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CLEMENTS: Good afternoon. Welcome to the Appropriations Committee. My name is Rob Clements. I'm from Elmwood. I represent Legislative District 2. I serve as Chair of this committee. We'll start off by having the members do self-introductions, starting with my far right.

ARMENDARIZ: Christy Armendariz, District 18.

DORN: Myron Dorn, District 30.

DOVER: Robert Dover, District 19.

VARGAS: Tony Vargas, District 7.

LIPPINCOTT: Loren Lippincott, District 34.

ERDMAN: Steve Erdman, District 47.

CLEMENTS: Assisting the committee today is Cori Bierbaum, our committee clerk. To my immediate left is our fiscal analyst, Mikayla Findlay. Our pages today are Cameron Lewis from Omaha, UNL student in polis-- political science and history, and Ella Schmidt from Lincoln, UNL student, criminal justice and political science. If you are planning on testifying today, please fill out a green testifier sheet located in the back of the room and hand it to the page when you come up to testify. If you will not be testifying, but want to go on record as having a position on a bill being heard today, there are yellow sign-in sheets at each entrance, where you may leave your name and other pertinent information. These sign-in sheets will become exhibits in the permanent record after today's hearing. To better facilitate today's hearing, I ask that you abide by the following procedures. Please silence your cell phones. Move to the front chairs to testify when your bill is up. When hearing bills, the order of testimony will be introducer, proponents, opponents, neutral, and closing. When you come to testify, spell your first and last name for the record before you testify. Be concise. We request that you limit your testimony to three minutes or less today. We have a lot of testifiers, so we're using a three minute timer today. Written material may be distributed to the committee member, members as exhibits only while testimony is being offered. Hand them to the page for distribution when you come up to testify. If you have written testimony but do not have 12 copies, please raise your hand now so the pages can make copies for you. With

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that, we will begin today's hearing with LB935. Senator Ibach, you may proceed.

IBACH: Thank you, Mr. Chair. Good afternoon, Chairman Clements and members of the Appropriations Committee. My name is Senator Teresa Ibach, I-b-a-c-h, and I am here to introduce LB935 today for your consideration. LB935 is a simple bill. LB935 seeks to increase the provider reimbursement rates for dental services provided-- reimbursed by Medicaid by an additional $6 million, or approximately 20%. This bill goes hand in hand with LB358, introduced by Senator Walz last year. This was advanced from General File to Select File on February 7th. For all intents and purposes, LB935 is the A bill for Senator Walz's bill. Even if adopted into law, Senator Walz's bill doesn't necessarily increase the appropriation for medical dental services. It simply states that it is our intent to increase provider rates by 25%, but doesn't necessarily require for us to actually do so. My interest in this topic was raised in August, when I read an article by the Flat Water Free Press titled Disappearing dentists: For low-income Nebraskans, long drives, long lines, little help, which I provided for your review. The article shook me. I will allow you to read it in its entirety, but while this article highlights a constituent of mine, the issue goes much deeper than one person. Nearly half of all counties, mostly rural western Nebraska, have zero dentists providing care in our lower income neighborhoods. In 2023, my legislative district that-- had four providers accept Medicaid patients. All three providers were in-- all but three providers were in Dawson County. Just west of Dawson County is Lincoln County, and there are three providers. There's one provider in Keith County. Just because they have accepted Medicaid patients doesn't mean they're accepting new patients, which then could create a very long waitlist. This means citizens like Arline Morris and others have to travel hundreds of miles to receive simple dental care, and depending on the situation, they may end up in an emergency room. I may have to waive my closing as I'm presenting a bill shortly in the Ag Committee. Testifiers following me will be able to further explain the urgent need to increase provider rates for dental services to help treat some of our most vulnerable citizens. While I know there are other budgetary requests and other pressing needs, this is a very important issue to a vast majority of our state. I hope to work with you to identify a path forward for increasing these provider rates. Thank you very much.

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CLEMENTS: Are there questions from the committee? Senator Dorn?

DORN: Thank you. Thank you, Senator Clements. Thank you for being here, I guess. I'm reading the green copy of the bill, OK, and it says in there that the federal funds to b-- are-- to be appropriated are from the funds allocated to the state of Nebraska for feder-- are, are for our Covid funds. Is that part of the ARPA funds then, or is this a different fund itself?

IBACH: I'm going to defer to someone behind me because I do not know that breakdown. I apologize.

DORN: No problem. Thank you.

IBACH: I know someone will cover it.

CLEMENTS: Are there other questions from the committee? Seeing none.

IBACH: Thank you.

CLEMENTS: Thank you Senator. We'll now welcome proponents for LB935. Welcome.

JESSICA MEESKE: Good afternoon. My name is Jessica Meeske, it's spelled J-e-s-s-i-c-a M-e-e-s-k-e, and I'm a pediatric dentist from Hastings, and I'm president elect of the Nebraska Dental Association. I'm speaking in favor of this bill. I also own practices in the communities of North Platte, Kearney, Grand Island, and Omaha, and we see a disproportionate share of kids with Medicaid in our state. For over 40 years, our practice has been highly engaged in caring for kids with Medicaid. But for the first time, we're having to reconsider our commitment to the program and families due to the high volumes of calls that we're getting. We're basically turning away 20 families a day at each location. Very few general dentists in rural Nebraska are seeing new Medicaid, or they'll take our --or will take our patients once they age out of our practice. This includes our very fragile, special needs patients, and it's heartbreaking to hear parents say they've called 30 dental clinics or more and no one will see them. Our dental Medicaid program is in real crisis. The number of people in Nebraska with Medicaid is increasing over time, and the amount of dentists willing to see this population is decreasing. So this creates the perfect storm of more Nebraskans suffering from tooth decay, gum

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disease, pain, infection, and early tooth loss. All of the dentists in my practice treat such severe cases that many children must be treated in the operating room, thus exponentially adding to the medical costs of Medicaid. And that's not all the people that show up to the emergency rooms. And all of this oral disease burden is preventable, if we could get these Nebraskans in for preventive dental care. When low income families in Nebraska who rely on Medicaid are unable to get dental care, it creates inequities. For example, we know that kids with unmet dental needs, they fiss-- they miss far more school than their peers. Children who are black and Hispanic experience more tooth decay than their non-Hispanic white peers. No matter how you vote this year to fund our public schools or expand education to our kids, no child who's living with a toothache or an abscessed tooth has the ability to pay attention and learn in school. Less than half of the kids in our state with Medicaid have received any dental visit, and the results are even worse for low income adults and seniors. The current waitlist in Grand Island at our federally qualified health center is nearly 4,000, just in Grand Island. The Nebraska Dental Association is working closely with MLTC and the managed care plans to work through these complex problems, and we're, we're making tremendous headway. However, the fundamental issue of being able to cover your costs and not lose money is what is at the crux of this problem. The laws of supply and demand and market forces can't be ignored. The request for a fee increase would still make Medicaid our lowest reimbursed payer, but at least we could cover our costs. All Nebraskans deserve a medical and a dental home, and Nebraska dentists hope that we can partner with the Legislature to make this a reality. Thank you for considering this important issue and investing in the health of Nebraskans. Be happy to answer any questions.

CLEMENTS: Are there questions? Senator Dover?

DOVER: So what do you see other states that are geographically challenged as Nebraska's. What do you see any creative solutions?

JESSICA MEESKE: Yeah, there's lots of creative solutions. The num-- the number one is funding it at a level so you're not displacing patients that have private or commercial insurance so everybody has an equal chance to get in. So South Dakota just raised their fees to 70% of what the average South Dakota dentist fees are. In other states-- oh, I can just tell you, in Nebraska we're working with our managed

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care plans to do emergency department diversion programs to keep dental patients out of the E.R. and try to get them dental homes. We're working on all kinds of creative things. The list is about five pages of the Nebraska Dental Association and what we're doing, working with the managed care plans. But the bottom line is, is if I'm going to pay my hygienist $50 an hour, and I do a dental cleaning, and let's say I only get paid $30 an hour, the math just doesn't work. So. But there's lots of creative things, and, and we are very much engaged in those conversations, both with the three managed care plans and with Medicaid and long term care.

DOVER: I just wanted to-- looking at the map here, it seems as though the dentists aren't in the right area, so they travel. Even if they had the funds, would it necessarily be-- wouldn't necessarily work anyway because they'd still have to drive. Is there any discussions as far as having traveling dentists?

JESSICA MEESKE: No, there isn't discussions having traveling dentists, but we do talk about things like tele-dentistry. So obviously I can't do a root canal through a computer. But I can triage a patient, I can answer a parent's question, they can hold a cell phone camera up to a tooth. So we're looking at things like that. You're right, we do have some counties that are just dental deserts, period. But even farther than that, we have these dental Medicaid deserts where we do have enough dentists. There's another bill this year in the Legislature that's looking at a loan specific program for new dentists based on the amount of Medicaid care that they would provide. So we had a hearing on that a couple weeks ago, and we think that's another creative approach to this.

DOVER: All right, thank you.

JESSICA MEESKE: Yeah. My pleasure.

CLEMENTS: Other questions? Senator Erdman.

ERDMAN: Thank you, Senator Clements. Thank you for being here. So South Dakota went to 70%? So what, what percentage would we be at?

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JESSICA MEESKE: OK. So right now for adults, we're at 38% of what a dentist's usual customary and reasonable fee is. And for the codes, the dental codes for children, it's at about 41%.

ERDMAN: And if this bill passes, what the percentage would be then?

JESSICA MEESKE: It'll-- if it goes 20, if-- I don't-- I think it falls more, closer somewhere in the 60% area. And the break even point when we survey Nebraska dentists is about 70%. So 70% is what overhead is for average Nebraska dentists, so the closer we can get to that, the better.

ERDMAN: Thank you.

CLEMENTS: Other questions? Getting a little note here on the-- the bill itself does not mention federal funds in the bill, but the new appropriation would qualify for federal matching funds, I believe. Is that correct?

JESSICA MEESKE: I believe that's correct. So the federal match is for the children and the adults, and I'm not sure of what the percent is in Nebraska. I think the last time I looked around 70%. So yes, you'd get your federal partner funds in this. So we just have so much pent up demand that we've got to catch up and help these people get into good oral health. And I-- because we're a small state, I feel it's very doable. And once we hit that critical point, I think it's going to be easier to keep people in better health and costs will go down.

CLEMENTS: And there are dentists that have discontinued Medicaid patients. Will dentists start treating people if we do increase the fee, are they willing to do that?

JESSICA MEESKE: So that's the $6 million question before you. And, we, we believe that we will get a number of more dentists to participate. But what you'll-- you're still going to have dentists that are never going to participate. We're never going to get 100%. But even for practices like mine that let's say-- well, it's about 60% of my patient population is kids with Medicaid. Would I be able to increase my capacity to see more? And the answer is yes. So I think for practices that see some Medicaid now, they would be willing to see more. And I think for some dentists that provided Medicaid care in the

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past, they'd be willing to jump back in. But that is the thing, that the burden will then be on the Nebraska Dental Association and our colleagues to go out and say, look, the Legislature stepped up, they have been a good faith partner, it's time for the dentists to step up and do what we can do to make sure everybody has the care they need.

