicaid population but also, as a whole, protects the critical services-- critical healthcare services for Nebraskans across the whole state. We do have some hospital leaders here today to talk about the, the challenges their hospitals are facing and how this could help, but I'm happy to answer any questions about the legislation or any questions about how the program would function. Thank you.

HANSEN: Thank you for your testimony. Are there any questions from the committee? Yes, Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you,--

JEREMY NORDQUIST: Yeah.

M. CAVANAUGH: --I was going to say Senator-- Mr. Nordquist. Fiscal note.

JEREMY NORDQUIST: Yeah.

M. CAVANAUGH: OK. So the fiscal note is that it would be approximately $9,230,000 would be sufficient to cover the administrative costs, costs which would be about 2% to DHHS. But then I look at the department's fiscal note and they are asking for more money.

JEREMY NORDQUIST: Yeah. Yeah. I think-- I think--

M. CAVANAUGH: Guess that wasn't really a question so much as a statement put to you. Do you have a response?

JEREMY NORDQUIST: Yeah, well, we think we can, together with the committee, work with the department to get to a, a reasonable number that we would all agree is, is reasonable.

M. CAVANAUGH: So how much would it actually cost for the state to administer this?

JEREMY NORDQUIST: Through some informal conversations, and I hate to speak for them, you know, I, I think--

RIEPE: You are under oath, you know.

M. CAVANAUGH: Well--

JEREMY NORDQUIST: I know-- I know.

M. CAVANAUGH: I don't know, maybe they'll show up.

JEREMY NORDQUIST: Maybe I'll go to this point.

M. CAVANAUGH: They haven't shown up all week so maybe they'll show up today to speak for themselves. So until that happens, go ahead and speak for them.

JEREMY NORDQUIST: The nursing home assessment program, which is not that dissimilar-- not, not, not that different from this is, is operated on about $150,000 a year. Now, you know, inflation, as I said, has driven up wages and other costs. So, you know, maybe we can come to a more reasonable number. We put the 2% number in there based on what Iowa did, our model is very similar to Iowa. They had an agreement over there of a 2% administrative cost to the state so that's what we started with in the legislation but we're happy to have those conversations and get to a number that, that we would agree to.

M. CAVANAUGH: So nursing home-- so somewhere between $150,000 and $9 million is maybe where we land on how much it costs.

JEREMY NORDQUIST: Somewhere in there.

M. CAVANAUGH: OK.

JEREMY NORDQUIST: Yeah.

M. CAVANAUGH: Just to follow up on the introducer's opening about the cost currently of operating without this Medicaid does not cover the actual expenses and so that does fall down to the hospitals to find a way to cover it in other revenue generating resources. So I guess I'm just, again, making a statement to you, Mr. Nordquist, that it seems odd and I'm going to go ahead and say inappropriate for the state to take money away that is intended to offset the cost of healthcare for those who have full coverage in their healthcare. So I'm just going to leave it at that. Thank you.

JEREMY NORDQUIST: Thank you.

HANSEN: Any other questions from the committee? Yes, Senator Day.

DAY: Thank you, Chairman Hansen. Thank you for being here today, Mr. Nordquist. I appreciate you mentioning labor and delivery units and rural hospitals closing those. I did an interim hearing over the fall on maternity care deserts and this was talked about quite a bit as one of the issues in terms of the cost of operations. And I was going to ask, if by chance, if you had those numbers in front of you in terms of what it costs in a typical labor and delivery, what it costs the hospital versus, versus what the reimbursement is currently--

JEREMY NORDQUIST: Yeah.

DAY: --versus what it would be if we were to pass a piece of legislation like this?

JEREMY NORDQUIST: I, I don't know that I have those in my packet. There might be somebody testifying after me that will.

DAY: OK.

JEREMY NORDQUIST: When we surveyed it was certainly, if I-- if I recall, around, you know, anywhere from 40 to 60% depending on the cost structure of the hospital of the reimbursement. But to your point and I-- this is something that I didn't know as a legislator or as, you know, president of the Hospital Association until I asked my team to pull it today. They said out of the pie of Medicaid hospitalizations, what's the breakout kind of by service category in terms of big buckets? And perinatal conditions in the perinatal period and pregnancy childbirth are about 42% of Medicaid hospitalizations and mental health is 18.6%. So that-- we're talking just those 2 buckets alone are about 60% of the Medicaid hospitalizations. So when we talk about the impact of this, we're really zeroing in on mental health, labor, and delivery are going to see the biggest benefit out of this additional investment.

DAY: OK. That's helpful. Thank you.

JEREMY NORDQUIST: Yeah.

HANSEN: Senator Riepe.

RIEPE: Thank you, Chairman Nordquist-- or Chairman Hansen. Mr. Nordquist, glad to have you here. One of the questions that I have is

what has been the primary driver of this? Is this because 15 years ago, as hospitals, we-- Medicaid has always been an issue for reimbursement. We throw a lot of money as a-- as a state to mental health, a lot of it recently. So my is, what are the contributing factors that have grown this greater discrepancy between-- because it's not just a matter of payment, it's, it's increased enrollment in Medicaid. Are those undocumented or what's going on that's driving this off? And the other one, which is a statement more than a question. I'm really concerned that all of this is more of a move towards a federalization of the entire healthcare system, which I see is inevitable, but that's a little editorial [INAUDIBLE] now with growth.

JEREMY NORDQUIST: Yeah. Well, I won't take your-- I won't take your bait on the last part of that but-- no, your comment. What-- I mean, the growth, the gap is right now. I mean, it has again exploded 40, 40% costs up. But when you add up the 2%, 2%, 2% over that same period of time, I mean, that alone has factored in significantly. Yeah, we are caring for more people with, with expansion, there's no doubt about that. But it, it really is the, the gap. And I have a-- I didn't bring it today, but a chart that goes back 20 years of our costs for hospital services year over year growth, the average over 20 years. And we can all point fingers about why hospital costs have grown 5% a year on average over the last 20 years. I'll look to former hospital administrators that maybe had a hand in that. But, but the, the reimbursement rates in Medicaid over that time period have also been only 1.56%. So it's, it's a 20-year gap that every year just keeps getting bigger and what-- and our hospital folks can probably speak to this, we're also now at a point where with that and with the Medicare losses private insurance is really starting to draw a hard line. They're like, there's only so much we can cost shift onto private ratepayers anymore and it feels like the negotiations are getting tougher. The, the hoops we have to jump through to get things approved by private pay is getting tougher. And if we don't have some pressure to relieve the losses on the public programs, we're going to have to start shedding more services.

RIEPE: If I may, 1 more? Obamacare has provided relief for people that might not qualify for Medicaid, but don't go the commercial route. So the payment there, I assume-- I'm not-- I'm not long enough-- I'm not familiar with how do they pay? Are they somewhere between Medicaid and commercial?

JEREMY NORDQUIST: So, so in, in terms of the expansion population or the private?

RIEPE: [INAUDIBLE] but-- well, the expansion has been very-- fairly significant.

JEREMY NORDQUIST: Right.

RIEPE: I think the question gets to be is, are their rates fundamentally under the break even for hospitals, too? I mean, they're contributing to the problem.

JEREMY NORDQUIST: I might let-- somebody else can clarify. But what I think the challenge with a lot of those plans are, is the deductibles are so high that hospitals actually don't recoup as much. Because there's a $5,000, $6,000 deductible on those-- a lot of those plans. And the national stat I heard the other day was when-- the national number when a hospital sends out a bill, they collect 41 cents on the dollar. And that's because of people just having plans that have such a big deductible that they can't meet that on, on an annual basis if they have high health costs. So while those plans are paying, there's so much at the front end that isn't collected by, by the hospital.

RIEPE: Yeah.

JEREMY NORDQUIST: Yeah.

RIEPE: And it is a problem.

JEREMY NORDQUIST: Right.

RIEPE: Thank you very much.

JEREMY NORDQUIST: Thank you.

RIEPE: Thank you, Mr. Chairman.

HANSEN: Any other questions from the committee? Senator Hardin.

HARDIN: Thanks for being here.

JEREMY NORDQUIST: Yeah.

HARDIN: Did we do redetermination correctly in your opinion?

JEREMY NORDQUIST: You know, I think compared to other states, I, I think we're, we're working through it. Other states, I think, have been flagged for more challenges that have been offensive to CMS. So I, I think we've had sufficient staff. I think our department did about as good as they could with the resources they had available.

HARDIN: OK.

JEREMY NORDQUIST: Yeah, I haven't heard-- I have not-- I have not heard a lot of complaints from our members about that process not being sufficient. It, it was a whole new workload thrown on DHHS. It-- you know, it, it politically is challenging because people were being moved off coverage. But we do have eligibility criteria that, that is set in statute and they had to redetermine their eligibility. So short answer, I think so.

HARDIN: Thank you for your willingness to be here.

JEREMY NORDQUIST: Yeah.

HARDIN: Any other questions? I don't see any. Thank you.

JEREMY NORDQUIST: Thank you.

HARDIN: The next proponent for LB1087. Welcome.

MEL McNEA: Welcome, sir. My name is Mel McNea, and I'd like to-- good afternoon, first of all. And Senator Hansen stepped out, but thank you to Chairman Hansen and the rest of Health and Human Services Committee. My name is Mel, M-e-l, last name McNea, M-c-N-e-a. I support LB1087, also known as the Hospital Quality Assurance and Access Assessment Act. And that's a tongue tier, by the way. I think it really strikes a balance between holding hospitals accountable for ensuring good healthcare, but also utilizing our resources well to improve that quality, ensure quality of access to care. I've been in healthcare for about 44 years. I retired one time, and served as Great Plains Health in North Platte CEO for about 7 years and currently serving as the CEO for Regional West in Scottsbluff. My whole intent in being in healthcare is really to ensure access to quality care and serving as a, a CEO of Regional West has granted me a better appreciation of the geographic expanse of western Nebraska. It sits about 2.5 hours west of North Platte. Both hospitals serve a large area of, of western Nebraska. Great Plains Health and Regional West Service are the 2 main independent hospitals out west. And it's important that we ensure their survivability. I was really involved in the COVID time frame at Great Plains Health, retired after that, and then came back into service to offer some assistance to Regional West. And I would have to say the post-COVID challenges are actually different and much more challenging than what I witnessed as actually serving during the COVID years. We have a high use of agency and locums. That's due to lack of workforce. We have early retirements

going on. Those occurred during the COVID years, but they are occurring now. We all know that the baby, baby boomers are starting to retire. We have-- during the COVID years, we saw a, a reduction in the amount of people in clinical rotations. And because of that, we left the COVID years and we did not have that surplus of nurses, physicians, radiologic technologists, lab people because they didn't do their COVID clinical rotations so we had fewer graduates. Inflation has hit every aspect of, of healthcare. And Senator Riepe indicated why are healthcare prices increasing? When I look at it and look at it now, we've seen a huge inflation in healthcare. So elevator repair, mechanical and electrical repair. We have a pilot shortage right now. Regional West operates a helicopter service. There's a shortage of pilots across the country. So everything is increasing in cost. We've gone from 40 cents on a dollar reimbursement when I was CEO at Great Plains to 32 cents at Regional West. So there's a lot of different challenges. The other one is pharmacology. Right now, we have a pharmacology company that we work with that demands payments every 5 days. Those payments are almost $300,000 a week. Medicare, Medicaid money does not come in every week. And so the challenge is coming up and paying your bills. Part of that is they've threatened to withhold pharmacy drugs from our inpatients in our institution, which they can do. So it's really important that we recognize the challenges that hospitals are facing. Recently, our radiology services announced that they would no longer provide services to Alliance, to Chadron, and to Scottsbluff because of the economics of supplying those individuals in Scottsbluff and in the western part was just too expensive. All the above are the other-- and other reasons are why in 2022, Regional West lost about $54 million. We-- in order to survive, we've dropped services to surrounding communities. We've hold-- we've held off on infrastructure improvements. We've dropped affiliation with one of the critical access hospitals nearest in Oshkosh. I'm concerned also about behavioral health. It does not exist as a good inpatient unit in the western part of the state. People in the western part of the state have to go to Denver or Cheyenne. They don't accept Medicaid from Nebraska. So they end up going to Omaha or Lincoln or North Platte, and it's too fast for them to travel. They go without instead. And for all those reasons, I support LB1087. I'm not one to rely on federal or state funding, but we keep talking about what we want to do for economy in our state. If we don't have a good hospital system, we won't grow. And I'll end there and take questions.

HARDIN: Thank you, Mr. McNea.

MEL McNEA: Thank you, Senator Hardin.

HARDIN: Questions? Senator Riepe.

RIEPE: Thank you, Chairman. My question is, what is your next step on losing radiology?

MEL McNEA: In finding radiology?

RIEPE: Well, or just whatever the plan is to replace it if that's a tough go?

MEL McNEA: Yeah, quite-- right now, we were just given notice about a week and a half ago from the group that is based out of Denver and so we're looking at some of the groups that provide services in Nebraska. Of the 2 I've talked to, both of them are at max, so, but are willing to help us out in a temporary position. So we've got to find something permanent. We're in the process of maybe recruiting into Scottsbluff, our own independent group starting. But it's pretty expensive because there's such a competition out there to recruit those individuals. But I know the group or the team out there will come up with an answer, but we just don't need telehealth. You need hands-on service within the institution. You need somebody that can drain fluid from somebody's lugs-- lungs hands-on right there in the building. It doesn't work through telehealth in all aspects of healthcare.

RIEPE: OK. Thank you.

MEL McNEA: Um-hum.

RIEPE: Thank you, Chairman.

HARDIN: Any other questions? If I may, I'm going to editorialize a bit.

MEL McNEA: Uh-oh.

HARDIN: You have done an amazing job in our hospital turning things around and I'm letting you know publicly we really appreciate the work you have done at Regional West. Thank you.

MEL McNEA: No. Thank you.

HARDIN: Additionally, would you give us a prognostication, looking off into the future after you are no longer with us and not just for that area, but across Nebraska? We went through a perfect storm in the last few years is kind of what I'm hearing you say. An unfortunate one. Do you see a time where things normalize, whatever that might be?

MEL McNEA: I think as healthcare leaders, we have to relook at how we deliver healthcare and how we really provide services or access to services to rural areas of America. And there's challenges out there, but we can meet the challenge. One of the things that I was sharing earlier that we started in North Platte and Scottsbluff, both, is really everyday we have a, a group of providers and professionals that sit down and meet, we talk about the patients. There's so many opportunities to make sure they're getting the right medications, not excessive medications. We've worked with the VA to not refuse patients on the weekends, our nursing home. So you're paying for patients staying in the hospitals an extra day because of the difficulty in referring to nursing homes, the VA system, some of those entities, and we work closely with them. We've created kind of a, a comradery with them and we're working together. Through that process, we've been able to reduce the length of stay by 1 day across the board for every admission, which is-- doesn't seem like a lot, but it helps financially. In addition, what we've been able to do then is turn over our beds, and it's kind of like through this whole COVID thing, too, what I've witnessed is hospitals have become that kind of, I want to say, dumping ground. That's not what I want to use. But on the one side you have people pushing patients into the hospital, but on the other side people not accepting them back into institutions like nursing homes. So we have a quarterly meeting with all our nursing homes, and we're working through issues like that. So there are a lot of things we can do to reduce the cost of healthcare and that's one of them. Looking at antibiotics every day, are we over prescribing for our inpatients? We've been able to reduce our reliance on agency by almost $11 million last year, because of offering our employees some incentives internally. We've also been able to reduce the cost of supplies at Regional West by about $7 million. So last month was the first month we were in the black in 2023. So we're turning a corner, but this Medicare or Medicaid funding would be-- help us to improve the infrastructure, but it would also help us be survivable into the future and make these changes.

HARDIN: May I ask you to tip toe out onto the ice a bit and give us some thoughts on agencies. Can't live with them. Can't live without them.

MEL McNEA: Yeah, agencies is, is a, a real hard situation right now until we see the supply of nursing, see the supply of radiologic technologists, see the supply of ultrasound, lab, all those areas come back from that-- where I indicated earlier, where during the COVID years we didn't have them in clinical settings. So the education just kind of stopped there. And so that's helped-- or helped create that

lack of a number of employees. But also as we go through the baby boomers retiring, too, I do see a time when-- that we're able to handle that. We've gone from about 105 agency down to 50, and we hope to reduce that in half by the end of this year, too. I've-- if-- I also feel somewhat sad about, but it's, it's going to be something that each community is going to have to deal with is some of our critical access partners like was mentioned are going to have to make tough choices for their communities, whether they're going to have acute care, whether they're going to have nursing home, and where they're going to operate clinics. Those are-- those are questions that we're facing right now in healthcare. And we had to sever our relationship with Garden County Hospital because of the financial drain on the system. So those are the tough choices that are coming down the road, too.

HARDIN: OK. Thank you very much.

MEL McNEA: Yep.

HARDIN: Any other questions? Seeing none, thank you.

MEL McNEA: Thank you, Senator Hardin.

HANSEN: We will take our next proponent of LB1087. Yeah, just in time. My favorite testifier.

MANUELA BANNER: Good afternoon, Chairman Hansen, health-- members of the Health and Human Services Committee. My name is Manuela Banner, M-a-n-u-e-l-a B-a-n-n-e-r. I serve as the president and CEO of Memorial Community Hospital in Blair, Nebraska. And we are a 21-bed critical access hospital. I'm here today to testify in support of LB1087 on behalf of Blair Memorial and the Nebraska Hospital Association. As you have no doubt heard many times now, approximately half of Nebraska hospitals have operated at a loss in recent years and more rural hospitals in that. This financial strain has been caused by a combination of rising salaries, workforce shortages, issues that we and our partners in the educational sector are actively addressing. The second and equally important cause of these financial challenges is uncompensated or under compensated care by payers, primarily Medicaid. Both of those issues stand to improve significantly if LB1087 is passed. Utilizing the full federal Medicaid provider rate authority would enable the state to support our hospitals without burdening the General Funds with the financial responsibility of increasing taxes. Under the-- excuse me, under the Hospital Quality Assurance and Access Assessment Act, hospitals would pay an assessment

that combined with the General Funds appropriation will meet the state's federal provider cap without necessitating additional General Funds. Currently, the additional federal funding allocated for our state remains untouched while many of our colleagues, myself included, are contemplating service cuts to maintain financial stability. Looking at high-cost and high-Medicaid utilization, labor and delivery services come to mind, primarily. To be clear, it's not my intent to cut those services in my facility, but this bill would be very impactful in continuing all services that we currently offer. Incidentally, labor and delivery is the area in our facility that has the highest rate of Medicaid use. 18% of our patients have Medicaid as primary coverage and when I add patients with no payer source at all, we're at 24%. In Blair, we deliver a relatively small number of babies. And looking at our location close to Omaha, you might say, why do we deliver at all? Well, our location is significant. We're located at the southern boundary of a maternity care desert that extends north along the Missouri River, covering the area from Blair all the way to Sioux City, a distance of about 75 miles. I'd like to share an example of a baby we delivered in Blair just this last fall. There was a, a medical emergency before the mom came to the hospital. Had we not been able to intervene with an emergency C-section this mom or the-- nor the baby would have made it. As local hospitals and healthcare providers, we're committed to serving our communities delivering much-needed care providing access to safe and appropriate healthcare services within our communities. LB1087 would support us by enabling hospitals to be reimbursed by Medicaid at a level closer to our actual cost, as opposed to the current payment which falls significantly short. With this, I urge you to actively support the approval of this bill. Thank you. Do you have any questions for me?

HANSEN: Thank you for your testimony. Are there any questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman Hansen. I guess my question would be is, what would be the impact on the community as such if your facility was not there?

MANUELA BANNER: I think it would be a significant impact on the community of Blair, specifically. But we also serve, as I said, a rather large area to the north. We have a clinic in Tekamah, Nebraska, about 20 miles north of Blair and they would have to go to Omaha. Is that horrible? I don't know, but we have an elderly population, especially as we move out towards the more rural areas of our service area and those folks have a hard time with transportation. Transportation is a problem in our own community.

RIEPE: What-- can you tell me what the percentage is of your Medicare and your Medicaid patients? On an average day, is it 80% or is it--

MANUELA BANNER: About 60. I'm sorry.

RIEPE: No, go ahead.

MANUELA BANNER: Depend-- depending on the service, it's about 60%.

RIEPE: About 60. OK. Thank you, Mr. Chairman. Thank you. Thank you for being here.

MANUELA BANNER: Thank you.

HANSEN: Any other questions? I got a couple questions.

MANUELA BANNER: OK.

HANSEN: I had to take off to introduce another bill, so I was hoping to ask the Hospital Association these questions. So if you can't answer them, that's OK. But I'll put them out there in the universe for maybe somebody else to answer later if we need to. Are hospitals mandated to do this in Nebraska if we pass this law?

MANUELA BANNER: I'm sorry?

HANSEN: Are hospitals going to be mandated to partake in this if we pass this law, do you know?

MANUELA BANNER: Not that I know.

HANSEN: OK. And, again, if you don't, it's fine, somebody behind you can answer too. They-- you mentioned this is to assure quality and access in the Medicaid program. Are those defined? What does that mean?

MANUELA BANNER: They're defined to a point. And I do believe that one of the Nebraska Hospital Association staff members would probably be more suited to answer that question.

HANSEN: Perfect. Yep. And one other one. What guarantee do we have as consumers that healthcare costs will not increase if this is passed?

