HARDIN: [MALFUNCTION] 48, and I serve as Chair of the committee. The committee will take up the bills in the order posted. We're going to start with some appointments today. And this public hearing today is your opportunity to be a part of the legislative process and to express your position on the proposed legislation before us. If you're planning to testify today, please fill out one of the green testifier sheets that are on the table in the back of the room. They're actually off to the little rooms on the side. Be sure to print clearly and fill it out completely. Please move to the front row to be ready to testify. When it's your turn to come forward, give that testifier sheet to one of the pages. If you do not wish to testify but would like to indicate your position on a bill, there are also yellow sign-in sheets back on the table for each bill. These sheets will be included as an exhibit in the official hearing record. When you come up to testify, please speak clearly into the microphone, tell us your name and spell your first and last name to ensure we get an accurate record. We'll begin each bill hearing today with the introducer's opening statement, followed by proponents of the bill, then opponents, and, finally, by anyone speaking in the neutral capacity. We will finish with a closing statement by the introducer if they wish to give one. We'll be using a 3-minute light system for all testifiers. When you begin your testimony, the light on the table will be green. When the yellow light comes on, you have 1 minute remaining and the red light indicates your time is finished. Questions from the committee may follow, which do not count against your time. Also, committee members may come and go during the hearing, this has nothing to do with the importance of the bills being heard, it's just part of the process as senators may have other bills to introduce in other committees. A few final items to facilitate today's hearing. If you have handouts or copies of your testimony, please bring up at least 12 of those. Give them to the page. Please note that thumb drives, CDs, DVDs, oversized documents, books, lists of signatures and similar items will not be accepted as exhibits for the record. Props, charts, and other visual aids cannot be used simply because they cannot be transcribed. Please silence or turn off your cell phones. Verbal outbursts or applause are not permitted in the hearing room. Such behavior may be cause for you to be asked to leave the hearing. Finally, committee procedures for all committees, all committees state that written position comments on a bill to be included in the record must be submitted by 8 a.m. the day of the hearing. The only acceptable method of submission is via the Legislature's website at legislature.nebraska.gov. Written position letters will be included on the official hearing record, but only those testifying in person

before the committee will be included on the committee statement. You may submit a position comment for the record or testify in person, not both. I'll now have the committee members with us today introduce themselves starting with Senator Riepe.

RIEPE: Thank you, Chairman Hardin. I'm Merv Riepe, I represent Omaha and Millard. It's in Legislative District 12 and the fine little town of Ralston.

HANSEN: Senator Ben Hansen, District 16, which is Washington, Burt, Cuming, and parts of Stanton County.

FREDRICKSON: John Fredrickson, I represent District 20, which is in central west Omaha.

G. MEYER: Glen Meyer, District 17: Dakota, Thurston, Wayne, and the southern part of Dixon County.

QUICK: Dan Quick, District 35, Grand Island.

HARDIN: Also, assisting the committee today is our committee research analyst, Bryson Bartels, and to my far left is our committee clerk, Barb Dorn. Our pages for the committee are--

SYDNEY COCHRAN: Hello, I'm Sydney, and I'm a sophomore studying history at UNL.

DEMET GEDIK: Hi, my name is Demet Gedik, I also go to UNL, and I study political science.

HARDIN: Today's agenda is posted outside the hearing room. And with that, we're going to get going with gubernatorial appointments with David Reese for the State Board of Health. Welcome.

DAVID REESE: Good afternoon, Senator Hardin. My name's David Reese, D-a-v-i-d R-e-e-s-e. And I'll just start from there.

HARDIN: Please tell us about you and why on earth would you want to do this?

DAVID REESE: Great question, Senator Hardin. Again, David Reese, I'm born and raised here in Lincoln, Nebraska. Real quick personal, I'm youngest of eight. My father was a physician, cardiac surgeon here in town for a number of years here in Lincoln. I have a number of folks in my family that are in health care. Born and raised Nebraskan. I have four kids of my own, wife is from Nebraska as well right here in

Lincoln. And I've worked at-- in health care for 29 years, 27 of those roughly at Bryan Medical Center and then Bryan Health in various administrative capacities. And now I'm at Madonna Rehab Hospital there as the Chief Administrative Officer, CAO. And so health care has kind of been in my family for years through my father, through my brothers, and so many other folks in health care and myself being in the, the field for 29 years. And so I just take a-- take an interest in it wholeheartedly, and also especially for the state of Nebraska, and just making sure we have good health care here in Nebraska, and especially in some of the difficult times we're in right now through health care and some of hard decisions we have to make going forward. I just think it's important to serve and help out. So that's why I'm involved and want to be involved again, so.

HARDIN: When you say hard decisions, can you unpack that a little bit for us, paint a picture for us? What kinds of things do you wrestle within this capacity? What do you anticipate?

DAVID REESE: So in health care itself?

HARDIN: Yes.

DAVID REESE: Boy, it's a big question. I would say there's probably three components right now that I think that are really difficult in health care. Staffing is number one. You've probably all seen the staffing issues, with the baby boomers retiring, burnout is a true issue. And it's not just physician burnout, it's burnout--staffing burnout, leadership burnout. Because of the, I think, the pressures that are on health care right now, you're seeing more of that burnout. So staffing is one, cost as associated with that. When we have less staff and less ability to find staff, your labor costs go up because you're having to pay. And with that labor cost, it's getting harder and harder for hospital systems, especially the smaller hospitals, rural smaller facilities, makes it harder because you're not part of a bigger network. And so the, the cost component is a big, big piece. And then, third, on top of that is reimbursement, the reimbursement component of it. So your costs are going up, but your reimbursement is not going up to the level that the cost is. And so that makes it really-- the pressure is even more so on health care. I know there's a lot of conversation at the federal level about provider tax and all that and how important that has been for keeping hospitals going. And I'll say that is truly from what I could tell on the rural side and others, it is very important. So to me those are the three big components we got going on from staffing, to cost, to reimbursement.

It's those three factors, it's a lot of pressure on health care right now.

HARDIN: OK. Let me open it up to the committee for some questions they may have. If they don't, I'll circle back. Anyone else? Any questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here and your willingness to serve. Are you a reappointment or are you, are you currently serving on the Board or is this a new appointment for you?

DAVID REESE: I'm currently serving on the Board, so it's a reappointment.

FREDRICKSON: OK. Fantastic. Thank you.

DAVID REESE: Yeah.

HARDIN: Senator Meyer.

G. MEYER: I was going to follow, follow very similar with Senator Fredrickson, so you're the current Board Chair?

DAVID REESE: Correct.

G. MEYER: OK. Thank you. And you, and you want to do it again. OK.

DAVID REESE: Yes, sir.

G. MEYER: That wasn't a question.

DAVID REESE: Again, going back just real quick, my family background where it's trying to make a difference and helping Nebraska out. That's, that's what we do in Nebraska, so.

G. MEYER: Thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. You said that you're currently on that Board?

DAVID REESE: Correct.

RIEPE: What, what are the things in another term do you think that you would like to-- and you have to obviously work together, but what, what are some of the things that the State Board might do that would

be more effective, efficient? You know, we have a major issue with rural health care and none of us have a final answer or maybe even some answers. Do you have some thoughts on the Board's-- your Board's role on that?

DAVID REESE: That's a great question, Senator. I think one component-- from what I've been on the Board from now-- from when I first started on to now, it's a good group of individuals, I think, we've got right now, a really good core group, good clinicians, good physicians that are on there. You'll, you'll hear from some of them coming forward here. I think utilizing some of that talent we have a little bit greater on getting maybe feedback or advice from some of the bills coming forward. I think we play a role in the 407 process to help out on scope of practice and some key, key components, which is a really good process. We've done some cleanup with it to make it a little more understandable on some of it. But it's been, it's a good process to help formulate and making sure we're doing things right to protect Nebraskans and their health. So that has been a good process. But I think also having the ability to be more connected with some of the state legislatures and the senators to-- you got a body of individuals here that have a good knowledge base to be able to maybe utilize State Board of Health a little bit more to get some-- get our feedback would be good. And we've tried that a little bit here and there but-- with maybe statements or saying, hey, maybe look at this, but maybe utilize us a little bit more on that side.

RIEPE: Do you get involved in the, I guess, the big-- one big, beautiful bill that is coming out of Washington and I know we're supposed to-- we have $218.5 million coming that we're supposed to spend before the 31st of October and, yet, we don't have any guidelines on that to date and time is of the essence on this thing. Do you guys talk about that? And, you know, the $1 trillion that's going to be lost to rural Medicaid, or not to rural, just only to Medicaid, do you guys ever wring your hands about that or--

DAVID REESE: From our scope of what we do based on our guidance?

RIEPE: Yeah.

DAVID REESE: No.

RIEPE: Oh, OK.

DAVID REESE: Because it's--

RIEPE: You try to do more higher policy stuff?

DAVID REESE: Right, and helping with DHHS on scope of practice, 407. We do monitor some of the legislative bills that come through the new bills that are dropped. And we-- as a committee, we look at that talk about which ones do we want to weigh on going back to what our mission is for the Board of Health, making sure that's in the forefront. Because that's what our mission, based on what the State Board of Health is, we focus on that and say, OK, do we want to weigh in on anything by sending a letter up to the senators about certain bills? We've done that occasionally here and there, but more on that federal level, on the big, beautiful bill, where the dollars are spent, that's outside of our scope. But it's a group--

RIEPE: And some of us--

DAVID REESE: --body that's worthwhile to get advice from.

RIEPE: There are some of us who have some concerns about the 407 bill that's been around for a long time. And we think it's probably time to have-- take a look-- at least take a look at it and maybe come up with some more objective way to it. We think it gets-- that's me talking a little bit. And I don't know whether-- you said that you feel like they're really doing a great job, though.

DAVID REESE: We had a period of time where there was, I can't remember right which one it was, but there was one that came through for scope of practice where we had some hiccups, it was revolved around the process. But I think even the language within the bill was-- there was double negatives and how you went through that process. So we worked with DHHS to help clean that up to make it more clear. So I think that has now helped us as a Board to be able to process that better. It would be interesting if, if any of the senators would want more conversation on that down the road as that bill's out there on changing the 407, getting some of the advice from some of our Board members would be, would be applicable because we've gone through the process of what works and what doesn't work.

RIEPE: OK. Thank you very much.

DAVID REESE: Oh, you're welcome.

RIEPE: Thank you, Chairman.

HARDIN: So State Board of Health, we set up technical review committees on things that are specific. Is that right?

DAVID REESE: Correct.

HARDIN: And so how does a technical review committee get formed? I mean, who chooses who's on that? And how, how does-- is it always the same number of people or kind of give us a little bit of the background from your perspective with the 407 process, that when-- if it's something related to chiropractors, if it's something related to PT, something related to heart surgeons, whatever it might be.

DAVID REESE: So I'll give you a great example of one that I was part of so it will help. I was a part of the Applied Behavioral Analysts, some of you remember that, brand new group. They wanted to come through and they wanted to get scope of practice so that they can be recognized. And part of it also stands from, if they get recognized, then they can also then now go out and get contracting insurance and it kind of goes from there. So I was on that one and I helped chair that. So in that we have a group of folks that come through, through DHHS, they got this application come through, and we set up the technical review committee. One of the Board of Health members then chairs that committee. Who wants to select? Who wants to volunteer and chair it? You know, sometimes the volunteering is like this, but we all go around, who wants to volunteer? So I'd volunteered for that one, not--

HARDIN: You get voluntold at times.

DAVID REESE: Voluntold, exactly. So then you chair that, and then we have representatives that DHHS gets from within the community of Nebraska. As folks that may have some health care specialty, we had an individual that was an attorney, just different folks that have, that have volunteered their time to be part of this technical review committee. And then as part of that process, there is a set process, and I don't know what verbatim in my head, but there's a set process where you have the proponents and opponents come in and present their side. The proponents will present the side of why we want to do applied, why we want to get that scope of practice, and those that will be against. And we have a series of meetings to have both sides present and try to find a way if there is some equitability to say, how can we make this happen or not happen? And then we have a recommendation that's developed from the technical review committee. And there's, I can't remember how many criteria, but nine criteria, and go through and do we recommend? Then the overall recommendation. And that goes-- that's the recommendation from the technical review committee, then that goes to the State Board of Health. And the State Board of Health then reviews all that and then we vote to say do we, do we approve of this? So we've got technical review approved, State Board of Health approved, and then it goes to the Director of DHHS. So

then they review it and then they approve or not and then it goes to all of you. So it's a nice-- the nice thing about it is there's a number of people that touch hands on this, so it gets a, a, a really thorough review of whether or not this change in scope of practice or, or license or new credentialing should occur before he gets to the State Legislature. And so it really allows for some of that to be fleshed out and try to keep the, how do I say it, the folks that may come in and try to-- not, not-- bribe is not the word, I'm trying to think of the word, anyway try to push their opponent more. It's very objective from saying, like, what's the right thing to do? And that's-- it works out well that I've seen, and that one worked out really well.

HARDIN: Good. Well, thank you. Any other questions? Seeing none, thank you so much.

DAVID REESE: Thank you, Senator.

HARDIN: This concludes our Board of Health appointment hearing for David Reese. Moving on, Jacob Sikes, State Board of Health. Welcome.

JACOB SIKES: Thank you.

HARDIN: Tell us about your world.

JACOB SIKES: My world is great. I slipped on the ice on the way in a little bit, but other than that, I'm good. I got a wet spot on the back of my suit.

HARDIN: We do that around here.

JACOB SIKES: So my name is Jacob Sikes, J-a-c-o-b S-i-k-e-s. I'm a board certified orthotist. I live in Riverdale, Nebraska, a little village of Riverdale, which is about 5 miles northwest of Kearney. I became interested in the Board of Health. I just finished the Leadership Kearney program and was looking for a way to serve. So I was surfing around on the website and found that this appointment was open and applied for it. Got the appointment. I wasn't sure what to think, but then I've been to two meetings. I'm the new guy. So I've been to two meetings, I love it. I love the people on the Board. They're very helpful. The people that organize the Board and get us our information are wonderful. And so you just heard Dave give you all kinds of great answers. I'm not that experienced. I might not have that great of answers, but I'll do what I can.

HARDIN: Questions? What happens at these meetings? Let us be a fly on the wall. What-- you've been to two, but tell us, because we've never been to these meetings.

JACOB SIKES: So there's committees, there's four committees, and you're assigned to two committees. I'm on the legislative committee, so I review bills and then bring them to the full Board to say is there anything here that we want to do, we just kind of give them a review on those bills. So those committees meet separately in the morning, then the full Board meets in the afternoon at 1:00 and we just go through and discuss what the committee has discussed and, and what we want to do and if there's any comments we want to make as a Board. So it's, it's--

HARDIN: Are they long meetings?