CLEMENTS: All right, thank you. Any other questions? Seeing none, thank you--

JESSICA MEESKE: Thank you.

CLEMENTS: -for your testimony. Next proponent, please? LB935. Good afternoon.

BRANDON CHAPEK: Good afternoon. Ladies and gentlemen, my name is Brandon Chapek, spelled B-r-a-n-d-o-n C-h-a-p-e-k. I'm a general dentist in Lincoln. Today, I stand before you to address a pivotal proposal, which includes the goal of increasing Medicaid reimbursement to dental providers as an attempt to mitigate the financial burden placed on those that provide Medicaid patients with basic dental care. And it's not just about numbers on paper. It's about the lives we impact and the communities we strengthen. Health care is not a privilege. It's a fundamental human right. Yet far too often, financial barriers stand between individuals, dental providers, and the care they desperately need. Ask any medical professional why they chose additional schooling, large debt, and placing their personal lives on hold, and they'd undoubtedly all state the same goal: to care for people. I stand here as merely one representation of the many dentists in Nebraska who desperately want to accomplish that goal, but find themselves in the battle of balancing their commitment and passion for care with keeping their businesses afloat. This dilemma is far and away the key reason that so few dentists sign up to become Medicaid providers. They simply cannot make ends meet due to the large demand for care occupying nearly all of their chair time, and the reimbursement levels being below their cost to provide the care. My practice offers treatment to patients that most dentists cannot through advanced oral surgery procedures and management of complex health history patients, which in itself is a difficult realm of treatment for the Medicaid population due to the lack of oral surgeon specialists. We also provide the administration of I.V. sedation, which is critical to some individuals being able to receive the

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treatment they need. Wait for an appointment in our office can be several months, which, while long to some, is still extremely short compared to other facilities that offer this form of care, which can stretch into the years. As our volume of Medicaid patients has skyrocketed, we've had to add additional doctors and increased our hours. It puts incredible stress on my staff due to added patient load beyond what our facility is designed for in a time where labor challenges for dental team members is very real. I risk burnout for myself and my staff, as the pace at which we are currently functioning is not sustainable. I do this because I was appalled at the lack of providers willing to see these individuals. Adults living right here in Lincoln are going to the ER in an attempt to find relief, sometimes resulting in them being admitted for the hos-- to the hospital for emergency procedures. A simple in-office procedure escalates to a full on medical emergency, and in terms of financial burden to the state, this is the difference of a few hundred dollars versus thousands, simply due to the fact that care is not available in a timely manner. Furthermore, poor oral health, pain, and infection have negative impact on the rest of the body, further increasing medical costs of the Medicaid program. Let's be blunt. There's a shortage of providers, largely because the current guidelines did not compensate them well enough to justify enrolling in the program. Increasing Medicaid reimbursement rates doesn't just benefit providers and individual patients, it's an investment in our community's well-being and enables healthy providers-- health care providers to continue their vital work without compromising on quality or accessibility. Together, let us embrace the opportunity to create a healthier, more equitable future for all Nebraskans. Let's care for our people. Thank you.

CLEMENTS: Are there questions? Seeing none, thank you for your testimony. Next proponent?

JOSEPHINE LITWINOWICZ: It would be nice to see, like the city council meeting if you can get a microphone. So, you know, sitting like this and others like it. Anyway. Hi, my name is Josephine-- Oh, I'm sorry, ChairmanCle-- Hello, Chairman Clements and the rest of your posse. My name is, Josephine Litwinowicz, it's J-o-s-e-p-h-i-n-e L-i-t-w-i-n-o-w-i-c-z. And I just want to give my personal account of this problem in this city. Because I, I was on traditional Medicaid, you know, and, I was able to, you know, use the dental college. I mean, that's, you know, bus route there and all that, and so that was

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pretty cool. And then I switched to the Dual Complete Plan, which I was cold called, by the way. I mean, there must be serious motivation to switch people over. I wonder if the rug's going to be pulled out after that. But anyway, so I, I, I tried to find a dentist, and a lot of them, yeah, they only take so many patients. Others, they have a significant amount, or at least they said that there was, they already had too many people they were saying. So you don't know-- I mean, maybe it's a polite way, I don't know, some of it's true, for sure. And so I found one place, after trying, you know, a bunch. Maybe I don't, I don't-- maybe I didn't-- there's other ones. I'm sure there are. But I it was Williamsburg Dental here, because they took --they accepted and they had a space open. So that's, that's, that's really how it is. I, I was pretty, you know, anxiety, you know, problems, over this. Because if your, your teeth go, eh. So thank you. And, it's just the personal account here. Have a good one.

CLEMENTS: Thank you. Are there any questions?

JOSEPHINE LITWINOWICZ: No there's not.

CLEMENTS: Thank you for your testimony. We have additional proponents for LB935. Good afternoon.

KENT ROGERT: Good afternoon, Chairman Clements, members of Appropriations Committee. My name is Kent Rogert, K-e-n-t R-o-g-e-r-t. I'm here to testify in support of LB935 on behalf of Nebraska Dental Hygienist Association and Molina Healthcare of Nebraska, one of the three MCOs that deliver this care to all Medicare recipients. Our CEO could not be here today because something came up, so I just wanted to come up and give you a couple of little points in this regard. So from about 2016 to now, there's been a 41% reduction in the number of dentists who have been enrolled in Medicaid. Insufficient provider reimbursement is the number one reason that they state. In 2022, we have 40 public health dental hygienists that are actively moving around the state. This small work force conducted over 35,000 oral screenings, and provided things such as fluors-- fluoride and sealant, sealants in about 79 counties. But it's nowhere near enough. As Doctor Meeske said, there's a long waiting list for people trying to get up-- get good services. It may seem like a small number, but 2.5 of total emergency room visits in the state are attributable to dental related conditions. Of those, 2.5% of the visits, 80% of those are considered

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avoidable with timely dental preventative and problem-focused treatments. So we, we're looking for an all-in approach. Some things that we've done to help are remove the $750 annual maximum cap, expansion of scope for those public health dental hygienists, alignment of program objectives within Heritage Health, and to fully manage a whole person's care and get, get everything kicked off. Two points I'll make and I'll be finished. Kids don't learn very well if they have a hurting mouth. They don't learn at all. And kids and adults who don't eat, they go to the E.R., which is way more expensive than just taking care of the problem to begin with. So thanks, and I'd answer any questions.

CLEMENTS: Are there questions? You're a lobbyist for whom?

KENT ROGERT: The Dental Hygienists Association and Molina Healthcare of Nebraska.

CLEMENTS: Which health care?

KENT ROGERT: Molina.

CLEMENTS: Molina.

KENT ROGERT: Yeah. So there's three, there's United, Total Care, and then Molina.

CLEMENTS: Molina, OK. And there's 41 fewer dentists serving since what date, over what period of time?

KENT ROGERT: 41% fewer since 2016.

CLEMENTS: OK. Any other questions? Seeing none, thank you for your testimony.

KENT ROGERT: Thank you.

CLEMENTS: Additional proponents? Good afternoon.

SHAWN KELLEY: Good afternoon. My name is Shawn Kelly, S-h-a-w-n K-e-l-l-e-y. And I live from Grand Island, Nebraska. I apologize, I'm not used to reading from a script. I'm the type that plays and lets God work it. Please bear with me. I'm from Grand Island, Nebraska, and

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I want to thank each and every one of you for giving me the opportunity to share my testimony with you on behalf of those that are suffering from dental needs. First, I want to say that this is no longer about me, that I want to speak for those that out there who are truly suffering on Medicaid. However, first I want to share a little bit about me. I'm a recovering addict, and I was-- when I was growing up, I suffered from a lot of trauma. From the age of three my grandma raised me. And by the time I was 12, I was sexually abused five different times by five different people. One of those guys, we-- we'd actually got put in prison, however, we had to call the FBI in because the city didn't want the publicity or the problems. I was abused in home by my grandma's husband, and by the time I was 16, I was involved in gangs and drugs. That's where I found my comfort was in drugs-- was drugs and gangs. My grandma had did the best she could by raising me. However, I took the wrong path. So over the-- over several years of meth use and drug use, I had ruined my mouth. In 2015-- as you can see, I still need to get some work done. In 2015, I found a 12 step program after, after facing some healthy charges of child abuse, and I relapsed several times after that. In 2020, I thought I was pretty committed to my recovery. However, I suffered from an abscessed tooth that I could not find help for. I tried dentists, I tried going to the hospital and getting medication, and no wanted-- no one wanted to help. So I turned to CBD. CBD turned to weed and then meth, meth again. I finally was able to get my tooth fixed. My clean date is March 19th, 2021. Most recently, my wife who was pregnant, I had to watch, watch her lay in bed and suffer from pain as she was pregnant because nobody would, would accept her Medicaid. She still needs help, she still needs her mouth fixed. However, we did get through that. I started this journey with Doctor Meeske a few months ago, and since then I have learned that this is a much bigger problem than I had foreseen. A friend of mine who had private insurance and Medicaid paid out of pocket $5,000 to have some work done, then used her insurance to get more work done, and they used her health insur-- they used her health insurance before they used the Medicaid, and that stopped her from getting the rest of the work done that she needed to get done. She has three kids that have not seen a dentist in about eight years. And a while back I shared my story in Hastings and a man came up to me after I shared that I got to share my story in Lincoln a while back with the dentist from Nebraska and told me that his wife takes care of

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elderly-- an elderly man with special needs who cannot get help because of his Medicaid.

CLEMENTS: Could you please wrap up your story, please? You're almost out of time. You are out of time. Let's go ahead and wrap it up, please.

SHAWN KELLEY: OK. I'm good.

CLEMENTS: Oh.

SHAWN KELLEY: Or if I could I mean, real quick?

CLEMENTS: Are there any questions? Let-- go ahead and close what your final point would be.

SHAWN KELLEY: If I could-- it'd just take a real quick to finish this. Just a little bit, if that's ok.

CLEMENTS: Go ahead.