MANUELA BANNER: I wish I could give you that guarantee. Unfortunately--

HANSEN: Oh, I was hoping you would because, I mean, you know, you're in my town, so you'd be, like, healthcare wouldn't raise at all, but OK. That's all right, maybe someone else can answer. My main concern and, and purpose of that question was, it seems-- we're hoping that the infusion of this federal money then would help all taxpayers by maybe lowering healthcare costs not just for Medicaid people, but for other people. Because-- unless that argument we've heard before from hospitals is because we can't maintain our current Medicaid program, that cost then goes on to non-Medicaid payers because we have to increase costs in other ways. So hopefully this then would say we're not going to raise those healthcare costs or potentially lower them since we're getting this infusion of federal money, that's the purpose behind the question, I think, so.

MANUELA BANNER: I would hazard to offer an opinion that we are working really, really hard with quality initiatives and things like that to lower the cost of healthcare at the moment. And as we get paid at a level that we need to get paid that covers our costs, that we have more opportunity to work on equality.

HANSEN: Awesome. OK. Seeing no other questions. Thank you.

MANUELA BANNER: Thank you.

HANSEN: All right. We'll take our next testifier in support.

RYAN LARSEN: Senator-- or Chairman Hansen,--

HANSEN: Welcome.

RYAN LARSEN: --members of the committee, I am Ryan Larsen, R-y-a-n L-a-r-s-e-n. I am the administrator and chief executive officer of Community Medical Center in Falls City. I'm also a doctoral candidate in health policy at Nebraska-- or at Nebraska Methodist College. And I am here representing the Nebraska Hospital Association and the Nebraska Rural Health Association. I-- I'd like to-- it's always easier when you have time to think about the questions, maybe respond to my understanding of some of your questions for Senator Hansen.

HANSEN: Sure.

RYAN LARSEN: I, I actually believe that if this bill is passed it would apply to all hospitals and there would not, to my knowledge, be an opt out. It would be general. Hopefully the benefits are enough that everyone would be behind that. And I, I believe they are, but I'm not aware of an opt out. Definitely, the issue of healthcare cost is

very complicated and is significant. I would hope that some of the shift that occurs could be ameliorated, but the, the long-term issues of rising cost are going to take additional structural changes. One of the opportunities with this bill is, I hope, in-- there are quality requirements with it, as Senator Jacobson testified. And I think there are opportunities for the state to provide direction and say this is where we want quality to go. And part of that can be, hopefully, ways that allow some innovation in our healthcare system. At least that's my opinion on that and I don't-- there was a third question I may have not addressed.

HANSEN: I think that was most of them. The quality and access-- I'm still kind of confused about because it seems kind of vague getting this amount of money from the federal government, like what-- when they say, well, so long as you assure quality and access, here's the money.

RYAN LARSEN: Yeah.

HANSEN: But I don't know what that means, right, or could--

RYAN LARSEN: It's an interesting federal policy choice. I wish it was more just, hey, we realize we need to match more, let's work it out with the states instead of going through an assessment. But that seems to be the, the method they're using. In my community, four and a half years ago, we stopped delivering babies. And, definitely, finances are part of that, as is lack of staff and just the challenge of trying to maintain the level of competence. Last night, I met with the medical staff and board about, well, if this bill passes, would we go back and restart the service? And sadly for us, after a lot of soul searching, we said, no, the-- what it would take to get everybody trained again and competent to where we can safely deliver babies is, is unrealistic. It is much easier to retain that type of service and so I think the funding then that could go towards that. And for us Medicaid, our last year I think was 65% roughly of our deliveries of 50, 60 deliveries. That hopefully sustains that. Right now, our big concern is behavioral health in our community. We're seeing people leave the community. That's another high Medicaid area. And we feel that funding is something that would allow us to do some things to, to, to increase that. Right now, delivering moms drive-- most of them hour and a half, 2 hours to Lincoln and Omaha to deliver babies, including some exciting stories about making emergency stops in Nebraska City to deliver one where they couldn't quite make it. Our doctors do cooperative prenatal care to try and not make it so much of a desert, but there's absolutely been an impact on our community. For

the record, I am-- I've been in Nebraska, I'm in my 19th year, I came here and, more importantly, have stayed here by choice. It's where I've raised my children, and I love rural Nebraska, and I work with some of the most amazing and dedicated people that you can imagine. And so you've heard about the costs going up: pharmaceuticals, wages, supplies, construction. I'd also point out that demand for services has increased with chronic diseases as our society ages and the neglect that, that we've had with preventative care. And so we're seeing that increase and Medicaid rates have not kept up with that. And we don't blame you, it is hard to balance the state budget. The effect of this for us is seen in reduced behavioral services in our community ceasing delivery. We're seeing a lot of challenges among children as a result and, in some cases, closures. We've done very well as a hospital. We've been recognized for the last 7 years as one of the top 20 critical access hospitals in the nation. And even with that, this year has been an additional struggle and, and we're in the red from operations and we need help. This bill has a chance to be transformational. In my opinion, it does not really cost the state all the funds to pay for it will come from the assessment and the drawdown is, is pretty amazing. We hear about drought conditions. Well, this is our chance to provide some water in the terms of funding. In my mind, it's also about quality and it does provide access because so many of our programs for the most vulnerable, the children, expecting moms, the elderly are high Medicaid. And this helps focus some of that. Some of our hospitals do not really seek out Medicaid. Hopefully, this makes it more attractive for some of those groups as well. I see that my time is up. I would say that one of the things I like about Nebraska is focus on limited but well-run government. I hope we continue that. I think that reasonable administrative fees make sense. I have worked in a state where they seem to take the idea of nickels being like manhole covers and said, oh, let's spend quarters getting those nickels by siphoning off a bunch of administrative fees that not just take those fees but lose federal match dollars. And I really hope that we do not head down that route. I believe this is an exciting opportunity and I believe it's time and I thank you for your support.

HANSEN: Thank you. Are there any questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman Hansen. Thank you for being here. I think I heard in your testimony that you were saying that these funds would help you to increase behavioral services [INAUDIBLE]. I'm sitting here as a-- as a member of this committee saying, OK, is this legislation to sustain current operations or is it to increase operations? And I'm a little bit less receptive if it's an expansion program.

RYAN LARSEN: Well, I think the example of obstetrics hopefully would be for those that are doing it to sustain. In our case, we have been trying to increase access because we see nobody else providing behavioral health services in our community or, or limited. And so I guess we're seeing an unmet need. I don't think we're ever going to be a behavioral health center, there are no plans to open inpatient beds but we're trying to figure out how to get people care. One example, a new medication has really powerful opportunities with depression, chronic depression that is untreated by traditional medications. But if you live in our area, not only do you have a 4-hour round trip to the city, but you do 2 treatments at least a week. It's a couple hours of treatment and you can't drive for 24 hours, which means no one from our area goes and seeks this. We've started offering it just because our doctors are telling us we need to do it. And most of the patients in Medicaid, we lose money. We're trying to see if we can make it viable. It's not an intention to become a major center. It's really just about trying to meet our peace of need. I, I don't know if that addresses your concerns. The goal isn't so much to grow, but we do feel there are a lot of deficiencies in rural areas and our health outcomes are clearly worse than in urban areas. And that disparity is not fair to our farmers and our other people that are doing the work. Just because we live in a rural zip code does not mean that we should settle for substandard healthcare.

RIEPE: If I may, Mr. Chairman? I think, you know, we have thrown a ton of money towards behavioral health and mental health and the various regents. My question would be is, are you working with the-- your mental health regents, there are 6 in the state down there--

RYAN LARSEN: Yeah.

RIEPE: --to try to find something that they might be able to help fund some of this, too, so it's not exclusive?

RYAN LARSEN: In fact, we give our behavioral health region a little over $20,000 a year to help them bring an extra counselor to the community.

RIEPE: You have to pay them?

RYAN LARSEN: We do. We don't make any money on it. But they said that they were going to cut counseling because they were losing money off of it. And we said how much are you losing, we'll make it up. Our local school district had no psychologists or counselors and we said how much do you need? We found another partner, 3 of us, and we're

paying about $24,000 a year to the school district to try and get that to the children. The, the regions are great but it isn't getting out to everywhere we need.

RIEPE: It's a little alarming to me, too, because we've also thrown a ton of money at education. And so I don't think that you should necessarily have-- and I'm standing up for the hospital side here--

RYAN LARSEN: Oh, thank you.

RIEPE: --that you should be the ATM machine for all these other agencies within the community. They need to step up and pay their share. Thank you very much. Thank you, Mr. Chairman. That felt good.

HANSEN: Senator Riepe needs this every once in a while. It's like therapy.

RIEPE: I got my voice back.

RYAN LARSEN: I think I came to the state just as he was in his final professional years and remember listening to his strong opinions.

HANSEN: Well, we appreciate them, actually, on this committee. Senator Hardin.

HARDIN: About how many beds is your hospital?

RYAN LARSEN: We're a 24-bed hospital.

HARDIN: 24 beds. When you had the opportunity to look at this bill and potentially what could be there financially for, say, a 24-bed hospital, even, say, maybe a 25-bed hospital like the one in my district in Kimball, Nebraska, what might that mean if you are scratching around on the back of a napkin at some point saying, geez, what number might, might that translate to?

RYAN LARSEN: So if we use 6 million-- or 6% of net-patient revenues as the assessment, we would expect to spend about $2 million a year paid out in a quarterly basis so $500,000 a quarter in the assessment. And we'll see what the actual numbers come in. The higher your Medicaid the more that would be. For us, it looks like it would be about $5 million in payments. So a net of about $3 million a year annually. Now, I, I understand there will likely be some of that going into wages and to other things so I don't think it's all bottom line net but it is significant for us.

HARDIN: Thank you.

HANSEN: OK. I'm still getting hung up on this. This is like the-- kind of the crux of my concern is assuring quality and access. Do you-- do you have to fill out any reports or how, how do they quantify that you are having-- you are assuring quality and access? So like--

RYAN LARSEN: We submit so much data and it differs from entity to entity, federal and state. It's one of our complaints sometimes is can everybody just agree on a few measures and calculate them the same way. So there's a lot that, that is reported. And if you mess up like a staff member is tired and puts in the wrong data, they never let you go back and, and-- as least seems so we, we, we absolutely do. And then I believe my understanding is the state has a health quality plan. And then our quality program for this would have to align with that and that, that then goals would be set. The Hospital Association has a working group with, with constituents. And I believe they have come up with 4 areas and metrics in each of those saying these will be our goals for 4 years but, but the state would have to provide some leadership if we're going in the wrong direction. And, and these would be metrics that would be reported. And we agree and I believe it's a requirement, some of these added dollars would be put at risk. If we do not hit these measures, either at an individual or perhaps even a state level, we would forego some of this to put teeth behind let's see the needle move on these quality measures.

HANSEN: So then the state set the metrics that you're talking about right now, right?

RYAN LARSEN: I think the state's responsible for approving them. I, I believe in order to work with the legislation, Margaret Woeppel from the Hospital Association has been putting together the details to align with what the Governor's team has said he would want to see.

HANSEN: OK. So I, I get the state part, but the federal government, right, who we're getting the money from.

RYAN LARSEN: I, I don't think they set these targets.

HANSEN: So what metrics do they set?

RYAN LARSEN: So they do have some and-- so especially for our larger hospitals, they have a penalty system that if you have too high of readmissions or have high infection rates, there are already penalties in place there. For us, our measures tend to be cardiac care. How quick we are in the ER. We look at our infection rates also. I think

at the state level, OB care with early elective deliveries has been an issue trying to eliminate infections and catheters, which then require patients to spend extra time, several weeks sometimes, get extra care that really could be reduced with better clinical care. I'm not a clinician and so I'm sure we could provide some of these details. So, so there are goals, for me it's often a hodgepodge and it gets very frustrating, OK, where do we-- where do we want to focus? For my hospital, sepsis has been huge. We said it doesn't happen often, but if somebody in our facility is having a crisis, sepsis can kill you within 24 hours. We have to get that right. So our focus the last 3 or 4 years has been how do we make sure that every time we get it right and recognize the signs of sepsis and, and get it taken care of?

HANSEN: OK.

RYAN LARSEN: Sorry, maybe I'm-- no, go ahead.

HANSEN: I don't know if you're alleviating my concern or making it worse. But the reason why is because--

RYAN LARSEN: Are they sweating behind me here?

HANSEN: No. The-- this is what I've seen for being here for 6 years now, especially in HHS, it seems like over time we have programs such as this that we are in conjunction with the federal government where they give us money. We give them $1, they give us $2 back if we just follow these certain metrics or directions. Right? And then it's pretty vague at first it seems like, but then about 5 years down the road they change those metrics and they say, well, now we want to do-- we want you to do this instead that's, that's more constrictive, I think.

RYAN LARSEN: Yeah.

HANSEN: And then here come the hospitals to us again saying, well, we have to do this or we're going to lose all this federal funding. And so then, of course, everybody in the Legislature freaks out because we can't lose federal funding. And so we're kind of stuck. We kind of painted ourselves into a corner. And so my concern is, is this another one of those programs? That's kind of what I'm looking out for, will in 5 years, will the federal government come and say now we're going to define what quality and access means? [INAUDIBLE]

RYAN LARSEN: Yeah.

HANSEN: That's, that's a concern I have with any of these kind of programs. I'm not saying they're wrong or right.

RYAN LARSEN: I think that could happen.

HANSEN: I want-- I want definitions and I want more specifics about what do they mean by this?

RYAN LARSEN: I don't know that it will come specifically because of this program. I think both administrations, Republican and Democratic, when I've gone and listened have said we want more value, we want better quality. And both of them have been saying, and even you rural hospitals, we're going to make it apply to you. So I think that's happening whether we do this or not. This particular program has been around and available for a number of years. We have not taken advantage of it. I would hope that with good communication, we can use this to help fund some innovation to really make a difference and not just say we're going to hit this number or that one. So overall, again, your fear is-- and the federal government does wield a sledgehammer sometimes, and they don't always make sense to us, but I don't know that it is limited just to this program.

HANSEN: OK. I just wish I trusted our government more, you know, and I'm-- I am in government so that's a problem. But OK, I appreciate you actually, you know, clarifying some of that stuff, though.

RYAN LARSEN: Thank you.

HANSEN: Any other questions from the committee? Yes, Senator Riepe.

RIEPE: Thank you, Chairman Hansen. I have a quick question. Is there speculation or a stipulation here that says to participate in this program, that the hospital has to be accredited by The Joint Commission or some other accreditation group so that we know that we're not-- that we're getting some level of standard? Is that a requirement? Are you aware of that?

RYAN LARSEN: I am only aware that if you are designated a hospital by the state of Nebraska, so you carry a hospital license, then this would apply.

RIEPE: So it's kind of one standard for everyone and there's no-- well, OK.

RYAN LARSEN: Is, is Jeremy nodding his head or shaking it behind me?

HANSEN: He's kind of going in circles right now.

RYAN LARSEN: I, I, I am not aware of any accreditation standard as part of this. Though, again, the state can set the lead on, on your strings and requirements as well. My hospital has voluntarily become accredited to try to hold ourselves to a higher standard. And I think that that is not unreasonable to ask of others, but I guess that's beyond my expertise.

RIEPE: Thank you. Thank you, Chairman.

HANSEN: Seeing no other questions, thank you very much. Appreciate it. And we'll take our next testifier in support of LB1087. Welcome.

PAT CONNELL: Sorry. Good afternoon, my name is Pat Connell, P-a-t C-o-n-n-e-l-l. I'm the health policy advocate at Boys Town National Research Hospital. I've been in hospital administration for over 35 years, serving in a variety of capacities from Chief Financial Officer, COO, and CEO. I am hoping to answer some of your questions when talking about access and quality. So I'm going to deviate a little bit from my testimony. But I do want to point out a couple of things. The first is, is the behavioral health community is very excited about this, because we have seen a steady erosion in the number of available psychiatric beds in this state for over 30 years. And I've been doing this for at least 35 years so I've been in a front row seat in seeing this. The second thing is, is that behavioral health is very heavily regulated by both the state, the Medicaid program, CMS, and The Joint Commission. And we talked earlier about accreditation Senator Riepe brought up, most hospitals have to have The Joint Commission in order to get paid by the payers. As a condition of a lot of the payers, if we're-- you to get paid, you have to be Joint Commission accredited. I looked to at one time, our Joint Commission accreditation of behavioral health had 450 standards beyond what is regulated by Medicaid and what is regulated by CMS. So how does this affect and why would-- why would we, we be excited about this? Well, first of all, what has happened is why the, the steady decline in the number of available beds in this is that the hospitals had to subsidize behavioral health inpatient programs. They were always losing money and so money was diverted from other programs and funds to pay for the behavioral health programs. What happens is when, when times get tough, they start looking at low-margin programs. Behavioral health comes up with-- is identified as a one of those. And so we reduced the program or we closed the program or, or etcetera. We see this as a opportunity for the hospitals to, to get their payment rates up. And, and therefore having some funds that would be looked--

they would look at creating the opportunity for either reopening some programs or expanding the capacity of those programs. When you talk about quality, you know, there's, there's many, many different agencies that, that want to measure quality. And they all have their different metrics, and metrics are sometimes measured differently and etcetera. I think the number 1 quality measure metric that we measure in behavioral health is access and access-- timely access is important. So if you don't get timely access, the problem develops further on from what you would-- to get treated in an outpatient setting. Then we go to the emergency room and it requires hospitalization and then requires a whole series of other services. So it's like if you don't take care of diabetes now, it's going to become a really big health problem down the road. It's the same, same thing with mental health. I always look at, there was a Princeton healthcare economist by the name of Uwe Reinhardt. And Uwe Reinhardt said this back in 1990 when somebody asked him, what do you need to do to increase mental health in this country? And he says-- it said something-- and, and I wrote the quote down in my-- at the end of my testimony. But in essence, it is-- it is in order to, to do-- to do so, you have to-- in order to increase access, you have to increase capacity, the size of programs. And then once you-- how do you get the, the capacity to increase? Well, you have to do that by being able to sustain and be able to pay for the operating costs and the capital costs of the-- of the project. So the behavioral health community, that-- those who understand what this does to our healthcare system have to look at this as a, a very positive thing to increase in access. Thank you.

HANSEN: Thank you. Are there any questions from the committee? I was looking just a little bit more when we were talking about, like, what kind of metrics or what do we have to turn into verify assurance of quality and access. And I didn't really see too much in this-- in the bill here. I did see, though, that DHHS shall collect data from revenue, discharge, and inpatient days from any hospital that does not file an annual Medicare cost report. So seems like the metrics are revenue, discharge, and inpatient days. I don't-- I-- I'm trying to understand if that really measures quality or access.

PAT CONNELL: Well, I would almost say neither.

HANSEN: Yeah.

PAT CONNELL: Those are sort of like headings, is what, what do you want to focus on? Like, for instance, one of the things that has been a tradition in healthcare is looking at length of stay. How much time

does a patient need to be in a hospital after a transplant or, you know, a hernia operation or etcetera? So the short of that, is the, the more it looks like that. But you also want to look at reinfection rates. You also want to look at, you know, how the-- how the patient responds. Do, do they need more antibiotics? I mean, so there's a whole set of different levels of, of quality that, that is looked at. I think the one thing that, that happens here is we don't have access and in the-- in the state and, and the only way we're going to get higher quality is to have greater access.

HANSEN: OK. And that may be part of the revenue part. And I think that's what they have to turn in. You would just kind of see what the assessment is. I think that's probably what it is, but that makes sense.

PAT CONNELL: Yeah. The, the other thing is almost every managed care company has quality metrics. If you're a part of an accountable care organization, they have their metrics. The 3 MCOs in the state, they have their metrics that you-- for quality that hospitals have to provide that data to, to confirm that they're doing things right.

HANSEN: Yeah. And I think the previous testifiers, I totally agree with them. I think there's a lot of information that they have to share to, to verify, you know, the quality of care and access. So I'm wondering, you know, is that what the federal government is asking for to justify giving us the money? You know, so that's the reason I was asking that, so.

PAT CONNELL: So my editorial comment to that is, we're at the end of the-- I mean, there's 40 other states that have already done this. And so the federal government is trying to figure out, OK, why do we give these states this additional dollars? Well, they got to have a reason. They had to go back and say, well, we want it for quality. You know, we want it to increase access. And, and, you know, again, Senator Jacobson needs to be commended because I think this is going to help be-- sustain and help these critical access hospitals in our communities to thrive. And then second of all, you know, just because we're friends here in this room, you know, I, I drive all over the state of Nebraska to go hunting and fishing. It's a wonderful state, wonderful parks and everything else. But I worry about having a car accident in a rural area as to whether or not they have the resources to, to save me if I-- if I needed that care. I think this will-- this will help push services back into those rural hospitals and, and hopefully save lives. But that's just my editorial comment.

HANSEN: OK. Seeing no other questions, thank you very much.

PAT CONNELL: Thank you.

HANSEN: We'll take our next testifier in support.

SARA HOWARD: Hi, friends.

HANSEN: Welcome back.

SARA HOWARD: OK. Thank you for allowing me to testify today. My name is Sara Howard, spelled S-a-r-a H-o-w-a-r-d. I'm a policy advisor at First Five Nebraska. I'm gonna start with an apology. You guys can totally start a hearing without a quorum. I phoned a friend. Always pay attention to staff when they are, like, stop listening to the lady in the back row. You missed it. But I was, like, you can't start without a quorum. And anyway.

HANSEN: If it was anybody else, we would be concerned but with you we're not.