JACOB SIKES: They can go a couple hours.

HARDIN: OK.

JACOB SIKES: Yeah.

HARDIN: And you meet how often, typically?

JACOB SIKES: About every 6 weeks.

HARDIN: OK. So you have about eight a year maybe, something like that?

JACOB SIKES: Yeah, that sounds about right.

HARDIN: OK. Very well. Senator Meyer.

G. MEYER: Thank you, Chair Hardin. What's an orthotist?

JACOB SIKES: That's a good question.

G. MEYER: I have been to many doctors, but I have never been to an orthotist.

JACOB SIKES: Never been to an orthodist. I'm not a physician, so I'm a CO, I'm not an MD, I'm a certified orthotist. I make braces, and I say that everybody thinks I make, like, dental braces.

G. MEYER: I understand orthodontists. We're probably still paying--

JACOB SIKES: Yes, so an orthotist makes--

G. MEYER: --for some of them, like for my kids.

JACOB SIKES: We make, like, braces for people that have had a stroke, external fixators, halo systems for people that break their necks, a brace called the TLSO, that's kind of my specialty is spine stuff. So when people break their backs we make braces to support their spines or, like, post surgical applications. That's, that's what I do. I also make prosthetic limbs for people, so that's-- it's a great field. It's very rewarding because you get to see people, they come into your office, they've just been through something terrible, and they're not able to walk, or they're not able to get out of bed, and then you get to provide them with a device that gets them up and going. And for the first time they get up and walk and they're in front of you and everybody has their phones out and recording it, and there's tears. It's a great-- it's a very rewarding job, I love my job very much.

G. MEYER: Thank you.

JACOB SIKES: Yeah.

HARDIN: That's great. Senator Riepe.

RIEPE: Thank you, Chairman. I'd like to follow up with that and say where did you take your training? Did you have formal training?

JACOB SIKES: So I've been doing this for 25 years. At that point, you could do it through an apprenticeship program. So I did-- I actually went to music school. I was a professional musician for a while. Decided that music is a better hobby than it is a career, for sure. So I came back to Kearney and enrolled in paramedic school. And I wanted to be a paramedic. And at that time, there was an orthotist in Kearney that was hiring an assistant. So I went and worked for him, loved it. So then you entered this thing that was called the Camp Institute of Applied Technology where you took several courses online, you travel to different schools, and then after a 6-year program, then you could sit for the board and take the test. So that's how I did it. So it was a 6-year program, but it wasn't formal education training.

RIEPE: How many are in your profession within 50 miles? I mean, is it-- it's pretty rare.

JACOB SIKES: You would think, but--

RIEPE: Can you get referrals from 50 miles away or--

JACOB SIKES: Oh, yeah. So I, I do a lot with rural health care. That's another big interest of mine. So we-- I go to Valentine, Superior, Cozad, and Hebron, like small towns and they have their outpatient clinics in those hospitals. Great programs because you just go in and you get to practice for a day, they have the nurses and everything set up there for you and you just get to see your patients in that town. So in those rural communities, there's no one. In the actual city of Kearney, I think there's six of us, which is quite a few, but Kearney is a trauma center, so like the spine stuff keeps me busy. The other guys aren't doing the spine things, they're doing more walking braces, things like that

RIEPE: Do you have a van that you-- you're kind of a, a big-- like a moving company [INAUDIBLE]?

JACOB SIKES: I, I should. At one time-- I don't know why I'm telling you the story, but one time I bought an old ambulance and I was going to fix it up and have a mobile lab and be able to drive around and build stuff in the back of this ambulance.

RIEPE: It wasn't a hearse, it was an ambulance?

JACOB SIKES: It was an ambulance. Yes. And, and so I bought this ambulance and we, we never-- it never ended up materializing, but it was a good idea. Maybe someday I'll go back to it

RIEPE: So you were Ghostbusters with it?

JACOB SIKES: Yes.

RIEPE: OK.

JACOB SIKES: Yes.

RIEPE: Thank you.

HARDIN: Any other questions? Senator Quick.

QUICK: Yeah, thank you, Chairman.

JACOB SIKES: Yes.

QUICK: So I, I know we're getting probably off the topic, but about your work, you also have to work with the patients to maybe help them, you know-- so you're building a brace for them and then-- now they have to learn how to really adapt to that, right, or prosthetics. So

do you work directly with the patient to help them be able to acclimate that or--

JACOB SIKES: I typically refer them to physical therapy.

QUICK: Oh, OK.

JACOB SIKES: I work very, very closely with physical therapists. One of the things that's very frustrating to me is some people in our field, they'll get, they'll get a call for an evaluation and they'll just make a brace and put it on the patient and send them on their way. You don't really know what the patient needs at that point. So when they come in for evaluation, I, I find out who the physical therapist is and I go to a visit with them with their physical therapist so I know the goals of the therapist, the goals of the patient, what direction they're going to head. So I don't do anything counter to what they're trying to, to achieve and then I build the brace and refer them back to therapy. And I usually go to a couple therapy visits with them to make sure everything is working as it should.

QUICK: OK. Do you also work, like, with the orthopedic doctors, too?

JACOB SIKES: Oh, yeah.

QUICK: OK.

JACOB SIKES: Yep.

QUICK: OK. All right.

JACOB SIKES: Yep.

HARDIN: Seeing no other questions, thank you.

JACOB SIKES: Thank you.

HARDIN: We appreciate it.

JACOB SIKES: Yes.

HARDIN: This concludes our hearing on the appointment for State Board of Health, Jacob Sikes. Next up, Dan Vehle, State Board Of Health. Welcome. Did I pronounce your last name correctly or did I get that completely wrong?

DAN VEHLE: It should have been anglicized about five generations ago at Ellis Island. So it's actually pronounced Vehle, but you'd never guess it by looking at it.

HARDIN: Thank you.

DAN VEHLE: In the Norwegian alphabet, there's a, there's a vowel that combines the A and the E together, and the back of the E and the A, it's kind of an "eh" sound. So some parts of the family drop the A, some drop the E, and we should drop the E.

HARDIN: And I didn't get either one of them correct.

DAN VEHLE: So there we go.

HARDIN: I'm sorry about that.

DAN VEHLE: There we go. You did great.

HARDIN: I'll do, I'll do better.

DAN VEHLE: You did great.

HARDIN: So--

DAN VEHLE: Oh, here, let me spell my name.

HARDIN: Please do.

DAN VEHLE: First name Dan, D-a-n, last name is spelled V-e-h-l-e, Dan Vehle.

HARDIN: Very well. Tell us about your world.

DAN VEHLE: It's great to be back here again. Today, is a, a reappointment hearing for me. I've served on the Board of Health now for 5 years. And I also just recently, having turned 70 years old, decided it was time to retire. So I had spent my 48-year career in medical sales and had progressed from an initial foray in pharmaceuticals into capital equipment sales, which then led to sales with interventional cardiologists and radiologists and that led me then to a 25-year career inside vascular surgery, supporting vascular surgeons in the new formed world of endovascular treatment which allows us to treat abdominal and thoracic aneurysms with a noninvasive or minimally invasive approach and can significantly shorten the time that people are, obviously, required to stay in the hospital for their treatment and discharge. So I spent that time doing that and it turned

out that, that over the course of time that moving to Omaha, I've grown up in a small town in South Dakota. I graduated from the University of South Dakota, spent the initial part of my career years there. I had an opportunity then to expand into this new and exciting development in interventional cardiology, which required me to move to Omaha. And now I've lived in Nebraska longer than I ever lived in South Dakota, so it's, it's my new home.

HARDIN: Wonderful. Questions? So tell us about what you have done in the past on the Board. How long have you been on the Board?

DAN VEHLE: 5 years.

HARDIN: 5 years.

DAN VEHLE: 5 years.

HARDIN: OK.

DAN VEHLE: Earlier, Dr. Riepe, or excuse me, Senator Riepe was asking about the 407 process. It's very interesting because this-- not this year, the previous year I was chair of the 407 review process regarding an effort to bring a new class of anesthesia providers to Nebraska. They would be known as anesthesia assistants, and they would be able to provide care then in surgery applications under the direct supervision of an anesthesiologist in the hospital. And so the, the question before the Legislature, which then led to the 407, was is this a, is this a correct move for the state of health care in, in Nebraska? And I was asked to chair that committee and it was an, it was an educational and an exciting time. So I'm sure that many of you who served in the Legislature are well aware of that bill and it's-- it was not accepted at the time. And I'm, I'm hopeful that if the people who had felt that it would be a move forward for Nebraska's health care situation would, would want to bring that again up for review, that I could serve as a-- could serve in that position again just so that I can be a, a fair arbiter I want. Mostly what I wanted to make sure was that both sides felt that I was honest and balanced and allowed each to present what they felt was their attributes, what were their positives in that, and allow the 407 process to work its way through because there are then-- as I'm sure you're well aware of, there are committees which then take the vote on several different levels of questions which are all part of the 407, which allow them to then make the decision. And it'd be one, two, three, four separate votes, and then they would finally have the final vote. And, of course, that whole process expand the period of about 12 weeks, I

think it was, we met at 6 or at 2-week intervals over a 6-week period, allowing each side to present information and also have witnesses regarding their positions. And so it was my responsibility, my task at that time to make sure that each, that each side felt that they, that they got themselves an honest opportunity to present their side for the, for the discussion for the final decision. So that was one thing that I did. There are other things, obviously, and serving on the committee as, as Jacob, the previous gentleman who was up here discussed, there are four different committees which you are assigned to on the, on the State Board of Health. I served on the Rules and Regulations Committee as well as the Licensing Committee. And it allows us to speak with people who have a particular interest in their own profession, whether it be an optometrist, dentist, podiatrist, psychologist, any of a number of the health care fields which are aligned [INAUDIBLE]. Surprisingly, when I came on the Board, discovering that there are 17 members on the Board, all representing different areas inside the health care field, which can go as far now as funeral directors and tattoo artists. So you have to have a-- you have to prepare yourself for whatever may be something that circles into the universe of health care treatment. And so it's an interesting time.

HARDIN: Given that you've worked in the cutting-edge world of technology and presenting what's available to some of the top surgeons in the world in that space, I guess I'm just curious, borrowing from that innovation that you are around, is our 407 process as innovative as the machinery we're bringing to it? Is it as shiny as it can be, as forward leaning as the process can be? Are there ways of improving it, as you see or is the manifestation of it we have the perfect manifestation of what it could possibly and humanly be?

DAN VEHLE: You do a great job asking questions. They're good questions. And I, and I would like to say that it's a perfect process, but being as we're all humans, there's always room for-- there will always be room for improvement. I think that the process that we did in, in my, my course of being chairman of that 407 on a very important issue, I felt that I discovered that it was, it was very workable. I also then served with Dr. Rusty Crotty, he's an optometrist, and Dr. Doug Vander Broek, who's a chiropractor, the three of us worked on just the 407 and presenting items to, to the Board to present back to the Legislature as how we might refine and, and improve the process, and that was part of our efforts then last year. I think that-- as senators, I think you can feel solid and reassured that the 407 process is, is a, is a stable platform. And I think that we can find ways to, to perhaps make it better. I know having worked in industry

for 48 years that there's always-- there always seems to be more paperwork. There are always more people who want to put their fingers in the pie and help be a chef in, in the kitchen. And at the same time, I'm never one to disregard anybody's attempts to contribute to the process because I always felt that there was-- there might be somebody here who has something that I hadn't understood before. So I think that the 407 process is, is really pretty solid. That doesn't mean to say that we can't find ways to, to find ways to improve it.

HARDIN: Senator Riepe.

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

DAN VEHLE: Yes, sir.

RIEPE: One thing I know is that you know how to take a bullet if you were with the 407 with the nurse anesthetist and the anesthesiologist.

DAN VEHLE: Yes, sir.

RIEPE: I followed that very closely. And it was, it was a highly debated, very controversial kind of an issue that was going down. So thank you very much. You, you showed them that you have the stamina for standing up and still wanting more. So God bless you. Thank you, Chairman.

DAN VEHLE: That's very kind of you. I found it to be a-- there were solid people on both sides. I understood-- well, from my perspective, I understood what the proponents wanted and what the opponents wanted. Yeah, you're right. It was, it was charged. And, yet, at the same time, when, when the, when the day's work was done, we all found ways to, to be cordial. And I think we found ways to be collaborative as well. I, I never had to raise my voice. I only had to ask one person to just wait a moment while we allow somebody else to finish. Anyway, it was a, it was a, it was a, it was a great educational experience.

RIEPE: Well, great. Thank you.

DAN VEHLE: I mean, sure. Absolutely. Thank you for, for bringing that up.

RIEPE: Thank you, Chairman.

HARDIN: Seeing no other questions, thank you. We appreciate it.

DAN VEHLE: All right. All right. Thank you very much.

HARDIN: This concludes our appointment hearing for State Board of Health, Dan Vehle. Next up, LB970, Senator Guereca. The room will transition just a bit, and we will get going. I believe we are ready.

GUERECA: All righty. Give me a second to just get settled in here. Good afternoon, Chairman, members of the Health and Human Services Committee. My name is Dunixi Guereca, D-u-n-i-x-i G-u-e-r-e-c-a. I represent District 7, which includes the communities of downtown and south Omaha, and I'm here today to introduce LB970. LB970 is a bill to direct DHHS to submit a Medicaid state plan amendment to include a program of early literacy promotion and an intervention during a well-child's visit covered by Medicaid for children from birth to age 5. Medicaid describes these well-children visits as Early and Periodic Screening, Diagnostic, and Treatment, or EPSDT. Great acronym. This program promotes well-being by identifying and addressing health issues early, serving as a foundational component of pediatric health care within the Medicaid system. Currently in Nebraska, EPSDT visit includes a comprehensive health exam as well as social determinants of health, such as nutritional status, behavioral assessment, and anticipatory guidance. A literacy program fits the requirement of EPSDT as literacy is a social determinant of health. Including a literacy component into the standard well-child visit would allow providers to get a deeper understanding of the growth and development of young children, as well as encourage parents and caregivers to read to their child-- young child at home. This provides strong foundations that will be built upon when these children enter kindergarten and begin learning to read. This state plan amendment would not require clinicians to become reading teachers or diagnose or treat reading difficulties, but would rather help clinicians develop stronger relationships with their patients and families using a book as a tool during these visits. Now, I have several expert testifiers behind me that can speak further to the importance of LB970. With that, I'm happy to take any questions. And I do want to mention that I did put an amendment that you all should receive a copy of that adjusts the funding source to CHIP. And then provide a little more clarity on the qualifications. Again, the experts behind me can really get into the minutia of that.

HARDIN: That is Senator Guereca's signal that he did not want questions,--

FREDRICKSON: I know but I [INAUDIBLE].