SHAWN KELLEY: Myself, these are the types of reasons why I've set out on a journey for-- of being fully self-sufficient. And today I pay. I pay for everything. I no longer get help of any sort. I don't get Medicaid, I don't get childcare, I don't get anything as a matter of fact. I'm in the tax bracket that pays good money, but it still is not enough. Did you know that just for me and my son, health care costs about $800 a month? And that's for him to have dental and not me. You add the cost of daycare and that runs about $450 a month, plus all our monthly bills. Here in September I'll have my daughter home with me and my-- and those prices double. Not everyone is able to afford this. I'll have to work really hard-- I've had to work really hard and sacrifice a lot of time away from my son to get to where I'm at today, and I'm not saying that this is not worth it because every minute has been worth it. However you take the ave-- you take the average person working at McDonald's, working at Burger King, working at Walmart, and it takes much longer to get to where I'm at. And let's be real, not everyone is built for this lifestyle, becoming fully self-sufficient. This lifestyle has its difficulties, and it's not an easy lifestyle to live as it does take a lot of time away from your family. There are countless people in recovery who want-- who one of the first things that they look forward to is getting their mouth fixed after all the

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damage that they have caused. You guys don't get to see what I get to see. And they have-- they come in with a new mouth, with new dentures, you put in-- you put a new smile on their face, a new glow on them, and they will-- they walk a little bit differently. They have a little more hope. I believe that if you pass this bill that we could help thousands of Nebraskans have a new smile. Thousands of kids have happier lives because their parents are feeling more confident with a new smile. Thank you for letting me share. I'll answer any questions you might have.

CLEMENTS: Are there any questions? Well, thank you for coming from Grand Island. I appreciate you coming down here and congratulations for turning your life around. We wish you the best. Thank you for your testimony.

SHAWN KELLEY: Thank you.

CLEMENTS: Next proponent for LB935, please? Good afternoon.

GARRET SWANSON: Good afternoon. Members of the Appropriations Committee, my name is Garret Swanson, G-a-r-r-e-t S-w-a-n-s-o-n. And I'm here on behalf of Holland Children's Movement in support of this legislation. We'd like to thank-- sincerely, thank Senator Ibach for introducing this legislation. At its core, this will provide approximately $6 million in state funds and over $11 million in federal funds to the Medicaid Assistance Program. The appropriation of these funds will help in several ways, such as improvement in access to dental care. Higher reimbursement rates can incentivize more dentists to accept Medicaid patients. This can lead to improved access to dental care for low income Nebraskans who rely on Medicaid for their health care needs. Better dental health will result in fewer missed days of work or school due to dental problems, leading to increased productivity in the workforce. Job creation. Increased Medicaid reimbursement rates may lead to more dental practices for opening or expanding their services. This expansion can create job opportunities for dentists, dental hygienists, dental assistants, and administrative draft-- staff, contributing to job growth in the health care sector. General economic growth in Nebraska. With more Medicaid patients able to access dental care, this could be an increase-- there could be an increase in demand for dental services. This increased demand can stimulate growth, and lead to higher revenues for dental

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practices, dental suppliers, and manufacturers of dental equipment supplies. The reduction in health care costs. By improving access to preventative dental care, such as regular checkups and cleanings, higher Medicaid reimbursement rates can help prevent more serious dental problems in the future. This could lead to cost savings for the health care system by reducing the need for expensive dental procedures that treat advanced dental conditions. In closing, I want to bring up a poll published last week by our sister nonprofit, the Holland Children's Institute. In this poll, Nebraskans were asked how important increasing Medicaid and Medicare reimbursement rates for a provider in several areas. 60% of Nebraskans agreed that this would be important for the state to do, and we agree. Thank you to Senator Ibach and the Appropriations Committee, and we urge this bill to be voted out of committee. Thank you.

CLEMENTS: Thank you. Are there questions? Seeing none, thank you for your testimony.

GARRET SWANSON: Thank you.

CLEMENTS: Next proponent?

DULCIE LUHN: Good afternoon. My name is Dulcie Luhn, spelled D-u-l-c-i-e, last name L-u-h-n. I'm a single mom of four kids, ranging from ages 5 to 17, and I'm unable to work due to my own health issues as well. There's a problem for us in Nebraska who have these Medicaid dental benefits. I try to be a good mom, but I don't feel like I'm fulfilling my obligation to my children when dental benefits are not being accepted to them even. There are few and far between options for dental care. I see more and more people being turned-- turning Medicaid patients down because of the reimbursement rates. What does that mean for the people that rely on Medicaid for their dental care? It means more times than not, we don't get to use our dental health benefit, which in the long run causes pain, illness, and more and --and much more with your mouth not being healthy. We currently utilize Pediatric Dental Specialists in Grand Island for my younger two children as they still have their baby teeth. They are great, well cared for, for teeth. My 13-year-old is disabled and is about to have to switch to a regular dentist here soon, which there isn't any options for, and there has to be someone that can understand her needs and be willing to accept them. My 16 and 17-year-old teenagers have

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outgrown the pediatric dentist, and adult dentists, again, will not accept our dental insurance as Medicaid. This has created a major problem to finding dentists for even the routine cleanings for the older children, and impossible to find to maintain their dental health as well as mine. Where are the providers? I called the back of the dentist-- the card you get from Medicaid and they-- I was told to call the 1-800 number back there, and they would tell me who was available that would accept Medicaid. When I called them, they said-- had nobody within 100 miles that would accept the teens or the adults. And the ones that it did list, you as soon as you called, they said, sorry, we're accepting children 13 or under and that's it. I myself have went without it too for even longer than my kids, and it would cost thousands to get my mouth back healthy again. If more providers could start accepting Medicaid again, preventative care would be more available to us and be able to fix problematic teeth before it becomes an expensive and painful experience. This is a plea for help, not just for me, but other Nebraskans as well. For me, as a mom, I try to do my-- like I said, I try to do my best with my children, make sure they get to school, medical appointments and they're well fed and a balanced diet. Most of these programs I rely on to care for my children are working, but dental is not. To wrap this up, when a mom cannot get dental care they need, it's hard to accept for me or for my children. And I don't want my children to grow up and deal with dental problems and pain like I have. I want to be able to eat, speak, have a good smile and be confident in school for my children as well. Thank you for listening to my story.

CLEMENTS: Thank you. Are there questions? Thank you for coming.

DULCIE LUHN: Thank you.

CLEMENTS: Thank you for your testimony. Next proponent?

EDISON McDONALD: Hello. My name is Edison McDonald, E-d-i-s-o-n M-c-D-o-n-a-l-d. I'm here representing The Ark of Nebraska. We're Nebraska's largest membership organization representing people with intellectual and developmental disabilities and their families. We support this bill to help expand access to dental services for people with disabilities. In Nebraska, 41% of adults with intellectual and developmental disabilities do not receive regular dental care. This is frequently one of the most difficult services for our members to find

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or to maintain, due to a lack of dentists who have experience working with people with disabilities. This hole is particularly evident in rural communities. This year alone, at least 14 states have been working on updating their dental laws, and another three states have pending legislation. There's an excellent study that I think really sums up a quality picture, and it says key findings include that in 12 states that do not currently provide dental benefits, the total estimated cost of providing extensive dental benefits to adults with IDD, intellectual and developmental disabilities, would be approximately $19.6 million annually, with those states responsible for approximately $7.3 million of that cost. NCD, the National Council on Disability, estimates that these costs would be more than fully recovered through reductions in emergency department use and hospital admissions, and reductions in the cost of treating several chronic diseases, the root cause of which are poor oral health. We estimate federal and state governments combined would realize a return on investment of approximately $7.7 million beyond recovering the initial cost annually, and the share of that ROI for those 12 states total close to $3 million annually. This report, and the experience that we see on the ground as we try to go and recommend families to dental sources. Doctor Meeske is one of the few sources that we find to work with outside of the Omaha and Lincoln areas. So I hope that you will support this legislation and move it forward.

CLEMENTS: Thank you. Are there questions? Seeing none, thank you, Mr. McDonald. Next proponent. Good afternoon.

JONATHAN SIMPSON: Good afternoon. Thank you for having me here. I'm Dr. Jonathan Simpson, J-o-n-a-t-h-a-n S-i-m-p-s-o-n, and I'm here to speak on behalf of the LB935 bill as well, for it. Members of Appropriations Committee, my name-- sorry. I was the first pediatric dentist to start a practice west of Kearney in 2008, and have served thousands of children in western Nebraska. We are, and have been, one of the few offices participating in Nebraska Medicaid, and at times have had up to 80% or more of my patient roster composed of children who fall under the umbrella of state aid. To the plight of the children out there. Historically, our research has shown that 80% of the decay is found within 20% of the population of children and adults who live in poverty. While the number of rural Nebraskans with Medicaid is increasing once again, the number of dentists seeing Medicaid is decreasing. This is a pattern I've, witnessed my entire 16

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years in North Platte. Those who cannot get care often have undiagnosed progressive tooth decay and gum disease, leading to greater and more expensive treatment needs. Children wind up at the school nurse's with toothaches, and in the E.R.. I've been called to the E.R., whereby I then had to leave my busy clinic to care for a child with a swollen face in the hospital, and I'm on call roughly 24/7 for any emergency room that calls me and asks for advice on, on their cases. So I-- it's all the time. Much of this is avoidable with access to a dentist early, and preventative maintenance being available to the child and parents being important. To the plight of the parents, parents struggle with locating someone for their child to see. They are advised by their pediatricians to establish a dental home early, but quickly discover they often have no options. I am stopped in the stores they shop, asked out what-- while out to dinner with my family, or contacted by churches and schools to see if I am available to see new Medicaid patients, and could I see theirs? I am often overwhelmed and exhausted. Good parents, without anyone to reasonably get into, will watch their children's oral health decline, feeling helpless. Despite their willingness to bring their children into whomever they can, they appear and feel negligent. It is a no win situation. On the adults, in the time moving out there, I have also watched the smiles on faces of adults around me literally disappear as the options for stable dental home have decreased or disappeared. Physicians, hospital CEOs, nurses and employers all complain of the number of dental emergencies that come through the E.R.. Parents of the children I see often relay the pain and despair they feel in seeking care for themselves, while being grateful for my treatment of their family. Adults with severe dental disease miss a lot of work, adding more stress to their lives. The burden on practices exhibits in the minimal and shrinking participation among practitioners in the west. It is largely a business decision. Dentists want to help this population. After all, they are part of the community in which they live as well. However, it is a losing deal financially. For me personally, it has added significant distress and stress, sometimes to the point I wonder if I'm valued for the sacrifice that we've made or whether I've meaningfully helped at all. My wife and I have conversations about leaving due to this stress, and then we think about how much worse it would get for our patients left behind, and it makes me sad. I grew up in North Platte. However, I can only hold out for so long. Western Nebraska needs dentists willing to see kids and

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adults with Medicaid. I need the help so I don't feel I'm the only one, and so that I can coordinate the care of these patients better. I encourage you to support this modest fee increase as part of the solution and for the future of our state.

CLEMENTS: Are there questions? Would you be able to provide more care? Or do you think there are dentists in your areas that would start accepting patients?

JONATHAN SIMPSON: I've talked to the dentist in my area. We are not dentally starved, but we are for providers in Medicaid. And there are providers that would be willing to see more if they had more comparable fees. As stated before, it is a losing situation oftentimes. Sometimes I've been advised over my career, an empty chair is more profitable than a chair with a Medicaid patient in Nebraska. And so it would help with some.

CLEMENTS: Thank you for your testimony. Next proponent, please.