SARA HOWARD: I was so mean about it, though. I'm so sorry, so I apologize. OK. All right. And I'm using my time for this, too. So First Five Nebraska is a statewide public policy organization focused on promoting quality early care and learning opportunities for Nebraska's youngest children. My position at First Five Nebraska is focused on the area of maternal and infant health policy, because we know that healthy moms and babies are critical to ensuring the long-term success of children in our state. I'm here to testify in support of LB1087. First, I want to thank Senator Jacobson for his support of hospitals in Nebraska, but also his support of maternal and infant health. Like literally, his first speech on the floor was about a bill around stillbirth death outcomes. And so he's been a real champion for moms and babies. So I'm going to talk to you about 2 things. One is maternal care deserts, and the other one is that quality peace. Please don't ask me any hard questions, Senator Hansen, about the quality piece, but I'm going to touch on it just very lightly. You're making a face, but I know you want to, and I'm not-- I'm saying no. OK. So 51% of counties in the state of Nebraska are considered a maternal care desert. That's a care desert where there's no hospital, there's no OB provider, there's no birthing center. So over half of our-- of our state is considered a maternal care desert. Senator Day had a really brilliant LR over the summer. Senator Ballard, you were there for that. It was in the fall, it was in October. And we really kind of dug into the issue around maternal care

deserts, what they look like, what they mean. And so, Senator Day, you would ask the question about cost, which is an excellent one. So we'll talk about a normal delivery. So a normal delivery, the cost of the hospital is $5,700. But the amount that Medicaid pays them is $3,500 or $3,500. So that's about a $2,200, $2,200 difference. Last year, in the first three quarters of 2023, there were 4,188 normal births that were paid for by Medicaid. So if you take that 4,188 times $2,200, that is a over $9 million deficit that our hospitals are absorbing without any hope in sight that their Medicaid rates are going to go up and meet the cost of care. And so when we think about LB1087, we're thinking about how to get that provider rate closer to parity with the actual cost that it might be. The other piece is right at the bottom. And this one is very, very sad. We keep talking about labor and delivery, in particular, but if you-- if you dig into the-- I'll just keep going-- if you-- that's not-- like--

M. CAVANAUGH: It's real.

SARA HOWARD: OK. Great. Cool.

HANSEN: Yeah, it's in your head.

SARA HOWARD: It's like a ghost or something. OK. Great. If you dig into the stats of those babies born to mothers who are covered by Medicaid, 48% of them have a neonatal code. That means that they were born prematurely, low-birth weight. They had additional medical needs. So not only are we not seeing parity in sort of the cost of delivery for a normal delivery, we're probably not seeing parity around the cost of care for a high-needs baby who is born in the state. So that's the first piece. The second piece that I will tell you about is that quality assurance piece. So they have to agree to quality measures with the agency with DHHS. One of the quality measures that they want to look at is maternal depression screens. So I'll take you back to 2022, Senator Walz had LB905. That was to ensure that mothers were being screened for maternal depression, prenatally, postnatally, and at that well-child visit. You passed this beautiful bill, it was unanimous. Excellent work. And that went through the Board of Health to really encourage providers to have an awareness that they needed to do those screens. We are still not at 100% of every mother getting screened at those visits. And that's where we're starting to see mothers fall through the cracks, right? And so when we think about a quality assurance measure as a part of the funding that would come down with LB1087, maternal depression screens is a really good one. And I'll just remind you of the stat that we talked about in 2022. For a state of our size for the number of mothers that we have, we have at

least 1 to 3 completed suicides every year from a mother who's given birth in our state. To me, that's tragic, and it's something that could absolutely be addressed by making sure that screens are done regularly. And so part and parcel of LB1087 is that quality assurance piece, where they're really looking at those maternal depression screens and getting us to 100%. So those are the 2 reasons why I'm here. Normally, you would say, Sara Howard, First Five, what are you doing here? But I really do think that LB1087 can, can move the needle on our maternal care deserts and specifically around some specific quality measures for maternal care. I'm happy to try to answer any questions you may have.

HANSEN: All right. Thank you. Are there any questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: Well, I just would like to say I was very confused because I was finishing a meeting. I apologize to the committee and Senator Jacobson, but I walked out of my office and they said they're calling you. And I was like, they've never called me before for a quorum.

SARA HOWARD: OK, two [INAUDIBLE].

M. CAVANAUGH: So now I know why.

SARA HOWARD: And Senator Hansen probably remembers this. One, I had a lot of anxiety when I was serving as Chair, but I would call you guys. I would be like, pages, you call them and you get their butts in seats.

M. CAVANAUGH: Well--

SARA HOWARD: But that's only because I was always nervous about starting without you.

M. CAVANAUGH: Ms. Howard,--

SARA HOWARD: Yes, yes, please.

M. CAVANAUGH: --are you aware of term limits? You're no longer the Chair of HHS.

SARA HOWARD: I don't work here anymore. Yes, and what a relief it is, truly.

M. CAVANAUGH: I'm just kidding. I almost called Mr. Nordquist senator earlier, so.

SARA HOWARD: I know. Right. It's confusing.

M. CAVANAUGH: Thank you. I actually don't have questions. I'm just, like, blown away by all of the data that you just held in your head and, and gave to us, so thank you.

SARA HOWARD: Just put it right there, hide it away. Thank you. That's very nice of you.

HANSEN: Senator Day.

DAY: Thank you, Chairman Hansen. And nice to see you, Senator Howard. I appreciate you mentioning maternal care deserts and specifically the interim study that we did. Can you-- can you repeat the statistic you mentioned about suicide rates in new mothers? What was that again?

SARA HOWARD: Yeah, so that's from the Maternal Mortality Review Committee.

DAY: OK.

SARA HOWARD: So we know that we have at least 1 to 3 deaths annually of a mother who's committed suicide within the first year after giving birth.

DAY: OK. Thank you. And then also you answered my question about cost. I appreciate that. Thank you. So then leading into if hospitals are absorbing a $9 million deficit when it comes to labor and delivery care, what do they do to alleviate that problem?

SARA HOWARD: They get-- they get rid of labor and delivery.

DAY: Yes.

SARA HOWARD: Like, that is-- that is what they do. What we heard in the hearing, there were 3 reasons. One was competency. So the physicians came in and they said, you know, if I'm not doing very many deliveries I don't necessarily feel like I can maintain competence. That's an excellent concern. The second one was time. So if I'm the only person doing labor and delivery in my area, I'm on-call 24/7, and that's untenable for me as a physician who's going to burnout. And the third one was cost. So really, LB1087 addresses one of those concerns around hospitals who are looking at their bottom line and saying labor

and delivery is something that we can't sustain. But it obviously doesn't address the competency issue and the-- and the time issue.

DAY: And that becomes a problem, especially in rural areas or in instances like a previous testifier mentioned, if their location wasn't there to provide the emergency cesarean section, neither the mother nor the baby would have made it. And that was a, a mother in rural Nebraska where she's going to have to drive an hour at best, 2 hours, maybe 3 hours to get to somewhere she can deliver, neither one of them are going to make it through that. And that's when we talk about access. I feel like maybe that articulates the explanation a little bit.

SARA HOWARD: Yeah.

DAY: Yes.

SARA HOWARD: Yes, yes you're doing--

DAY: OK.

SARA HOWARD: --better than me.

DAY: Thank you for being here.

SARA HOWARD: Excellent work. Thank you for-- thank you for your testimony.

HANSEN: Any other questions from the committee? I'm not going to burst your bubble, but I'm pretty sure we don't need a quorum.

SARA HOWARD: No we don't. That's what I said, we don't.

HANSEN: Yep, yep. OK.

SARA HOWARD: And I apologized. I apologized to Senator Hardin.

HANSEN: Oh, OK. All right.

SARA HOWARD: This was-- I was full of apologies.

HANSEN: Because I just wanted to look into it, only when we're voting, so.

SARA HOWARD: Yeah, you know, and then I, like, texted a friend and I was like, oh, no, no you don't. You just can't, like, vote. Don't, don't do votes without quorums.

HANSEN: Oh, yeah.

SARA HOWARD: Don't do that.

HANSEN: That's probably not good. No wonder why you called me so often when I was on HHS Committee.

SARA HOWARD: Oh, I was constantly, where are you? I have sandwiches, get here.

HANSEN: Yeah, that worked every time. OK. Seeing no other questions, thank you very much.

SARA HOWARD: Thank you so much.

HANSEN: Is there anybody else wishing to testify in support? Welcome.

MARCIA MUETING: Good afternoon. My name is Marcia Mueting, M-a-r-c-i-a M-u-e-t-i-n-g. Chairman Hansen and the members of the Health and Human Services Committee, I'm a pharmacist, I'm the CEO of the Nebraska Pharmacists Association, and I'm a registered lobbyist and I'm going to keep this short. There's been a lot of really great things said about this bill. And I want you to know that the, the Pharmacists Association, our members support this bill because inadequate reimbursement for Medicaid impacts every single department in the hospital including pharmacy. Meeting quality measures, as outlined, is going to take the entire medical team. Pharmacists stand ready to do their part to improve patient care. We applaud Senator Jacobson for offering a solution to allow an increase in Medicaid payments without the use of general-- additional General Funds while focusing on quality improvement. Any questions?

HANSEN: All right. Best testimony yet. [LAUGHTER] Any questions from the committee? All right. Seeing none, thank you very much.

MARCIA MUETING: You bet.

HANSEN: Appreciate it. Anybody else wishing to testify in support of LB1087? All right. Seeing none, is there anybody who wishes to testify in opposition to LB1087? OK. Is there anybody wishing to testify in a neutral capacity? Welcome.

JEREMY BRUNSSEN: Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Jeremy Brunssen, J-e-r-e-m-y B-r-u-n-s-s-e-n, and I am the deputy director of finance for the Division of Medicaid and Long-Term Care within the Department

of Health and Human Services, or DHHS. I am here to testify in neutral capacity for LB1087. First, I would like to thank Senator Jacobson, Governor Pillen, and the Nebraska Hospital Association for working on this transformational legislation for Nebraska. We look forward to continuing to work on an amendment to the bill to ensure that the bill meets the intent of all parties involved in this process. As written, LB1087 will create a new hospital assessment of up to 6% of their net patient revenue and create a new cash fund, the Hospital Quality Assurance and Access Assessment Fund. It also requires the department to consult with the Nebraska Hospital Association to increase hospital payments through a managed care directive payment and seek federal financial participation to match funds received via the assessment. This bill also establishes a floor for General Fund appropriations intended for hospital rates that cannot be reduced now or, or in future budgets. The transformational initiatives in this bill would significantly benefit the state, but we do have some technical concerns with some of the language. The department is concerned with the establishment of a hospital payment rate floor in statute based on state fiscal year '24. Our concern is that the floor binds the future legislators and department to a continual increase from that floor. Another concern is that the bill does not allow for any of the revenue from the assessment to be moved into the state General Fund, which conflicts with the requirement that the directed payment be paid before receiving the assessment revenue. If left as written, this would result in the department paying the initial quarter's total directed payment from state General Funds and federal funds, and then depositing the assessment in the new cash fund. This would result in the significant obligation to the state General Fund that is unappropriated. This is because the bill has prohibitive language regarding moving money from the cash fund to the state General Fund to offset that expense. Thank you for the opportunity to testify and happy to answer any questions.

HANSEN: Are there any questions from the committee? Is-- one of the concerns that you have is that-- I believe, it's the second to last page, page 5, section-- subsection (6) says: The department shall prohibit a Medicaid managed care organization from setting, establishing, or negotiating reimbursement rates with a hospital in a manner that take into account, directly or indirectly, a directed payment program that a hospital receives. Is that part of the concern that you had?

JEREMY BRUNSSEN: That wasn't-- that was not the specific reference I was making. There's a, a, a section in the bill that essentially establishes that the, the, the amount of appropriations intended for

hospital payments, for Medicaid payment, is, is not to ever go below what's been appropriated for state fiscal year '24. So it's a different section. I'd be happy to look for it and find it or I can send it to you afterwards.

HANSEN: Yeah. Did you guys say you had an amendment or you're working on one?

JEREMY BRUNSSEN: The Governor has been working with the Nebraska Hospital Association with DHHS to try to make small changes, technical changes to this. We support the concepts in the transformational change and opportunity this presents. But there is some language that we'd like to work together on to, to make sure that we can all, you know, implement this in a way that benefits all of the state, all of the providers across the state and make sure that we can increase sustained access for all of our Medicaid patients.

HANSEN: OK. Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thanks for being here. It's nice to see you. I'm going to try and ask questions that you can answer. I realize that some of these might be outside of your purview. It looks like the 2024 language that you're talking about is on page 5, line, line 22, but it's Section 7. So it is the intent General Fund appropriations for these services in fiscal year. I think that's where-- cannot-- shall not reduce-- shall not be reduced to an amount below the rates paid in General Funds. So it's the rates not the-- it's not a dollar amount. So basically they're saying you can't lower the rate beyond what we established as the floor for this year. So it's not-- so if, if the rate-- if the dollar amount changes as to like the overall, that would fluctuate. I, I guess I don't quite understand what the problem is with tying it to a specific rate.

JEREMY BRUNSSEN: So I think just generally the department typically, you know, always takes a position that we don't, you know, that we don't want to kind of bind ourselves to future, you know, periods because we don't know what the future may hold. And typically, the way we would change our provider rates in Medicaid are through a couple different avenues. One is legislative direction and then, in some cases, we rebase rates based on cost reports and other cases like that.

M. CAVANAUGH: OK.

JEREMY BRUNSSEN: So that's why we tie the rates to the appropriation.

M. CAVANAUGH: So the fun thing about the Legislature is we can put something into statute. And if the fiscal situation changes in a future Legislature, we can adjust that. So we aren't-- we're binding ourselves, but we're not permanently. This isn't like a constitutional amendment binding. This is a binding, like this is the intention of this Legislature moving forward. And if there's something that needs to change, we do still have the opportunity to change it. So I guess I question why we would need to put more flexibility into the language in statute now, when we could always change it in the future if, hypothetically, the financial situation changes. So it seems like we're trying to troubleshoot for 20 years in the future, which doesn't quite seem reasonable. Is that fair?

JEREMY BRUNSSEN: I would say thank you for your perspective, Senator. I, I don't think we're, we're trying to create flexibility. We're just asking for it to stay as is.

M. CAVANAUGH: I, I appreciate that neutrality in your answer. I do have additional questions, but I didn't-- if anybody else wanted to jump in. The fiscal note. OK. So can we walk through this?

JEREMY BRUNSSEN: Yeah, absolutely. So I, I did hear your question earlier, and I think it might be helpful to share. When I pulled the fiscal note that was on-- published on the, the legislative site, it looked like the Legislative Fiscal Office, in whole, for the most part, agreed with our fiscal note.

M. CAVANAUGH: Well, I'm going to pause right there, because the Legislative Fiscal Office has of late taken the department at their word. So let's just go to your fiscal note.

JEREMY BRUNSSEN: OK. So the fiscal note is based on essentially what is permissible in the bill. Right? So we know through working with the Hospital Association roughly what we believe the potential assessment value is worth, which the bill then identifies that 2% of that value of that assessment could be used by the department to implement provisions of the bill. And then there's also an additional 1% that could be used to fund the Hospital Association, for example, to assist the department in the implementation and working through things like quality metrics and other aspects of complying with the bill and improving access.

M. CAVANAUGH: OK. So Mr. Nordquist said that the nursing homes seem to cost around $150,000. And what they have assessed in here is $9 million-something. And so my question to you is not what is

permissible, what does the department say-- believe is the actual cost for administering if this were enacted? What is the actual cost to the department?

JEREMY BRUNSSEN: I would say that we do not know the exact estimate right now. There are differences between the nursing facility and the ICF/DD--

M. CAVANAUGH: I absolutely [INAUDIBLE].

JEREMY BRUNSSEN: --program and a directed payment. The direct-- there are a lot of operational details that we are-- we're meeting weekly with NHA to work through, because how we decide to implement this does have significant impact on the amount of resources that it would require for us to make sure that we stay compliant with all of the aspects of this, because we'll have to get waivers from our federal partners. The assessment piece, we'll have to do an annual directive payment arrangement. There's a-- it's 21- or 23-page--

M. CAVANAUGH: So the--

JEREMY BRUNSSEN: --preprint that we have to complete in addition to.

M. CAVANAUGH: But the agency does a lot of these things. They, they get waivers-- federal waivers. They do payment pro-- like these are all mechanisms of DHHS that happen in other areas. So it's hard for me to understand how you cannot give us a model for what the projected cost would be to implement this particular program. And I'm asking this question because if we were to do this, this is not for the state to make a profit. This is to sustain our hospitals across the state that clearly are telling us they need help being sustained. And the Governor last year did not-- or he vetoed hospital rate increases, which I did-- full disclosure, I did not vote to override the veto. So this is another avenue for hospitals to find a way to pay for their costs to keep their doors open. But I don't personally believe that we should do this to generate income for the state on the backs of hospitals. So if we do this, I think we should know what the actual cost is to the state of implementing it. This is not a profit opportunity for the-- for the Property Tax Relief Fund, which is exactly what the Governor has stated he wants every cent he can find to go into. And I find it very problematic. And I know that this is not you, but you are a representative of DHHS. I find it very problematic to have DHHS put forth the fiscal notes that are going to take dollars away from the healthcare industry to do property tax relief. I actually find it abhorrent, and I would like the people who

have say over this above you to understand how inappropriate it is to put forth a fiscal note that takes money away from a program to provide healthcare across the state so that we can put money in the Governor's $200 million random unplanned for Property Tax Relief Fund. And that is exactly what this is doing. And I don't think that it is appropriate use of government resources. I appreciate you, and I appreciate you sitting here while I have my little conversation with myself. Thank you.

JEREMY BRUNSSEN: Thank you, Senator.

HANSEN: Any other questions? All right. Thank you.

JEREMY BRUNSSEN: Thank you.

HANSEN: Anybody else wishing to testify in a neutral capacity? All right. Seeing none, we'll welcome back Senator Jacobson to close. And before he does, we did have some letters for the record. We did have 9 letters in support of LB1087 and 1 in the neutral capacity. It's all yours.

JACOBSON: Thank you, Chairman Hansen. First of all, let me answer the question that was being raised before with regard to the metrics. OK. The metrics are determined state by state, OK, based upon conditions. So NHA will be working with CMS and with, with DHHS on those metrics. What they're proposing at this point would be 4 metrics: patient safety, patient behavioral health readmissions, postpartum screenings after birth, screenings to connect patients to food, housing, and transportation. Those are the metrics. As it relates-- and let me give you a little path down this bill. I worked with NHA prior to the session beginning. The bill was ready to go. There have been constant negotiations with the administration to-- and CMS and, and with DHHS to get this bill done. We reached-- finally reached an agreement. They reached an agreement. I introduced the bill late in the 10-day session. We currently have 32 cosponsors. Senator Armendariz was the second-- was, was the first cosponsor and has indicated with, with this coming out of the committee that she would prioritize the bill. Time is of the essence. We need to keep moving or are we going to lose this year's funding. So we need to keep moving. I'm certainly hopeful, and thank you, Senator Cavanaugh, for your questions. I think the last time I was before this committee, I got rolled on a fiscal note, and you pointed it out. I don't want that to happen again. There, there-- this negotiation continues to go on. And what I've learned about negotiations in my-- over my years is when you set deadlines, negotiations seem to get done. But if there's no deadline,

negotiations never cease. The deadline would be Select File. So my hope is that this committee will not only bring this forward, but Exec on it as soon as possible. Let this hit the floor, let it get a priority, let it get scheduled and negotiations can continue, but they ought to be wrapped up by the time we vote on Select File. This is a great bill. Let's not let perfection get in the way of success. Any questions?

HANSEN: Any questions? Yes, Senator Riepe.

RIEPE: Thank you. Thank you again. My question had to do, is I think the second metric was on behavioral?

JACOBSON: It is.

RIEPE: OK.

JACOBSON: Patient behavioral health readmissions.

RIEPE: OK. That's-- because these are not mental health hospitals, that, that surprising me.

JACOBSON: Oh, let me be clear on that. That's a good question, Senator Riepe. So these are not individual hospital metrics. This is the state as a whole. All the participating hospitals would be contributing to these metrics. So we're, we're measuring the outcomes at a statewide basis, not on an individual hospital basis.

RIEPE: It just seems like I didn't think that that would qualify to be one of the top 4.

JACOBSON: They're working with-- like I say, this is a negotiation with DHHS. It had to be approved by CMS. But, but the point of is this-- and these could move around but I believe these will be the ones that they adopt. But it's, it's not done. Obviously, they can't do negotiations on CMS until we get the bill approved and we start the process moving. So, so that's the key there. But I think it's important to note that this is not the federal government dictating what those are going to be. And as we've said, there 43 other states that are already out there. I met with the Governor as recently as yesterday. He's assured me that he's on board with this bill. And, and I think he's-- his only question is, why haven't we done this long before now? And my point today is we're going to be waiting another year if we don't get it done. So it's time to stop the negotiations. It's time to get something done.

RIEPE: Thank you.

HANSEN: Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Senator Jacobson. I mean, obviously, it's a negotiation. So if you don't want to answer this question, I totally understand. But what is the crux of the negotiation at this point?

JACOBSON: Well, let me put it this way, that there was a-- there was a big ask out of the gate which was summarily rejected. OK?

M. CAVANAUGH: Um-hum.

JACOBSON: And so I think where we're at today is it's really looking at what will the costs be. And let's just say that the fiscal notes that's being put in front of you today will not be the fiscal note in the end, and it'll be significantly less than that.