HARDIN: --but he wants, he wants to ask a question--

GUERECA: Always welcome for my colleagues in this committee.

HARDIN: --anyway. Senator Fredrickson.

FREDRICKSON: Thank you for being here. Thank you for introducing the bill. I think it's-- I, I love the idea. I think it's-- obviously, childhood literacy is a huge component of overall success. My, my only question is-- one of the, one of the things that we sometimes grapple with in, in this committee is, you know, I'm thinking of my son just had his annual pediatric visit about a month ago and, you know, kind of a crunched amount of time.

GUERECA: Sure.

FREDRICKSON: You know, sometimes providers come in, concerns about additional mandates, etcetera, etcetera. I can't imagine providers would not be on board with the idea here but have you had any feedback from provider organizations on this and whether or not that's something that [INAUDIBLE]?

GUERECA: Now, I know in the fiscal note there were some questions on how it would actually be implemented in the visit. Again, like I said in my opening, I certainly don't expect the clinician to sit there and read to the child for 20 minutes. So this is the real-world application of what it would look like. I know I have some testifiers behind me that they can answer that question, clear up, and then if they can't, I'll come into my closing and truly try to iron out that answer for you, Senator. How does that sound?

FREDRICKSON: Sounds great. Thank you.

GUERECA: Perfect.

HARDIN: Other questions? Will you be with us at the end?

GUERECA: Absolutely, I will, sir.

HARDIN: Great. Thank you.

GUERECA: Thank you so much.

HARDIN: Proponents LB970. Welcome.

KRISTIN CHRISTENSEN: Thank you. Good afternoon, Chair Hardin and members of the HHS Committee. Thank you for the opportunity to testify today. My name is Kristin Christensen, K-r-i-s-t-i-n

C-h-r-i-s-t-e-n-s-e-n. I'm here today as the Nebraska Program Manager with Reach Out and Read Midwest and in support of LB970. Reach Out and Read is a literacy and early relational health promotion program similar to what the bill would seek CMS to require. I want to make it clear, however, that Reach Out and Read would not receive any funding from this bill. I'm here today simply to explain what a literacy promotion and intervention program within the well-child visits looks like in practice and to advocate for increased literacy opportunities for young children. Reach Out and Read works to increase access to literacy and books to children from birth to age 5 by utilizing the existing health care system. This typically looks like health care providers bringing a book into the well-child visit with them, using it as a tool to assess development and build relationships with the child and caregiver, and providing coaching and encouraging to caregivers to read at home with their children. We currently have 41 pediatric and family practice clinics across the state that partner with us using this model. Our model is research-based and it's the only literacy promotion recommended by the American Academy of Pediatrics. As an early childhood initiative, incorporating books and literacy efforts into well-child visits from birth to age 5 aligns with the Nebraska Literacy Project Plan that the State Board of Education passed in February of 2025. This plan has five core tenets that all aim to increase literacy proficiency rates by 2030. One of the five core tenets focuses on family literacy and pre-K services designed to strengthen literacy and language development, so that kids start kindergarten ready to learn. The State Board Of Ed and NDE agree that to increase the literacy proficiency rates of third graders, we must begin early and we cannot wait until a child reaches elementary school. To highlight this need, we can look at recent kindergarten through third grade reading data that was reported to the Legislature in September of 2025. According to this report, one out of every five kindergarten students that school year were identified as having a reading deficiency while nearly one out every three third graders were also identified as needing more support. And we can look to other states to see how a similar model of incorporating books into well-child visits through CHIP Health Services Initiatives can aid and increase the literacy proficiency in school. North Carolina approved a CHIP HSI for Reach Out and Read in 2020 through 2022 for just over $3 million. According to a report published by the North Carolina Department of Public Education, students in first through third grades are now outperforming peers on their reading screening assessments. And they continue to increase the percentage of students that are reading at or above grade level. It's important to note, however, that North Carolina, their CHIP kids are about 80,000 to 100,000 kids, so

their fiscal note for that is significantly higher than what ours would be. The Legislature is talking at length this session about literacy and various strategies to improve literacy for students in the early grades and it has been and continues to be a priority of the Governor. It is important-- it's an important goal that deserves time and attention and LB970 offers a creative and proven prevention strategy in a child's early stages of learning as an alternative to later interventions that are more costly and time consuming. I urge the committee to advance this bill, and happy to take any questions.

HARDIN: Thank you. Questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Harden. Hi.

KRISTIN CHRISTENSEN: Hi.

FREDRICKSON: Nice to see you. So I'm hoping-- I don't know, maybe you can answer the question I had asked of Senator Guereca just in terms of, like, when you operationalize this, what does this actually look like now, do you have to put it together?

KRISTIN CHRISTENSEN: Yep, yep, there's a few different models. Reach Out and Read is the one that I'm the most familiar with. And usually in practice, kind of what I mentioned earlier, it really only takes a few minutes at most during the well-child visit. So what we hope to see is when the doctor, the, the physician, comes into the, the visit with the kids, they're bringing a book with them, and handing it right to the kid. Noticing how the, the child is turning the book right side up, how they're flipping the pages the right way, they're logging all of that as their assessment of fine motor, language, gross motor, all of these skills that they want to assess during the well-child visit. The book gives them that information. And at the same time, they're saying, oh, look at what your child is doing. You can encourage reading at home. You can sit with them while you're doing your bedtime routine, but using the book as kind of that anchor point during the visit. So it's not, like Senator Guereca said, it's not like adding 20 minutes at the end to read the whole book and ask questions. You're really just bringing it in, handing it to the kid, and then going about your visit.

FREDRICKSON: Understood. So it's, it's almost like kind of assessing how a child interacts with the book, like [INAUDIBLE].

KRISTIN CHRISTENSEN: Totally, yes, yes. Yep.

FREDRICKSON: Understood.

KRISTIN CHRISTENSEN: And that gives more information than just, like, the survey that you might fill out like the Bright Futures or whatever. Do you read with your kid? Do you sing with your kid? They're getting firsthand assessment of what the kid can do and where they should be with their milestones.

FREDRICKSON: Got it. Thank you.

KRISTIN CHRISTENSEN: Yeah.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair Hardin. Welcome.

KRISTIN CHRISTENSEN: Thanks.

G. MEYER: Nice to see you here today. Are you working in conjunction with any of the school programs?

KRISTIN CHRISTENSEN: Currently, no. We've been partnering with Nebraska Growing Readers through Nebraska Children and Families Foundation just making sure that we're both kind of hitting pockets of populations so that we are not missing anybody but we're not directly tied or working with the ESUs or school districts because ours is through the health care system rather than a school-based system so it's different avenues but always open to partnering with, with more.

G. MEYER: We're considering legislation, retention of third graders or promotion to fourth grade, however you want to, however you want to couch that. Marketing says promotion. Do you think there's an opportunity to coordinate with the school systems to improve reading--

KRISTIN CHRISTENSEN: Essentially.

G. MEYER: --or are we working at cross purposes here?

KRISTIN CHRISTENSEN: No, I don't, I don't think we're, we're, you know, in different silos here, and definitely we don't want to be when it comes to literacy. I should say Reach Out and Read is beginning to partner with Charles Drew in Omaha and getting into some of their school-based health care clinics. So, in that sense, we, we kind of are. I, I view this more as a prevention strategy that would ideally decrease the number of students that we'd be looking at to retain. So, certainly, there's always room for collaboration, but I'm not sure, I guess, in practice what that would look like right now.

G. MEYER: Well, the science of teaching and the process of, of how we educate our teachers. Right now, reeducate our teachers in how to read, it would seem that we should have some uniformity, perhaps, between your program and our school programs so that we're not working at cross purposes. So the science of reading and those types of things that we are incorporating in our school systems, you should be mutually supportive, I would hope.

KRISTIN CHRISTENSEN: Sure.

G. MEYER: And so perhaps down the road, there would be an opportunity to work with the school systems.

KRISTIN CHRISTENSEN: Yeah, and to clarify, the, the providers that are doing our program or, or incorporating books into their well-child visits aren't giving reading instruction to the kids or reading instruction to the parents to then give to the kid. It's really building home libraries, encouraging parents to snuggle up and, and bring your child onto your lap and read a book before bed. So nothing like teaching of the science of reading or anything like that, though it does support building literacy skills by reading together at home with, with kids.

G. MEYER: OK. Thank you.

HARDIN: Senator Quick.

QUICK: Yeah, thank you, Chairman. And I, I know that you mentioned the fiscal impact maybe from on other states and from [INAUDIBLE]. I know there's an amendment to maybe use the, the CHIP funds. So can you talk a little bit about that?

KRISTIN CHRISTENSEN: Yep. Yep. Thank you. Yeah, North Carolina, like I mentioned, approved over $3 million for this. What I'm hoping that we can do with the amendment that was dropped today is to limit the scope from all kids that are receiving Medicaid and CHIP to just CHIP, so that significantly reduces the amount of kids that we would be serving with the state of the budget that we're in right now. And opens it up-- the amendment opens it a little bit so it's not so prescriptive on what program or what exactly the providers need to be doing, gives a little bit more flexibility in how they can implement this into their practice. DHHS, their, their neutral testimony showed a little bit of a misunderstanding in how I kind of mentioned earlier where they were under the impression that it would take 20 minutes and there might need to be some more codes or reimbursement, but if it's really

just a quick, here's a book, I'd love for you to read at home, then it shouldn't add too much burden to the, to the providers and providers that we work with note that it doesn't add a burden. In fact, it enhanced their visit-- enhances their visits. So I, I think the fiscal note could be adjusted based on timing and different things like that.

QUICK: OK. All right. Thank you.

HARDIN: Senator Ballard.

BALLARD: Thank you, Chair. Thank you. Good to see you, Kristin. You mentioned a report by North Carolina Department of Public Education. Can you high-level outline that report and maybe--

KRISTIN CHRISTENSEN: Sure.

BALLARD: --send it, send it to us if possible?

KRISTIN CHRISTENSEN: Yep, I'd be happy to email it to you. Yeah. It's-- their-- it's like their Department of Ed, but it's only for public education. North Carolina does it a little differently. But it was highlighting how North Carolina has implemented the science of reading for all of their teachers. They've changed how they're assessing their students, and it gave similarly to what Nebraska does, how they assess their kids three times a year with a reading screener. The data that I pulled from that report was their beginning of the year screening assessments showing that they've made gains over the last few years, and that it was after Reach Out and Read was implemented. So happy to send that to you.

BALLARD: Yeah, because I, because I think this is great. But it's just like, well, literacy at home, reading at home--

KRISTIN CHRISTENSEN: Sure.

BALLARD: --how do-- I just want to know how, how North Carolina managed that? They can, they can go to their, their checkup, and that's great. But it's just like, it's, it's a longer period and not just the home literacy, the, the needs of reading books at home. Like, I just was curious about that.

KRISTIN CHRISTENSEN: Yeah, I'll send it to you.

BALLARD: Thank you.

HARDIN: Other questions? Any states besides North Carolina that are doing this?

KRISTIN CHRISTENSEN: Yep, Oklahoma also has a CHIP HSI. I should note that North Carolina and Oklahoma, the HSI money went directly to Reach Out and Read, not to the, the clinics themselves. So Reach Out and Read received the dollars and then disbursed it to clinics across the state. That's not how this bill was written, so Reach out and Read wouldn't be receiving any of this funding. But North Carolina, Oklahoma are the two largest recipients of CHIP HSI funds. Yep.

HARDIN: All right. Thank you. Seeing no other questions, we appreciate you being here.

KRISTIN CHRISTENSEN: Thank you.

HARDIN: Proponents, LB970. Welcome.

TAMARA WHARTON: Good afternoon, Chair Hardin and members of the Health and Human Services Committee. My name is Tamara Wharton, T-a-m-a-r-a W-h-a-r-t-o-n, and I want to thank you for the opportunity to testify today here in support of LB970. I am a teacher. I have dedicated 33 years to education, primarily in kindergarten and first grade. I worked in the Omaha Public School System for 23 years, and then I've spent the past decade at Nelson Mandela Elementary School in Omaha. First as a kindergarten teacher there, and now I'm the literacy coach, reading support teacher, and Spalding Certified Teacher Instructor. I've also completed the Early Literacy Workshop and the early Literacy Facilitator's Workshop through the University of Nebraska at Omaha. So my support for LB970 is grounded in more than three decades of experience teaching young children to read and preparing educators to do the same. The conclusions I share today are informed by both research and lived classroom experience. So research consistently demonstrates that access to books in the home and daily reading with the caregivers can significantly strengthen early literacy development. And books can provide that exposure. The language that children encounter in books differs from your everyday conversational language. It has more complex sentence structures, broader vocabulary, and diverse ways of expressing ideas. According to some research that's led by Jessica Logan at Ohio State University, children who are read just one book per day hear approximately 290,000 more words by the age of 5 than children who were not regularly read to. That difference is substantial and it makes-- and it matters. Because when children enter kindergarten, their brains are not hardwired to read. Our brains are hardwired for language, but not for reading. So there's

no single reading center in the brain. Instead, reading requires the formation of connections between regions that are responsible for spoken language, visual recognition, and pattern processing. So when children have been immersed in spoken language and read aloud experiences, those neural pathways are primed and ready to build upon. Reading aloud also strengthens emergent literacy skills. Between the ages of 3 and 5, children's understanding of print can grow rapidly when caregivers engage them in simple practices, such as pointing to words while reading, tracking the direction of the print, clapping out words in a sentence. But all of these activities require access to books, so that is one of the primary reasons I support LB970. As I stated, I'm a kindergarten teacher, and I welcome students with a wide range of readiness levels. And while I use differentiated instruction and targeted interventions, books were the backbone of the classroom. They reinforced decoding, strengthened comprehension, modeled effective writing, and expanded students' understanding of the world. And anyone who has spent time in a kindergarten classroom knows that it's a very active and lively place to be. My classrooms were no different, but there was one moment of calm every day, and that was story time. And during that time, the room would settle, students would focus, listen, and connect, and it was a shared experience that built language, knowledge, and community. And that period of calmness doesn't have to happen just in the classroom, it can also happen in the home. And so that's why I support LB970.

HARDIN: Thank you. Senator Meyer.

G. MEYER: Thank you. Welcome. Glad you came today. Are, are you familiar with the Reach Out and Read program?

TAMARA WHARTON: No, not really.

G. MEYER: OK. Is-- that's it for now. Thank you.

HARDIN: Is there any connection between? greater exposure to early childhood literacy and greater IQ?

TAMARA WHARTON: Is there a connection between that?

HARDIN: Developing the formation of my ability to comprehend better, frankly, recognize more words earlier, faster. That, that exercise that you were saying ages 3 to 5, if we have that exposure, is there a greater ability to translate that into our, our intelligent quotient later in life like when we're old, like age 7?