CORINNE VAN OSDEL: Good afternoon, Senators, members of the committee. My name is Corinne Van Osdel, C-o-r-i-n-n-e V-a-n O-s-d-e-l. I do work at the University of Nebraska Medical Center, but I'm here representing my own personal views, and to testify as a proponent to LB935. The views I'm sharing today are my own and do not represent an official position of the University of Nebraska system or the University of Nebraska medical center. That being said, I am a native Nebraskan and I am a hospital dentist working in Omaha. I primarily serve special needs and medically compromised adult patients. This includes patients who are preparing for solid organ transplants. They're unable to communicate, they may be preparing for life saving cardiac procedures, or they cannot cooperate for any oral examination due to certain behavior issues. I see patients of all ages, many of whom live in care facilities and nursing homes. Most of my patients are on Medicaid. Many caregivers travel over three hours with very fragile, special needs patients to see me, because there's no one in their area that takes Medicaid. Within the three hour radius of Omaha, there are five dentists, three of whom are my own colleagues, that I'm aware of that take Medicaid special needs adults to the operating room when they need that for their treatment. This is a crisis because we have a one year waitlist to examine these types of patients and assess if we can even attempt care in a traditional setting, or if we need to

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proceed to the operating room for care under general anesthesia. And then the patients that do need care in the operating room get placed on our waitlist that is well over four years long at this point. There are many dentists in Nebraska that have the training and ability to see patients in the operating room. I train them at our residency program. But as a majority of these patients are on Medicaid, dentists will not see them. Treatment in the operating room adds to the expense of care, and dentists cannot cover their costs when seeing Medicaid patients with or without general anesthesia. We do not know how severe a special needs patients dental disease is until we are able to get them into the operating room. And in four years, this can become catastrophic. This amount of time in between general dental care and surgeries has led to the worsening of oral disease in an already vulnerable population, and therefore they have a more compromised medical state. The special needs patients that require treatment in the operating room are also losing their teeth due to the inability to be seen in a timely manner, and we cannot replace missing teeth for these patients, as all tooth replacement options require multiple appointments with a high level of cooperation. It's heartbreaking for me to tell a caregiver or a parent that we cannot see their adult child or dependent for dental care for four or more years, and that when we do, their dental disease will have progressed to the point where we will likely need to extract teeth and then be unable to replace them. This life altering situation is entirely preventable. If dentists were able to cover their costs when seeing patients on Medicaid, more would be able to care for our medically compromised and special needs Nebraskans to improve their health. I ask the committee to support LB935, and I thank you all for your time. Any questions?

CLEMENTS: Are there questions? Seeing none, thank you for your testimony.

CORINNE VAN OSDEL: Thank you.

CLEMENTS: Next proponent please. Good afternoon.

KIERSTIN REED: Good afternoon, Chairman Clements and members of the Appropriations Committee. My name is Kierstin Reed, that's K-i-e-r-s-t-i-n R-e-e-d. I serve as the president and CEO of LeadingAge Nebraska. I come before you today to rise in support of LB935 regarding Medicaid funding for dental services. LeadingAge

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Nebraska is a membership association representing nonprofit and mission driven long term care providers. I would like to share with you the story of an all too familiar situation that long term care providers experience when they are assisting residents in securing dental care with Medicaid. While this story is about a rural provider, it affects urban providers as well. This provider is a small nursing home in rural Nebraska near the Kansas border. The local dentist no longer accepts Medicaid, and they are forced to look elsewhere for dental care. At one point, they were able to find those services in Atwood, Kansas, approximately one hour from their facility. This worked for about a year until that provider would no longer accept Nebraska Medicaid. They set out again to find dental services and found another in Holyoke, Colorado, which is an hour and 30 minutes from their facility. That office ended up closing to Medicaid about six months after they started, and they again found themselves on the search for a dentist. The next option was in Paxton, Nebraska. Now they're one hour and 45 minutes away from their community. They were able to get two appointments in until that dentist also would no longer accept Medicaid residents. This nursing home has searched all the sites that claim to have lists of dentists that accept Medicaid. Unfortunately, upon calling list after list, most of them are only accepting children with Medicaid, will not accept new Medicaid clients, or will only accept clients within a certain distance of their practice. They have looked up to three hours surrounding their nursing home in an attempt to find a dentist for their residents. Most nursing home residents are in debilitated conditions and would be unable to make the trip any further than that. Currently, the facility has Medi-- if they have Medicaid clients that have emergent care needs, then they take them to their local dentist and they pay out of their own funds. This is a familiar story we hear from long term care providers. Dental care is vitally important to older adults, and it seems that there are not enough dentists accepting Medicaid. It is reported that due to this-- is due to low reimbursement rates. Searching for new dentists and long trips is difficult on older adults and the staff that are supporting them. Our goal is to ensure that seniors do not lose access to this care, and that they find the services that they need. LeadingAge Nebraska appreciates the support of the Appropriations Committee in evaluating the rates for these services, and believes that addressing the payment rates will go a

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long way in assuring that older adults have care in Nebraska. Thank you for the opportunity to testify today.

CLEMENTS: Thank you. Are there questions? Seeing none, thank you for your testimony. Next proponent. Welcome.

KELSEY ARENDS: Thank you. Good afternoon, Chair Clements and members of the Appropriations Committee. My name is Kelsey Arends, K-e-l-s-e-y A-r-e-n-d-s, and I'm the health care access program staff attorney at Nebraska Appleseed testifying in support of LB935 today on behalf of Nebraska Appleseed. We are a nonprofit legal advocacy organization working to ensure that all Nebraskans-- excuse me, that fights for justice and opportunity for all Nebraskans. One of our core priorities is working to ensure that all Nebraskans have equitable access to quality, affordable health care. Because increasing reimbursement for Medicaid dental services has been linked to increased provider participation in the Medicaid program, and therefore has been inc-- leads to increased enrollee access to dental services, Nebraska Appleseed supports this bill. Even though oral health is a critical part of overall health, many Nebraskans do not get the care they need, and this is particularly true for people enrolled in the Medicaid program, which provides health coverage to hundreds of thousands of Nebraskans. Even though some dental coverage is included, a majority of adults with Nebraska Medicaid are not utilizing any dental services, suggesting barriers persist to accessing oral health care. Increasing access to dental care in Nebraska's Medicaid program presents a wide range of benefits, from improving individual health, to addressing racial disparities, to improving the economy. Attached to my testimony being handed out to you today is a recent policy brief on the dental access issue and a policy update, covering these issues and more for your reference. I won't repeat a lot of the compelling testimony you've heard from folks today about the significant barriers that exist for folks who want to access dental care through Medicaid. I would note quickly, that the federal financial match varies, to match the General Funds appropriated varies depending on the type of Medicaid. For Medicaid that match currently in Nebraska is over 57%. For the Children's Health Insurance Program or CHIP, it's over 70% for federal funds that could match the General Funds we're talking about today. So I will stop there, but happy to answer any questions.

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CLEMENTS: Are there questions? So that's why-- that's why maybe there's-- the kids were able to get treatment more because their reimbursement is greater.

KELSEY ARENDS: So the the difference there that I'm talking about is the federal share coming in. I, I actually don't know if the provider rates are different for adults versus children.

CLEMENTS: This bill is asking for $6 million of state funds. Do you know how that number was set? Why was it set for 6 million? Did your research--

KELSEY ARENDS: I bet that's a good question for--

CLEMENTS: --did your research talk about that?

KELSEY ARENDS: Sure, Senator Ibach might be able to answer that perfectly, but I do think it closely matches the fiscal note of Senator Walz's bill last year to increase provider rates.

CLEMENTS: Oh. OK.

KELSEY ARENDS: Yeah.

CLEMENTS: Thank you.

KELSEY ARENDS: Thanks.

CLEMENTS: Next proponent? Welcome.

KRISTEN LARSEN: Good afternoon. My name is Kristen Larsen. That's K-r-i-s-t-e-n L-a-r-s-e-n, and I'm here on behalf of the Nebraska Council on Developmental Disabilities to testify in support of LB935. Although the council is appointed by the Governor and administrated by DHHS, the Council operates independently and our comments do not necessarily reflect the views of the Governor's administration or the department. We are a federally mandated independent council of individuals and families of persons with developmental disabilities, community providers, and agency reps who advocate for systems change and equality services. The council serves as a source of information and advice for state policymakers and senators, and when necessary, we take a nonpartisan approach to provide education and information on

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legislation that will impact individuals with DD. Oral health is essential for general health and the well-being of people throughout life. For too long, individuals with intellectual developmental disabilities have experienced health care disparities, including having unmet general needs, and many face challenges receiving dental services due to limited access, availability, and accommodations. LB935 has the potential to address this issue, and I'm speaking on behalf of people with lived experience. You've heard from some of those as well. I have a son who also uses Medicaid, and this is a real issue. Prompt dental care has not been readily available for individuals with disabilities. Research indicates that people with disabilities experience a higher prevalence of dental problems. In the U.S., one in four adults have some form of disability and are more likely to have poorer health, suffer chronic diseases, and face more significant barriers to health care. Adults with disabilities are less likely to visit a dentist within the past year compared to their adults without disabilities. Research shows that children and youth with special health care needs are at an increased risk for inadequate access to dental services, higher rates of local hospital E.R. department dental visits, and poor dental health. According to the Nebraska State Oral Health Surveillance System Report, and I provided a link in my handout, between 2012 and 2020, there was a dramatic 42.3% drop in dentists who accepted any Medicaid patients. This staggering evidence shows that Medicaid patients, especially underserved populations like those with IDD, face a barrier in accessing dental services. The report provided a recommendation to increase the number of dental Medicaid providers. I have way too much to go into, but I talk about where do they end up if they're not getting dental access, they go to the E.R.. And then that the problem there is that they're receiving medication, pain relievers, antibiotics, antibiotics to address their oral health pain without serving the proper dental care to treat the underlying conditions. I also talk about other challenges for this IDD population. A lot of times dentists are not trained to work with them or simply just don't feel like they have the skills, so that shrinks that area even more. I'm pleased to say that the, the Nebraska DHHS office of Oral Health and Dentistry was selected in 2022 to receive a HRSA Oral Health Workforce Grant that will be used to implement innovative programs to address the dental workforce needs of the state designated dental shortage areas. It's a step in the right direction, but there's so

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much work that needs to be done, and I just feel like this will, really dovetail with Senator Walz's LB358 to provide better funding and really increase access, but especially for this particular population.

CLEMENTS: Thank you. Are there questions? Thank you for your testimony.