M. CAVANAUGH: So the fiscal note that we have right now is reflective of the bill as introduced. And the bill as introduced, I assume is the result of what you said were the negotiations leading up to the 10th day of bill introduction. And I'm looking at the letter that we've received-- well, the testimony. I always appreciate the copy being given, but the 2 concerns that they put in here are tying ourselves, which we, as a Legislature and future Legislatures can change these things if we want to. It's our prerogative to do. So that, to me, is, is while a good thing to keep in mind, not a relevant concern right at this time. The other is the ability to move the assessment to-- into the General Fund, etcetera, which didn't quite make sense to me. I assume if there's any cleanup language that we would need that that can be taken care of on the floor. So that also seems like maybe that's a technical fix of language that needs to be fixed. So it seems like the crux of the concern here is how much money the state can rip off. And those are my words, not yours. But that's exactly what I'm seeing happening here. And, again, I find it extremely upsetting and offensive to the people of Nebraska that we would try and rip off the people of Nebraska's healthcare so that we can do property tax relief, so.

JACOBSON: That is your word, not mine.

M. CAVANAUGH: It is.

JACOBSON: But I--

M. CAVANAUGH: For the record.

JACOBSON: --but I would say that that has been something that has-- that I've been insistent on and, and I've defended all the way through this process. I don't think I dropped this bill until about Day 8, and it was ready long before that. And there were a lot of back and forth. And, and I would agree with you on, on both those points. My understanding is that the question here comes down to-- and I think when you listened to Mel McNea's testimony earlier, is the timing of the payments. OK? So if the assessment has-- the fee has to be paid before CMS reimbursements come back, that could be a hardship on hospitals. So the question is, can the state General Fund fund it and get reimbursed shortly thereafter? I think that's the crux of that piece of it. I agree-- the first point, you're exactly right. You're spot on. It's a rate. OK. It's a rate. And we can always change that.

M. CAVANAUGH: Yes. Can I-- one last question. What was the initial ask?

JACOBSON: Let's say quite a bit more.

M. CAVANAUGH: You're not-- you're not comfortable saying?

JACOBSON: I'm not.

M. CAVANAUGH: You want me to say?

JACOBSON: Oh, you go ahead. It's, it's your-- it's your committee.

M. CAVANAUGH: My, my understanding was that the-- you can tell me if it was more or less than this number. How about that?

JACOBSON: There you go.

M. CAVANAUGH: Was that the initial ask from the state was $200 million.

JACOBSON: You're probably in, in the ballgame.

M. CAVANAUGH: So just for those watching at home and those sitting here today, the state wanted to take $200 million from healthcare for property tax relief. This is not how government should function. I appreciate you so much for bringing this, Senator Jacobson.

JACOBSON: Well, thank you very much. And for the record, I think there was a very quick recognition that once they dug into what this meant and how the, the numbers worked.

M. CAVANAUGH: You're much more generous in spirit than I am.

JACOBSON: Well, thank you very much. I, I don't get-- I don't accused of that-- be accused of that often, but, but thank you. I'll certainly take that from you. So thank you.

HANSEN: OK. I might have a couple questions.

JACOBSON: Oh, great.

HANSEN: And if not, Jeremy can maybe can answer them afterwards. And this might be the department's concern, I think, is does the state have to pay the assessment before the federal government gives us the money?

JACOBSON: My understanding is, is that, that, that that's the piece that's kind of unknown, is that the hospitals would pay their assessment to get their reimbursement. I think there's a timing issue there that's being worked out.

HANSEN: I think that's what it is. So the, the hospitals send in their assessment,--

JACOBSON: Yeah.

HANSEN: --the state pays them and the state then waits for the federal government to give them money.

JACOBSON: Yeah, I think that's-- we're, we're-- that's what they're working through.

HANSEN: And I think that might be it because that, that would be a legitimate concern, because now then we're hanging it on the taxpayers in Nebraska if the federal government doesn't give us the money, which I'm assuming they will.

JACOBSON: Well, if they're in the program, I would expect-- usually a federal government-- you know, government receivable is pretty good receivable so it's probably more of a timing issue.

HANSEN: Yep. And it's been going on for a while anyway, so I would expect nothing different.

JACOBSON: Yeah.

HANSEN: And so it sounds like that, that CMS does have to approve of our state plan amendment.

JACOBSON: They do. Well, there's-- well, they have to approve. The Hospital Association will work with DHHS on these, these quality metrics. CMS has to sign off on them. I don't expect that to be a problem. But, again, they need to get the process moving if we're going to get in this program this year.

HANSEN: Yeah, and the metrics are the ones you mentioned earlier. Right?

JACOBSON: These 4 metrics. Yes.

HANSEN: Wasn't one about food insecurity, too? Was it-- was it--

JACOBSON: Well, it's, it's screenings to connect patients to food, housing, and transportation.

HANSEN: OK.

JACOBSON: You're probably aware of this, but, but I mentioned that here. It probably got lost in the last 3 days of this nonstop floor testimony, but, but I did mention at one point that most people don't realize that hospitals are faced with patients that are in the hospital, have been treated ready for release, and the hospitals aren't allowed to release them until they can release them into a safe environment, which means-- which includes housing. And if they can't release them, they keep them. But nobody's paying the bill, not, not Medicare, not Medicaid, not insurance so the hospital will eat that cost.

HANSEN: Well, Medicaid is now because of our last year's bill.

JACOBSON: Yeah.

HANSEN: So--

JACOBSON: But it-- but it's been, it's been a real challenge. Oh, yeah, and I, I just might add and I'll-- certainly, I'll refer you to Ivan Mitchell and one of the latest who's the CEO of the GPH. Yeah, we're 52 days out waiting for a Medicaid reimbursement on one patient right now, and I'm sure that's gone up from-- that was-- that was about 2 weeks ago. So, so that's not working as smoothly as it should.

HANSEN: OK. Seeing no other questions, thank you very much. Appreciate it.

JACOBSON: Thank you very much.

HANSEN: All right. That will close the hearing on LB1087. All right. And we will welcome Senator Hunt to open LB913. Sorry, it might be a little noisy.

HUNT: I have paperwork.

HANSEN: You do have invited testimony. You want me to mention it in that order?

HUNT: Yeah.

HANSEN: OK.

HUNT: That's fine. Thank you.

HANSEN: It's all yours. Whenever you're ready.

HUNT: Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Megan Hunt, M-e-g-a-n H-u-n-t, and I represent District 8, which is in the northern part of midtown Omaha. And I'm here today to present LB913, a bill that would extend postpartum coverage for high-need mothers and babies for at least 6 months post-birth. The group of mothers referred to in this bill are moms who do not have insurance, but are currently eligible for a limited array of prenatal and pregnancy-related health services under a special CHIP-eligibility category called 599 CHIP. That's what we call it in Nebraska. This name comes from the bill that created this coverage group in Nebraska in 2012. LB599 from 2012. In passing that bill, the Legislature opted into a federally allowed unborn child option under CHIP, saying that the Legislature found it important to the health of unborn children that their mothers receive care prior to and leading up to birth. So LB599 created prenatal coverage for all pregnant women in Nebraska who are uninsured and ineligible for Medicaid or other health coverage options. This 599 CHIP group, which currently stands today, includes minors whose parents income make them ineligible for other coverage for their pregnancy, women who are undocumented, and other women who are pregnant but lack coverage for prenatal care through other options. The weeks following birth are critical to women, the baby, and the whole family's long-term health. You'll hear more data from testifiers after me, but a couple of figures that stood out to me and my staff when we were researching

this bill were that 53% of pregnancy-related deaths occur between 1 week and 1 year postpartum, and the black and native populations have pregnancy-related mortality rates that are up to 3 times higher than white populations. This bill offers a proven solution to both of those disparities. Last year, we came together in recognition of this need and advanced Senator Wishart's LB419 with the support of the Governor to extend postpartum coverage for Medicaid-eligible moms from 60 days up to a year. In Nebraska, we now offer a year of postpartum coverage for moms and babies on Medicaid. This committee actually unanimously advanced that bill, and I'll give thanks to Senator Wishart for her work on that bill, and Senator Vargas for prioritizing that bill, to Governor Pillen for his support, and for this body for getting that passed. And it's been, you know, a great thing for women in Nebraska ever since we got that implemented. But with the passage of that bill, we left out a really important group of vulnerable women and moms and babies who aren't eligible for other types of postpartum care. And that is the 599 CHIP moms who aren't eligible for Medicaid. The reasons for supporting last year's Medicaid postpartum bill are the same reasons for supporting this bill. These moms face barriers to seeking healthcare after childbirth, and that providing them with postpartum coverage is proven to reduce maternal mortality rates, and it helps to ensure that we have healthy babies with healthy mothers who can take care of them and help them thrive in these critical early years. This bill includes mothers who we left out for technical reasons based on the complexities of Medicaid and eligibility. But what these mothers all have in common is that they're generally low income, and they don't have access to pregnancy-related care through other means. So with LB913, this bill today, what we're saying is we've agreed that Medicaid moms and their babies deserve postpartum care. And we also believe that these 599 CHIP moms do as well. This would include lower income women that are Medicaid ineligible because of their immigration status, minor girls who are pregnant but Medicaid ineligible due to their parents' income, and other women who are uninsured and ineligible for Medicaid. Currently, as it stands today, 599 CHIP moms's benefits are limited only to prenatal and pregnancy-related services, and their coverage ends the month they give birth. So in Nebraska, we've got these 599 CHIP moms. They already get help with their pregnancy. They already get help with prenatal care. But it's almost like a cliff. When they give birth, they're done. No more care for them. And what we said last year with our bill was that we were going to make sure that all Medicaid-eligible moms would not fall off that cliff. And this bill will just include these 599 CHIP moms. LB913 calls for a state plan amendment to the CHIP Program to extend postpartum coverage for

mothers covered under the unborn child option, or 599 CHIP. It uses an innovative option called a Health Services Initiative, or HSI, to ensure a federal match for the benefits offered to these mothers so that we, as a state, can be getting the maximum return on investment. Former Senator Sara Howard from First Five Nebraska will be here to explain more about that funding and how that health service initiative works. And she's the master of explaining the nitty-gritty of that type of stuff. I understand it probably 25%, so I'm happy to answer questions about it. But I would refer you to the expert, of course. As far as where the money comes from and what it will cost us, I want to touch on the fiscal note. It is-- I don't know, I think that many of us in the Legislature have had changes in our fiscal notes so far this year, and this bill will probably be no different. But the key numbers you'll want to look out in the chart are found at the bottom of the front page of the fiscal note. In that chart, you'll see that they've laid out what our General Fund expenditure would be if we provided postpartum care for this group for varying lengths of time. The language in the bill, it provides for at least 6 months, but it allows us to go up to a year, which I think would be great because then that would match what we're doing for Medicaid moms already. So the number I'm keeping in mind is that $999,834, in the 6 months of coverage General Funds box, basically about $1 million. That's what we would be looking at if we went with 6 months of coverage. I have an amendment to provide a different option. I, I distributed the wrong amendment to you, but that's fine. That doesn't matter. I'll get you the right one and we can talk about it. And what this amendment does, is it's a different pay for that says we're not going to use General Funds for this. It states the Legislature's intent to use the Medicaid Managed Care Excess Profit Fund to implement the bill. And that fund is specifically for filling service gaps under the Medicaid Assistance Act. So this would be an allowable use of that fund. I'm confident that there is an avenue for funding this as an alternative to General Funds if the committee supports this principle, and there are testifiers after me who can explain more about that funding principle, too. From a fairness perspective, I think there's a case to be made that the benefits that we provide to these 2 populations, the Medicaid moms and babies and the 599 CHIP moms and babies in Nebraska, they should align and they should just be the same. It shouldn't matter, you know, your, your Medicaid-eligibility status if you don't have enough money and resources to get insurance. That's what Medicaid is intending to cover. And these 599 CHIP moms are already receiving services from the state. So we want to wrap them into what we're already giving other, other moms for their postnatal care. So with

that, I'm excited about the federal match in this bill as well and I'm happy to answer any questions.

HANSEN: Thank you. Are there any questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Senator Hunt. I actually-- I wanted to provide some clarification. So last year when we passed the Medicaid postpartum expansion, it was very similar to this. It was 6 months with the opportunity to go [INAUDIBLE].

HUNT: Correct.

M. CAVANAUGH: So I just wanted to mention for the committee's refresh and the fiscal note that the department or the Governor's office can decide to go up to 12 months, but this bill is providing that it can start at 6 months so that is the fiscal note that we as a Legislature would be approving. And I'm going to go ahead and speak for my colleague, Senator Riepe, because he loves, loves, loves when DHHS just finds money that we don't appropriate. It's one of his favorite things. I'm being very sarcastic. For the record, he does not like that. But if the state agency does decide to go to the 12 months that is permissible, it, it does not come out of our General Funds. That is something that the state agency would fill the gap. So just wanted to let-- for the record.

HUNT: Yes.

HANSEN: Senator Riepe.

M. CAVANAUGH: Oh, oh, no.

RIEPE: Dangerous dual.

M. CAVANAUGH: I'm sorry.

RIEPE: Thank you, Chairman. Of the federal match, are we able to use the-- what's the over pay, if you will, from the managed care organizations? Can we use that money to a federal match?

HUNT: I don't know, Senator Riepe.

RIEPE: Obviously, I don't--

HUNT: I'm not on this committee and that's the type of stuff you guys deal with a lot. So that's kind of out of my wheelhouse. But, obviously, I could get that answer for you in about 3 minutes--

RIEPE: No, that's OK.

HUNT: --so you'll get your answer for sure.

RIEPE: OK. Thank you very much.

HUNT: Thank you for the question.

RIEPE: Thank you, Chairman.

HANSEN: All Right. Seeing no other questions, you staying to close?

HUNT: I will stay to close.

HANSEN: All right.

HUNT: Thank you, guys.

HANSEN: All right. So we will take our first testifier in support of LB9-- actually, before I start there, Senator Hunt did have invited testimony up here and I want to make sure I get them in the right order. So, so we'll go through invited testimony first and then after that if there are other people who would like to testify, we can bring those up. And so if we could welcome Sara Howard-- Senator Sara Howard. Welcome back.

SARA HOWARD: Thank you for having me again. Are you ready? OK. All right, hit it. Chairman Hansen and members of the Health and Human Services Committee, thank you for allowing me to testify today. My name is Sara Howard, spelled S-a-r-a H-o-w-a-r-d, and I'm a policy advisor at First Five Nebraska. First Five Nebraska is a statewide public policy organization focused on promoting quality early care and learning opportunities for Nebraska's youngest children. My position at First Five in Nebraska is focused on the area of maternal and infant health policy, because we know that healthy moms and babies are critical to ensuring the long-term success of children in our state. I'm here to testify in support of LB913, and I want to thank Senator Hunt for bringing this bill because she's really passionate about supporting moms and babies. OK, so the, the 2 things that I know I have time to cover with you, one is I'm going to give you the history of CHIP 599 moms and sort of where they came from and how it came about. And the second one is, I will walk you through a Health

Services Initiative because I think that's a little bit sticky. And then if I have time, I will talk to you about the Medicaid Managed Care Excess Profit Fund. OK. So the history of these-- this population of moms. So for 20 years as you-- I'm not going to-- I'm not going to walk you through categories in Medicaid because you guys are super smart and you already know how it works. So for 20 years, the state of Nebraska was covering mothers who were undocumented in their Medicaid program. And in 2009, Governor Heineman got a letter from CMS and said, hey, you guys are doing it wrong. You cannot cover them through Medicaid. But there is another option called the unborn child option in the Children's Health Insurance Program that you can cover it with. So if you just want to make that administrative change, no bigs, will just move them all over there. And Governor Heineman unfortunately declined to make that administrative change. And so in 2011, Senator Kathy Campbell, she's also a previous Chair, she introduced LB599. It ultimately passed in 2012. That was my mother's last year in the Legislature, and it was one of her last nights in the Legislature. And Governor Heineman had vetoed LB599, and they needed 30 votes for the veto override. And my mother's memory of this night is that Mike Flood went out to the Rotunda, and he came back in and he walked up to my mom on the aisle, and he was like, Gwen, you're going to be really proud of this next vote. And he was the 30th vote to override the, the Governor's veto of LB599. And that's how we created this population of CHIP 599 moms. There aren't very many, about 840, 820 annually. It's not very many of them. But last year when you expanded-- extended postpartum care with LB419, you were only doing it for the moms who are covered in Medicaid. Now last year, if you had brought in the CHIP 599 moms, you actually wouldn't have gotten a federal match. So you really do-- you, you did need LB913 to sort of make sure that you were doing it right to get a federal match for this population. So here's what I'll tell you. The only way to draw down a federal match to provide postpartum care for CHIP 599 moms is through a Health Services Initiative. These HSIs are very flexible. The first thing I thought was loosey-goosey, but they are flexible. States can use them in whatever manner they so choose to improve the, the health and well-being of low-income children in their state. Four other states already have approved HSI state plan amendments for a year, and 2 other states have HSI state plan amendments for 60 days, which is what our Medicaid had previously been at. Senator Hardin, you had mentioned that earlier. This population of mothers actually lose coverage the month that they give birth or sometimes the moment they give birth, really, there is no postpartum coverage for them. If they have an emergency issue, they might get some support through emergency Medicaid. But ultimately, there's a possibility that the hospital just

isn't going to get paid for their care and coverage. And so a HSI works like this, the state can use 10% of what they spend in CHIP for administrative expenses. So right now we spend $85 million in CHIP. We have $8.5 million that we can kind of play around with for our admin. We only use $5 million for admin. I see Senator-- I'm wondering if Senator Hardin is writing it down. We use $5 million for admin-- oh, it's putting it on a phone-- oh, good-- $1 million for poison control for an HSI that's already existing for poison control, and then we have $2.5 million left over that we could use for an HSI of this-- of this ilk. And so when you consider the fiscal note, $1 million fits well inside of that $2.5 where you can draw down your CHIP match, not, not your-- it's not the match that you would get on the postpartum previously, that was a separate match. Your CHIP match right now is 71 cents. So for every dollar that we spend, we can draw down 71 cents from the federal government for this purpose as long as you are using an HSI. There is no other way to cover this population with postpartum care and draw down that federal match. I see I'm at my yellow light. If anybody wants to ask me about the Medicaid Managed Care Excess Profit Fund, I'm happy to try to answer that question.

HANSEN: Seeing no other questions. I'm just joking. Senator Cavanaugh.

M. CAVANAUGH: I would love to ask you about the managed care--

SARA HOWARD: Yeah, it is a mouthful.

M. CAVANAUGH: --etcetera, etcetera.

SARA HOWARD: Yes, yes, yes. OK, so-- and, and it's funny-- it's funny you're asking me and it's funny as Senator Hansen's here because it, it was Senator Arch's priority bill in 2020. We actually passed it during our COVID session. So that August period of time, that was like a whack-a-doodle 3 months. That's when we passed this bill. It's probably why a lot of people don't remember that it exists. So this is a cash fund. Senators discovered in 2017 that when a managed care company makes too much money, they actually have to return that excess profit back to the state. Before it comes into the state sort of coffers, the federal portion is returned to the feds. So everything that's sitting in this cash fund is state dollars. So in '17, we found out that our leader at Medicaid had funded a variety of projects to the tune of about $20 million that the Legislature had no oversight or direction in and we were justifiably upset. And so Senator Arch introduced a, a bill to ensure that we were able to view what was happening or have some insight into what was happening with these funds. So you have a guiding statute for this, and I'm going to just

cheat for a second, it's 68-996. And the first purpose for this Medicaid Managed Care Excess Profit Fund is to offset any losses. So if we have any losses in our Medicaid program, we're supposed to use this fund first. We never have any losses, nor should we, because we always try to budget above what we need in Medicaid, because we never want to come back for a special session and fill it out. The next thing is for filling gaps in services, and that's where LB913 really fits in with the statute that we put in place in 2020. This is a gap in service. We agreed last year that mothers deserve postpartum care, and so this would be considered a gap in, in services that would fall appropriately under the statute. The next one is system improvements. When we talked about it and, Senator Hansen, you may remember this, we talked about how, you know, they always want to have a new MMIS System. The-- this would be an appropriate fund for something along those lines. But the Managed Care Excess Profit Fund currently has about $38 million in it right now. And it's growing because the managed care companies have managed to lower the cost of care to the point where they're making more profit off of the fees that we are paying them. And so there is more that keeps coming back to the state from that Managed Care Excess Profit Fund. So this would, in, in my opinion, but it would also have to be yours, this would be an appropriate use of that fund. I'm happy to try to answer any other questions you may have.

M. CAVANAUGH: Thank you for answering my question.

SARA HOWARD: Thank you for ask [RECORDER MALFUNCTION].

HANSEN: Any questions? Can we take this from the Health Care Cash Fund?

SARA HOWARD: Oh my gosh. You know what? I'm-- serious questions only. All right. Honestly, you probably could, because mil-- these--

M. CAVANAUGH: Don't tell him that.

SARA HOWARD: I mean, I know. I-- but honesty, right? Five million was going out of the Health Care Cash Fund for CHIP. So we were using some of the Health Care Cash Fund for-- you're nodding because you know. So this, this would also be an appropriate use of that fund, but, but you have this better one.

HANSEN: I'm not recommending that because--

SARA HOWARD: You have a better option.

HANSEN: --you'll be in my doorway the second that ever happens.

M. CAVANAUGH: Banging.

HANSEN: Yes.

SARA HOWARD: For sure.