TAMARA WHARTON: You know, I'm not a, a scientist who can give you the exact data on that, but what I can say is being in the classroom with kindergarten students for so many years, you can see the difference in the knowledge that's brought in and the ability to comprehend concepts that were going on. And if exposed, then that knowledge, that increases. But down the road when you're 70, I can't testify to that. I would like to say yes.

HARDIN: I would just love to find out what we could do for 14-year-olds, so. Very well. Any other questions? Senator Quick.

QUICK: Yeah, thank you, Chairman. So our son struggled when he was little, too, with a learning disability. There were certain words he couldn't recognize and so my wife would read to him at night. And at some point, she didn't think that he was interested. So she just stopped reading to him. And then he'd come back to her a little while later and said, how come you stopped reading to me? So I think children are interested in learning and hearing the stories when they can't recognize the words themselves. And I'm sure you've worked with children like that.

TAMARA WHARTON: Yes, yeah. As when I transitioned from a kindergarten teacher into the literacy coach and also providing reading support, the students that I provide support to are the students that score lower on our MAP testing that we do or the Woodcock-Johnson testing or even informal assessments in the classroom. And then I work with those students closely and do a lot of progress monitoring. And then when they reach certain thresholds, then I may scaffold my support and pull back because they have reached those points we want them to reach, but definitely even when it seems like they're frustrated or not listening, they really are, and it may come back a day later, a week later, a month later, but it does, it does have a huge impact.

QUICK: Thank you.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair Hardin. I think I have my thoughts together now. We are dealing with, unfortunately, diminishing outcomes in our fourth and eighth grade testing. And one of the things we've been dealing with in the Education Committee, which I'm a part of, deals with identifying very early the problem with dyslexia. And being a kindergarten teacher and, and involved in reading, certainly very heavily involved in reading, is there some way that we can make that identification test sooner? Senator Quick was, was sharing about his

son, perhaps not-- enjoyed being read to but was having a hard time recognizing, perhaps, words, and I'm not putting words in his mouth, but having a difficult time reading himself, but enjoyed being read to. They have an interest in reading, would really like to do it, but there's some compelling reason why they-- they're not recognizing words, they can't-- you know, they can't visualize properly to, to read properly. As part of your experience, is there, is there an opportunity to identify that sooner, certainly kindergarten or sooner?

TAMARA WHARTON: I believe so. At our school with our incoming kindergartners, if there's any sort of concern, then I will do some screeners. It's not going to tell me yes, specifically, there's dyslexia, but it may put up a red flag and say, OK, there is something going on that we need to address and try and figure out where exactly the difficulty is. There's very quick, 1-minute screeners that can be done even with kindergarten students. Obviously, they're not going to be able to read a passage and count how many words they read correctly in a minute, but do they recognize letters? Can they tell you the names of those letters? Even doing some very simple things like that, can they tell the sound they hear at the beginning of the word? Can they identify those medial sounds, the ending sounds? Doing some screeners like that can give you a, a good idea of students that may need that more scaffolding and support immediately, rather than waiting until they get a little bit older to determine.

G. MEYER: Some of the statistics that we see, approximately 20% of, of the reading problems that we encounter, certainly in our early years, is attributed to dyslexia. And so it seems like that would be the first go-to look. If we're having some problems, that would be the first place we would look. But I realize it's probably very difficult to test at a very young age to try to make a determination if that's the problem or not, so.

TAMARA WHARTON: Yeah, sometimes you have to weed out if there's not been a lot of exposure to language or print in the home, sometimes that can have an impact. So when you're identifying doing these screeners, if we start working and then all of a sudden everything clicks, great, they've got that support they needed and now they can move on or if they're not then, then that's a student that we might continue to look at and see what we can do and, and do we need to go further and determine what exactly is causing the difficulty whether it's dyslexia or-- yeah.

G. MEYER: Thank you. I appreciate that.

HARDIN: Educate us. You're working with rough stuff here. Is there a difference-- or what is the difference between evidence-based and evidence-informed?

TAMARA WHARTON: So evidence-based and evidence-formed: evidence-based, there's, there's research, there's been studies to back it up to show the effectiveness; evidence-informed, it, it could be, the evidence seems to show that, but there's not the research or the, the studies to show that it really has been affected.

HARDIN: More anecdotal?

TAMARA WHARTON: Yeah.

HARDIN: OK. Seeing no other questions, thanks for being here. We appreciate it. Proponents, LB970. Welcome.

BETTY MEDINGER: Hi. Good afternoon, Chair Hardin and members of the HHS Committee. Thank you for the opportunity to testify today. My name is Betty Medinger, B-e-t-t-y M-e-d-i-n-g-e-r. I'm here today in support of LB970, based upon my past 45 years of experience working in a number of capacities to support promoting healthy child development and strengthening families. My experience includes working first in state government, serving in numerous direct service and administrative capacities within child welfare and the office of economic and family support. This was followed by 13 years working in the nonprofit arena and retiring in 2023 as senior vice president with Nebraska Children and Families Foundation. I came out of retirement to offer time-limited consultation services in the Midwest, Nebraska and Iowa. The national program Reach Out and Read is delivered through medical clinics. I am now fully retired. I am not here to promote any specific program, but instead to support the practice of literacy support from the physician's office during the routine well-child visit. Therefore, I support LB970 for all the reasons the others have testified to today. To reiterate, advances in neuroscience have demonstrated the critical period within the first 5 years of a child's brain development, the irreplaceable role that the parent plays in supporting their child's early social-emotional development through developing strong parent-child bonds. New parents are eager for information about their developing infants, naturally seeking guidance primarily from their own parents and their trusted family physician. Therefore, stressing the importance of talking, singing, reading to your developing child to promote language and literacy during this active period of brain development is a natural opportunity that we should not miss. It is a prevention service in the purest sense of the

word. There's no stigma, no additional meetings required, just being more intentional about sharing good information in a setting that already exists, rather than more costly interventions down the road. When parents and caregivers know better, they can do better. A couple of clarifications, this legislation offers intentionality in literacy promotion during the well child visit and would be part of Nebraska's overall strategies relating to promoting the parent-child relationship and early literacy. This doesn't mean the physician is using the time to purely read to a child, as has been explained. The Nebraska Growing Readers Initiative is a unifying infrastructure connecting the dots in literacy promotion across Nebraska. The focus continues to bring literacy resources through settings such as home visitation programs, childcare settings, schools, and libraries. Offering a book and stressing the importance of reading to a child while delivering Medicaid CHIP supported medical care during a routine office visit addresses a vulnerable population by offering information and a resource to take home. It is another piece of Nebraska's overarching strategy and integration within the framework of Nebraska Growing Readers. Thank you for time and consideration.

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

BETTY MEDINGER: Yes.

HARDIN: LB970, proponents. LB970, opponents. Those in the neutral. Senator Guereca. We have 19 online proponents, nine opponents, one neutral.

FREDRICKSON: Do we have one more? Sorry.

HARDIN: Oh, I'm sorry, we had one more. And, and you're neutral?

JAQUALA YARBRO: Yes.

HARDIN: Come on down. Sorry to cut you off, you're welcome. Come on up.

JAQUALA YARBRO: Thank you. Hello, everyone. First off, I'm Jaquala Yarbro. I am the Executive Director and founder of the Compete Institute of Socioeconomic Policy and Education. I know, I didn't come up with the name, the board did that. But I am a huge proponent of early literacy, especially--

HARDIN: Could, could you spell your name for us, please?

JAQUALA YARBRO: Sorry. J-a-q-u-a-l-a, last name Yarbro, short version, Y-a-r-b-r-o, although the longer versions are our cousins. So I think this sounds magnificent on the surface. I just jotted down a couple of notes. I've been a part of a number of literacy initiatives throughout Nebraska in partnership with folks like Nebraska Children and Families. And I sat on the Board of Educare for 3.5, 4 years and did some policy council work for Omaha Public Schools. So this is near and dear to my heart. What we tend to see in these spaces, which is a concern for me, I think it sounds great on the surface, but it's important to tease out what we will potentially meet in the weeds at an administrative level before we get it in stone, is what the interaction will be during the appointment. My concern, particularly, is for families who are of poor socioeconomic stature, normally we see the primary amount of reports that come in to CFS, we see those come from medical providers for any one reason. So my concern would be, is there a potential for any adverse action against families who might refuse or who may not necessarily be comfortable with that particular interaction or experience during that well-child visit. I would also have concerns about the, the languages in which the information is presented. Would the literature only be in English, or would it be in the respective languages of perhaps our Burmese culture that's here or Somali individuals who are here, would we have literature available for families that only speak those languages? On the Board of Educare, the issue that we had was, and I thought of this when we talked about IQ, Senator Hardin, it's very-- that's very, very, very important because we saw that children who were not-- who did not speak formal English, so maybe students who came from, maybe a household who spoke Ebonics, but they spoke English. They scored very poorly on assessments and did very poorly in, while they were being observed during their reading assessments because they were not, I guess, identifying with the literature as it was presented. But those students scored off the charts as far as their abilities go. And so I don't think that-- I think it's very important for us to assess how literacy will be presented so that we get a true testament of what students are able to do in that environment. And I'm not sure if that's the environment where that can be done because-- I mean, I have kids. Well-child visitors are very in and out, very loud, you know, but I think if we can tease that out, I think that would be a very, very great program and I'd be in support of that.

HARDIN: Thank you. Senator Meyer.

G. MEYER: Thank you, Chairman Hardin. I see you brought support staff today. I was wondering if we were going to have an opportunity to hear from them also?

JAQUALA YARBRO: Perhaps, you never know.

G. MEYER: I, I, I think they probably could share a great deal with us, so.

JAQUALA YARBRO: Oh, yes, for sure.

G. MEYER: Thank you.

JAQUALA YARBRO: Thank you.

HARDIN: Seeing no other questions, thanks, appreciate that very much. Anyone else in the neutral? If not, Senator Guereca. Welcome back.

GUERECA: Thank you, Mr. Chairman, members of the committee. Obviously, the issue of, of literacy is something that's front of mind in this Legislature, across the state. The reaction of Senator Ballard will be heard, the results out of North Carolina was, well, I need to see that report. It's clearly something that is a concern to folks on every corner of the state. And, Senator Meyer, I think you asked a great question. Is this going to be in our-- is this going to be crossing paths or not flowing well with what our folks are doing in the K-12 space? I think this, this interacts perfectly with it because this is before they get to that point. I mean, if you hand, if you hand a fourth grader a book-- or a 4-year-old a book, and it's upside down, it's little things like that, right? It's using that, that book as a tool to allow these providers to pick up on little subtle things. That say, hey-- allows that provider to direct them to resources that could cut off and say, hey, let's, let's catch that dyslexia early, right, so it's all about rowing in the same direction. This is one of the great problems that we have in this state that we need to address and we're going to address it by coming at it from the medical profession coming at from our educational institutions, everyone's got to be working together. And I think this is a tool. This isn't a silver bullet, but it is going to be a tool that could be used. You know, again, and we do need to look at in North Carolina, Oklahoma, how it was implemented. How can we do it better here in Nebraska? We do great things here in Nebraska. So let's see how we can innovate that to, to fit the unique circumstances that we have across the state. So, again, this is just another tool in the great battle that we have, one of the great battles that we have in our time. And with that, I'll take any questions that my great testifiers couldn't answer.

HARDIN: I'm, I'm a little-- and, and this isn't your fault, our committee is a little confused as to why we're now getting housing

bills and, and a few other categories of bills, and that's the Referencing Committee. Are they listening at the Referencing Committee? This is one of those bills, though, Senator Guereca, I look at it and I'm, and I'm going, how come this is in HHS instead of Education, particularly when it comes back to this issue of evidence-informed versus evidence-based. Evidence-informed is what we, we now see in your, in your wording, in your amendment, which is the shall we say the lesser exacting of the two.

GUERECA: Sure.

HARDIN: And so it kind of feels like we're a, a target, if you will. Hey, HHS has lots of money, let's go shop it over there. Because this is not exactly straight over the plate for us in HHS. That's how it-- this feels to me. Does that make sense? I'm, I'm all about early childhood literacy and that's why I asked some of the loaded questions earlier that I did. But I'm, I'm just concerned about, you know, how, how does, how does this work? And then I'll follow up with an, an additional question. Is, is, is this a priority for you or how might we get to this to the floor in 2026?

GUERECA: So, so my answer-- and, and that's a great highlight, Chairman, and I think the, the language change was made to give that extra flexibility to the department, right? And you ask, why is this before you? Again, this is something that all aspects of society, we have to be working to address this great issue of, of childhood literacy. And I think that-- there was intentionality behind that, is to allow DHHS to make sure we're not handcuffing our providers to a methodol-- to a system or method that is cumbersome, that, you know, won't provide the results that our society deserves and that our kids deserve and our taxpayers deserve. So I think that was-- that--to, to let the professionals at DHHS come up with that right solution.

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

GUERECA: Thank you, sir.

HARDIN: Appreciate it. This concludes LB970 for the day. Next up, LB1213.

G. MEYER: Thought I was in Education Committee there for a minute.

HARDIN: We'll wait for the room just to clear out a little bit and then we'll get going.

MICHAEL A. LEE JR.: Perfect.

HARDIN: Is Senator McKinney wrestling today?

MICHAEL A. LEE JR.: Yeah. Yeah.

HARDIN: Well, maybe he's not wrestling, but--

MICHAEL A. LEE JR.: He's coaching right now.

HARDIN: --he's, he's probably yelling at other people who are.

MICHAEL A. LEE JR.: Yep.

HARDIN: I'm just guessing.

MICHAEL A. LEE JR.: Safe-- what do they say? Hands-on experience. That's what he's doing. I've had that myself.

HARDIN: We are ready when you are ready.

MICHAEL A. LEE JR.: Perfect. Good afternoon, Chair Hardin and members of the Health and Human Services Committee. My name is Michael A. Lee, Jr., M-i-c-h-a-e-l L-e-e. I am Senator McKinney's LA, and he's not here-- able to be here today. I'm here to present LB1213. LB1213 adopts the Case Management Licensure Act. This bill establishes a licensure and oversight framework for individuals performing case management functions within, within Nebraska's child welfare and foster, foster care system. Under current law, we rely heavily on internal processes to ensure accountability. However, inconsistent case management practices, excessive caseloads, and insufficient oversight has contributed to harm for children and families, as well as jeopardize federal title-- I'm sorry, Title IX-E [SIC] funding. I think that's what it is. LB1213 requires individuals performing case management, investigative or supervisory functions in child welfare to be licensed and renew that license every 2 years. The Foster Care Review Office will serve as the licensure and oversight authority with the ability to adopt standards, receive and investigate complaints, and impose disciplinary action when necessary. This bill creates a formal complaint and appeal process with defined timelines assuring fairness and due process for all parties involved. It also establishes clear disciplinary standards for misconduct, including falsification of records, submission of misleading information or actions intended to improperly influence a case outcome. Additionally, LB1213 directs the, the adoption of standards to reduce investigation timelines, improve communication with families and foster parents, and ensure greater transparency in the lifecycle of investigation. The office will submit an annual report to the Legislature detailing licensure

activity, disciplinary trends, and fiscal impacts. LB1213 is about strengthening professionalism, accountability, and public trust in Nebraska's child welfare system while protecting children and families. Thank you. I look forward to the committee's conversation.