***MATTHEW KASLON:** Dear Senators on the Appropriations Committee: I am writing on behalf of the Nebraska Council on Developmental Disabilities (NCDD) to express our support of LB935. Although the Council is appointed by the Governor and administered by the Department of Health and Human Services (DHHS), the Council operates independently, and our comments do not necessarily reflect the views of the Governor's administration or the Department. We are a federally mandated independent Council comprised of individuals and families of persons with developmental disabilities, community providers, and agency representatives who advocate for system change and quality services. The Council serves as a source of information and advice for state policymakers and Senators. When necessary, the Council takes a nonpartisan approach to provide education and information on legislation that will impact individuals with developmental disabilities. This is Matthew Kaslon, I am writing a letter of support for LB935. This bill intends to appropriate $6,000,000 from the General Fund for fiscal year 2024-25. These funds will go to DHHS for program 348 to increase provider's reimbursement rates regarding dental services under the Medical Assistance Act. I feel this would be very crucial for dental providers that do not take Medicaid or Medicare in the dental industry. People with I/DD face many challenges finding a dentist who can accommodate their special health needs. Some dental practices in other states are fortunate and are focusing on treatment for people with cognitive, developmental, or physical disabilities. Dentists working with children and adults who have an I/DD may use special equipment, such as certain chairs, cleaning tools, or general anesthetic to ensure the comfort and safety of the patients. Most dentists in Nebraska who cannot provide dental care for people with an I/DD are required by law to make a referral. This can cause further complications with finances, scheduling, and traveling to go where they are referred to. People with disabilities face greater challenges than people who do not have a disability in finding access to affordable dental care and having access to a dentist who

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can provide the skills, comfort, and safety of the person. From personal experience, I know how hard this can be and also confusing for some. I was going into the dentist to get my tooth pulled and had to pay for it 'out of my pocket'. Nebraska needs more dental providers that can improve their reimbursement rates. Thank you for your consideration.

CLEMENTS: Next proponent for LB935? Seeing none, is anyone here in opposition of LB935?

JESS LAMMERS: I oppose. Chairman, I oppose.

CLEMENTS: Welcome.

JESS LAMMERS: Jess Lammers. J-e-s-s L-a-m-m-e-r-s. Here's why I oppose. April 30th of 2020, the poorer list-- the, the agency with the poorest management in the state of Nebraska, the Nebraska State Patrol, assaulted me. They knocked out all my teeth. Cost me about $20,000 to replace all my teeth because no one in Nebraska accepts Nebraska Medicare except-- especially no dentists. Now, here's my problem with the language of the bill as presented. You're going to increase the rates for providers, but there's no guarantee that providers are going to increase their client base. So their current client base, they'll get better rates. But that doesn't mean that I'm going to receive any services as a new patient because my dentist retired. My dentist was Doctor Charles Schaepler in Kearney, Nebraska. He retired. I can't get any dentist to work on me unless I pay cash at the door. I got cash, I'll pay cash at the door. But then why are we giving Molina Healthcare in Omaha, Nebraska, at 14748 West Center Road, suite 104, why are we giving them a government contract for services that can't be provided to constituents? I see they kindly sent a lobbyist and I see everyone wants to increase rates, but when you increase rates, that's the current client base. That doesn't mean they're going to take any new patients. And someone kindly said that the kids are getting taken care of. Well, everybody has empathy for children. But what about when a state agency or any adult, one with special needs as someone brought up, any adult needs services? The rates should be comparable, but if the rates are going to be comparable, shouldn't there be expressed language in the bill saying if we're going to up the rates to 60%, I want to see each provider take in so many new number of patients, or that doesn't justify an up

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in the rates. I would yield any time to the-- back to the committee for questions if there are any.

CLEMENTS: Are there questions? Thank you, Mr. Lammers, for your testimony.

JESS LAMMERS: Thank you, Senator.

CLEMENTS: Are there other--

JESS LAMMERS: Have a great day.

CLEMENTS: --other opponents? Seeing none, anyone in the neutral position? Seeing none. Senator Ibach waives closing. Do we have position comments? Comments for the record. We have 38 proponents, no opponents, 2 in the neutral. ADA accommodation testimony, one proponent, no opponents, and none neutral. That concludes LB935. We now open the hearing for LB941. Senator Dorn. Wait just a minute. The door is about to shut, I think. There we go. Please proceed.

DORN: Thank you, thank you. Good afternoon, Chairman Clements and the fellow members of the Appropriations Committee. My name is Senator Myron Dorn, M-y-r-o-n D-o-r-n, representing District 30, here to introduce LB941. LB941 will appropriate funds for Medicaid waiver assisted-living facility services under Program 348. The bill would appropriate approximately $2,917,000 in General Funds, and $4,129,000 in federal funds for the state fiscal year '24-25. This is the amount necessary to increase rates to the amount recommended by the department's contractor. Those of you who served on Appropriations Committee two years ago may recall that former Chairman Stinner introduced LB988 to appropriate funds to the department to carry out a formal Medicaid waiver assisted-living rate study. The bill was advanced to General File, File, but time ran out on the session and LB988 was not taken up for debate. In the meantime, the department opted to contract with a third party to carry out their own rate study of Medicaid waiver services by conducting a detailed cost analysis and the rate comparison with other states. LB941 would appropriate the funding necessary to increase the Medicaid waiver assisted-living rates to the level recommended in the study's preliminary report, which identified a significant gap between the current payment for these services and the actual cost of care. Current daily rates were

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set at $62.73 for rural facilities, and $73 for 91-- $73.91 for urban facilities. The DHHS study recommended parity between rural and urban facility rates, as the study found no difference in the cost of care, regardless of where the facility was located. Based on speaking with assisted living providers in my district and other parts of the state, it is important that Nebraskans, especially those who rely on Medicaid, are able to access assisted-living services when they need assistance but don't require 24 hour nursing care. This bill would increase the daily rate for both urban and rural assisted living facilities to $78.45. We all know this is nowhere near what it actually cost an assisted living facility to provide for the care, especially as the study was based on 2021 cost report data. But at the very least, LB941 moves us closer to the actual cost and helps relieve the financial burden placed on assisted living facilities to provide this essential care to their clients. Following me will be a provider and a family member who will provide their perspectives. Following them will be Jalene Carpenter, representing the Nebraska Assisted Living Association, and she may be able to provide additional information and respond to any questions. Thank you for your attention.

CLEMENTS: Are there questions? Seeing none, thank you Senator. First proponent. Welcome.

MARV FRITZ: Good afternoon. Thank you, Senator Clements and members of the committee. My name is Marv Fritz, M-a-r-v F-r-i-t-z. I represent the Evergreen Assisted Living in O'Neill, Nebraska. And I'm here to-- in support of LB931. My comments pretty much deal with the DHHS wa-- wa-- waiver study that was done. It was actually 2019 cost that it was based on. You're paying a $62 and a few cents in change. And, and in 2000-- the 2019 study showed about an $85 change-- cost of, of operations. So these numbers, even though they're-- was done a couple of years ago, they're using four year old numbers, so they're seriously out of date. Since '19, our labor cost is up 29%, our food cost is up 40%. And going back six and a half years to 2017, we've only got 12% increase over all of those years. And that was based on a 2001 base rate that was way low to start with. And then our labor costs are locked in this year at another 4% higher because, everybody else in the state got a 4% raise. The rural and operating costs were shown to be the same, but DHHS has not changed anything since then and doesn't have-- seem to have a reason for that. But labor's over two

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thirds of our cost of operations, and the Governor wants us to cut that cost. But at the same time, when everybody else, mostly state employees, get 4 to 6% increases, we have to compete with that hiring and and are forced to pay more. I can only speak for our facility, but AL is far more than it was 20 years ago. Our care level can be high, much higher than a low end nursing home. As an example, we had some people move from the assisted living to a nursing home for a couple of different reasons. One wanted to be close to-- closer to their family. The state cost went from $60 and some cents a day, up to $225 a day for the same care. Another didn't want to walk to meals, so he went back to the nursing home for $182 a day. And then another one went for from $60 to $225. So it's costing the state $82,000 versus $20,000-- $22,000 that you're paying us. The state pays more for just two people now at at those nursing homes than they're paying for the entire eight people that we had in the facility after that. It's just a difference of AL being a social model, not a medical model. And if, if we can take care of people in a social setting, we just can't do it for a fourth of what you're paying a nursing home. And if you don't change this pretty fast, we're going to have to get out of that business because we can't-- we're over $1,500 a month that we're losing versus our private pay, and we just can't afford to do that anymore. Thank you for your time. Any questions? I'd be glad to answer them.

CLEMENTS: Are there questions? I was wondering, how is your close your percentage of Medicaid residents?

MARV FRITZ: We have-- we've run from 17 to 23, but we averaged pretty close to 20% over the years. 20 some years.

CLEMENTS: 20%?

MARV FRITZ: Yeah.

CLEMENTS: And it, it has not increased? It's been-- is that about steady?

MARV FRITZ: Actually, it stays pretty steady, don't-- you know. And don't ask me why. And a lot of our-- a lot of what happens is people come in on private pay and then they run out of funds and they switch over to, we have taken some straight Medicaid, straight in the door.

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But, unless they're really, really low care, we don't do that anymore. But if they've been there, we hate to have them move on, so.

CLEMENTS: I see. Are there other questions? Thank you for coming.

MARV FRITZ: Thank you.

CLEMENTS: Thank you for your testimony. Next proponent?

JOSEPHINE LITWINOWICZ: Again before it talks about-- before the clock goes on, I'd like to mention about a microphone or something? Because I can make a little collage of all the times that I-- I was here. I mentioned-- that's why I'm doing it. OK. So my-- my name is Josephine Litwinowicz, J-o-s-e-p-h-i-n-e L-i-t-w-i-n-o-w-i-c-z. It wears me out. Yeah, I, I really would like a provider rates increase for assisted-living and nursing homes. Because I tell you what, with the way people in nursing homes are, are treated right now, I will-- I will turn out my own lights. Guarantee it. That-- those are disgusting places. Just, you know, do you know, do you care? Go and look. People sitting in whatever. And but I'm relating what I would like-- I, I, i, I think there should be amended to the bill provide rate increases for home health. You know, it's funny. You know, we don't-- home health people don't have a the beats, the big beats, like in nursing homes and assisted living. But I'm telling you, from my own experience, I had, had trouble sometimes because you can make $15 an hour working at Chipotle, or $14.50 wiping someone's ass. now which one are you going to do unless-- the best health aides are the one that we're committed, that really enjoyed it. But, you know, it's hard. I've had a hard time filling some, you know, appointment times. And I tell you what, in here-- if I have to go to a nursing home-- one time, the fire department said, you know, you, you better get this covered or whatever it was. I'm telling you, that would be one of the possible couple straws that would break the camel's back. You know, I come in here and I mentioned, you-- oh, the Governor. I, I told the Governor's Office that there was a, there's a health-- home health facility in Wilber, Nebraska. OK, this person paid the price of having a successful business. You can't renegotiate with the state, right? Once your provider rates are set, and increases, maybe none or half the years and maybe not tied to inflation and insufficient the other years. So what happens is, if you're-- you get punished for being in business for a long time because eventually you can't pay your

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employees because other people that incorporated after you, years after you, they're gonna, you know, you just can't-- you can't do it. So what she had to do, she was creative. I-- if anybody wants to, I can say who it is, but-- so she reincorporated, you know, because she got to renegotiate. That's what she had to do for having a successful business. She had to reincorporate and pay a lawyer to do that. And the Governor, you know, I, I brought this up to the governor's office. I was I was telling one of the people there, and then I said, no, we-- could I please talk to him about this because, you know what? You know, ta-- you have to-- you have to increase. I know the Governor doesn't want to do anything because I don't know, is that part of the gee with roll whizz, roll up your sleeves thing, and just do it that way? Well you can't, you have to pay people. And, yeah, there is no definite tie for increasing provider rates and employee salaries. And that should be in there because it's like stock buybacks. And, you know, that's what they're going to do. They're just going to, you know, keep the money in whatever fashion. Anyway, I have more to say on, on the next one. If you think about it, there's more to the story.