HANSEN: OK. Seeing no other questions, thank you very much.

SARA HOWARD: Awesome. Thank you for your time.

HANSEN: All right. We'll take our next testifier in support of LB913. Welcome.

ANN ANDERSON BERRY: Good afternoon, Chair Hansen and members of the Health and Human Services Committee. Thank you for having me here to testify today. I'm Dr. Ann Anderson Berry, A-n-n A-n-d-e-r-s-o-n B-e-r-r-y. I'm a faculty member of UNMC and the medical director of the Nebraska Perinatal Quality Improvement Collaborative, or NPQIC. However, I am not speaking as a representative of the University today. I am here speaking as an individual, and on behalf of the Nebraska Medical Association as well as NPQIC. I am here testifying with regards to LB913. As the medical director of NPQIC and a neonatologist, I work with hundreds of families each year with high-risk medical situations for both mother and baby. Through NPQIC, we support healthcare professionals from across the state who provide care that leads to the best outcome for Nebraska mothers and infants, working to ensure that every family has the healthiest start possible. We are very grateful to the committee, Legislature, and Governor for extending postpartum Medicaid coverage to 12 months. Unfortunately, we still face a situation here in Nebraska, where some vulnerable mothers have inadequate access to healthcare, impacting maternal and child health and well-being. In the neonatal intensive care unit, we have many preterm and seriously ill newborns whose stays extend past the end of their birth month or the period that Nebraska currently provides postpartum coverage to the mother under CHIP 599. It is common for mothers to discuss their health with me, as their infant's doctor. When medical coverage expires, mothers lament their ability to refill antihypertensive medications, seek care for perinatal depression, or easily treated illnesses like mastitis, which left untreated can prevent breastfeeding and cause serious illness. This lack of healthcare also has impacts on the newborn infant, the family, and other Nebraskans. Postpartum care is an ongoing process that typically requires multiple visits and follow-up care that may last a

full year. This is particularly important for those who experience pregnancy complications or have chronic cond-- conditions such as hypertension or diabetes. The implications of lack of healthcare coverage for maternal health are profound, and play a role in rising U.S. maternal mortality rates. We heard already, suicide drives mortality rates in the first year among pregnant and postpartum people and has risen over the past decade, with poorer access to treatments among communities of color and low-income women driving disparate outcomes, exactly the women that are covered by the CHIP 599. Mental health treatment and coverage can prevent death. Mothers are screened for postpartum depression through the first year and can be treated by their primary care or delivery physicians. Suicide prevention is critical. As a neonatologist, I know from experience, the death of a mother is one of the most tragic events that can befall a family and community. The short and long-term impact of such a tragedy on her surviving children, family and community, and the healthcare professionals who cared from her can not be overestimated. Untreated maternal depression significantly impacts the health and well-being of women, infants, and families. Low-income mothers are more likely to experience depression, as high as 40-60%. Perinatal depression is associated with poor outcomes in children, including increased morbidity and mortality, family dysfunction, increased risk of abuse and neglect, impaired parent-child interaction, and bonding and attachment issues leading to delays in motor, cognitive, and language development, discontinuation of breastfeeding, failure to thrive, colic, and emotional and behavioral disorders that persist into adolescence. Untreated maternal depression is also associated with increased medical costs and inappropriate medical treatment of the infant. We also know that the health of the child is linked to the mother's health. Improving these outcomes for mom will also improve the health of a child, as noted in the 2020 Surgeon General's Call to Action and the Health and Human Services Action Plan. Lack of access to healthcare and insurance coverage contributes to poor outcomes and racial and ethnic health disparities. Extending coverage provides an opportunity to monitor recovery from pregnancy and birth, as well as to address ongoing health concerns and behavioral health. Improving women's overall health reduces the chances of complications during subsequent pregnancies, preventing costly subsequent NICU admissions for the state, as well. A study in 2017 found that improved maternal coverage was associated with improved attendance at well-child visits, which are the primary platform for growth and developmental screening, vaccination, and provision of anticipatory guidance. Children who attend these visits are more likely to complete immunizations and less likely to have avoidable hospitalizations, also reducing state costs.

In conclusion, Nebraska's CHIP 599 mothers and babies need the support of all stakeholders, including, most importantly, our state governing bodies. Supporting maternal healthcare for 12 months after delivery for these mothers will have an important and positive impact on Nebraska babies and their families. I urge you to provide this coverage to all Nebraska mothers. Thank you to Senator Hunt for introducing this legislative bill. The Nebraska Medical Association and NPQIC will continue to work to support perinatal healthcare coverage to ensure Nebraska moms and babies have the healthiest start possible. I'm happy to answer any questions.

HANSEN: Thank you. Are there any questions from the committee? Seeing none, thank you very much.

ANN ANDERSON BERRY: Thank you.

HANSEN: Take care. Now we will welcome next invited testifier, Tom Venzor, with the Catholic Conference. Welcome.

TOM VENZOR: Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Tom Venzor, T-o-m V-e-n-z-o-r. I'm the executive director of the Nebraska Catholic Conference, which advocates for the public policy interests of the Catholic Church and advances the gospel of life through engaging, educating, and empowering public officials, Catholic laity, and the general public. Catholic social teaching has a rich tradition of contemplating and solving the difficult issues that face our society and common humanity. One important principle, among others, offered by Catholic social teaching that should-- we should constantly keep in mind, is a preferential option for the poor. Preferential option for the poor is a special form of primacy in the exercise of Christian charity. It affects the life of each Christian inasmuch as he or she seeks to imitate the life of Christ, but it applies equally to our social responsibilities. This love of preference for the poor and the decisions which inspires in us cannot but embrace the immense multitudes of the hungry, the needy, the homeless, those without healthcare, and above all, those without hope for a better future. The Christian charity due to mothers and families who lack access to basic and necessary healthcare is the impetus for the NCC's support of LB913, which would ensure low income and undocumented mothers do not lose healthcare coverage shortly after giving birth. Maternal mortality and morbidity are issues that are increasingly on the consciousness of many, in large part because of the significant increase of both issues in recent years. As a report on maternal morbidity and mortality in Nebraska states, CDC reports that the rate

of maternal mortality has been increasing since the 1980s, with the United States experiencing a higher maternal mortality rate than most other developed countries. The report further states that the severe maternal morbidity is more than 100 times as common as pregnancy-related mortality, and has increased up to 75% in the last decade. But this does not have to be the case. Access to basic medical coverage for an extended time frame postpartum can provide the continuity of care needed to avoid and diminish the cases of mortality and morbidity our Nebraska mothers are facing. For a mother who has her own set of healthcare needs, is without adequate support, and is also responsible for taking care of the needs of her child or children, it becomes imperative for the state and federal government to step in and provide the necessary assistance for healthcare coverage. To draw, again, from the Catholic social teaching tradition, this type of support, assistance, and care is in line with the principle of subsidiarity. Subsidiarity recognizes the basic fact that there are times when local and intermediate institutions such as families, churches, nonprofits, and private industry cannot fulfill some important need of the larger community. When this occurs, it is wholly appropriate and even necessary for the larger political community to assume a proportionate responsibility in our care and concern for those in need. While the Nebraska Catholic Conference is not the public health expert on this topic, the personal and public healthcare benefits of LB913 are numerous. Extended postpartum coverage will help mothers deal with any number of issues they can present during the perinatal and postpartum period, such as gestational diabetes, preterm labor, recovery from cesarean sections and high-risk pregnancies, pre-eclampsia, maternal depression and other mental health concerns, sepsis, pulmonary edema, and acute heart failure. Coverage also provides for future healthier pregnancies, as well as assisting mothers to be more proactive in the healthcare they pursue for their newborns and infants. It can also help improve the healthcare disparities which occur among, among racial minorities and the poor. The benefits are numerous, and though the cost is not negligible, it is a cost that is well worth the benefits to the common good and to our recognition of the human dignity of the mother and her baby. In the post-Roe v. Wade culture of life we are trying to build here in Nebraska, where every preborn human life is accepted in their full and inviolable dignity as a human being, it is also incumbent on us as a political community that we are walking with mothers in need. The Nebraska Catholic Conference firmly believes that LB913 is an important piece of advancing a culture of life that loves them both. For these reasons, the Nebraska Catholic Conference respectfully urges your support of LB913, and thank you for your time and consideration.

HANSEN: Thank you. Are there any questions from the committee? Don't see any.

TOM VENZOR: All right.

HANSEN: Thank you.

TOM VENZOR: Thank you very much. Have a good day.

HANSEN: We'll take our next invited testifier, Ms. Rosa Pinto, with the Heartland Workers Center. Welcome.

ROSA PINTO: Thank you. First I want to say this is my first time doing this, so I apologize if I get tongue-twisted. Dear Chairperson Hansen and members of the Health and Human Services Committee, my name is Rosa Pinto, R-o-s-a P-i-n-t-o. And I have been a resident of the state of Nebraska for the last 20 years. I work as a community organizer for the Heartland Workers Center. The Heartland Workers Center's mission is to organize and develop leaders, promote workers' rights, and create a culture of civic engagement so that we can build power and create change with the immigrant and underrepresented communities. I am here today to express my strong support for LB913, to provide postpartum care for new mothers in Nebraska that right now don't have any coverage after they get birth. After complications with my pregnancy in 2021, I was put on medical restrictions that only allowed me to work part-time, therefore affecting the income that I was bringing my family, and I also lost my private insurance coverage. At that time, I had to rely on CHIP for pregnancy coverage, and I appreciated being able to continue the care for my at-risk pregnancy. Right after giving birth, however, I lost all medical coverage. In the short 6 weeks after having my son, I dealt with mastitis, but I could not go to the doctor anytime soon as I couldn't pay for it, and I was already saving as much as I could for the 6-week postpartum care that I knew it wouldn't be covered either. Not only I was affected and my health was affected, but also my son's, who was a newborn, because I couldn't feed him properly. I strongly believe proper, proper postpartum medical coverage will help us mothers of U.S. citizens take better care of our children, as it will allow us to take care of pregnancy and birthing-related problems before they become too serious. Furthermore, providing health coverage for new mothers is also taking care of new U.S. citizens, as their quality of life, for the most part, depends 100% on us mothers taking proper care of them. For these reasons, I urge you to please move this bill onto General File. I appreciate the opportunity to testify, and I would be happy to answer any questions.

HANSEN: All right. Thank you for your testimony. Did pretty good for your first job-- first time. And it was good.

ROSA PINTO: I'm shaking.

HANSEN: Everybody does. Any questions? Yes, Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thanks for being here. So is your son almost 3, then?

ROSA PINTO: He is two and a half.

M. CAVANAUGH: Two and a half. OK. And how is he doing now?

ROSA PINTO: He's doing good. Thank you. Thank you for asking.

M. CAVANAUGH: Good. Well, I am sorry to hear about your experience, because I had a very different experience because I had the fortune of having health insurance. I cannot imagine dealing with mastitis without having healthcare. So you are one strong mama, and thank you for being here and sharing your story with us today.

ROSA PINTO: Thank you very much.

HANSEN: Are there any other questions from the committee? Seeing none, thank you very much.

ROSA PINTO: Thank you very much.

HANSEN: All right. Next up we have Andrea Skolkin with One World Health Center Association of Nebraska. Welcome.

ANDREA SKOLKIN: Thank you. Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. As you heard, my name is Andreas Skolkin, A-n-d-r-e-a S-k-o-l-k-i-n, and I'm the chief executive officer of OneWorld Community Health Centers. And our main campus is in south Omaha, but we have 22 service locations across Omaha, Bellevue and Plattsmouth. I'm here today in strong support of LB913. Since 1970, OneWorld has been a cornerstone in south Omaha, offering comprehensive primary, medical, dental, behavioral health and pharmacy support to all people, regardless of insurance status or ability to pay. We also collaborate within the community to address the social determinants, or those factors that affect health, like access to safe housing, food security, and economic well-being. Last year, we cared for 52,000 patients, 87% who had incomes below 200% of federal poverty and were racial and ethnic minorities, and 1/3 served

in a-- best served in a language other than English. In 2023, we provided prenatal care to more than 1,700 moms and delivered, not at the health center, over 1,000 babies. We offer comprehensive maternal and family health programming, from medical care to educational classes, and even have an onsite baby boutique, where par-- patients can shop and redeem, redeem baby bucks for attending their prenatal appointments for essential items. We are very committed to supporting moms and babies and reducing maternal mortality among our patients. As you've heard, women of color experience disproportionately higher incidences of pregnancy-related death, postpartum depression, and medical complications. Pregnancy also exacerbate or can exacerbate chronic health conditions such as heart disease, disease, diabetes, hypertension, and may lead to the long-term need to support these diseases. The health and well-being of a baby is intertwined with the health and well-being of mom, and those that are uninsured have a higher likelihood of those kinds of disparities. New moms who have access to postpartum coverage are 3 times more likely to access behavioral health services, and they are much more likely to seek preventive care for themselves and their babies. For the moms we care for at OneWorld, ongoing health insurance coverage means that the moms and babies will be able to thrive as providers guide them with bonding, breastfeeding, emotional and nutritional support, care for complications from pregnancy, or postpartum baby blues to psychosis that can have a devastating impact, impact on the babies and their families. As you know, having a baby can be a wonderful time, but it also can bring worry and uncertainty. Parents often have questions and concerns as the baby is new in whatever the baby brings. Often, parents need support to make good decisions to take care of themselves and their new baby. The weeks and months following birth lay the foundation of long-term health and well-being for both the mom and her infant. Therefore, it's critical to have a reliable postpartum period that includes long-- comprehensive postpartum care. As you also heard, in 2012, Nebraska took a bold step in supporting the health and well-being of Nebraska families when Medicaid was extended, regardless of immigration status, for prenatal care. I happened to testify at that hearing and have seen a lot of the result and the impact in positive birth outcomes and healthy moms and babies. LB913 will continue that commitment to supporting children as they grow and thrive, by ensuring moms have healthcare access during the critical postpartum period. So let's support our tiniest children by giving all moms the opportunity to help their babies thrive. I, too, would like to thank Senator Hunt for introducing this important legislation and strongly encourage the committee to advance LB913 to General File. Thank you for listening and I'm also available for questions.

HANSEN: Thank you. Are there any questions from the committee? Seeing none, thank you. All right. Next up, we have Taylor Givens-Dunn with IBBG. Welcome.

TAYLOR GIVENS-DUNN: Thank you. Good afternoon, members of the Health and Human Services Committee. My name is Taylor Givens Dunn, T-a-y-l-o-r G-i-v-e-n-s-D-u-n-n, and I'm the policy and power building manager at I Be Black Girl. I Be Black Girl serves as a collective for black women, femmes and girls to actualize their full potential to authentically be, through autonomy, abundance and liberation. We are the only reproductive justice organization in Nebraska that centers black women, femmes, and girls, and we're happy to be here today in support of LB913. At I Be Black Girl, our goal is to expand access to quality and culturally relevant maternal health services. We know that if you center those most marginalized when considering policy solutions, all women and birthing people will benefit. Racial inequities in healthcare access and health outcomes across all sectors-- racial inequities in healthcare access and health outcomes across all sectors of our healthcare system are important, but maternal and infant health outcomes present some of the starkest disparities. We know that black women die from pregnancy-related causes more than 3 times the rate of white women, and one contributing factor to this is the lack of the healthcare safety net for postpartum women. 599 CHIP provides medical insurance coverage to pregnant women who may be ineligible for Medicaid due to their income, pregnant minors if their financially responsible's parent income makes them ineligible for Medicaid, and pregnant women who are ineligible for Medicaid due to their immigration status. Currently, once a child is born, 599 CHIP cases are closed at the end of the birth month, and critical healthcare coverage is lost. To improve maternal health outcomes in Nebraska, we need a comprehensive approach that improves access to quality care. Extending postpartum coverage in LB5-- in LB913 does exactly that. We know that many pregnancy-related deaths can be prevented, and many factors stem from a lack of insurance. Nebraska's Office of Maternal and Child Health Epidemiology reports that of factors contributing to maternal mortality, almost 40% are due to lack of access, lack of financial resources, or continuity of care. And many of the pregnancy related complications Nebraskans face, including death, occur after that 60-day limit. Comprehensive postpartum care that extends for at least 6 months can address elevated health risks during the postpartum period, including through management of chronic health conditions like hypertension, as well as treatment of mental health conditions like postpartum depress-- depression, which can impact infant health and well-being. Postpartum

care can also include counseling on nutrition, counseling on breastfeeding, and other preventative health topics that support maternal and neonatal health. Research shows that the coverage after pregnancy facilitates access to care, supporting positive maternal and infant health outcomes well after childbirth. To achieve optimal maternal health outcomes in this state, it is essential to expand further meaningful access to affordable and consistent healthcare for birthing folks wherever they live, whatever their socioeconomic status, whatever their immigration status. Last year, this body passed legislation to extend postpartum medical assistance from 60 days to at least 6 months. This is further expanded by Medicaid to provide 12 months of necessary postpartum healthcare coverage. LB 913, LB913 is good policy that reinforces that decision that this Legislature already made, ensuring that every Nebraskan has access to affordable health coverage and the chance for well-being that it provides. I Be Black Girl would like to thank Senator Hunt for her commitment to maternal health, and we urge this committee to advance LB913. Thank you so much.

HANSEN: Thank you. Are there any questions from the committee? Seeing none, thank you.

TAYLOR GIVENS-DUNN: Wonderful. Thank you.

HANSEN: We'll take the last invited testifier, Kelsey Arends, with Appleseed. Welcome.

KELSEY ARENDS: Thank you. Chair Hansen and members of the Health and Human Services Committee. My name is Kelsey Arends, K-e-l-s-e-y A-r-e-n-d-s, and I'm the Health Care Access Program staff attorney at Nebraska Appleseed, where one of our core priorities is ensuring that all Nebraskans have equitable access to quality, affordable healthcare. Because this bill addresses important gaps in access to postpartum healthcare, which is critical for keeping Nebraska moms, babies, families, and our communities healthy, Nebraska Appleseed supports this bill. LB913 provides postpartum care for new Nebraska mothers who currently, currently have no coverage after they give birth. Today, pregnant community members who receive services through 599 CHIP coverage are able to access prenatal, labor and delivery services but receive zero coverage for postpartum services. For background, as you've heard, 599 CHIP is a category of Medicaid for pregnancy-related services for certain pregnant moms who do not qualify for traditional Medicaid coverage. Compared to traditional pregnancy eligibility, 599 CHIP does not require citizenship or specific immigration status for the mother, and has different income

counting rules for pregnant minors. Right now, postpartum services are excluded from 599 CHIP coverage, despite the known benefits of postpartum care. Poor postpartum health is a significant problem in the United States. Postpartum care is critical and tied to improved health outcomes for pregnant people and for newborns. Four in five pregnancy-related deaths are preventable, and systemic inequities mean that poor outcomes disproportionately impact people of color. The poor health outcomes can be tragic, tragic, and extreme. Over half of pregnancy-related deaths occur in the 12 month postpartum period. Monitoring birth recovery, treating complications, providing reproductive care, treating chronic conditions, and providing mental health treatment are all important components of postpartum care. Disruptions in coverage during the pregnancy and postpartum period, which is what can happen when Nebraskans lose access to Medicaid-covered services immediately after birth under current 599 CHIP, unevenly impact Nebraskans of color. Currently, some long-time Nebraska community members, who contribute important talent, work, and taxes to our local communities, are unable to access basic, important postpartum services while navigating a complicated immigration process. Basic postpartum coverage keeps Nebraska moms and babies healthy and reduces costs for communities and healthcare systems. 599 CHIP provides access to services for Nebraskans with limited options for other coverage, including minors who are pregnant but who do not qualify for Medicaid because of their parents' income. Without ensuring coverage for postpartum services, all 599 CHIP moms are left without access to healthcare while their bodies are still actively healing from caring and delivering newborns. Notably, federal funding is available to states that provide postpartum coverage for those who receive care through the "from conception through the end of pregnancy" or "unborn child" option, which in Nebraska is the 599 CHIP category, through a CHIP Health Services initiative, or HSI. States can leverage federal funding to help improve the health of children with low income, sub-- subject to federal approval. Currently, 6 states use federal matching funds from approved CHIP HSIs to provide coverage in the postpartum period to people who qualify for the "unborn child" option, again, in Nebraska, which is by 599 CHIP. Beginning in 2025, our neighbor, Colorado, also plans to implement a CHIP HSI to provide coverage for community members after pregnancy up to 12 months who would otherwise be eligible for Medicaid or CHIP, but for their immigration status. Additional states provide postpartum coverage to those who do not meet traditional Medicaid immigration status requirements through fully state-funded programs. Ensuring that Nebraska mothers have access to postpartum care is the right thing to do for moms and babies in Nebraska. Providing postpartum care is also

cost effective for Nebraska. Health coverage lowers the risk of catastrophic healthcare costs, reduces medical debt, and improves financial well-being. Without comprehensive postpartum coverage, some patients turn to hospital emergency rooms, where care is more costly, less timely, and less efficient, and which leaves providers and patients less equipped to deal with chronic conditions or able to promote long-term preventive, healthy behaviors. By leveraging federal matching funds to ensure postpartum access for those receiving care through 599 CHIP, more costly, unnecessary, and sometimes tragic medical problems are avoided down the line. The postpartum coverage in LB913 will ensure healthy outcomes for Nebraska moms, babies and families, and cost savings for individuals, communities health systems in our state. Because this bill promotes health and coverage stability in the important and impactful postpartum period, Nebraska Appleseed encourages your support of this bill.