HARDIN: Thank you so much. And proponents, LB1213. Ms. Yarbro.

JAQUALA YARBRO: Oh, you remembered.

HARDIN: Well, anyone I cut off and embarrass and I remember, I'm so sorry, so take it away.

JAQUALA YARBRO: No, that's fine. Thank you. Do I respell my name again?

HARDIN: Yes, please.

JAQUALA YARBRO: I'm Jaquala Yarbro, J-a-q-u-a-l-a Y-a-r-b-r-o. My name is Jaquala Yarbro. I am founder and Executive Director of the Compete Institute of Socioeconomic Policy and Education, policy research institute in Omaha. The Compete Institute in, in partnership with the Nebraska Children and Families Foundation leads Nebraska's thriving family safe for children team. It's a child welfare reform initiative sponsored by the Centers for Disease Control, the Annie Casey Foundation, Jim Casey programs, Prevent Child Abuse America, and the Administration for Children and Families, as well as our lived experience leaders. Since 2018, we've interacted in various forums with the Nebraska Children's Commission, the Foster Care Review Office, the Department of Health and Human Services, and communities to review data and develop feasible solutions for providing the best care for children and families, increasing federal funds for DHHS programs and services, reducing overuse of funds for investigations in which 63% are unfounded, improving compliance with state and federal mandates, and reducing, reducing latency in implementation of policies and practices. Multiple interdisciplinary teams have convened over the past 5 years to appropriately address the harm to families, the lack of case management oversight, the difficulty of navigating the complaint's process, the latency in delivering results for families, and the lack of digital resources that could improve communications and case updates throughout the department. The Case Manager [SIC] Licensure Act would promote compliance by case managers as a means of maintaining their license. It would also provide the state with protections from potential lawsuits, causing case managers to assume the cost of any findings of negligence and malfeasance. Since the Foster Care Review Office is already mandated to review cases and

provided-- and provides recommendations, expanding their oversight to include licensing authority would be most appropriate and feasible. The Case Manager [SIC] Licensure Act is similar to legislation adopted in California, Texas, Georgia, South Carolina, North Carolina, New York, Maryland, New Jersey, and Connecticut. These states experience direct increases to IV-E funding as a result of increased compliance, reduced complaints, and more efficient spending. Thank you.

HARDIN: Thank you. Questions? Kind of in plain language, what are we seeing that's not happening well in this space that this would help fix?

JAQUALA YARBRO: Well, so for, for starters, the-- we have, we have a lot of the right things in Nebraska. The Foster Care Review Office is an essential piece for oversight. The issue in Nebraska is, to put it plainly, they have no teeth. So they can make recommendations. They produce the most, I would say, in-depth report annually and-- but the Department of Health and Human Services does not have to adopt any of their recommendations. Much of the information is repeated year after year after year. I participate in a number of interdisciplinary teams annually and we talk about the same things like, hey, let's do a gap analysis. What are the problems? Where are the issues? We are still seeing, last year, I think we were up to 58% of cases that were screened in for an investigation. We were seeing 58% of those being unfounded, that's more manpower, more money being put towards manpower that's unnecessary. We were seeing-- mind you, during that time, a lot of those children were separated from those families. We saw 2-- between 2-4% of children reunited with their families within 30 days, that 2-4%. So someone takes your child because I called in and I said, hey, I had a concern, Senator Hardin told his kid he couldn't have ice cream. I think, I think that he's abusive, he used the wrong tone. And someone just, you know, screens it in and says-- you know, they'll-- they have a tool-- structured decision-making tool and that they can look on that tool and say, hey, I'm interpreting this to mean that, yes, we need to take a, a closer look at this. And someone can say, an investigator can say, hey, I want to go see that child at the school. Another investigator can, hey, I think that's grounds for removal until we can make sure the child is safe. And so there's, there's just too much discretion within investigations and I think we're seeing that play out in the fact that 63% of these cases are unfounded. And those kids still remain in the system because you have to wait for a court date which can be 30, 60, 90 days for a judge to say, hey, that child can then go home and be reunited. But kids don't get reunited the same day as the court date. Sometimes that takes 2 weeks, 30 days, 2 months. Just depends on the speed of which their case management

team is moving. We do see that there is a lot of-- there's not really oversight for investigations as far as from the community standpoint. So if a family feels that perhaps they're being targeted within the department, or they've had some type of ill interaction or encounter with case management staff. I've seen where-- obviously, we have a family resource center, I don't know if I divulged that, but we work with families to help them kind of navigate through the system when they're having these problems. We kind of reach out to the case management team. We help them to advocate for themselves and maybe reach out to their counsel, their legal counsel. Reach out to move forward the complaint's process. Reach out to the Foster Care Review Office. But at the end of the day, as it stands, the case management team has the final say until you get to court. Now the judge only sees what the case manager submits, so the judge can ask that individual during a, a court hearing, you know, what are your thoughts on XYZ? But they're not as-- nearly as prepared as the case manager. I've had four cases in the past year get overturned simply because I helped family members advocate for themselves. And so when I say this is a department-wide problem, I've worked extensively with DHHS. I've spoken with Amy [INAUDIBLE] about it prior to her last maternity leave. Congratulations, Amy [PHONETIC], if you're watching. But it, it truly is a problem. And I think the department would say, yes, our priority is children first, so we don't apologize for that. But from a community standpoint, I would say that children are as whole as their families are. And as long as we're taking children from their families, but we're returning them to the same community, then I think we need to be asking ourselves a greater question. Like, why are we spending all this money separating families, and we're really not getting to the root of the problem, if there even is a problem. And so there's just-- there's a need for an additional set of eyes that's not within the department. I think there are a lot of people, a lot of great people within the department. I think the department serves an awesome role and I've seen some magnificent work that they've done. But when it comes to holding case managers accountable, there just is no accountability. There is none. I, I can just about tell you the, the chain of command. I'm a foster parent. I've dealt with it myself. I've, I've been-- I've lucked out and got very great investigators as a foster parent that said, you know, there's no reason we're even here, you know, we're here because potentially your case manager-- you have paperwork that shows that this case manager hasn't been to your house for 3 months. And because you reported this case manager, this looks like retaliation. And so luckily, I'm in the space that I'm in and I can advocate for myself. However, there's, there's a lot that goes on that, unfortunately, those-- the people who are victims of it

don't really have the tools to assist themselves. They don't have money to pay an attorney. They don't-- you know.

HARDIN: How long, how long have you been working in this space?

JAQUALA YARBRO: Since 2018.

HARDIN: OK.

JAQUALA YARBRO: Yes.

HARDIN: Very well. Any other questions? Thank you. We appreciate it.

JAQUALA YARBRO: Very well.

HARDIN: Thanks. Proponents, LB1213. Proponents? Opponents, LB1213. Those in the neu-- oh we've got one. We've got a winner.

KATHRYN O'HAGAN: I'm moving slowly, sorry.

HARDIN: And you're a, a proponent, or are you an opponent?

KATHRYN O'HAGAN: Opponent.

HARDIN: Thank you. I just needed to get my thinking straight.

KATHRYN O'HAGAN: Not that slowly.

HARDIN: OK.

KATHRYN O'HAGAN: Just a little slowly.

HARDIN: Take it away.

KATHRYN O'HAGAN: Good afternoon, Chair Hardin and members of the Health and Human Services Committee. My name is Dr. Kathryn O'Hagan, K-a-t-h-r-y-n O-'-H-a-g-a-n, and I'm the Director of Programs for the Division of Children and Family Services in the Department of Health and Human Services. I am here to testify in opposition to LB1213. The department shares the underlying goal, reflected in this bill, of ensuring a strong, well-qualified child welfare workforce that supports safe, positive outcomes for children and families. Workforce quality, professional development, and accountability are critical to the work we do every day, and we appreciate the Legislature's continued focus on strengthening the child welfare system. The department operates within an established framework of oversight and monitoring, including the Foster Care Review Office and the Office of

Inspector General, as well as the federal oversight by the Administration for Children and Families. These systems provide continuous review of practice standards, accountability measures, and overall system performance. The department utilizes a structured competency-based workforce preparation model for child and family services specialists, our case managers, that aligns with nationally recognized best practices. Prior to independently managing cases, case managers complete a comprehensive onboarding process that includes approximately 87 hours of formal instruction, 120 hours of supervised field experience, and 14 hours of targeted coaching. Formal evaluations are conducted throughout the training process via readiness assessments. This preparation is followed by ongoing supervision and a required minimum of 24 hours of annual continuing education. This layered model emphasizes competency, supervision, and accountability, reflecting the core elements widely recognized as essential to professional development in human services roles. Nationally, licensure is not the standard for child welfare case managers. The 2023 State Child Abuse and Neglect Policies Database indicates that only three states require licensure for child welfare case managers. Similarly, a 2020 analysis conducted by the Association of Social Work Boards found that social work licensure statutes frequently include exemptions for certain government employees performing human services functions. Across 40 states, 163 exemptions were identified, reflecting that many public child welfare roles are governed through structured agency oversight rather than licensure. Licensure may only serve to hinder the department's ability to recruit and hire case managers without any discernible benefit. In fact, additional workforce obstacles could and likely would harm the families that we serve. LB1213 assigns licensure, oversight, and establishment of standard operating procedures and disciplinary authority for case managers to the FCRO, a statutorily created independent board, while the department continues to employ the case managers who provide child welfare services. This structure creates a division of authority. And I see that my time is up. I'm happy to continue if you would like me to. Otherwise, I'm having to answer any questions.

HARDIN: You can wrap up your thoughts, Dr. O'Hagan.

KATHRYN O'HAGAN: Yes.

HARDIN: Then we'll ask some questions.

KATHRYN O'HAGAN: Yes. The bill's current definition of case manager appears very broad. Should every individual captured by this

definition be required to hold a professional licensure, there are significant administrative and operational burdens. The ambiguity in this definition creates a risk of substantial unintended consequences, including staffing and administrative costs to the department.

HARDIN: Questions? Senator Quick.

QUICK: Yeah, thank you, Chairman. And-- so my question would be-- because I know I-- when I served the first time, there were changes to, like, removing children from the home and those type of things. And I know I went to a couple meetings where they were talking about new training formats for some of the caseworkers. And, of course, this was under the previous administration, so. And I know that some frustrations were coming out in those meetings, too, as well. But my question is based on-- so even us as senators-- and we all come from different walks of life and we don't-- sometimes we haven't walked in someone else's shoes to understand what they're actually going through. And for some of the case workers, maybe it's the same way, you know, they come from a, from a certain walk of life, and so is there training to actually help them understand maybe where someone is actually coming from to-- so they can help them address their issues instead of having their preformed opinion about what we should do for you?

KATHRYN O'HAGAN: I really appreciate that question. Absolutely. A good portion of the training is about the trauma-informed approach needed to be a strong child and family services specialist. So that would include not bringing your own opinion about how a family should operate into your casework. So, yes, we do ensure that that's part of their training process.

QUICK: And I would guess that, you know, the majority of the caseworkers are doing their, their jobs. Is there something-- you know, I'm sure maybe you get complaints from time to time. And so is there a way to address that issue? Maybe that, maybe that certain caseworker isn't following through with that training.

KATHRYN O'HAGAN: Absolutely. There's certainly some really simple ways that individuals who work with case managers might ensure that there's consequences to behaviors that we wouldn't want our case managers to reflect. Let's say they're not communicating. They can escalate that to a supervisor really easily who can escalate that even further. Additionally, we do have a grievance process for our families who participate in the child welfare system where they can submit an official grievance of their experience to our department and we work

through that process as folks might anticipate a grievance process to be like. If there are specific HR situations that might come up, so human resources situations, I know some of the previous testimony talked about a way to hold caseworkers accountable. There are times that a complaint might come up that we're going to say this, this has and will be address-- this has been or will be addressed. And it absolutely will be, and at times, just-- I'm sure you all would understand the human resources part of that is I can't share a personnel situation that may come up. So it could feel like we're not as responsive to some folks when we 100% are.

QUICK: OK. All right. Thank you.

KATHRYN O'HAGAN: Does that answer your question?

QUICK: Yeah. Yeah. Thank you.

KATHRYN O'HAGAN: OK. Great.

HARDIN: Senator Ballard.

BALLARD: Thank you, Chair. Thank you for being here, Doctor. So I'm trying to boil down your opposition. So is it the, the fact that there is-- the bill is requiring a licensure or the fact that it shifts it to a different oversight mechanism in FCRO? Because we license everything in this committee, so I'm just trying to figure out, boiling down the opposition, is it more the licensure or is it the shifting of the oversight?

KATHRYN O'HAGAN: It is both, not necessarily one over the other. So for licensure, we're not opposed necessarily, right, to the professionalism that can come with licensure. We feel that professionalism exists within our current structures. So licensure in and of itself doesn't necessarily equate to better case outcomes for our families. We feel like that might be a detractor. Further, the independent oversight mechanism that exists with the FCRO wouldn't any longer be independent if they are responsible for disciplinary action based on that licensure.

BALLARD: OK. And what are your disciplinary actions right now? I mean, you can fire the caseworker, of course, but, like, what, what is your disciplining action currently and what-- kind of what mechanisms do you go through?

KATHRYN O'HAGAN: Yeah. So they're actually-- and I don't want to misspeak, because there are a lot of disciplinary actions that are

overseen through human resources, but also the unions. And so it's not necessarily that there's no structure, there certainly is, but that structure is, is guided through union, human resources, but also standard conversation between supervisor and worker, you've got to do this as explained in our policies and processes. Is that helpful?

BALLARD: Yeah, that is helpful. Is there a complaint-- is there an outlet for these families that have a complaint for caseworkers?

KATHRYN O'HAGAN: Absolutely. Yes. So families participate in family team meetings. They'll have a team of individuals of which they can talk to about their experience in the child welfare system. That might be a guardian ad litem. It might be the caseworker supervisor. It's a number of individuals. So there are a number of avenues in which they can submit a concern. But then the grievance process I mentioned earlier is more of that official way that they can file an official grievance against their experience in the system.