CLEMENTS: All right. Thank you for your testimony.

JOSEPHINE LITWINOWICZ: Thank you.

CLEMENTS: Questions? Next-- Then let me comment. We have senators who are missing are presenting bills in other committees. And that does happen to time-- from time to time. But we appreciate your testimony. And the next proponent, please.

DAWN BROCK: Good afternoon, Chairman Clements and members of the Appropriations Committee. My name is Dawn Brock, Dawn Brock. And I'm here to testify in support of LB941. Thank you so much for your time today. I'd like to tell you a story of my parents.

CLEMENTS: Could you pull that microphone toward you a little?

DAWN BROCK: I can.

CLEMENTS: Thank you.

DAWN BROCK: Is that better? OK. I'd like to tell you a story of my parents. They are hardworking. My father worked as a securities trader. I tried to convince him to retire. He wouldn't. He actually

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worked as a courtesy clerk at Hy-Vee until he was almost 80 years old, until he got very sick. He had multiple medical problems. He was a proud man. And my mom worked as a nurse. And then she volunteered to the school, and then worked her way up to be a para, taught piano, Sunday school. She also got sick. And so then for the last year, I have had tremendous amounts of difficulty finding them placement together in assisted-living facility. They've lived in Lincoln for the past five years. They used to live two blocks away from me, so I could go see Dad, do PT with him on my lunch break. But it became impossible for them to be successful together at home. Mom started calling me early in the morning, saying that she had gone over to the grocery store and come home, and Dad was disoriented. She couldn't find him. She also, you know, I would go over to look in on Dad for his PT appointments, and he couldn't remember my name. I am connected to the health care community. I did Leadership Lincoln. And so I started asking questions about how I could find them placement. And I was told that unfortunately, even though they had saved and saved and saved, because of the medical bills that they had accrued, they weren't going to be able to be placed in Lincoln. Now they are placed, but they're placed 45 minutes away. And so I can't see them as often as I would like. So I-- it is my hope that you will do the right thing, and fund this so that people who might have parents that they would like to see, who used to be close to them, will be able to see them more. I can still see them sometimes, but not nearly as often as my two blocks away. What questions do you have that I can answer?

CLEMENTS: Are there questions? Seeing none, thank you for your story. Thank you for your testimony. Next proponent for LB941. Good afternoon.

ELDONNA RAYBURN: Good afternoon, and am I close enough?

CLEMENTS: Yes.

ELDONNA RAYBURN: My name is Eldonna Rayburn, E-l-d-o-n-n-a R-a-y-b-u-r-n. I am speaking today in support of LB941. I am the executive director of the Lexington Assisted Living here in Lincoln at 5550 Pioneers Boulevard. The Lexington is one of the larger assisted-livings in Lincoln, and has always served the majority of residents on the Medicaid waiver program for assisted-living. The Lexington's mission is to provide affordable housing to the-- to the

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elderly and others in need. We can serve up to 104 individuals, and our average occupancy is 97%. The Medicaid Waiver Program serves the elderly and people with disabilities with care in an assisted-living community, versus a more costly long term care facility. Nebraskans are very fortunate to have the Medicaid waiver program to provide these services to those on very limited incomes and save taxpayer dollars. Over the last couple of years, we've averaged over 80% of Medicaid waiver residents. As a for profit, we have been able to make this business model work. That is until Covid. Covid impacted our world. We did have to rely on expensive agency or outside staffing to cover for those who either left our employ or were recovering at home. We did have to increase wages by over 20% to retain and recruit highly qualified individuals to meet our mission of providing the highest levels of care. With government's additional funding of $20 per day per Medicaid waiver resident. We were able to continue to provide services and pay our bills. At the end of Covid, the additional funding went away and inflation became, became our next big challenge. I'm here to say that we will not cut quality care from our community. We cannot reduce staff or cut services. In order to meet our financial responsibilities under the current Medicaid waiver rate structure, we would have to cut back on the amount of individuals that we serve on the Medicaid waiver program. We do not want to do that. The need for Medicaid services has only grown significantly in the last few years. We move in about 40 to 50 people a year on the Medicaid waiver program. The last thing we want to do, as I said, is cut services to this population of former nurses, missionaries, business-- business owners, farmers, veterans, mothers, fathers and grandparents that need and deserve quality and compassionate care. As you know, Health and Human Services contracted with a third party to complete a rate study for the Aged and Disabled Waiver Program in 2022. This study concluded that an average of $4.54 in a daily rate for services was needed. This increase will help, help offset our expenses and continue to serve those who are most vulnerable. Please support LB941 so that we may continue serving these people in need. Thank you.

CLEMENTS: Are there questions? Could you repeat what percentage of Medicaid recipients do you have in residence?

ELDONNA RAYBURN: On average, it's 80% in our building, it's been as high as 85%.

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CLEMENTS: And you're able to break even with that?

ELDONNA RAYBURN: We belong to a tax credit program that has helped us out in the past. But now the expenses have increased to a level where that, that balance isn't, isn't helping us out anymore.

CLEMENTS: Thank you.

ELDONNA RAYBURN: Thank you, I appreciate it.

CLEMENTS: Next proponent?

KIERSTIN REED: Good afternoon, Chairman Clements, members of the Appropriations Committee. My name is Kierstin Reed, K-i-e-r-s-t-i-n R-e-e-d. I serve as the president and CEO of LeadingAge Nebraska. I come here today in support of LB941. LeadingAge Nebraska is a membership association representing long term care providers. Our membership consists of all types of aging services, with over half of them being assisted living providers. We are proud to support our nonprofit and mission driven organizations that do their best to serve their community, many of those who are receiving Medicaid funding. There is an age old saying no margin, no mission. This is true for all businesses, even nonprofits. Your business losing money over goods and services, how long are you going to be able to provide those goods and services? This is the question that Medicaid assisted living providers are asking. Nebraska currently does not cover the cost of these services. And as you've heard today, it is becoming more and more difficult to find Medicaid assisted living services in our state. The Nebraska Study of Home and Community-Based services found that the cost of these services was great-- was greater than the reimbursement rate. This study showed that the assisted-living across all of the areas, urban and rural, should be set at the same rate. The study recommended equalizing those payments at a rate of $78.45 per day. This results in a nearly $5 increase for urban providers, and a nearly $18 increase for our rural providers. Based on the feedback from our membership, this rate increase would go a long way in assuring that they were covering their cost of care, particularly in the urban-- or in the rural areas. When providers were receiving an increased payment of $20 a day during the Covid public health emergency, providers felt that they were much closer to covering their costs. The overall concern is the difficulty that we are experiencing finding Medicaid

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funded assisted-living placements in our state. Providers are having to tighten their belts in order to remain open, and this all means that the Medicaid funding is being less and the private pay is being utilized more. In order for all Nebraskans to be able to receive services, we need to assure that Medicaid is covering the cost of care. Providers want to continue their mission, and they want to be able to serve Nebraskans that are in need. But they can't do this in the absence of their bottom line. I encourage you to support the increases for assisted living providers and continue to support the important services they're providing across our state. I'm happy to answer any questions you have. Thank you for allowing me to testify today.

CLEMENTS: Are there questions? Seeing none, thank you for your testimony. Next proponent for LB941, please?

JALENE CARPENTER: Good afternoon. I think I'm your last one, so I will be brief and not repeat what others have said. Good afternoon, Chairman Clements and members of the Appropriations Committee. My name is Jaylene Carpenter, J-a-l-e-n-e C-a-r-p-e-n-t-e-r. I'm the president and CEO of Nebraska Health Care Association which represents Nebraska Assisted-Living Association. I'm here on behalf of our 230 nonprofit and proprietary assisted living community members. And I'm here today to testify in support of LB941. A Nebraska assisted living facility is a residential setting where shelter, food and personal care assistance with services such as social services, housekeeping, laundry, medication assistance, or transportation services are provided. Nebraska seniors who meet both the financial and the level of care criteria may qualify for Medicaid waiver covered services at assisted living. I would like to be clear, these are Nebraska seniors who have outlived their resources. These are families who planned, but many times simply outlived the money that they had saved for their care. I have passed out the study that was completed by the Department of Health and Human Services. The final report came in December of '22. Excuse me, it was completed by December of '22, and it was released in September of '23. And the recommendations for assisted living providers are on page seven. Nebraska's aged and disabled waiver program has been established since the late 1990s, and it's our understanding this is the department's first rate study that has been completed. You have already heard that the study recommends parity between urban and rural. And our-- specifically, LB941 recommends that

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they-- we institute the rate of $78.45 per resident per day. The study was based on old cost data, and I will note that our request simply implements the Medicaid waiver rate and does not include any inflation factor at this time. I urge the committee to include the funding for LB941 within the budget proposal this year, and I'm happy to answer any questions. Would like to also think Senator Dorn for his introduction of the bill.

CLEMENTS: Are there questions? I, I had one question. I believe Senator Dorn said currently the rural rate is about $63, $62.70. And you're saying this would go to $78?

JALENE CARPENTER: Correct. It would bring the urban and the rural rate into one rate.

CLEMENTS: And somebody mentioned that this is going to be about an $18 increase. It's more like a $15 increase the way I--

JALENE CARPENTER: Your math seems accurate.

MIKAYLA FINFLAY: Almost $16

CLEMENTS: Almost $16.

JALENE CARPENTER: Correct.

CLEMENTS: OK, just clarifying that. Thank you for your testimony.

JALENE CARPENTER: You're welcome. Thank you.

CLEMENTS: Other proponents for LB941? Is anyone here in opposition? Seeing none, are there any testifiers in the neutral position? Seeing none, Senator Dorn, you're welcome to close.

DORN: Thank you very much. I thank her for handing out the report there at the end. As we had discussion, I don't know whether it was the last year or two years ago, I still remember when Senator Stinner brought the thing to do the study and it didn't get passed or whatever. And then we had the agency in here, and they talked about doing the study on their own. And I remember Senator Erdman asked the question, so you're going to do the study. Why are you going to study when you never funded? And referring to the fact that we do studies a

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lot of times and then we don't follow through. And I still remember Senator Erdman asking that question. So thank you. That's all I have for LB941.