HANSEN: Thank you for your testimony. Are there any questions from the committee? Seeing none, seeing-- Senator Riepe. Yes.

RIEPE: Thank you. Thank you, Chair. We heard earlier that there were probably, I think, 800 maybe patients. Is there a percentage of those that are undocumented?

KELSEY ARENDS: I don't have the specific numbers in the fiscal note. It lumped all of the moms together, as about that 800 number. So I don't have more specifics about that.

RIEPE: Just curious about where we're at with that. Thank you. Thank you, Chairman.

HANSEN: Yes. Seeing no other questions, thank you very much.

KELSEY ARENDS: Thanks.

HANSEN: All right. Is there anybody else wishing to testify in support of LB913? Welcome.

ECHO KOEHLER: Hello. My name is Dr. Echo Koehler, E-c-h-o K-o-e-h-l-e-r. I have a Doctor of Nursing Practice degree and have been a registered nurse for 21 years. I am here on behalf of the Nebraska Nurses Association, speaking in support of LB913. The American Nurses Association is a leading advocate nationally on the important issue of identifying policy gaps in maternal and infant health. The ANA recognizes that these gaps contribute to poor birth outcomes and maternal morbidity and mortality, and the important role of Medicaid and CHIP in addressing those gaps. While the American

Nurses Association advocates nationally for federal funding, as the state members association the Nebraska Nurses Association has the responsibility to advocate at the state level to extend postpartum coverage for mothers, as LB913 proposes. Nurses are critical to ensuring that reproductive age women have access to maternal healthcare services and serve in multiple direct care, care coordination, and administrative leadership roles across the full spectrum of healthcare settings. You've heard from others here about the bene-- health benefits of postpartum care. Healthy child development begins with healthy parents. We need healthy moms to have healthy babies. Here is where I want to add a personal note. While I am here postpartum-- my baby's in the background. I'm going to talk about childcare access at a different hearing. But I think it's important for you to see the faces of people that these bills impact. While I'm an educated, professional working mom now, my motherhood journey started as a teen mom. So I was able to go to nursing school because I had access to Medicaid and other state assistance, and I was able to take care of my son and, and raise them to the great adult human that he is now, but I wasn't alone. Many of my nursing colleagues or peers in nursing school also received Medicaid and other state assistance. That's how we were as young mothers, able to continue our education. Studies show that children and families covered by CHIP and Medicaid lead to better health outcomes, higher educational achievement, and greater economic success later in life. You have an opportunity here with this bill to invest in the health of women, aiding in their ability to care for themselves and their families, and to continue their education, as I did. Recipients of, of other assistance programs are your friends and your neighbors and your colleagues. I hope that by sharing my personal story, you can see this isn't an abstract idea. It's hard to quantify what the return on investment is it-- is here, with this bill. But I have to say, if it's better health outcomes for our babies, higher educational achievement and greater economic success later in life, that return on investment may just be the product of a nurse who may save your life, or the teacher who educates your kids, or an early care-- childcare provider that babysits your kids. Those are all predominantly female staffed fields. The Nebraska Nurses Association is the overarching organization of 30,000 registered nurses in Nebraska. We're bound by a code of ethics. Nurses have a duty to provide, advocate for, and protect the health, safety and rights of patients, whether it's an individual, family, group, or community. Extending postpartum coverage would offer a healthy start for Nebraskan families. For these reasons, the Nebraska Nurses Association supports LB913, and we ask the committee to advance this bill.

HANSEN: Thank you. Any questions from the committee? I don't see any. Thank you.

ECHO KOEHLER: Great. Thank you.

HANSEN: Anybody else wishing to testify in support of LB913? Maybe? Maybe not. OK. All right. Is there anybody wishing to testify in opposition to LB913? Is there anybody wishing to testify in a neutral capacity to LB913? Seeing none, we'll welcome back up Senator Hunt. And for the record, we did have 33 letters in support of LB913 and 1 in the neutral capacity.

HUNT: Thank you, Chairman Hansen. I don't have much to add. I think that was a really thorough hearing and we heard from a variety of stakeholders. I-- I'm always really proud because I know that I have a reputation for sometimes being one of the more controversial members of the body or, you know, doing some things that are more on the fringes from what others do. And I'm really proud when we can do a bill together, that brings together such a diverse group of supporters. And you know, for me, that's kind of what this work is about. It's what makes me excited to do it. I wanted to answer, I think it was Senator Riepe's question, about the breakdown of the, you know-- it was with 800 and 830 or so people who would be impacted by this bill. The breakdown of how many of those people are undocumented Nebraskans, a lot of these people are DACA recipients. They're already people who are getting care as 599 CHIP mothers. But we asked DHHS for those numbers to break that down, and they weren't able to give that to us. And so that just might be something we don't have data on.

RIEPE: OK. Thank you.

HUNT: Yep. Other than that, happy to answer any other questions. And thank you for your patience and time.

HANSEN: Yeah. Are there any questions from the committee? I don't see any.

HUNT: Thanks, everybody.

HANSEN: All right. Thank you. All right. And that'll conclude our hearing for LB913. That's just fine. All right. And we will open it up for LB1003, which is my bill. And we'll hand it off to Senator Hardin, to take control.

HARDIN: Welcome.

HANSEN: Thank you. Hoping this bill won't take an hour and a half like each one did before me, so we'll see. But it is just as important, I might add. All right. Good afternoon, Senator Hardin and members of the HHS Committee. I am Senator Ben Hansen. That's B-e-n H-a-n-s-e-n, and I represent the 16th Legislative District. Outside of Washington County, my district serves Burt, Cuming, and parts of Stanton County, which are considerably rural counties. I have heard from them and others, being chairman of the HHS committee, about the lack of childcare options for our state's workforce. Parents often find themselves either placed on a waiting list or simply without childcare. I think the whole licensing procedure for in-home daycares could be reconsidered, allowing for capable, safe and trusted members of rural communities to care for children. However, in an effort to start a conversation and also to alleviate some of the issues, I brought LB1003. Currently, DHHS lays out the guidelines for childcare centers across the state. There are 5 types of licenses. State statute describes what kind of license a daycare must hold based on the number of children they serve, the number of staff employed, and their location. Also, the statute permits a city, village, or county to have the ability to adopt rules, regulations, and ordinances establishing physical well-being and safety standards for the daycares in their communities, as long as they are more stringent-- as long as they are stringent or more stringent than DHHS standards. So as a state, we have a certain amount of trust in local government to understand the needs of their community when it comes to childcare. I am looking to increase local control in one area, the area of staff-to-child ratios. After discussing the topic of-- topic of staff-to-child ratios with many daycares across the state, I found that both rural and urban daycares would benefit from LB1003. This bill will use the same system that is currently in place for cities, villages, and counties to adopt rules and give them the ability, the ability to limit or expand staff-to-child ratios, whatever is best for their community. The conversation of staff-to-child ratios includes safety, sickness, the nurturing of children, developmental benefits, staff wellbeing, accountability, and the list goes on. These were all aspects considered by the parents and childcare providers who spoke with my office in support of LB1003. Many of them couldn't come today because they have jobs, come from rural Nebraska, and are the ones taking care of our children. I had one daycare that is a drop-in hourly center and often has a wide range of ages. It's a franchise, and says that Nebraska is one of the only states required to have a separate ratio by age and a facility where all children are in the same space. Having an option for a facility to use a single ratio, for instance, 10 to 1, because of our mixed ages, would benefit them greatly. Their other

locations in other states are doing well. I heard from Robin [PHONETIC]. She wanted to come, but one of her employees retired yesterday and another is out sick. Each daycare in support of LB1003 is caring for children today. They are capable and know the kids that they serve. What if we let them present a need to their local city council or county board, and come to a staff-to-child ratio that works best for their community? The current staff-to-child ratio standards are considered ideal for our state. What about other states? They are also successfully and safely caring for children with the same research and numbers taken into consideration. Nebraska's child to staff ratios are 4 to 1 for infants up to 18 months. What about the 3 states allowing the ratio to be 6 to 1? What about the 2 states allowing 9 to 1 for 18 months? Are they not safe? Nebraska says that daycares must have 1 staff for 12-- 1 staff for 12 5-year-olds. 37 other states are more lenient. Some have 15 to 1, and others, such as Florida, being 25 to 1. On the other hand, Nebraska is more lenient than 17 other states who require their 4-year-olds to have a child to staff ratio of 10 to 1. Here in Nebraska, we say there can be 12 4-year-olds per 1 staff member. Are the Nebraska ratios saying that 17 other states are unsafe? And no, LB1003 does not give daycares the option to be unsafe. It does, however, give them the ability to serve their community with the oversight of local government. I appreciate the opportunity to hear the discussion around LB1003 today, and hope with-- that with all the comments, we can further explore how to support local childcare options. I believe LB1003 does precisely that. Thank you for your time, and if you have any questions, I'd be happy to answer them.

HARDIN: Thank you. Any questions? I'm sure I'll have some after [INAUDIBLE].

HANSEN: I'll be here to-- I'll be here to close either way. So.

HARDIN: You'll be here. Wonderful.

HANSEN: Yep.

HARDIN: Any proponents for LB1003? Hi, there.

ALAYNA HAM: Hello. Good afternoon, Vice Chair Senator Hardin and members of the HHS Committee. My name is Alyana Ham, spelled A-l-a-y-n-a H-a-m. I'm here today to voice my support for LB1003. I'm going to guess that the experience parents have in cities like Lincoln and Omaha is a little bit different than my own. And I'm hoping that by sharing my testimony that I can help you all understand the

perspective of those of us in small communities struggling to find daycare. I'm a Spanish teacher at a small school in a rural Nebraska community. Daycare in our community is impossible to find, as we only have 1 local provider and a few rural in-home daycares. I live in Hastings. And after I found out that I was pregnant with twins, I got on the waitlist at every licensed center in Hastings. No one ever called me. And 2 years later, I called several of them back, and all of them still had me on their waitlist. So when my boys were born, I was very lucky to have a local in-home provider that happened to have 2 infant openings. My kids attended her daycare until she moved to a much larger building in town, in order to increase the number of children she could watch. Since she started this process, her prices have increased substantially to cover the costs associated with converting an old building to adhere to DHHS regulations. With no other options, we had to agree to pay the increased costs. In August, we-- all the parents received a message that she'd been temporarily shut down by the state, and we immediately had to scramble to find other means of care so that my husband and I can continue to work. Multiple parents missed several days of work without pay. Several parents are teachers at the same school, and our school had to pay for substitute teachers to cover our classes while we stayed home to try to find childcare. Grandparents started to take days off work to help. Parents contacted other daycares in nearby towns, begging for them to take extra kids above their ratio so they could get back to work. When contacting the backup daycares, we all found that several other daycares in the area had been shut down, as well. The principal at our school, struggling to keep substitute teachers in the building to cover all the teachers staying home with their kids, started looking into how he could help us provide childcare. Everyone was met with dead ends because the process is too complicated and too expensive, and there just simply aren't enough options. We essentially all gave up. Months went by and we all just had to accept that she was closed indefinitely because the required changes she needed to make were expensive and time-consuming, and they required her to make appointments with inspectors, plumbers, construction workers, and more. She had to find a way to tell parents whose children have been in her care since birth that she was no longer able to provide care for them [INAUDIBLE] the ratios set by the state. Eventually, we all just had to be OK with the options that were left, lowering our standards of care for our own children because we couldn't afford to continue to miss work. I eventually found a college-aged girl from a nearby town who was willing to come watch my kids and another family's kids in a private home. This home was certainly not up to the standards set by the DHHS for childcare. It was more expensive for us,

even after we split the cost, by giving her more children to care for, and the girl was certainly not as qualified as our regular provider. All the parents were forced to lower their standards in terms of the best childcare for their kids. Children need a schedule. They need to know what to expect every day. Every day was different for them for months because we never knew who could watch them or where they could go to be cared for. Several parents had to take their kids with them to work, at school, at local businesses, and even on their family farms. These places are not regulated, they're not safe, they're inconvenient, and they cause problems for more than just their parents. I know that my children were safe, loved, and cared for by our provider, probably even more so than they would be at home. Then a stranger calls into the state to report her for watching too many kids, and my children's lives are uprooted. Was the number of children being cared for by my provider placing my own children in imminent danger? In my opinion as their mother, no. It was not. My own home is much less safe than the facility my kids spent their days in. How is this better for my children and for the community? For the other parents? For the economy? How is this better for my students, who missed several days of instruction? For my kids' grandparents, who also took days off work to help out? My childcare provider is knowledgeable, loving, nurturing, and competent. She provides my children with an environment that I, the parent, find to be perfectly acceptable. She teaches my children and provides them with valuable social interactions. It shouldn't be this expensive and this challenging for her to provide care for my children. She should not have to worry that someone in the community can call and file a complaint against her, and that she might be immediately shut down when she's providing excellent care to several children. She shouldn't have to worry that her assistant may get sick and she'll have to close for the day because she'll be over the current ratio. There are no substitutes for daycare providers. I should have the freedom of right to det-- to determine what is safe for my children. Local municipalities have the democratic duties as elected officials to hear what actual parents think. Why would there be 1 set of rules for a state that has 2 completely different demographics? In Omaha, a city of a little under 500,000, people have more daycare options and daycares are able to have higher prices, allowing them to pay more staff members to watch fewer kids. In my small community of 300 people, there's 1 option and no competitive market for her to increase prices and be able to aff-- excuse me, afford more employees who aren't available anyways. If small communities and villages are able to oversee the ratio standards at local daycare centers, they'd be able to take specific things into consideration, because we know these

community members personally. They know the facilities. They know the work it takes to accommodate legal requirements, and they can build their standards based on that. Do I have to stop now? Can I keep going?

HARDIN: Just wrap up your final thought, if you would.

ALAYNA HAM: I have, like, a paragraph, I'll finish it for you. Let's see. Parents are the best advocates for their children, and won't we be looking out for our children's best interests when helping to determine what's safe and unsafe in a childcare center? Why can't a local governing official-- officials that I vote for, who I know personally, whose children I have in class, be the ones who determine my child's safety? I'm in favor of this bill because it gives me more power to determine what is and is not safe for my kids. It gives small communities the option to operate their daycare centers under their own standards, rather than the same standards as much larger cities in our state. This bill would be a big step in the right direction when it comes to making daycare more available in rural communities. Thank you.

HARDIN: Thank you.

ALAYNA HAM: Do you have any questions?

Speaker 1: Any questions from the committee? You're from Hastings?

ALAYNA HAM: Hastings, yeah.

HARDIN: OK. Just a-- I'm from Scottsbluff-Gering area. We're struggling with the same kinds of issues. I'm just wondering, have you-- one of the things that we've come across and it wasn't my own thunder, but I think it's an interesting idea, is we're approaching local businesses. And the local businesses have employees, the employees have children, and we're going business by business and just kind of saying, would you be willing to reserve X number of spots for the average number of employees that you think would require care this year? And so, it is something that we're trying to get the local businesses to help us with in the process. Has Hastings considered anything like that? As far as you know?

ALAYNA HAM: Not as far as I know. And I-- so I, I live in Hastings, but where I work and do most of my business is in Nelson. So.

HARDIN: In Nelson? OK.

ALAYNA HAM: Yeah. I don't know too much about how Hastings-- I gave up after they were all--

HARDIN: Full.

ALAYNA HAM: --you know, several years ago, we asked.

HARDIN: Have you heard, anecdotally, numbers about how many kids need childcare that there just aren't slots for?

ALAYNA HAM: I don't know, numbers, but I do know that there is a large conversation, and our small community is about like, people-- people are just struggling. They can't find-- nobody can find anybody. So people, when they, when they find out that they're pregnant, that's the first thing that they do, so they'll be eight weeks pregnant and trying to find daycare for when their kids are born.

HARDIN: Right. OK. Well, thank you.

ALAYNA HAM: Yeah. Thank you.

HARDIN: The next proponent for LB1003. Hi, there.

LISA BROWN: Hello. Good afternoon, Vice Chair Senator Hardin and members of the HHS Committee. My name is Lisa Brown, spelled L-i-s-a B-r-o-w-n. I am here today in support of LB1003. As of today, my daycare has been closed for 6 months. My husband and I have exhausted our backup options for our children and are in desperate need of daycare. Our ability to dedicate the necessary effort to our workplace is pressured weekly while trying to find childcare. I also speak for several other young couples who have made their home in rural, south central Nebraska. In order for our communities to continue to encourage young couples to move back after college, accessible daycare is a nonnegotiable. While I understand regulations are in place to provide the safest environment for our children, which I greatly appreciate, the demand for daycare is at an all time high. However, this shortage of providers has put stress on couples all throughout our towns and even forced families to discuss relocating to larger areas. Before my husband and I became pregnant with our first child, we worried about the options we had. However, having a family is the cornerstone to our relationship. Between my 2 close-knit communities, there is one licensed childcare center. One. And as I previously mentioned, there are several young couples in my community as well as surrounding communities who are raising their families in rural Nebraska. Do we tell those families tough luck? What works in Omaha must work throughout the entire state? In neighboring towns with over

1,000 residents, which is more than double the size of my 2 communities combined I just mentioned that I reside in, there is one licensed childcare center accepting infants and toddlers and one preschool taking children from 3-6 years of age, during school hours, of course, who likely need outside childcare until parents are able to pick up their child. There is a handful of other options in more distant towns, and even more choices in larger municipalities more than 45 miles from us. However, many of these have waitlists. I personally work in the healthcare field as a nurse, and I do not have the typical 8 to 5 job. At times, work requires my presence before daycare opens without being able to leave before they even close. My husband and I work together to get our children to and from daycare. Therefore, a center must be close to our small community. Multiple centers have been shut down for not being licensed, mine being one of them. Our daycare provider treats all children as if they were her own. The kids are shown, shown love and are provided with opportunities to grow physically and mentally. There were no safety concerns when the state came in and shut her down. When the time for daycare for our firstborn arose, my husband and I reached out to the provider and were fully aware of the environment in which our daughter would be sent. Many of our close friends made the same choice. Our family felt confident and comfortable in our decision as to where we were sending our child. We now have no one to turn to, as multiple centers have been shut down in our small community. And as I mentioned previously, the options are scarce. Small-town daycares do not have the manpower to match every minute detail drawn up in the red tape of Lincoln legislation and agencies. I strongly request that the requirements from the state to operate a licensed childcare facility be reevaluated at this time, like is presented in LB1003, which again, I strongly support. The state of Nebraska is the heartland of America and provides a plethora of opportunities. We have 2 booming cities and vast farmland to not only provide for our residents, but for the country as a whole. However, the people in small towns of this beautiful state should be given the chance to regrow these communities that their grandparents once prospered in. Thank you. I'd be happy to answer any questions.

HARDIN: Thank you. Any questions? I'm going to ask the same question of your community. Which community are you in?

LISA BROWN: We're actually from similar communities.

HARDIN: OK.

LISA BROWN: Yeah. Nelson. Lawrence-Nelson.

HARDIN: Anecdotally, again, are you, are you hearing anything out there in terms of how many people are kind of looking?

LISA BROWN: I mean, when our daycare got shut down, I mean, I don't know specifics, but I mean, 20 kids-- I mean, there-- were displaced, and others--

HARDIN: So it was 20 kids, at least.

LISA BROWN: Yeah. My sister-in-law and my brother just had a baby. And they searched up until she had to go back to work just yesterday, to try to find somebody. Grandparents are staying home to help them. And other people, you know, before they're even pregnant are worried about it at this point, because the wait lists, like, my friend just talked about, I mean, 2 years and you don't hear from anybody. So, I don't have specific numbers, but--.

HARDIN: Sure.

LISA BROWN: --everyone in the county is, you know, concerned about where their child might go.

HARDIN: You bet. Thank you.

LISA BROWN: Yeah. Thank you.

HARDIN: Anyone else in support of LB1003? Welcome.

SCOTT THOMAS: Hey. Good afternoon, Health and Human Services Committee members. My name is Scott Thomas. I'm with Village in Progress, Nebraska. S-c-o-t-t T-h-o-m-a-s. And I agree with what I heard already. Localizing the authority to make determinations as to the appropriate care for children is functionally in the best interest of children. And so, in accordance with Article 25 of the 1948 UDHR and Article 27 of the 1948 UDHR, entitling children to special consideration by government and a functional form of government, respectively. I support this bill and I'd be happy to take any questions from the senators. I'm from Fremont, before you ask. Yes, sir.

HARDIN: Fremont. OK. Very good. Any questions? Tell me about your community. What are you hearing in Fremont?

SCOTT THOMAS: Same thing.

HARDIN: Same thing.

SCOTT THOMAS: Shortage in childcare.

HARDIN: Yeah. Yeah.

SCOTT THOMAS: It's pretty prevalent.

HARDIN: Do you have a sense in terms of what it costs if you can get a slot in, for, I don't know, a 2-year-old? What's it cost?

SCOTT THOMAS: You know, I don't-- I wouldn't, I wouldn't want to speculate.

HARDIN: OK. Got you.

SCOTT THOMAS: Yeah.

HARDIN: Well. Thank you.

SCOTT THOMAS: I appreciate it.

HARDIN: You bet. Anyone else in support, LB1003? Anyone in opposition, LB1003? Welcome.