BALLARD: OK. And then what happens-- because we, we heard testimony about retaliation. So what's the, what's the-- is there reassignment? Is there-- how often is-- I know, I know there's a workforce shortage, of course, so it's hard probably, but, like, I'm trying to figure out what's the avenue for these families to remedy their situation?

KATHRYN O'HAGAN: Yeah. That's a really good question. I don't know that I have, like, specific data on outcomes for our grievances necessarily. I do know that they can escalate, so once a grievance is submitted there's a response to that. If they're still un-- or if they're still concerned and unhappy with that response they can escalate it to our director as well. So there's multiple layers there, but I, I could try to get you some data on the here's the typical response.

BALLARD: OK. I'd appreciate that.

KATHRYN O'HAGAN: Yeah.

BALLARD: Thanks for being here.

KATHRYN O'HAGAN: Yeah.

HARDIN: From 2 million feet up, it takes agencies to issue licenses, right? That's a big thing to issue a license.

KATHRYN O'HAGAN: Mm-hmm.

HARDIN: And so that's not something that an office somewhere can do. So that's purely the domain of an agency to be able to do that in any of the state departments, am I right?

KATHRYN O'HAGAN: That's right.

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

KATHRYN O'HAGAN: Thank you.

HARDIN: Opponent to LB1213.

BILLY STOCK: Glad I got the Friday blue memo.

HARDIN: Welcome.

BILLY STOCK: Good afternoon, Chair Hardin and members of the Health and Human Services Committee. My name is Billy Stock, B-i-l-l-y S-t-o-c-k, and I'm a field representative for the Nebraska Association of Public Employees, NAPE/AFSCME Local 61. I'm here in place of our Executive Director, Justin Hubly, who couldn't be here today. And our union represents more than 8,000 frontline state employees, including more than 600 child and family service specialists. And I'm providing testimony in respectful opposition to LB1213 on behalf of our union. I think it is all of our shared goal to improve child welfare outcomes for the vulnerable Nebraskans that our members serve each and every day. And it's our opinion that this bill misses the mark in accomplishing that goal. The bill itself seeks to hold the frontline caseworker accountable through a licensure structure that is going to exacerbate an already challenging staffing situation in which the state, quite frankly, really struggles to retain and recruit these critical employees. In addition, the proposed system seeks to treat these frontline case managers as licensed professionals, but the current pay structure and job expectations are anything but professional. And while these employees don't get paid quite as little as you all, their starting salary is $45,000 a year. These workers have to work on-call shifts throughout the year where they get called day and night to work emergency cases. The situations that they find themselves in are immensely challenging and very stressful, and part of my job is hearing from them each and every day. And what I hear a lot of times is they feel often unsupported. To that end, the employee turnover rate last year at DHHS was 26%. So one in four employees quit working for the agency and of that 26% nearly 20% resigned within their first year of employment with the agency. So we believe that

this licensure system is just going to make that worse. There's already been mention that there's procedures in place already for filing complaints against a state employee. And we're not here to protect bad apples or employees who fail at their jobs. We're just here to ensure that each employee who faces any sort of disciplinary action receives due process. And more often than you'd think, there's a lot of frivolous claims that come from that and they're substantiated ones and there are avenues to address that. At the end of the day, we believe in accountability. But the current mechanisms that the state has in place through the state personnel system, we believe are more than adequate to address concerns. With that said, we're more than happy to partner with Senator McKinney, partner with the Legislature, and DHHS to ensure that we can attract and retain the high-quality CFS specialists that we need. And I see my light is red. I'd be happy to wrap up for you, Chairman, if you'd like.

HARDIN: Questions? Senator Quick.

QUICK: Yeah, thank you, Chairman. So my question is more around, like, the training piece or education piece for caseworkers. And maybe you can't speak to it. I don't know if you can or not. But do they feel like it's adequate training, or has it helped them to be able to work in some of the most-- there's, there's some pretty difficult situations, I believe, so.

BILLY STOCK: Absolutely, Senator. It's-- it is very difficult situations and from at least the feedback we've received, and, and Dr. O'Hagan testified about this, a lot of the new training they have received does feel beneficial. And, I think, in most situations more training is certainly a good thing. However, adding a licensure requirement to this, I think, would just really put a burden on an already very, very difficult job and it would be even more difficult to fill those roles that are very clearly needed.

QUICK: Another follow-up to that is, do they have continuing edu-- I should have asked Dr. Higgins [SIC] about that, too. Is there continuing education, like, each year for maybe new things that come up, or do you know?

BILLY STOCK: It's my understanding that there is, and if she's still here maybe she can-- big, big head nod from the back, from the doctor. Yes, absolutely there is.

QUICK: OK. All right. Thank you.

BILLY STOCK: Thank you, Senator.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair Hardin. I missed-- I apologize, too, Director O'Hagan for having missed her, her testimony. Job description with regard to filling these positions, case managers, what, what, what's the requirements? Do you know off the top of your head?

BILLY STOCK: There is a pretty extensive list of job qualifications, and just for the sake of your time, I'll tell you what I can do, Senator, I will send you a direct link to the exact page for CFS specialists for all the requirements that are, are required. I think it's a two or three-page listing of every expectation and qualification that they need.

G. MEYER: Educational requirements?

BILLY STOCK: I believe it's a bachelor's degree.

G. MEYER: OK, and starting salary is $45,000?

BILLY STOCK: Yes, sir.

G. MEYER: Graduated up as years of experience, I would imagine?

BILLY STOCK: Can, can you repeat that?

G. MEYER: Graduated up as years of experience.

BILLY STOCK: So the, the salary itself is based on the, the union contract that's negotiated and, yeah, years of service, you go up each step with positive performance, so, yes, very much so.

G. MEYER: OK. Thank you.

BILLY STOCK: Yes, sir.

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

BILLY STOCK: Absolutely. Thank you all. Happy Friday.

HARDIN: Those in opposition to LB1213. Those in the neutral, LB1213. Welcome

MONIKA GROSS: Thank you, Senator Hardin and members of the Health and Human Services Committee. My name is Monika Gross, M-o-n-i-k-a

G-r-o-s-s, and I'm the Executive Director of the Foster Care Review Office, testifying in the neutral position on LB1213. First, I wholeheartedly support the intent of this bill, which is to improve child welfare outcomes. That is our agency's mission in a nutshell. I support strengthening accountability, improving compliance, protecting due process, and safeguarding federal funding streams, which are very important in child welfare. There's a lot in this bill. I've worked in the child welfare system for over 25 years now, and throughout that time, if there's one common theme I've heard repeatedly, it concerns case manager training and preparation to do the work. And it doesn't matter who is in charge or who is delivering the training or how it's delivered, there are always questions from interested parties about what is trained and how it is trained and whether case managers are adequately prepared. LB961 passed the Legislature in 2012 and it made significant findings related to the training of case managers. LB853 in 2014 required DHHS to create a formal system for measuring and evaluating the quality of training and requiring all case managers to complete a formal assessment process after initial training to demonstrate competency prior to assuming responsibilities as a case manager. So clearly, case manager competence is important to Nebraska taxpayers. LB1213 would task the FCRO with licensing child welfare case managers. I'll be blunt, we do not have the infrastructure or the capacity to take this on within our current funding and staffing levels. The fiscal note indicates some of the needs we would have if LB1213 is advanced in its current form. In that case, we would submit an amended fiscal note with cost estimates to meet those needs. In addition to licensure, the bill would require a formal complaint process, a disciplinary process, including license suspensions and revocations and an appeal process. In some cases, it appears license revocation would be mandatory and perhaps permanent. Would these processes be subject to the Administrative Procedures Act? We also have concerns about a conflict between our statutory review responsibilities and this licensing and enforcement function. Section 9 of the bill, beginning on page 5, line 7, discusses investigations, but it's not clear what type of investigations are referenced. Are these investigations to be conducted by the FCRO or by DHHS? Who or what is the subject of the investigation? It's not clear. I'm willing to work with Senator McKinney and Ms. Yarbro and others to address the issues raised in this bill because they're important and they directly impact children, families, and communities. Thank you for the opportunity to speak with you today and I'd be happy to answer any questions.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair Hardin. Welcome. Appreciate seeing you again here today. It seems like you're a frequent flyer.

MONIKA GROSS: A regular.

G. MEYER: You're a frequent flyer here. With regard to licensure, is-- are, are any of the case managers or case manager supervisors, are they licensed in any way right now?

MONIKA GROSS: Not for purposes of case management in, in the state of Nebraska. Some of them may have a, a clinical license, like a social work license or a mental health practitioner license, but that's not required as-- to be a case manager.

G. MEYER: Do other states require that, are you aware?

MONIKA GROSS: The only state I'm aware of that statutorily requires certification for case managers is Florida, and they have a certification board that is in charge of that. Other states have certification, I'm not, I'm not well versed in that, other states has certification programs, and maybe that means that they get paid a little more. It might be required by their agencies, but not statutorily.

G. MEYER: I would think holding a license would put it on par with a profession and in all probability would be greater exposure as far as salaries and things of that nature. Is, is getting a license burdensome? Is, is, is-- are there several years of additional education required or is it, is it something that just simply from a time standard and, and perhaps expense is, is burdensome for an individual to get licensed?

MONIKA GROSS: Well, I think it would depend. What I'm familiar with is more of a certification process. And I think that depends if the certification is provided by the child welfare agency or by a third party, an independent third party. Sometimes it's provided through a university, which there would be a cost to that, and I'm not sure because we don't require that in Nebraska, I'm not sure who bears the cost of that. But I imagine in most cases, unless it's within the child welfare agency, it's the individual.

G. MEYER: The supervisory staff doesn't necessarily have to be licensed to sign off on disposition of cases, things of that nature, so.

MONIKA GROSS: No.

G. MEYER: OK.

MONIKA GROSS: No, not, not in, in this state.

G. MEYER: OK. Thank you.

HARDIN: We've talked a lot about licensure, that term, and all that that means. Rules and regs, is that also not the domain of purely an agency within a state government? I mean, an office can't develop rules and regs.

MONIKA GROSS: The Foster Care Review Office is an independent state agency, a noncode agency, and we do have rules and regulations. We do not have anything around-- we have no regulations around licensure at this time.

HARDIN: OK, very well. Other questions? Thank you for being here.

MONIKA GROSS: You're welcome.

HARDIN: Appreciate it. Anyone else in the neutral, LB1213? If not, this concludes our time together today. For those of you who may be new to the process, when a senator is not here, the LA can present, a legislative aide, but they can't take questions either at the beginning or at the closing at the end. I would say that online, we had one proponent, zero opponents, one in the neutral. And we are moving over to LB1033. Senator Spivey.

SPIVEY: Thank you, Chair Hardin and members of the HHS Committee. I don't think I've seen you this year, it's very odd for me. So glad to be here even if it's close to the end.

HARDIN: Welcome to the fun committee.

SPIVEY: Welcome to the fun. I am Senator Ashlei Spivey, A-s-h-l-e-i S-p-i-v-e-y, representing District 13 in northeast and northwest Omaha. I might say just the best district in Nebraska. I am here to introduce LB1033, a bill that updates Nebraska's Low Income Home Energy Assistance Program, or LIHEAP, crisis assistance cap by increasing the maximum annual payment from $500 to $800 per eligible household per program year. I first just want to thank the partners that I worked with this on. You'll hear from a few of these folks later, but energy assistance and energy burden is really important for folks in my district, but really people across Nebraska. This is about a basic need and providing kind of a, a point in time support for energy, which is super important, and so I just appreciate the support

from community partners around this. This adjustment and what is being proposed in LB1033 reflects current energy cost, and it modernizes a limit that has not been updated since 2015. So Nebraska receives approximately $40 million annually in federal LIHEAP funding and serves nearly 40,000 households each year across our state. Eligibility is limited to households at or below 150% of the federal poverty level, which is approximately $48,000 annually per a family of four. LIHEAP is a federally funded block grant program administered by our Nebraska Department of Health and Human Services, and there is no general funds allocated, or state funds, to this program. So LIHEAP currently operates with approximately a $3.5 million annual surplus, so there's money in this pool of funds that is-- that are used for LIHEAP. Only $1.1 million or just under 3% of the block grant is used for crisis assistance payments. The block grant can be used for other items. You, you all do have a handout in the packet that I gave you around, just like how this money is used, but for LIHEAP and what I'm in front of you for is about $1.1 million. Currently, crisis payments are capped at $500 per household per program year without a waiver. Families can access more, more dollars than the $500 if they want, but that becomes a waiver process which creates a little bit more administrative burden. Nearly 3,000 Nebraska households annually rely on crisis assistance to prevent loss of heating or cooling service, again, which is a really important basic need. Crisis assistance payments are designed to respond to a temporary unexpected emergency. Payments are made year-round directly to the utility providers and may cover reconnect fees, deposits, or limited repairs necessary to remain service. It does not go directly to family or individual. Eligible households must demonstrate significant hardship, including involuntary income loss, medical emergencies, the departure or death of a wage earner, or similar destabilizing events. It is becoming increasingly common for many legit crisis situations to exceed the current cap of $500. You'll hear from a partner that says it's on average about $800 and that's kind of how we got to that number, which triggers a requirement for an extenuating circumstance waiver. Because these cases are inherently time sensitive, the waiver process can create unnecessary delays and increasing-- and increase administrative costs during an emergency. During the last fiscal year, Nebraska spent approximately 9% of its LIHEAP block grant on administration. Federal law does cap administrative cost at 10%. If Nebraska exceeds that 10% threshold, the state would be responsible for covering the difference with state funds. By increasing the standard cap to $800, LB1033 reduces the number of waiver requests for payments between $500 and $800 and lowers that administrative workload. So in essence, LB1033 increases the standard annual crisis payment cap up to 800% [SIC].

Department of Health and Human Services still has discretion. It preserves that existing authority for higher payments in true extenuating circumstances. It reduces some administrative delays and barriers and improves efficiencies while maintaining fiscal responsibility within the federal block grant structure. LB1033 ensures that Nebraska's crisis assistance structure reflects real-world energy costs. I don't know if you all look at your energy bill. I was mad paying mine just this month, so. We know that it's high and it's getting higher. But this protects vulnerable households and maintains compliance with federal administrative limits. Before I wrap, I just want to take a moment to talk a little bit about the opposition. So there were about nine comments in opposition that met, like, officially on the record. There may be more. But the theme of all of that opposition was around spending state dollars for this program. They didn't want to spend more. And this program is not funded by state dollars. As I mentioned, it's a federal block grant. It's all federal money. So there is nothing to address with the opposition because it is not relevant for this bill. And so with that, I'm excited for this opportunity to be in front of you. I'm excited for LB1033, and will be happy to answer any questions from the committee.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair Hardin. Thank you for coming in today. If we're going to increase payments to this particular program out of the $40 million block grant work, where do you suggest that the other funding come from? I see it in the pie chart, 10% is other, where, where, where will the additional funds for that be taken from as part of the $40 million block, block grant?