CLEMENTS: Are there questions? Seeing none, you can stay there.

DORN: Yes.

CLEMENTS: We have public position comments for the record. Proponents, 16, opponents, 1, neutral, none. That concludes the hearing for LB941. We now open the hearing for LB942. Senator Dorn.

DORN: Thank you. Good afternoon, Chairman Clements and fellow members of the Appropriations Committee. My name is Senator Myron Dorn. M-y-r-o-n and D-o-r-n, representing District 30, which comprises all of Gage County and a portion of Lancaster County. I am here to introduce LB942 to the state-- to state the intent regarding appropriations to the Department of Health and Human Services for Medicaid nursing facilities. LB942 would appropriate funds for Medicaid nursing facility services under Program number 348. In conversing with stakeholders, the total Medicaid amount requested for the biennium would be $44 million, which would reflect roughly $9.3 million in state General Funds for each of the next two fiscal years, based on the legislative fiscal note. Those of you who served on the Appropriations Committee previously may recall former Chairman Stinner intent with the nursing facility appropriation. Last session, nursing facilities received a significant increase in appropriation for the purpose of offering competitive wages. Based on his analysis, Chairman Stinner clarified previous years' funding was not sufficient to make nursing facilities viable over the long term. Chairman Stinner's intention was to close this gap over a three year period, with a plan to appropriate an additional $20 million towards Medicaid nursing facility services each year. I've heard from members of my constituency that operate skilled nursing facilities about the tremendous increase in costs these facilities are facing. These costs, coupled with staffing shortages, unfunded federal mandates, and inflationary costs are crippling to facilities not only in my district but across the state. We will, will hear from a few of them this afternoon. We have an opportunity this yea due to the cost of living adjustment for Social Security recipients, with which the state is able to use utilize its Medicaid nursing facility savings to aid in

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funding this proposal. There will be testimony following my introduction to provide more information.

CLEMENTS: Are there questions? Seeing none, we welcome proponents for LB942.

JOSEPHINE LITWINOWICZ: I just want to state for the record before my clock starts that we really need a, you know, microphone, so that, you know, for digging it, because I don't want to be like this. And this is part of the collage, the number of times that I'm going to stick together and in a video upload, I gotta learn how to do that. Anyway, my name-- oh, sorry. Thank you, Senator-- Chairman Clements, and the rest of you guys that are in this skeleton group. My name is Josephine Loitwinowicz, J-o-s-e-p-h-i-n-e L-i-t-w-i-n-o-w-i-c-z. Yeah, this is a, we need to override the Governor, I'm sure, because I went into his office-- this is just after I got a-- not long after I got a five minute meeting, you know, about why I exist as I am. And so I can tell by the way, you know, I was, I was blown off because I brought up the story about the Wilbur. I said I have some-- something to bring to the table on this. And whoever it was kind of laughed and, you know, did one of these, so I don't know who was behind me. But, and so, you know, so the Governor is just-- you're going to have to override because these rates have to go up, nursing homes. There's a couple of things that I, I particularly wanted to say. So, yeah, I didn't get a chance to talk to the Governor about this, even though I told th aide that this, this is a story. You know it should be hot off the press. And so, but he's the kind of person that, you know, it's fitting, when you think about it because how he keeps his pigs, you know, gestation crates. It's the same thing with a nursing home. And so, you know, they're, they're in crates not big enough that they can't even turn around. And when they escape, they try to free others. Pigs will try to free others. But, so that's the kind of man we're dealing with along with the nitrates and and poisoning the soil. So we're going to have to override. We need-- we need rates for, you know, the small beaks to home health. Because if we default there, then we're going into more expensive locations. And, you know, so, you know, I, I tried to tell-- I tried to talk to him. And when I-- he's just the kind of person like, you know, the, the concealed carr,. When he did the bill signing. I made sure I was there so I could talk to him, that's how I got the first talk, and I said, you know, when he finally went in his office, I was in the big room and wasn't far away from his door, I

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said, will you be willing to talk to me or someone in my community? You know, about who we are? And he just kept walking and I said, can you be a man and answer the question? Can you just be a man? And so I got a fi-- I don't know if that was part of it, but that's the kind of person he is. You know, he wants the Pencify ou school system. Mike Pencify. And so that's what-- that's the override that we're going to have to contemplate and, and, and do with, with the inclusion of the supermajority or, the caucus, the Republican supermajority. Nonpartisan my butt. Anyway, so that's something to think of. And my senator, I brought this up to you, and, you said basically, oh you can talk to somebody else, you know, because you were-- you had too much on your plate. But there's just in my building, there's five people with disabilities, in, in your district. And then-- but you, you didn't pay any time to, to to, you know, to contemplate it. Just like when you admitted, you know that, that there wasn't reasonable accommodation for people with disabilities, and so did Speaker Arch, and now, all of a sudden, we're not doing it. Anyway, disabled people, we suffer in a lot of ways, nursing homes, trying to get aides, home health aides, and whatnot. And I'm done. And, please pass this out of committee and override the Governor, the inevitable, occurrence of that. Thank you. Thank you.

CLEMENTS: And I have discussed with leadership here about the microphone situation also. That's being worked on. Next proponent for LB942, please?

MARK SROCZYNSKI: You have to have some stamina to be in these committees. I can barely tolerate sitting in these chairs. Good afternoon. My name is Mark Sroczynski, M-a-r-k S-r-o-c-z-y-n-s-k-i. I'm the chief operating officer for an organization called Emerald Health Care. We have eight facilities in Nebraska: Cozad, Columbus, Grand Island, Lincoln, and in Omaha. We service 550 Medicaid patients every day in all of those facilities. That equates to approximately 70 to 75% of our patients are Medicaid driven. Now, a lot of organizations come up here and express their desire to have dollars allocated to, to them. We're no different. We're looking for the 5% ask on this. But what I want to do is, yes, I could go into the comments about wages and DME and the cost of maintenance, but what I want you to take away from this is our organization is focused in on quality measures. We are part of a larger group of providers, well over 100, that are focused on quality measures and outcomes. I chair

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that committee. That committee will focus in on falls, emergency visits, reductions, and rehospitalizations, just to give you an idea. So the ask is your reinvestment into us will be those quality metrics that we, we intend to, to effect. How will that money be allocated? Training, education, certifications and getting third parties involved in our nursing homes to help us improve. That's how in all these counties and all these facilities and all these towns that I just mentioned, that's how we're going to sustain nursing homes, not only in the urban areas, but in the metro as well. Do you have any questions?

CLEMENTS: Are there questions? You say you're at least 70% Medicaid. What's the trend been in the last five years? The-- increasing, or about the same?

MARK SROCZYSKI: Oh no doubt it's increasing. Yeah. The, the population is increasing. The population is, is simply outliving their funds. That's what's happening in a vast majority of people. They're outliving their funds through no fault of their own or, or they were born unfortunate. However you want to define that. That's the reality right now.

CLEMENTS: All right. Thank you for your testimony.

MARK SROCZYSKI: Thank you.

CLEMENTS: Next proponent?

KIERSTIN REED: Here we go again. Last time. Good afternoon, Chairman Clements and members of the Appropriations Committee. My name is Kierstin Reed, K-i-e-r-s-t-i-n R-e-e-d, and I serve as the president and CEO of LeadingAge Nebraska. I come before you today to support LB942, LeadingAge Nebraska is a nonprofit association representing long term care providers, and our membership consists of 44 nursing homes across the state. By now, we've all seen the headlines of the closures in small town newspapers across our state. So today, I'd like to tell you what happens to residents and families when a nursing home makes the difficult decision to close their doors. First, they will be notified by the administrator of the impending closure. As you can imagine, those conversations are just as difficult to deliver as they are to receive. Residents and families will see-- receive information

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on the transfer and relocation of their loved one, as well as the notice that they have 60 days to complete this. The nursing home is charged with assuring that residents are transferred, discharged, or relocated prior to their closing. Residents must be transferred in the most appropriate and feasible facilities that are available to them in the setting in terms of quality, service and location. Over the past three years, this process has been experienced by hundreds in Nebraska. In an ideal world, residents would find a new place to go and adjust to that community without any decline in their health. Despite the best efforts of nurses, social workers and other medical professionals, sometimes this is all just too much. This is called the relocation stress syndrome, otherwise known as transfer trauma. This is a psychological and/or psychosocial disturbance experienced by older adults when they are moved from one facility to another. Transfer trauma is associated with increased mortality and morbidity. Residents grieve the loss of the environment, the community, both staff and residents. Disruptions in their routines and familiar-- unfamiliar practices can cause cognitive, emotional, and physical changes and reduce their independence. With the number of closures in Nebraska increasing, the available options to residents to transfer to is decreasing. The current location-- the closest location may be hundreds of miles away from any sliver of familiarity, including family. This results in loneliness and isolation and ultimately can lead to transfer trauma. As our future population explodes in the next ten years, we are going to be-- have less options available. We need to continue to address Medicaid reimbursement rates by covering the cost of these services. We appreciate the Legislature's attention to older adults in Nebraska. I appreciate the opportunity to testify today, and I'm happy to answer any questions you may have.

CLEMENTS: Questions? Seeing none, thank you for your testimony. Are there additional proponents for LB942? I'm seeing that LB941 and LB942 might have been better combined. Welcome.

JALENE CARPENTER: They technically come out of two different Medicaid budgets.

CLEMENTS: Yes.

JALENE CARPENTER: That's why they're separate. Good afternoon, Chairman Clements and members of the Appropriations Committee. My name

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is Jalene Carpenter, J-a-l-e-n-e C-a-r-p-e-n-t-e-r. I'm the president and CEO of Nebraska Healthcare Association. I'm here today on behalf of our 171 nonprofit, proprietary skilled nursing facility members. I am also here on behalf of the Nebraska Chamber of Commerce and Industry, to testify in support of LB942. Nursing home care is for those who have complex medical conditions, multiple chronic illnesses, and those who need assistance in performing their own basic care. For Nebraskans to qualify for Medicaid to pay for their nursing home care, the individuals must meet financial criteria. This basically means they have low income and have no more than $4,000 in assets, and then the individual must be determined to meet Medicaid's medical necessity, or necessary requirements, which include having a medical need for care determination that a nursing home is the most appropriate placement. It's critical to understand that nursing home residents who receive Medicaid benefits are hardworking Nebraskans who supported their families and contributed to their communities. They truly believed they planned responsibly for their future. They just simply outlived their resources. According to the department, in January of 2023, 60% of Nebraskans in nursing homes relied on Medicaid to pay for their care. A decade ago, Medicaid payed-- Medicaid was the payer for 52% of nursing home residents. This means that Nebraska nursing homes are currently serving fewer private pay individuals, as they have spent down their resources and are now relying on Medicaid. Based on the department's numbers, Nebraska nursing home team members are currently caring for approximately the same numbers of individuals as they did prior to the pandemic, but this is in fewer available nursing homes. In your packet, you have a map of the care desert that now exists, which shows that 20 of the 93 Nebraska counties are without a nursing home, with several more counties just one closure away from being included in that care desert. It is important that all Nebraskans have access to the right level of care when and where they need it. Although our request for a 5% increase in Medicaid nursing facility appropriation for this year does not close the $49 per resident per day gap, as a solution focused organization, we are asking for this funding to allow nursing facility providers time that is needed to explore the impact that increasing our current provider tax would have. With a number of nursing facilities on the bubble, we need time to develop a pathway to ensure that this possible solution does not exacerbate the situation and result in more closures. I would

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like to thank Senator Dorn for the introduction of LB942, and happy to answer any questions.