MYRA KATHERINE HALE: Thank you. Vice Chair Senator Hardin and members of the Health and Human Services Committee, my name is Mary Katherine Hale, M-y-r-a K-a-t-h-e-r-i-n-e H-a-l-e. Along with my husband, I'm the owner/director of Pearl Academy, also from Fremont. I can tell you that in Dodge County, there are currently 900 kids on the waitlist for childcare. I am testifying here today in opposition to LB1003. I specifically mentioned that I'm the owner and the director, not just the owner, to make you aware that I'm at my center daily. I'm in the trenches with my staff. I know the challenges that early childhood educators are facing. I know the challenges that parents are facing. I have worked in early childhood education for 24 years. While I sincerely, sincerely appreciate Senator Hansen's effort to address childcare gaps, I have deep concerns regarding this bill. Giving cities and counties the authority to set their own childcare ratios that are less stringent than the standards set by the state could have serious consequences for the safety of our children. I firmly believe that there are more responsible and effective solutions that could be explored to face the challenges that we're, we're facing. As a side note, the amount of children that can be enrolled is based not only on ratios, but also on square footage of our buildings. I currently have enough staff to enroll 73 children, but I only have enough square footage to enroll 53. So for many centers, this would not even address the childcare gap. Many providers across the state already struggle

with staff turnover and burnout. Directors will be put in a very challenging position to tell their staff, who are already overworked and underpaid, guess what? Your workloads are increasing. We're going to make your job tougher. My fear is that teachers will leave the field and support staff will go down the street for a higher paying, less stressful job. Local government plays a vital role in our communities. I've worked with my city council closely over the past 5 years and I value the relationships that we have built, but I don't think that this is a decision that should be placed on their shoulders. The current ratios have been set in place for the safety and well-being of our children. Making ratios less stringent would create supervision issues, safety concerns and as I mentioned earlier, increase in staff burnout. Beyond safety, this bill would affect quality, our quality of care. Pearl Academy participates in the Nebraska Department of Education's program called Step Up to Quality. This program equips and supports centers as we strive to offer the highest quality of care possible. Increasing the amount of children that teachers are responsible for will make it almost impossible to meet these quality standards. In terms of quality, we're not going to see these outcomes until years to come, and then it will be too late. Here's what I-- here's what I want to urge. Support the creation of new centers. Support the creation of centers in our rural communities. Help train staff and educators. Review the square footage regulations. Pour resources into a struggling and fragile industry. But please do not put these decisions into the hands of leaders who may not have the knowledge or expertise necessary to navigate the complicated landscape of childcare industry. Vote no on LB1003 so that we can continue to offer Nebraska's children the best care and early learning experiences like mine have to offer. Thank you to the committee, and I am happy to answer any questions that you may have.

HARDIN: Thank you. Senator Ballard.

BALLARD: Thank you, Senator Hardin. Thank you for being here, making the trip down. Do you know the square foot regulations for childcare centers off the top of your head?

MYRA KATHERINE HALE: So for a childcare center, it's 50 square feet per child.

BALLARD: OK, 50 square feet. And if I have one more question, if I may. I'm going to kind of put you on the spot here.

It's OK.

Can, can you-- I understand the, the opponent testimony, but can you elaborate? What, what red tape would you cut to make your job easier?

MYRA KATHERINE HALE: OK. I am no fan of the Department of Health and Human Services, but I know you have all been here a long time, so I'll keep that part short. The-- I, I think that one of the reasons we don't have more centers is because how hard the Department of Health and Human Services makes it to open a center. We just poured close to $50,000 into a building, as someone mentioned earlier. Plumbing, our-- getting our fire up to code. Those are super important things. What's hard is when, when a state person comes in and you're over ratio, I mean, they don't shut you down just for that. So we-- we've been in trouble plenty of times. Someone no-shows at 8:00. You're out of ratio until you can call someone in, or you call parents and say, no one can drop off until, until I give you the red, you know, until I give you the OK. But part of it is there's no nuance with licensing, and I, and I heard that from, from the mothers, too. Right. Like you can go in and you can see that these kids are safe. I think that the Department of Health and Human Services is supposed to be there to serve us, to help create centers, to help us succeed. But I often refer to them as the "Department of Hell and Hopelessness," because they, they don't. They, they, they come in to catch you. That's what they want to do. But I don't think that this bill and just giving my city council the ability to say, OK, well, I can care for 25, 5-year-olds instead of 12 5-year-olds is the answer, because my staff is already burned out. If I tell Kelsey Appleby that-- she's taking care of 6 toddlers, is now going to be taking care of 12 toddlers, and doubling the amount of diapers, and doubling-- we, we lose the opportunity to engage with these kids. If we have so many kids in our center that-- I mean, right, we're starting to need-- parents need the childcare, I totally see that. But if we increase ratios, then all we're doing is OK, got to feed you. OK, got to wipe your face, got to wipe your nose, got to change your diaper. Oh, time to eat again. Time to change your diaper. Like, there's no time for sit down on the floor, engage with these kids and, and, and build those relationships. And, you know, we talk a lot about kindergarten readiness. We don't use that term in my center, because I know that kindergarten teachers are going to be ready for the children in our care. But if we don't build in those what are called executive function skills, right, we don't build-- they don't, they don't go to kindergarten knowing how to wait in line and to take the turns and put their coats on. Like the things that teachers want them to know, we're not going to have time to teach that. And when the Department of Ed says, this is what you want for quality, so Step Up to Quality-- I've been in Step Up to Quality for 5 years, and I'm only

at step 2, like the quality standards are so incredibly high. And if, if this passes and they increase ratios, I-- we'll just withdraw from the program, because there will be no chance of meeting those quality standards, although I don't have to increase my ratios. I do get that.

BALLARD: I have one more question. And, and I probably know the answer to this question but I'm going to ask it anyway. How-- how's your workforce? Do you have available workforce in Fremont for, for childcare centers?

MYRA KATHERINE HALE: I will tell you that we have been incredibly fortunate. We are privately owned. My husband and I are very good to our staff. So as I mentioned, I have enough staff for 75 children. But it's kind of the 80/20 rule. About 80% of our staff are-- they are committed. I don't, I don't see them turning in their, you know, resignation tomorrow. And then you've got about 20% that kind of come and go. We compete heavily with fast food. We compete heavily with gas stations. And to be honest, like, we should be pouring money into our educators so that we have educators with bachelor's degrees in early child, but that's, that's not affordable. I mean, like, it's just-- it's, it's just not. So, you had asked earlier, there's 900 children on the waitlist for Dodge County as of last fall. But there are a lot of centers that have closed rooms because they can't staff them.

BALLARD: Thank you for being here.

HARDIN: Anecdotally, can you share with everyone either what you've witnessed at your own center, God forbid, or somewhere else? Give us an example or 2 briefly, what are the worst things that could happen?

MYRA KATHERINE HALE: The worst things that could happen if we-- yeah. Well, I'll tell you what. We-- when we opened, we grew too fast. There were-- we were 1 room, and so yeah, you did have to go to that lowest ratio. And we grew faster than my ability to, to-- we just-- because people needed it. And I don't answer my phone anymore because I can't say no and I have no [INAUDIBLE]. And so, we had a, a large group of kids in the room and probably not enough staff, and a little autism boy walked out the door. Praise the Lord. It was a, a, a-- it was a-- into a, a playground that was fenced in, but my staff didn't catch him. We, you know, you look at this terrible-- and this wasn't a racial issue, but you look at this terrible incident that happened in Omaha recently, with the child dying in the van. I straight up put my van on the market that day, because the responsibilities that we're giving to these-- to our staff is, is, is just monumental. I will tell you another example. We were out of ratio one morning-- and you can

look me up, up on the DHS, you'll see all my little indiscretions. So I'm, I'm not this big rule follower. I'm just saying, I don't think this is the answer. But we were found out of ratio one morning, and someone no, no-showed, no-called. We had 2 teachers in the room. One decided-- like was working on something, maybe breakfast. The other decided just to go to the bathroom and leave the kids unattended. And so the-- if we had had that teacher that was supposed to have been there, you know, and been in ratio, then, then someone can go to the restroom. And so I-- there are plenty of ways that we can change legislation [INAUDIBLE] Legislature. And I, I believe that, because they make it so difficult, that-- I can't tell you how many times I wanted to quit. Like, it's not even worth it. Right. But then I'm looking at these families that I serve, and I-- my biggest thing right now is out of protection of my staff. It's-- it feels very unfair to them. And, you know, maybe, maybe some of these providers think they can take care of 30 children, but I feel like the engagement and the quality, at some point, is, is going to decline.

HARDIN: Thank you.

MYRA KATHERINE HALE: Yeah.

HARDIN: Appreciate it, and we appreciate your testimony. Thank you.

MYRA KATHERINE HALE: Absolutely. Thank you.

HARDIN: Anyone else in opposition to LB1003? Hello. Welcome.

BETSY TONNIGES: Thank you, Vice Chair Harden and members of the committee. My name is Dr. Betsy Tonniges, B-e-t-s-y T-o-n-n-i-g-e-s, testifying in opposition to LB1003, as it is stated. I own and operate Primrose School of Lincoln at Wilderness Hills and operate Primrose School in conjunction with Hudl headquarters in downtown Lincoln. Both locations have undergone Cognia accreditation, meaning we adhere to high-quality standards for learning, growth and development of all children. In listening to early childhood issues that not only impact local, but rural communities, we're all in agreement that crucial steps must be taken to preserve Nebraska's future, the quality of our education for our earliest learners, and Nebraska's working families who need the care and stability of care to contribute greatly to the workforce in addressing the shortage everyone is facing. I appreciate Senator Hansen for taking an interest in finding solutions to the childcare shortage in Nebraska. And as you can tell, it is pretty multifaceted. Many of us have heard the statistic that we know the school-to-prison pipeline trajectory, based upon third grade reading

data. Studies are now finding a correlation between development of gestures and language from 9 to 16-month-olds predicts language ability 2 years later. This then translates and predicts the ability for successful outcome, illustrating the importance of quality care and education opportunity. You might assume that a provider like myself would welcome higher ratios as a way to serve more children and have a better chance at survival at our center. While the staffing required to maintain teacher to child ratios makes up the vast majority of my budget, consistent ratios are essential for the quality of my program and all programs across the state, regardless of the zip code. I would never want to serve more children if that meant potentially jeopardizing their health, well-being, and safety, or the quality of their education at the most pivotal time in a human's life, 2 other aspects that are critical to the success of my business. I am concerned about many other potential impacts of this proposal, like my ability to maintain or obtain liability insurance in the future. This expenditure is currently in the top 3 for my business. The mixed ratios and an unclear message about what is deemed safe and appropriate for adults to students to operate. With mixed ratios, as someone who runs more than one center, this could be detrimental in whether I could obtain coverage, let alone at a rate that I could actually afford. The bill in its current state is not clear on who the authority is or who makes these decisions. I fear that to meet the demand, providers will be put in an unfavorable position, in either having way too many children to care for with not enough adults to assist, or reducing a further ratio and not being able to make ends meet or provide, due to the lack of professionals in the early childhood field. I give you an example from a colleague. In Florida, the Department of Children and Families, which is an extension of the state of Florida, manages some counties. And the state of Florida manages other counties. Since DCF can establish their own ratios, they are different from the state-established ratios. DCF has established lower ratios than the state, and his center, located in Pinellas County, is unable to meet the demand. This creates confusion when, just a few short miles away, the ratios are different. The main factors that are already clear is that this approach, with its current ambiguity, creates discrepancies in licensing expectations, inequitable employment opportun-- expectations for staff, ability to recruit and keep talented professionals in the field, and does not actually solve the root issue of the rising costs and availability of running a high-quality early childhood center, which is often solely placed on the parent, who deserves a choice in where their child receives care. In closing, I appreciate the intent behind LB1003, and I'm grateful to Senator Hansen. The early childhood education issues

Nebraska's-- Nebraskans are facing, and not only a shortage in early childhood programs, but a drastic shortage in quality programs, and that's why I'm here today. In my experience in running a center and with my clear understanding in the brain science behind how crucial the first 5 years of a child are, trusted relationships between providers and families are critical, and this approach would have long-lasting effects. I may offer one solution, and the previous person actually stole my proposal. Senator Ballard, it's actually 35 square feet indoor per child, and 50 square feet of outdoor play space per child. So there's 2 different ratios-- or regulations there. In states such as Texas, the square footage is 30 square feet. This allows centers to serve more students, still in alignment with consistent ratio for teachers without compromising care for both students and the professionals who serve them. The more students who can be served in one space, it helps ease the financial burden. Childcare is the law of large numbers. Expanding a center's operating capacity to have the ability to serve more children would have greater impact and not compromise the health and safety and education of our littlest Nebraskans. So, for example, when we built our building, we were told we could serve 210 students by the franchise that we work with. But when Nebraska licensed it, it's only-- I can only have 180, so.

HARDIN: OK. Thank you.

BETSY TONNIGES: Please let me know if you have questions.

HARDIN: Any questions? Senator Ballard.

BALLARD: Thank you, Senator Hardin. I'm just curious, because you recently opened the, the Primrose at Hudl, correct?

BETSY TONNIGES: Um-hum.

BALLARD: How, how has that been going? It-- that's a partnership with Hudl, or is that just-- OK.

BETSY TONNIGES: Yes. It's, it's a, a wonderful partnership. As you know, it's brand new. Hudl does subsidize part of the tuition for their employees, and so they receive immediate access to childcare. They also receive it at, at a reduced rate, which, they have seen some wonderful benefits of, just in the first 6 months that we've been open. It is also available to community members and corporate partners as-- at-- as well, at a different childcare rate that is not subsidized unless their employer chooses to do so.

BALLARD: And then, do you have a wait list for your-- for, for your childcare? OK.

BETSY TONNIGES: We do.

BALLARD: OK. Thank you.

BETSY TONNIGES: Yeah. We haven't accepted-- I want to say we haven't accepted very many infants that are not a sibling for the last 2 years.

BALLARD: OK. Thank you.

BETSY TONNIGES: Um-hum.

HARDIN: What curriculum do you use at your centers?

BETSY TONNIGES: So Primrose has been around for over 40 years. We use our own proprietary curriculum called Balanced Learning. So it's a combination of the Montessori approach, in combination with direct instruction in what's developmentally appropriate for children. So they get the aspect of play and learning through exploring and curiosity and asking questions, but then are also oppor-- provided the opportunity to learn from teachers and with teachers the, the skills necessary to be ready for kindergarten.

HARDIN: Do you provide babysitting or do you provide early child education?

BETSY TONNIGES: It's been my mission to get rid of the word daycare. We are a school and we provide education. And we do call our teachers "teachers," they're professionals. And, you know, I think that that is part of the culture that we have, that we're trying to elevate early childhood profession. Because if we can prevent things birth through 5, it sure helps a lot of my former colleagues in the K-12 sector with challenges that they currently face.

HARDIN: Would there be a danger associated with having city councils, who may or may not have someone-- a background like yours, making decisions about whether or not they're providing a distinction between babysitting and early childcare education?

BETSY TONNIGES: Yeah, I think for me, part of it is-- my worry is, you know, having inconsistent ratios across the state. I mean, I think I would be for exploring, you know, what other states are doing and having a, a consistent ratio across the state. My worry is exactly

what you had, had mentioned, that there would be people that would be determining these factors and don't understand the importance of birth to 5, and just how critical of that time in a child's life is. And it may become an issue more about feelings rather than what's in the best interest of the child. But I certainly can understand having families from smaller communities, just the childcare desert that is out there and the lack of options.

HARDIN: Well thank you.

BETSY TONNIGES: Yeah.

HARDIN: Anyone else in opposition to LB1003? Welcome.

MITCHELL CLARK: Thank you. To you, also. I forgot. OK. Vice Chairman Harden and members of the Health and Human Services Committee, thank you for allowing me to testify today. My name is Mitchell Clark, M-i-t-c-h-e-l-l C-l-a-r-k, and I am a policy advisor for First Five Nebraska, a statewide public policy organization focused on early care, learning and well-being of Nebraska's youngest children. I'm here to testify in opposition to LB1003. I want to start by thanking Chairman Hansen for the opportunity to discuss why the current staff-to-child ratios are not only important for safety and quality of care, but the viability of the early care and education. And I do sincerely appreciate his interest in this issue for making childcare and early learning more viable across the state. However, First Five Nebraska believes LB1003 is not the right approach. It is important to recognize that the ratios the Nebraska Department of Health and Human Services has set, or DHHS, are not arbitrary, but rather, they serve an important function for safety, health and positive outcomes. The U.S. Administration for Children and Families, or ACF, provides recommendations to states based on industry best, best practices. For instance, in center-based settings, the ACF recommends a staff-to-child ratio of 1 to 3 for infants, 1 to 4 for toddlers, 1 to 7 for age 3, 1 to 8 for ages 4 and 5, 1 to 10 for school age 6-- for school age 6 through 8, and 1 to 12 for school ages 9 to 12. In comparison, Nebraska's ratio requirements for this setting are less stringent than federal recommendations, at 1 to 4 for infants, 1 to 6 for toddlers, 1 to 10 for age 3, 1 to 12 for 4 and 5-year-olds, and 1 to 15 for all school ages, 6 up to 12-years-old, or excuse me, up to 13-years-old. LB1003 shifts responsibility from DHHS as the sole authority in the state for determining child care ratios and places it on Nebraska's municipalities and counties. While First Five Nebraska does not anticipate that local governments would set ratios that are overtly dan-- dangerous, LB1003 would subject those local governments

to unwanted scrutiny. From a public relations standpoint, those entities that opt to loosen their ratio would be responsible for potential safety incidents involving children. LB1003 could also produce a number of other unintended consequences that would hurt the viability of the childcare industry. The first is higher premium costs, as some of the other testifiers have alluded to earlier, or a drop in coverage for business liability insurance. This is already an issue facing many providers. Ratios, risks related to accidents and injuries, and risks related to claims of neglect are all considered in insurance coverage. Secondly, without a standardized ratio requirement set by DHHS, it would be tasked with maintaining separate ratio requirements depending on location. And again, as you've heard alluded to from the other testifiers, could slow down the licensing process, create inconsistencies, and add another layer of regulatory burden on providers. Staff-to-child ratios must ensure the safety and supervision of young children. This is especially important for infants and young toddlers, who are unable, without assistance, to navigate emergency situations such as fires. Ratios also serve as a safeguard against accidents and injuries, mitigate transmissible illnesses, and allow for supervision of interactions between children. While they aren't the only factor related to positive outcomes, ratios do contribute, as well, to quality of interactions between staff and children in their care. This includes 1-to-1 interactions, responsiveness to the individualized needs of children, and consistent caregiving. If the ratios are set too high, then individualized care becomes less likely, which can lead to poor outcomes. In addition, LB1003 could contribute to increased burnout, another issue which you've also heard from the 2 other testifiers. Right now, that turnover rate in the early care and education industry in Nebraska is at 30%. Unlike school-based settings, most of these staff do not have the same levels of support, such as paraprofessionals and teacher assistants. And so, this means that any of these increase in-- or excuse me, any increases in ratio heighten that risk, that I've alluded to already. So in conclusion, I wanted to thank Chairman Hansen for the interest he has taken in viability of early care and education in Nebraska. And while we do not believe the LB1003 is the right approach, there are few steps that the Legislature could take to ensure viability. Number 1, reduce the regulatory burden on providers in a way that does not risk the health and safety of children. Number 2, streamlining those regulations which are needed but could be made more efficient. And number 3, provide supports to bolster compensation for providers. So I just wanted to end by thanking Senator-- or excuse me, Chairman Hansen again, and members of the committee, for this

opportunity to discuss LB1003. I would be happy to answer any questions you may have.

HARDIN: Thank you.

MITCHELL CLARK: Speed reading.

HARDIN: Nicely done. Any questions? Seeing none--

MITCHELL CLARK: OK. Thank you.

HARDIN: Anyone else in opposition to LB1003? Going once, going twice. Anyone in the neutral for LB1003? Hi.

CHRISTY ABRAHAM: Hello, Senator Hardin. Good to see you-- thank-- and the Health Committee. My name is Christy Abraham, C-h-r-i-s-t-y A-b-r-a-h-a-m. I'm here representing the League of Nebraska Municipalities. And I just want to say it does this League heart person's good to hear Senator Hansen talking about local control. We're always happy when senators talk about how they think that locals can make good decisions. So thank you, Senator Hansen. We appreciate that. This is a really important issue. And as you have heard in the testimony, this does give municipalities a little bit more discretion about 1 aspect of childcare, and that is that staff-to-child ratios. I will tell you, I have great confidence in city councils and village boards. I think they make good decisions. I think they would do a good job of-- they would look into it. They would research it. They would make careful decisions. We also really appreciate the concerns that you've heard, that, if there's a safety issue or some other issue that needs to be considered. So we are coming here in the neutral capacity to tell you that we think this is an important issue. And as you're moving forward to sort of come to a solution on this issue, we just ask that the League be part of those discussions. So I appreciate your time today and I'm happy to answer any questions.

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

CHRISTY ABRAHAM: Thank you.

HARDIN: We appreciate it. Thanks. Senator Hansen.

HANSEN: You know me, Senator Ben "local control" Hansen.

HARDIN: We do have 3 proponents, 29 opponents, and 1 in the neutral.