SPIVEY: So there's, there's currently a surplus in the block grant, about $3.4 million, and so it would come from that. And this doesn't, this doesn't mandate that the payments have to be $800, it just raises the cap. So if I come in and I need energy assistance, I might apply for the $500. I might put-- apply for $350 or if I met that cap of $500 and my shutoff notice is really $650, currently I would have to apply for a waiver for that. And HHS could still approve it based on that waiver. So what LB1033 says is that HHS has discretion up to $800 dollars as the cap without that waiver, but they can decide anywhere within what that person is requesting to provide assistance. So it's not mandating that amount, but the fund does have a $3.4 million surplus. So, ideally, it would come from some of the funds that are not being utilized currently.

G. MEYER: I certainly understand the need and the, the, the opportunity that people have, the challenges that people have. $3.4 million is excess in the account right now, anticipated future excesses, or is this an ongoing, ongoing fund, something that's continually funded and we're seeing a, a, a, a constant opportunity for extra dollars being in that particular fund?

SPIVEY: So the fund is a block grant from the federal government and so that is going to be based on what is, you know, coming down from our federal government for that. Being on-- a member of the Appropriations Committee, I look at all the cash funds for the agencies and we see that there was no indication that they would not be receiving this, like these federal dollars, if there's any instability in that. I mean, that could always be the case. And, in general, then LIHEAP would go away. And so then this bill wouldn't even be applicable because there would be no funding for this type of assistance in the same way. And so I think-- hopefully, I'm answering your question, Senator. The idea is that we, we have secured this funding, and we know that we're using it. We're, we're meeting Nebraskans' needs. And if we adjust from the $500 cap to the $800 cap, we're really removing that administrative burden for the waiver because costs are increasing and folks are more closely aligned to needing $800 for their emergency assistance and $500. But HHS still has all autonomy to make the decision around what they are providing in crisis assistance programs. This is not mandating any certain amount that has to be used. It's just raising that cap so that there's more flexibility and less administrative burden when HHS needs to do that.

G. MEYER: As is always a concern when we expand or initiate a new program it becomes an entitlement and if there aren't sufficient federal funds to cover it up almost always seems like it ends up falling into the general. I would assume there's some danger of that or not?

SPIVEY: No, because this does not have a current appropriation for a state fund, so they couldn't take it from there anyway. It's not a new program, it's been in existence. And there's, there's not a dependency on general at all. So like there's no state dollars that go into that. The, the only risk that I named with state dollars is if we exceed our administrative cost. And so when a person needs $650 and the cap is at $500, well then there's a waiver that is done that increases the administrative cost which puts us closer to the 10% cap that we can have for that. And so this would reduce that administrative burden which I think keeps us in line with the federal money so that we don't

have to look at any state funds to address any administrative costs. But from a funding standpoint, it's not a new program and has never relied on state dollars and it's not appropriated to do that.

G. MEYER: OK. Thank you, Senator Spivey.

HARDIN: Senator Quick.

SPIVEY: Yeah, of course. Thank you for the questions.

QUICK: Thank you, Chairman. And I don't know if you-- well, so the app, the waiver process, does that go actually through the Department of Health Human Services?

SPIVEY: Correct.

QUICK: So people would apply through that [INAUDIBLE]. And then also that's-- it's really for all across Nebraska, for rural communities, too, right, for someone who--

SPIVEY: Absolutely, yep, this program serves all Nebraskans across the state. I, of course, I live in a district that has power, so OPPD. I actually have the north plant in my backyard in District 13, and I worked with OPPD and some other partners on this bill. We were talking about energy burden and assistance and where there's some opportunity and we felt like this could be a really-- a, a very bipartisan way to support Nebraskans that are seeing increasing emergencies and to remove that administrative cost with raising the cap. So they were one of the partners that I worked on with this.

QUICK: OK, and as far as when the money-- so they get-- you know, given so much money for their utilities, does that go directly to the, to the power-- or, you know, utility?

SPIVEY: Correct.

QUICK: OK.

SPIVEY: Yep, it does not go directly to that family.

QUICK: OK. All right. Thank you.

HARDIN: I want to ask about two sides of the same coin. So on one side, what's an extenuating circumstance? If you can give me kind of an example on the other side of it, what's not an extenuating circumstance?

SPIVEY: Yeah, Senator, I don't know if I would be able to answer that because that decision is held within HHS. They have internal policies and practices based on federal regulation that decide that, but I can request that from their department to make sure that I can get that to you. I just don't want to answer incorrectly since they administer it.

HARDIN: Also, how did we land at $800?

SPIVEY: So that was when working with the power folks and what they're seeing with community partners, that is about the average cost between the cap now and then the waiver that's being requested. So it felt like a, a good, happy medium based on what they were seeing from data.

HARDIN: OK. Any other questions? Will you stick around?

SPIVEY: I would not miss it for the world.

HARDIN: Nice.

SPIVEY: Thank you, Chair.

HARDIN: Proponents, LB1033.

FREDRICKSON: Welcome.

BRITTON GABEL: Good afternoon. All right, I see Chairman Hardin is not here anymore, but--

FREDRICKSON: I've got the reins now.

BRITTON GABEL: Yeah. Hundred percent. Chairman Hardin and members of the committee, my name is Britton Gabel, B-r-i-t-t-o-n G-a-b-e-l. And I'm the Manager of Advocacy Solutions at Omaha Public Power District. Thank you for the opportunity to submit testimony to the Health and Human Services Committee on this important legislation. OPPD supports LB1033. I'm also testifying in support on behalf of the Nebraska Public [SIC] Power Association. The NPA is a voluntary association representing all 165 consumer-owned public power systems, including "munis", public power districts, public power and irrigation districts, and rural power districts and rural electric cooperatives, engaging generation transmission and distribution of electricity in Nebraska. I'm also testifying on behalf of Metropolitan Utilities District in Omaha. I'd like to thank Senator Spivey for sponsoring this worthwhile legislation that will truly help Nebraskans that are struggling with heating and cooling costs. My comments are based on my unique professional experience working for the Nebraska Department of

Health and Human Services and being responsible for administration of the Low Income Home Energy Assistance Program prior to joining OPPD in January of 2019. This viewpoint that I'm outlining today outlines the benefit of the LIHEAP program and the opportunity that this bill addresses. LIHEAP helps low-income households stay safe and healthy by providing financial assistance to offset costs of heating and cooling. LIHEAP particularly helps households that pay a high portion of household income to home energy to meet immediate home energy needs. The LIHEAP program provides heating assistance, cooling assistance, year-round crisis assistance, emergency furnace and repair replacement, and weatherization services to eligible Nebraskans. This legislation is not asking the state of Nebraska to use state funds to support utility assistance. It's asking the state to take action to better utilize federal dollars to provide utility assistance to residents that need it the most. LB1033 would make an important change to the LIHEAP program. Nebraska Administrative Code Title 476 that governs the LIHEAP program limits crisis assistance payments to no more than $500 per program year. This important legislation will increase that amount to no more than $800 per program year. OPPD's average disconnect amount when in the field is $749 when disconnecting a customer's power. That's up from $471 in 2022. This is a 47% increase. The $500 crisis assistance threshold is no longer high enough to alleviate an eligible household-- household's electric or heating crisis situation. Nebraska's LIHEAP crisis assistance limit is much less than surrounding states per the federal LIHEAP clearinghouse. LIHEAP crisis assistance limit was $4,310 in Iowa, $5,200-- $4,310 in Kansas, $5,200 in Iowa, and $2,400 in South Dakota in 2025. Part of the difference is due to Nebraska electing to have an annual LIHEAP cooling program, unlike states mentioned, but yet there's enough LIHEAP funding to support this legislation. In 2025, OPPD received $514,639 of crisis assistance funding, serving 1,429 customers. This accounted for 7% of the LIHEAP funding we received. OPPD receives $2,717,999 of supplemental payments.

FREDRICKSON: And, Mr. Gabel, I'm sorry, I have to cut you off, you're in the red zone here, but I, I, I see, I see you do have your testimony here. We'll see if there's any questions from the committee. Are there any questions from the committee members? Seeing none, but thank you for providing a written copy of this. We can [INAUDIBLE].

BRITTON GABEL: Yeah, definitely, thank you.

FREDRICKSON: Thank you. Next proponent for LB1033. Welcome.

JILL BECKER: Good afternoon, Senator Fredrickson, members of the Health and Human Services Committee. My name is Jill Becker, spelled J-i-l-l B-e-c-k-e-r, and I'm a registered lobbyist for Black Hills Energy. Given the weather, I actually submitted my comments online, and given the preference of the Chairman, who's actually not here to say what it is, I would stand on those comments and invite you to read them. We are in support of this legislation because, as Mr. Gabel started to indicate, we really believe that in order for the LIHEAP crisis assistance to be most effective, it needs to alleviate the crisis. And depending on what that cap is, it may not do so in all situations. So I want to be respectful of your process and, like I said, stand on my online, my online comments, but wanted to show our support for this legislation today. And with that, I'd be happy to answer any questions.

FREDRICKSON: Thank you for being here. Are there questions from the committee? Seeing none, thank you.

JILL BECKER: Thank you.

FREDRICKSON: Next proponent for LB1033. Welcome.

ALICIA CHRISTENSEN: Hi. Good afternoon. Thank you, Health and Human Services Committee. I'm Alicia Christensen, A-l-i-c-i-a C-h-r-i-s-t-e-n-s-e-n, and I'm testifying in support of LB1033 on behalf of Together, an Omaha-based nonprofit helping community members access necessities like food and housing. So for our housing services, we often work with participants and low-- that are low-income families that struggle to pay their home energy bills. And LIHEAP is a critical resource to these families, striving to maintain their housing or to exit homelessness into stable housing. Some of the factors, this is all part of sort of these interconnected threads that build up to housing instability. So with nearly a third of U.S. households with children unable to pay their energy bill, at least one month out of every year, a lot of times they'll try to keep their energy bills affordable by adjusting the heat to unsafe or unhealthy temperatures. So that affects everybody's health and safety, ability to work, to go to school. And so LIHEAP plays a really important part in health as well as housing stability, which are also interconnected. And they also might have to choose between paying their electric bill or buying food or medicine or other necessities. Nationwide, 43% of lower-income renter households regularly had to reduce or forgo spending on basic household necessities to keep up with energy bills, with 21% making this tradeoff every month, or almost every month I should say, that's important. Anyway, I wanted to just reiterate, you know, kind of what

everyone has said, and I wanted to mention that these are sort of vague, but DHHS does provide a list of sort of the crisis situations that constitute something where you could get this specific assistance. And, of course, it isn't, like, 800 times out of ten someone has $800 every time someone has a crisis, it's whatever your shutoff notice fee is. So one family might get $800, but another one might be $473 or something. So it's, it's not a lump sum no matter what your need is. It's specifically the amount that you need to keep your utilities on and your heat on. So the crisis situation has to be an unanticipated inability to pay home energy costs within the last 90 days. So it's things like an unexpected medical or household expense, a significant permanent involuntary loss of work hours, wages or employment, departure of the wage earner, inability of that wage earner to work due to illness or injury. So you get the idea. So those are the kind of things that would constitute a crisis. And so it would really be an unanticipated emergency loss of funding for those things. So unless you have any questions, that's it for me. Thank you for hearing me out.

FREDRICKSON: Thank you for your testimony. Are there questions from the committee? Seeing none, thank you for being here.

ALICIA CHRISTENSEN: Thank you.

FREDRICKSON: Next proponent for LB1033. Welcome.

MATT WALLEN: Good afternoon, members of the Health and Human Services Committee. My name is Matt Wallen, M-a-t-t W-a-l-l-e-n, and I serve as the Chief Operating Officer for United Way of the Midlands, a 501(c)(3) nonprofit located in Omaha. I'm here to testify in support of LB1033, a bill that would authorize the Department of Health and Human services to provide up to $800 per program year in crisis assistance payments under LIHEAP. For 103 years, United Way of the Midlands has served the Omaha metro by supporting our community's most impactful health and human services programs. United Way's funded programs and direct services like the 211 Helpline, JAG Nebraska, and the Weatherization Assistance Program in Douglas County focus on strengthening a healthy community, creating youth opportunity, supporting financial security, and building community resilience. We work alongside public, nonprofit, philanthropic, business, and government partners to strengthen coordinated efforts that support individuals and families. Our community counts on us to have a deep understanding of the conditions people face in the organizations working to create better opportunities and outcomes. We have a, we have a proven track record of stewardship and consistency aligning

resources with community needs, stretching every dollar to do the most good. Through services like the 211 Helpline, we connect people experiencing urgent challenges to essential resources such as food, housing, and utility assistance. In fiscal year 2025, United Way's 211 Helpline received over 315,000 contacts. Utility assistance is consistently the second highest need representing roughly 20% of all needs to the helpline. In January of 2026 alone, 211 received close to 2,000 requests for help with utility bills. The need for utility assistance is significant and private philanthropy and donations can't keep up with it. Even with the most generous donors supporting Goodfellows program and Dollar Energy program in partnership with OPPD and MUD, demand exceeds available resources. Last fiscal year, we spent over $150,000 providing energy assistance support to individuals in crisis. We're seeing the average past due amount on utility bills hovering around $500, not including current charges leaving many households struggling month to month to keep the heat on. DHHS currently administers the LIHEAP crisis assistance program in Title 476, Chapter 3, Section 003.02 of the Nebraska Administrative Code. It says that DHHS can make crisis assistance payments up to $500 per program year. The section also notes that under extenuating circumstances, DHHS may authorize a payment of more than $500. We see that the resources necessary to resolve the crisis often exceed $500, that's why LB1033 introduced by Senator Spivey is so important. LB1033 would increase the standard amount for program year from $500 to $800. This adjustment would strengthen the department's ability to stabilize households in crisis and prevent further hardship. The need for energy assistance is real and I encourage you to support LB1033. Thank you for your time today. I would be happy to answer any questions that you might have.

FREDRICKSON: Thank you for your testimony. Are there questions from the committee? Senator Meyer.

G. MEYER: Thank you, Vice Chair. This probably was a question I should have asked Senator Spivey, but, unfortunately, I didn't realize that it was a question I needed to ask. In 2022, the cost-- disconnect cost was about $471, last year it was $749, that's a 47% increase. Why only are you asking or why, why only is the ask for $800 because it would appear that we'll probably surpass that this year and it'll be $900 or $1,000 in another year? This seems like it's an exponentially growing problem, so will we see you again next year in a very similar circumstance?

MATT WALLEN: I hope not. My understanding is that Senator Spivey worked with the utilities to kind of identify $800 as being what, what

the ideal amount is and what they're experiencing now. I, I can't predict whether, you know, the increase of utilities or energy costs are going to continue to rise or not, but hopefully $800 is what the, the magic number is to, to meet the need.