HANSEN: All right. I actually really do appreciate the opposition that came in. Myrna, I think-- Myrna-- no. Myra and Dr. Tonniges. Yes. They do bring up some good points, actually, about other, like, aspects of rules and regulations we can look at in daycare. I really like their idea of maybe addressing the square footage issue. I think that sounds like a great compromise amendment we could put in this bill, to allow localities to also maybe look at what they determine is the best ratio for square footage. Here's the great thing about this bill. If a locality determines they want to move from 12 to 1 instead of 10 to 1 ratio, the daycare provider doesn't have to follow that. They can stay at 10 to 1 if they feel like their employees are being burnt out, if they feel like it's unsafe, if that's what the majority of the parents of, of the children they are taking care of want, they can keep it at 10 to 1. Nothing changes, whatsoever. If somebody's in a town next door wants to go 12 to 1 because they have limited resources, unavailable staff, that extra person employed there, so if somebody calls in sick they aren't able to take care of them, where they can maybe reshuffle some kids. I mean, that's the beauty about this bill. They can determine what they want to do, no matter what the city or county determines is best. And so, they also discuss about safety concerns, which I get. I also, and this is kind of-- sometimes a difficult position to be in, when, when we're in a position of power, such as we are, being state senators, to trust parents, and trust families, and trust county boards, and city councils to determine what they feel is best for their community and the parents. I bet you 10 bucks if a city council to decided to put on their, their agenda for that day, they're going to address child-to-staff ratio in daycares, there'd be a lot of parents that are going to show up, and childcare providers, and give them the best opinions that they can get. And I trust that they will listen to that. But does that mean other states who have higher ratios are, are more unsafe? I looked at some of the data for just 5-year-olds. I believe Nebraska for 5-year-olds is 10 to 1. No, we're 12 to 1. Thirty-seven other states are higher than us, some being 25 to 1, 20 to 1, 18, 15-- a lot of them are 15 to 1. So they're all more unsafe than us? What about schools? Five-year-olds, I think, around kindergarten. Does that mean should we limit, limit kindergarten size 12 to 1? I think schools are just as safe as daycare facilities. And just as I trust the opposition with their opinions, I also trust the people who came in support. We had a teacher and a nurse both come, saying they felt safe sending their kid to somebody who had a different ratio or themselves changing it. And I believe, actually, more than almost anything else, there's another opinion that was brought up, that this does address the cost of daycare. Supply and demand. If you have a higher child-to-staff ratio, you have higher

revenue, which then would allow you to lower the cost per child for daycare. But if you don't feel you want to do that, you don't have to do it. If you're concerned it might raise your insurance, your liability, your liability insurance higher, keep it 10 to 1. We're leaving it up to the local authorities, the parents, the daycare facilities, to make this decision better than a department that's all in Lincoln, or 49 senators who are stuck in this building. I think they know better, and I trust them. So that's the essence of this bill. And I do believe we should be addressing a whole host of other things when it comes to rules and regulations in daycares in the state of Nebraska, which I'm sure the majority of them behind me would, would appreciate. So with that, I'll take any questions. Thank you.

HARDIN: Any questions? Senator Ballard.

BALLARD: Thank you, Chairman Hansen. And thank you for bringing some opposition back to the Health Human Services Committee.

HANSEN: Yes.

BALLARD: It's refreshing.

HANSEN: Yes. No problem.

BALLARD: I thought we were going to have an opposition-free day. Do you know-- the department, are these numbers set? Is there-- do-- found any studies on how these numbers are set by the department?

HANSEN: I think--

BALLARD: These ratios, I mean?

HANSEN: --somebody did bring that up. I think that they, they look at studies that are done by a certain organization. I think First Five brought that up. I didn't.

BALLARD: OK.

HANSEN: --if you know that, because I, I feel like some of these are arbitrary numbers, I guess. They just say-- I'm sure they listen to--

BALLARD: Yeah.

HANSEN: --facilities in the state of Nebraska and, you know, the department. And they make a recommendation on what they think is the best. Now, why it's 10 to 1 for a 5-- 12 to 1 for a 5-year-old, I

don't know, like where they came up with that determination specifically, and why they just didn't say, well, why not 10 to 1? That's more safe. Why-- like, why do we stop at 12? I just don't know-- I don't know the empirical evidence or data supporting that, I guess.

BALLARD: Yeah, because they do seem arbitrary. So thank you. Thank you for bringing this.

HARDIN: Any other questions? Seeing none--

HANSEN: Thank you.

HARDIN: This wraps up LB1003. And we'll be going to LB1187.

BALLARD: Senator Hardin, welcome to your Health and Human Service Committee.

HARDIN: Thank you. Thank you, Chair Ballard. And good afternoon, fellow senators of the Health and Human Services Committee. I'm Senator Brian Hardin. For the record, that is B-r-i-a-n H-a-r-d-i-n, and I represent the Banner, Kimball and Scotts Bluff Counties of the 48th Legislative District in western Nebraska. This afternoon, I bring you LB1187, to allow registered nurses to perform auricular acupuncture under the supervision of a licensed physician, nurse practitioner, or physician assistant. Auricular acupuncture, also known as battlefield acupuncture, is an emerging method in medicine used for the treatment of acute or chronic pain, or to manage symptoms of withdrawal during treatment of substance use disorders. Battlefield acupuncture, BFA, was developed in 2001 by retired Air Force Colonel, Dr. Richard-- is it-- Niemtzow, during the Iraq and Afghanistan wars. The practice gained traction by treating the pain of wounded military men and women at Walter Reed Army Medical Center in Washington, D.C. During treatment, needles are placed in five specific points in one or both of the patient's ears. The needles remain in the ear, typically for 3-- up to 3 days before they fall out or the patient removes them. The practice influences the central nervous system pain processing through its effects on a, a somatotopic organization, or it's a point-for-point, of the body represented in the ear. The therapy causes the release of beta-endorphins to elicit short-term pain relief or anti-inflammatory cytokines for long-term results. Those are proteins. The treatment lessens the need for prescription opioids to treat chronic pain, while also lowering the possibility of addiction to pain meds. In 2018, the Defense and Veterans Center for Integrative Pain Management and the Veterans Health Administration National Pain

Management Program Office completed a 3-year, $5.4 million acupuncture education and training program. This program deployed certified BFA trainers to receptive Department of Defense and Veterans Administration medical centers, where over 2,800 providers were trained in BFA. In the years following the initial training, BFA reduced pain for those with headaches, neuropathic pain, and acute and chronic back and musculo-- musculoskeletal pain. BFA is a proven treatment for relieving pain. It's an important tool in the toolbox for medical providers in providing relief for patients. The goal of LB1187 is to simply allow for more providers the ability to provide this treatment, so that more people suffering from chronic pain or dealing with symptoms of withdrawal during the treatment of substance use disorder can have relief. An important note to remember is that BFA is not a replacement for treatments of substance use disorders. BFA is only intended to assist in the management of withdrawal symptoms during treatment of substance use disorder. There are some concerns around the lack of clear-cut language for what the instructional program and supervised clinical practice would be on page 3 of this bill, and I look forward to working with the committee and all interested parties to clear up what the training requirements will be for the registered nurses. I'm ready to answer questions you may have for me, but following me today will be an individual who has experience in performing battlefield acupuncture.

BALLARD: Any questions for Senator Hardin? Senator Riepe.

RIEPE: Thank you, Chairman. If I recall right, last session, you had a bill on earwax?

HARDIN: This is just staying outside the, the ear. That's correct.

RIEPE: Do you have an ear fetish?

HARDIN: No. No. But you know how themes can develop.

RIEPE: OK.

HARDIN: Themes.

RIEPE: Just wonder. It's Friday and I don't [INAUDIBLE].

HARDIN: I hear you.

RIEPE: It's not the 13th, but the question I do have is, a reasonable question, I think, you've-- you, you said this was for registered nurses, but I know physical therapists that do acupuncture.

HARDIN: And--

RIEPE: And so-- and I'm trying to--

HARDIN: --nurse practitioners.

RIEPE: --focus in on why you would limit us so much as to have it be strictly nurses, registered, registered nurses.

HARDIN: Registered nurses.

RIEPE: Not even an LPN.

HARDIN: Registered nurses is what this is focusing on, because if-- I think if they go through, both PAs and nurse practitioners can already, with the, I think it's typically 100 hours of training, do full-body acupuncture. That's the part of it, Senator Riepe, that we're not quite sure of, is we think it would be less than 100 hours of training for this. And so, anyway, the person following me has some recommendations that have already been utilized by the VA for these registered nurses.

RIEPE: But physicians assistants, as such, are not RNs.

HARDIN: They're not.

RIEPE: And just [INAUDIBLE].

HARDIN: And have more education.

RIEPE: Well, and, and even clinical nurse practitioners would qualify but not physicians that are, you know, practice equal to with clinical nurse practitioner. I'm just trying to make sure or would like to know or would like to feel that we aren't so confined that we'll be back here next year, saying oops, but maybe we'll hear more from--

HARDIN: I think if they're certified right now, and the person coming behind me, mis-- will straighten me out if I'm wrong on this, but I think PAs, nurse practitioners, and obviously physicians all have the--

RIEPE: OK.

HARDIN: --ability to do this if certified.

RIEPE: I'm also going to ask them, when, when that individual's here, about reimbursement, because I don't know that many of the commercial

insurers pay for acupuncture. But I'll save that for the, the next soldier up.

HARDIN: But your HSA and your flexible spending accounts will let you spend those dollars on it.

RIEPE: Oh, that's true. Is that a plug?

HARDIN: Yeah. That's correct.

RIEPE: OK.

BALLARD: Thank you, Senator Riepe. See-- seeing no other questions, you going to stay to close?

HARDIN: Yeah.

BALLARD: OK. First proponent on LB1187.

LARRY KRAFKA: Thank you [INAUDIBLE] Senator. And thank you, committee--

BALLARD: Welcome.

LARRY KRAFKA: --for taking the time to listen to me. Just a little history about myself. I'm a veteran of 2 different services. One, was I was a dental technician corpsman. The other one, I was a lieutenant in the United States Army. I've worked for the VA for 21 years, and thank God, I retired a year ago. No, I love taking care of veterans there. One of the things that I did there, I worked in an area called Whole Health Care, where we had acupuncturists, chiropractors, and massage therapists. And one of the things that other VAs were doing that I heard about was the battlefield acupuncture, which is the placement of 5 needles in the ear on each side. In the information that I handed out there, there's actually a picture of the ear, and it's not those big tacks that we stick in. But that shows you the location in those. I-- at the VA. I saw, on average, about 30 patients a week, providing battlefield acupuncture, some coming back as many as 57 times every week to get that treatment because it worked. And the literature shows that it works about 78% of the time. So anyway, but I'm, I'm-- my name is Larry, L-a-r-r-y, Krafka, K-r-a-f-k-a, and I'm reading this letter in support of LB1187 on behalf of the Nebraska Nurses Association legislative, advocacy, and representation committee. Auricular acupuncture is simple procedure that involves the stimulation of 5 specific points on the outer ear using semi-permanent needles. LB1187 allows registered nurses to perform auricular

acupuncture under the direction of a licensed provider in the treatment of acute or chronic pain, or manage symptoms of withdrawal during the treatment of substance abuse disorder. Registered nurses would be required to complete an instructional program and supervised clinical practice to establish competence in this procedure. Ample, rigorous research supports integrative medicine that may incorporate acupuncture as an effective, low-cost, low-risk treatment of chronic and acute pain. Pain can impact quality of life and limit individuals' ability to work and perform activities of daily living. Auricular acupuncture provide a nonpharmacological, low-risk alternative to chronic and acute pain management. Nurses have a duty to advocate for health of all. Growing the number of qualified healthcare professionals, including registered nurses who can perform regular acupuncture, will increase the opportunity of those experiencing acute or chronic pain or to manage symptoms of withdrawal during the treatment of substance use disorder or receive this treatment. The Nebraska Nurses Association supports LB1187, and we ask that the committee-- to advance this bill. I've had chronic pain since I got out of the service. When I first got out the service, I came back and then started nursing school, and worked at St. Elizabeth Hospital, here in Lincoln. I lifted a patient over the back of a wheelchair. At that time, we didn't have all the fancy lifts that they do these days. I hurt my back, and I've had sciatica every since then. I have had battlefield acupuncture. And for me, it works sometimes. And sometimes, it doesn't. It just kind of depends upon where that's at. So I'm open to any questions. As far as training is concerned, at the VA, we did a 4-hour session for nurses to be trained. They have a PowerPoint, they have a man-- they have a manual that they go through. They, they practice on-- we practice on each other, to do the skills. And then, initially, when we first were able to train, one of the instructors would actually come and watch us do 5 patients before they would sign off on us doing the treatment. Any questions?

HANSEN: OK. Thank you for your testimony, by the way. Yes, Senator Riepe.

RIEPE: Thank you. Thank you for being here. Was this a procedure such that had to go through the 407 scope of practice review?

LARRY KRAFKA: I am not aware of that, sir.

RIEPE: Well, we have the author of the 407 sitting there on the corner, so we can either compliment him or get after him over it. I don't know which.

LARRY KRAFKA: I'll be glad to let him talk about it.

RIEPE: He-- I think the only concern I would have is given our nursing shortage and everything else, is I'd almost rather see substitute language in there that-- instead of saying LB1187 allows registered nurses, I'd like to see it say something like trained professionals, whatever those are. I'm not sure it takes an RN. With all due respect, I'm not sure it takes an RN to--

LARRY KRAFKA: Yeah, and the criteria itself--

RIEPE: It's, it's not very invasive.

LARRY KRAFKA: Yeah. The VA had the criteria it had to be a registered nurse. But that's--

RIEPE: Well, but that's the federal government. So--

LARRY KRAFKA: --you know, that's the government. So--

RIEPE: There you go.

LARRY KRAFKA: Yeah. So.

RIEPE: OK.

LARRY KRAFKA: I probably agree that LPN can probably be trained just as well. And I think, where I see this being used is, patient comes in to see their physician. Physician can refer them to a nurse or have a nurse on their staff if they allow them to have LPNs or they have PAs or NPs that could do that in the clinic, or I-- also, I see it being one of the places in a hospital. Patients come in, they have a minor procedure instead of starting them on, on opioid. OK. We're going to try battlefield acupuncture, and see if that's going to take care of you. They do keep the--

RIEPE: Does--

LARRY KRAFKA: Oh, go ahead.

RIEPE: I'm sorry. Go ahead.

LARRY KRAFKA: They do keep the needles in for 3 days. Yeah, and [INAUDIBLE]--

RIEPE: So because it's a federal facility, they're not obligated to play by the state's rules.

LARRY KRAFKA: Yeah.

RIEPE: But my question-- next question would be, if I may, is what's the reimbursement or acceptance of this by third-party payors? Because my experience with some friends is that they don't. Oftentimes plans, good plans, don't.

LARRY KRAFKA: That, I'm not aware of. I would need to explore.

RIEPE: That-- I mean, that would be our next step, then, is to mandate that commercial payors pay for it, and on down the slippery slope, if you will. But thank you very much for being here--

LARRY KRAFKA: Yeah.

RIEPE: --on a Friday after 5.

LARRY KRAFKA: I appreciate your taking the time.

HANSEN: OK. Any other questions from the committee?

RIEPE: Thank you, Chairman.

HANSEN: All right. Seeing none, thank you very much.

LARRY KRAFKA: Thanks.

HANSEN: Anybody wishing to testify in support of LB1187? All right. Seeing none, is there anybody who wishes to testify in opposition to LB1187? Welcome.

TRACY HUBER: Thank you. Thank you to the members of the Health and Human Services Committee. My name is Tracy Huber, T-r-a-c-y H-u-b-e-r. I'm the spouse of Donna Huber, a licensed acupuncturist in the state of Nebraska for the past 21 years. None of the licensed practitioners could be here today due to full patient schedules. I am testifying today as a concerned citizen, as well as a nonpractitioner member of the Nebraska Licensed Acupuncturist Association. I have witnessed firsthand their uphill battle to be recognized as the experts in their field. Thank you for the opportunity to speak today regarding LB1187, allowing registered nurses to perform auricular acupuncture as prescribed. As a group of licensed acupuncturists and concerned citizens, we object to the fragmentation of the whole system of medicine that is practiced by those with a 4-year master's degree, followed by board exams and continuing education requirements. As the experts in acupuncture field with their rigorous education,

certification, and oversight, we will always object to the placing of acupuncture needles as a modality or technique, regardless of what various professions call it. We may be able to justify the use of auricular, also known as battlefield acupuncture, as a standalone technique, but we know that that is a slippery slope. We understand the difference, but patient population does not. Without a standardization program of education, certification, and oversight, we are at the mercy of practitioners self-regulating and hoping they'll do the right thing. We have already witnessed physical therapists community in the U.S. doing trigger point dry needling, claiming to be just doing trigger points and not Chinese medicine, yet posting all over their social media accounts how they are treating sinus infections, fertility, and other internal medicine presentations. Several patients reported to our practitioner members that when receiving acupuncture from some chiropractors in Nebraska, the needles were placed through their clothing, a complete violation of Clean Needle Technique, a training and certification program, which is absent in the short training perform-- programs we see for physical therapists, chiropractors for battlefield acupuncture. One bad apples spools-- spoils the whole bunch. And historically, most of the bad apples were not properly trained practitioners. These battles have been fought and occasionally won in the U.S. for many years. Our collective position has never been one of battle over turf. Rather, it has been the concern for patient-public safety and removing the barriers to access. If you want a small part of this medicine in a very limited scope, then you also have to put the profession that's delivering it, licensed acupuncturists, into the healthcare system. This is the real issue. The practitioners are not on an equal playing field. They are restrict-- restricted to their private practices and often with much scrutiny. If a patient can receive battlefield acupuncture at the VA or Methodist or CHI or UNMC by a nurse, then it absolutely should be able to be performed by a licensed acupuncturist, the most trained of all in every one of those buildings and yet, this is not the case. Until they are included, have a seat at the table and an invitation to work in the settings that these practitioners with the lowest level of training work. We will always object. Acupuncture needles are considered a medical device. The needles used for battlefield acupuncture are called ASP, aiguille semi-permanent. Included in the hardcopy provided the committee members is a weblink to learn more. Insertion of the ASP needles is more of a secured-- excuse me, more of a surgical procedure, as they are left in from 3 to 30 days. What are the guidelines for at home care for these devices that are left in the ear? How are they removed? Who removes them? Is this clear in the training and are the practitioners tested on their

knowledge and understanding? Who is regulating the nurses using ASP needles? Is it stipulated that only ASP needles are used, and only in the ear? Are those directing and/or supervising nurses also trained in battlefield acupuncture? Where are the ASP needles? Excuse me, where are the standards? Where is the code of conduct? Does the nursing code of conduct discuss use of ASP needles? Will the nurses be, be required to maintain competency with CMEs specific to battlefield acupuncture? Because this is a scope practice, will there be a 4017 [SIC] review? Which, I think, you already touched upon, sir. And will this be covered by private insurance and the government? We look forward to learning more. Thank you.

HANSEN: Thank you for your testimony. Are there any questions for the committee? Yes, Senator Riepe.

RIEPE: Thank you, Chairman. Would you help me out a little bit here on what does it take to become a licensed-- I'm, I'm, I'm-- licensed sounds very authoritarian.

TRACY HUBER: Yeah, licensed acupuncturist, a 3,000 hours master's degree program.

RIEPE: OK.

TRACY HUBER: For the state of Nebraska.

RIEPE: OK, so is her [INAUDIBLE] if it's a master's program, is there a required degree in biology, or--

TRACY HUBER: It is its own degree. It's a master's degree in--

RIEPE: It's a straight-through master's?

TRACY HUBER: Um-hum.

RIEPE: Oh, OK. OK. Okie-doke.

HANSEN: OK. I'm--

RIEPE: Thank you.

TRACY HUBER: Thank you.

HANSEN: Yes. No problem. I think I have, maybe, a question. So do you think like a licensed physician, nurse practitioner, or physician assistant who has to be on the-- over the purview of the nurse doing

this, would be qualified to know what-- to answer some of the questions that you asked, like who removes them, you know--

TRACY HUBER: Right.

HANSEN: --at-home care. Do you think they would be qualified to do it?

TRACY HUBER: It all depends on the training they receive. I mean, there's specific training to, to needling and to needle technique and removing the needles.

HANSEN: Yeah. OK. Just curious. OK. All right. Any other questions? Seeing none--

RIEPE: I have a question.

HANSEN: Oh, yes.

RIEPE: Thank you, Chair. A quick question. In your experience with your wife's practice, is she able to bill commercial insurance companies, or Medicare or Medicaid?

TRACY HUBER: Her practice does not bill it, but it can be billed.

RIEPE: It is allowable.

TRACY HUBER: It is allowable, depending on if that particular insurance company--

RIEPE: OK.

TRACY HUBER: --allows it.

RIEPE: I know some-- I think it depends upon the plans, too.

TRACY HUBER: Right.

RIEPE: I know some Blue Cross plans that don't. So. OK. Thank you, Mr. Chairman.

HANSEN: Yes. Thank you for your testimony.

TRACY HUBER: Thank you.

HANSEN: Anybody else wishing to testify in opposition? Is there anybody wishing to testify in a neutral capacity? All right. Seeing

none, we will welcome up Senator Hardin to close. And for the record, we did have 2 letters for the record, both in the neutral capacity.

HARDIN: Well, thank you. And thank you to everyone who came and testified on, on both sides of this bill. I think what we're hoping to do is to see if we can figure out a way to help people hurt less. And so we're also open to learning about what we can do to, to make the bill better. And so, with that, I guess I would just add one more thing. Anecdotally, I have received this myself, and it-- I found it helpful. I've struggled with back pain for years, so.

HANSEN: Awesome.

HARDIN: Thanks.

HANSEN: OK. Any questions from the committee? Seeing none, thank you.

HARDIN: Thank you.

HANSEN: And will close our hearing for LB1187 and close our hearings for today. Thank you.