G. MEYER: I'm not trying to be critical, it just seems like we're, we're seeing a very definite exponential increase year over year on this so just anticipating that we may be having a very similar conversation very soon. So thank you. I appreciate that.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here and for, for your testimony. So United Way of the Midlands has obviously been around for a while.

MATT WALLEN: Yes.

FREDRICKSON: It has been involved with, I'm assuming, LIHEAP since-- I mean, when did LIHEAP start? Was it the '80s? Was it-- I don't want to put it in the spot, but it's been around for, you know, since I think early 1980s, if I'm remembering correctly. I, I guess-- so some of the concerns that-- I, I was reading some of the online comments as well, I know Senator Spivey addressed this in her opening a little bit, but it seems like the big concern that I'm hearing about this is folks are concerned that this is somehow going to cost the state dollars or cost the state more money. Can you just kind of tease that out a little bit more. I mean-- so, like, if, if the federal dollars, for example, were decreased or ran out or they didn't provide this block grant or if it was eliminated as a block grant, my understanding is, like, LIHEAP, it would just go away. Is that correct or--

MATT WALLEN: That's my understanding, yes. If the federal government didn't provide LIHEAP funds, it would go away.

FREDRICKSON: OK, so no state liability or no state--- like, we opted into this, so we are on the hook for this or--

MATT WALLEN: No, I, I think DHHS wrote a very clear and thorough fiscal note, and they identified very clearly that these are federal funds that are involved in the LIHEAP program.

FREDRICKSON: All right. Thank you.

HARDIN: Other questions? Seeing none, thank you.

MATT WALLEN: Thank you for the opportunity.

HARDIN: Proponents, LB1033. No other proponents, opponents, LB1033. Anyone in neutral capacity, LB1033? Senator Spivey, you're all already back.

SPIVEY: Thank you, Chair. I know you all missed me. Welcome, Senator Hansen. I have everyone now. I was saying how I didn't get a chance to come in front of you all this session, so I miss my HHS friends. Again, I thank you for your time with LB1033. I will keep this short, because I know you have another hearing after mine. But to answer your question, Senator Fredrickson, you are correct. The program has been around since 1981. And then Senator Meyer, to your question, I would-- if you want to entertain an amendment, and we can get this out 7-0 from the, the committee to move it to $1,000 so I don't have to come back next year and bring a bill, I would be happy to do that. Because I think you're right, you know, we can't predict how energy costs are rising. We know that folks are needing more assistance. And so if you, if you like that idea, I love it. And I would be happy to make that amendment. And with that, I will answer any questions the committee has.

HARDIN: Senator Meyer seems to be coming with a rebuttal.

G. MEYER: It was nearly an observation and not a, not a suggestion or an attempt at an amendment, but I, I appreciate, I appreciate your efforts.

SPIVEY: No problem.

HARDIN: Senator Quick.

QUICK: Yeah, thank you, Chairman. Do you know, like, some of the history where how many times it has been changed over the years, or do we even have that information?

SPIVEY: Yeah, the last time that it's been updated to $500 was 2015. And so I can check to see before 2015, but that was the last time that cap moved to the $500.

QUICK: OK. All right. Thank you.

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

SPIVEY: Thank you, Chair. Thank you, committee.

HARDIN: We had online 19 proponents, 8 opponents, zero in the neutral. And this concludes LB1033. Next up, LB740. We'll move around in the room a little bit because that's what we do. I believe we are ready.

MICHAEL A. LEE JR.: Perfect. Good afternoon and happy Friday. Thank you, Chair Hardin and members of the Health and Human Services Committee. My name is Michael A. Lee, Jr., M-i-c-h-a-e-l L-e-e, Jr., and I'm here standing in for Senator McKinney. I'm here today to introduce LB740, the Housing First Supportive Services Act. LB740 is about something very simple but very different, recognizing that housing is health care and that stability saves lives and taxpayer dollars. Across Nebraska, individuals and families experiencing homelessness often cycle through emergency rooms, jails, shelters, and crisis systems, not because services don't exist, but because those services are disconnected from stable housing. Decades of evidence show that without housing, treatment does not stick. Recovery is harder, and public costs rise. LB740 adopts a housing-first approach that prioritizes permanent housing without preconditions, paired with voluntary supportive services that help, help people remain housed and stabilize their lives. This model has been proven across the country to reduce chronic homelessness, improve health outcomes and lower Medicaid and correctional system costs. This bill directs the Department of Health and Human Services to seek federal approval to cover supportive housing services under Medicaid using existing federal authority. These are services that help people obtain housing, keep housing, and avoid evictions such as tenancy support, care coordination, and housing navigation. The bill also creates a Housing First Supportive Services Fund to draw down federal matching dollars and support housing-related costs not eligible for Medicaid reimbursement. Importantly, LB740 does not mandate sobriety, treatment, participation, or criminal justice compliance as a condition of housing. It recognizes that stability comes first and that services work best when you are-- when they are voluntary, flexible, and person-centered. At its core, LB740 is a public health bill. It is a, it is a fiscal responsibility bill, and it is a human response to homelessness. This bill does not expand the government for the sake of expansion. It leverages federal dollars, coordinates existing systems, and invests upstream to reduce long-term costs. I look forward to the committee's conversation and to hearing from providers, advocates, and individuals with lived experience. And I respect-- or the senator respectfully asks for your consideration for LB740.

HARDIN: Thank you. Proponents, LB740. Welcome.

ALICIA CHRISTENSEN: Hello. Good afternoon, members of the Health and Human Services Committee. I'm Alicia Christensen, A-l-i-c-i-a C-h-r-i-s-t-e-n-s-e-n, testifying in support of LB740 on behalf of Together, an Omaha-based organization that works to help community members facing food insecurity, housing instability, and homelessness. I am super excited to be here. I love demonstration waivers for health-related social needs. Research demonstrates that social determinants of health are the principal drivers of health outcomes. That's more significant than clinical care or health behaviors like whether you smoke or if you exercise regularly. However, these weighty nonmedical factors aren't traditionally part of health care. To put it another way, 90% of U.S. health care spending goes to medical care. But 80% of what affects a person's health happens outside of a medical setting. This is part of the reason that despite outspending nearly every other developed country, the U.S. ranks below its peers in key health indicators like life expectancy. Demonstration projects like the ones proposed by LB740 are strategic policy adjustments designed to improve health outcomes, lower utilization rates, and contain health care costs. Currently, 30 states have CMS-approved programs to address health-related social needs, but each state has the flexibility to tailor its program to its specific needs and goals. I've been working on this issue and researching the opportunities to address health-related social needs for Medicaid beneficiaries for a while, and, and I wrote a couple of interim study reports about it for this committee, one for LR366 in 2024, and then last year I collaborated with Senator Dungan on LR226. Reporting on outcomes in other states that have adopted this type of program. I've highlighted some of those and I went over my two-page handout limits, personal limit that I imposed, to bring some of those to you. Overall, the evidence shows that programs targeting frequent system users, like people experiencing homelessness, realize the best results. Since these beneficiaries often cycle through costly crisis services, receiving health care in emergency rooms, outreach through law enforcement, and shelter at correctional or detox facilities. This reactive approach consumes enormous public resources and doesn't deliver lasting results. One of the things that are highlighted in there is, I think, particularly illustrative of how LB740 would make an important intervention. It's a study of chronically homeless individuals' use of emergency services and acute care here in Lincoln, showing that people experiencing homelessness had 2.5 times higher spending than housed Medicaid beneficiaries and showing that providing housing-related services for these frequent system users would avert $20,000 to $30,000 per person per year in medical costs. So, in sum, I would urge this committee to support LB740 and allow us to capitalize

on this potential throughout the state, implementing a proactive approach that's proven to lower health care costs and improve health care outcome-- health outcomes. Thank you for listening to my, like, super excited speech on this one, but I am, I'm a, I'm a nerd and this is exciting. Thank you so much.

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

ALICIA CHRISTENSEN: Yes. My pleasure.

HARDIN: Proponents, LB740. Welcome.

ZEKE ROUSE: Thank you, Chair Hardin and members of the HHS Committee. My name is Zeke Rouse, that's Z-e-k-e R-o-u-s-e. I'm a policy analyst and lobbyist for Spark, an organization based in Omaha, focused on revitalizing disinvested neighborhoods, here to support LB740. In our work, we see how housing instability impacts every aspect of a person's life, whether that's health or employment, education, long-term stability. As Alicia previously mentioned, these are known as social determinants of health, and stable housing is one of the strongest predictors of positive health outcomes. The Housing First model has been tested and proven across the country. Studies from the U.S. Department of Housing and Urban Development, as well as the U.S. Interagency Council on Homelessness, show that when individuals are provided permanent housing without preconditions, such as sobriety or treatment compliance, more than 85% remain housed compared to only 47% requiring those. Participants in Housing First programs experience fewer hospitalizations, reduced incarceration rates, and significant decreases in emergency services costs. The Community Preventative Services Task Force, which is an independent body appointed by the U.S. Centers for Disease Control and Prevention, found that every dollar invested in Housing First saves approximately $1.44 in public costs by reducing reliance on emergency room shelters and correctional systems. The At Home/Chez Soi study in Canada, one of the largest randomized controlled Housing First trials involving over 2,000 participants found that participants in Housing First were housed twice as consistently as those in traditional programs and that every $10 invested produced $21.72 in savings for high-needs individuals. So we can see this works in both the U.S. and abroad. Additionally, the U.S. Department of Veterans Affairs and HUD's House America initiative permanently housed more than 140,000 people in recent years using the Housing First model, including over 40,000 veterans, contributing to an 11% drop in veteran homelessness since 2020, the largest decline in over 5-- or in over 5 years. And LB740 brings that approach to Nebraska by authorizing the Department of Health and Human Services to

seek federal approval for Medicaid reimbursement of supported housing conditions. This bill would allow Nebraska to leverage federal funds to help people obtain and maintain housing. A Housing First approach also complements Spark's work with our Developer Academy, which supports emerging local developers to build housing in under-invested neighborhoods currently in Omaha, Fremont, and Norfolk, as well as doing site visits in Blair. LB740 saves the state money, improves health outcomes, and enhances quality of life for Nebraskans. And by investing in housing as a cornerstone of health, we create stronger, more resilient communities across our state. I urge the committee to advance LB740, and I thank you for your time.

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

ZEKE ROUSE: Thank you.

HARDIN: LB740, proponents. Welcome.

LEE HEFLEBOWER: Good afternoon. Thank you for letting me speak today. My name is Lee Heflebower, L-e-e H-e-f-l-e-b-o-w-e-r. I represent the Nebraska Coalition to End Sexual and Domestic Violence. The Coalition's network of 20 programs collectively serves all 93 counties in Nebraska and they're the primary service providers for survivors of domestic violence, sexual violence, and human trafficking. And I'm here to testify in support of LB740. It would provide an opportunity through Medicaid waiver to improve housing stability and health outcomes for Nebraskans in need of support and reduce health disparities. Over the past 5 years, both the supply of affordable housing and the access to funds that support housing stability has decreased across the state. The need to develop solutions to this is critical, and LB740 is an important step towards that. This approach is especially important for survivors of domestic violence who face difficulties in regaining financial stability and often have lower household incomes after leaving the abuse. Survivors must often make a distinct choice between remaining in an abusive relationship or becoming homeless due to a lack of affordable housing. As a result, domestic violence is a leading cause of homelessness nationally and in Nebraska. Stable housing is also a significant health issue for survivors. The traumatic experience of abuse puts survivors at an elevated risk for a broad range of injuries, physical and mental health issues. Housing instability increases these risks for poor health outcomes, as do other social effects faced by survivors and their children, including poverty and social isolation. Safe, stable housing can be a critical factor in stabilizing the health impact on survivors. LB740 gives survivors of domestic violence, people with

significant health needs, and others facing housing stability a path forward. I also want to make a comment that's not included in my notes here that the need for affordable housing across the board is continuing in, in Nebraska. People who are at the brink of really struggling financially and housing instability is growing. For direct service providers, we're seeing people show up at our doors who normally would have been able to figure out a way to make ends meet and they're not able to anymore. In the Appropriations Committee, this session, there's a bill, LB1072, that calls for transferring $5 million from the Homeless Shelter Assistance Trust Fund to the General Fund. The home-- the trust fund primarily funds programs that provide housing, supportive services, shelter, basic needs that we have to have and we need to find some other solutions for this. If we're losing money, if the need is increasing, I, I really encourage you to support this bill and help, help find some solutions to what's become a snowball issue across our state. Thank you for your time.

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

LEE HEFLEBOWER: Thank you.

HARDIN: Proponents, LB740. Opponents, LB740. Those in the neutral, LB740. Welcome.

MATTHEW AHERN: Thank you. Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Matthew Ahern, M-a-t-t-h-e-w A-h-e-r-n, and I'm the Deputy Director for the Division of Medicaid and Long-Term Care in the Department of Health and Human Services. I'm here to testify in a neutral capacity for LB740. As indicated by the bill's legislative findings, housing stability is a, is a significant driver of health for people, and DHHS appreciates the intent of expanding supportive housing services. That said, we want to make note of some administrative and operational considerations. DHHS has done some projections based on national and local data and preliminary assumptions including up to 12 months of targeted case management per member to support housing navigation, eviction prevention, and stabilization services. Based on these projections, we feel there is material risk that the program would not meet federal requirements for budget neutrality for a Section 1115 waiver. Additionally, LB740 establishes a Housing First Supportive Services Fund to cover services not eligible for federal match including short-term rental assistance, operating subsidies, and capital-related supports. DHHS notes that federal rules governing the use of federal and nonfederal funds are complex and not-- and do not allow certain funding sources to be commingled. We have concerns that the use of

this fund as spelled out in LB740 may introduce associated risk. While the bill directs DHHS to implement Medicaid coverage of supportive housing services, the additional time would be required for-- internally for us to fully develop and operationalize the program in compliance with federal Medicaid requirements. The department recommends an effective date of the bill would be changed to December 31, 2027. Finally, LB740 creates a new reporting requirement for the department beginning January 1, 2027. For previously mentioned reasons, we would recommend moving the first report date to December 31, 2028 and continuing annually on December 31 for 5 years. This has the report due date prior to the federal holiday, as well as allows the report to provide implementation updates to the Legislature without prescribing it into perpetuity. Thank you for your time. I'd be happy to answer any questions on this bill.

HARDIN: Questions? Seeing none, thank you.

MATTHEW AHERN: All right, thank you.

HARDIN: Those in the neutral, LB740. There were online, 21 proponents, 9 opponents, zero in the neutral. There were no ADA comments on any bill for today. This concludes LB740, and our hearings for today. Thank you.