CLEMENTS: Are there questions? Seeing none, thank you. Next proponent? Good afternoon.

JAY COLBURN: Good afternoon, Senator-- sorry, Chairman Clements and the rest of the members of the committee. My name is Jay Colburn, J-a-y C-o-l-b-u-r-n, and I'm from York, Nebraska. I'm here to testify in support of LB942. As background, I've been a nursing home administrator in the state of Nebraska for over 20 years, and that's across the state. When I selected service to elders as, as my life work, part of the attraction was the constant challenge I knew would be present in the industry due to the thin margins and heavy regulation. The gentleman who hired me out of my college and was my mentor summed up the challenge well. Operating nursing homes is like trying to get a rabbit to climb a tree. What in the world does that mean? Turns out a rabbit will only climb a tree when it has to. I've owned two dachshunds, and I can confirm rabbits are capable climbers when they have to be. For nursing homes to maintain operations during my years in the industry, we have always had to find a way to scramble up and jump up to the next branch. Things like regulatory changes, reimbursement methodology changes, mandates from CMS, wage and hour audits, OSHA pressures, reimbursement shortfalls, staffing shortages have all been constant challenges. We have always managed, found a way, made it up the next year, got it done and the rabbit climbed the tree every year. The pandemic put extraordinary pressures on the health care labor market. Our labor costs are right at 80% of our total costs in my facility currently, and following the unprecedented labor market issues, inflation arrived and drove up costs for food, supplies and energy. At my facility, York General Hearthstone, costs per patient day are up 45% from 2019 to June 2023. Medicaid rates have increased about 35% over the same timeframe if my math is correct. The increases were appreciated, but we were already behind on payment levels and our reimbursement problem has only compounded. Many skilled nursing facilities are reaching for the next branch to survive the next challenge, but they're missing it. Some facilities have been holding on by their fingertips for quite a while, and others have had to close their operation. So what fresh purgatory awaits the sector around the corner? Looking just a few years in the future, we know that minimum wage in the state is due to continue increasing, and

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historically in senior living, we have not been able to attract staff for entry level positions unless we have a decent delta between our starting wage and general retail businesses. That means more pressure and more pressure on wages. So the pressures have yielded changes in our state. We've always had around 220 skilled nursing facilities since 2001, when I started my career. And now we're down in the 180s. As facilities first started to close, it looked like some typical consolidations and things would level out. In theory, the remaining facilities would be healthier financially. But the closures have not really slowed down. And now we are talking about care deserts in our state that are likely to worsen, as many skilled facilities are at risk in rural areas. You can see I'm not telling a cute story about short dogs chasing a rodent up a tree. These closures are hurting Cornhuskers' lives, and particularly damaging the quality of life for rural Nebraskans. I know the state needs to maintain a balanced budget, so I am not asking for anyone to make our day-to-day operations easy, but please help us make it doable. If we fail to start narrowing the gap of what our actual costs are versus the Medicaid rates, facilities will con-- continue to close.

CLEMENTS: That's your time, if you could wrap it up.

JAY COLBURN: You betcha. Sorry about that. The facilities left standing will be faced with the difficult choice of which Medicaid dependent community members they can afford to serve as our population rapidly ages over the next ten years. Again, I ask the Appropriations Committee to help protect our rural way of life by investing in it.

CLEMENTS: All right. Are there questions?

JAY COLBURN: Thank you for your time.

CLEMENTS: I had a question. What's-- you're at one facility, is that right?

JAY COLBURN: Yes, York General-- York General Hearthstone. And then we also operate an assisted-living facility.

CLEMENTS: And what percentage of Medicaid recipients do you serve now?

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JAY COLBURN: Historically, we've operated around 45 to 50%. Today we're at 37%. And that is on purpose. That's a forced, forced choice we have had to make.

CLEMENTS: That's the maximum-- you think that's the maximum you could afford to accept?

JAY COLBURN: Right now, we believe so. And--

CLEMENTS: All right.

JAY COLBURN: --it's a lousy deal.

CLEMENTS: All right, thank you for coming.

JAY COLBURN: Thanks for having me.

CLEMENTS: Next proponent for LB942, please. Seeing none, is anyone here in opposition? Seeing none, anyone here in the neutral capacity? Seeing none, Senator Dorn. Senator Dorn, I had a question for you if you would come forward. I was speaking with the fiscal analyst. The bill appears to just be affecting fiscal year 2025. Is that correct?

DORN: That-- I noticed that, too, when we looked at it that that should be yes.

JALENE CARPENTER: Yes.

DORN: yes.

CLEMENTS: I wasn't sure who I could ask for, so I waited.

DORN: But I wanted to look too, to make sure.

CLEMENTS: And in fiscal year 2024, was there a 3% increase? That's what I thought. And so this would continue the 3% and add 2%? Or is this going to be 3% plus 5%?

DORN: 2 or 5?

JALENE CARPENTER: Just 5. Additional 5.

DORN: Additional 5.

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CLEMENTS: This is--

JALENE CARPENTER: [INAUDIBLE] zero.

DORN: Yes. Because they weren't included in the second year.

CLEMENTS: Oh. All right. Yes.

DORN: That wasn't vetoed.

CLEMENTS: Last year's increase was 3% in the--

DORN: 3% and zero, it was.

CLEMENTS: And none-- OK, so that's--

DORN: Because of the veto.

CLEMENTS: So with this--

DORN: Now, it's--

--would be the--

DORN: The 5 would put it back.

CLEMENTS: --3% plus another 2%--

DORN: Yeah.

CLEMENTS: --for 2025.

DORN: The 5 would put it back to the 3. And plus a 2, which was the original last year which is 5%. So that's why 3-- 3 and zero now is 3 and 5.

CLEMENTS: That's what I was thinking. I was, I was-- just wanted to clarify that.

DORN: No.

CLEMENTS: Any other comments?

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DORN: No. Well I thank Mikayla for catching that and asking those questions to get, or whoever to get clarification so that we understand that. Now, thank you. Thank you very much for listening. And thank you very much for allowing us to introduce some of these thoughts.

CLEMENTS: All right.

DORN: This is great. Thank you.

CLEMENTS: Senator, we have position comments for LB942. Proponents, 14, opponents 1, neutral zero. That concludes the hearing for LB942. Now we will open a hearing for-- well, OK. We'll open a hearing for LB958. And we'll wait just a minute for the room to clear. OK.

WISHART: OK.

CLEMENTS: Welcome, Senator Wishart.

WISHART: Thank you. Good afternoon, Chairman Clements and members of the Appropriations Committee. My name is Anna Wishart, A-n-n-a W-i-s-h-a-r-t, and I represent the 27th Legislative District, including west Lincoln and southwestern Lancaster County. I'm here today to introduce LB958, a bill that would tie the reimbursement rates paid to providers of shared living services to those with developmental disabilities to the consumer price index. The state of Nebraska defines shared living as a service provided in a private home by a person, couple, or family that is known to you. You have chosen to share a life with this person by sharing a home. This person is called a shared living provider, and you mean to live in the same home and you share a daily life with them, and it's as part of a 24 hour residential service. So what are the benefits of shared living for people with intellectual developmental disabilities? They improved health and safety for the person supported through having a consistent and reliable caregiver. Overall quality of life is enhanced due to the personalized nature of this service delivery model. The person's choice is top priority. Ability to live in a home environment in a setting of your choice. And then there are so many more opportunities as you can imagine. And I became aware of shared-- the-- a shared living opportunity for people with developmental disabilities last year. I was, I was not aware that this was a provided service to

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people and had some meetings with individuals that you'll, you'll hear coming up later. Because I do think that this is a pretty incredible opportunity for people with developmental disabilities to be able to live in an home environment, and those individuals in that home provide that service to those individuals in need. So how will LB958 support the state's budget? The state could save, on average, $18,000 per individual per year if a person with an intellectual or developmental disability chooses a shared living setting or a group home setting. By tying the rate for shared living to the CPI, DD providers will not need to come back year after year, asking for rate increases for shared living. This will give providers more time to expand services and stay focused on providing high quality services to people in these shared living settings. Behind me, you'll hear from providers of these services that can speak to the benefits of shared living, not only to the individuals in these environments, but also as well as the cost savings that you can see if more Nebraskans utilize these services. And especially in some of the more rural areas of our state where we're hearing that there is challenges to accessing these types of services from providers, being able to have an in-home provider, somebody in that community who decides that in their life they're capable of taking in a person who has a developmental disability and sharing their home with them and providing them services, I think is a way to help us address some of the shortages that we're seeing in parts of our state. So thank you. I would be happy to answer any questions, and I will be here for closing.

CLEMENTS: Are there questions? Seeing none.

WISHART: Thank you.

CLEMENTS: We would welcome the proponents for LB958, please come forward. Good afternoon.

NATE PANOWICZ: Good afternoon, Chairman Clements and members of the Appropriations Committee. Thank you for the opportunity to share my testimony regarding LB958. My name is Nate Pierce Panowicz, N-a-t-e P-i-e-r-c-e P-a-n-o-w-i-c-z, and I am an executive director for Mosaic of Nebraska. Mosaic is a nonprofit health care organization, and we support 600 Nebraskans with intellectual and developmental disabilities. Of these 600 people supported, 160 are supported in our shared living services. People are asking to live in a more

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individualized setting, where they have more choice over their daily life and needs. Shared living meets this request. Mosaic has been providing shared living services in Nebraska for over 30 years. In order to stabilize personalized services in Nebraska, we need to ensure those dedicated are able to continue supporting others during ever-changing economic times. So what is shared living? Shared living is a 24 hour residential setting provided under home and community based services. Shared living is where a member of the community opens their home for a person with IDD to move into. The shared living provider is contracted with the agency, such as Mosaic, and we provide them the on-- ongoing monitoring, oversight and training. The person is able to receive high quality, personalized services via their shared living provider. One success story involves an individual supported who transitioned to their services and lost over 150 pounds. It is the consistent and dedicated shared living provider who worked with this individual in their home to make this happen, and LB958 will help alleviate the DSP workforce crisis, increase continuity and consistency of care, and decrease safety concerns. It will also assist with positively impacting the waitlist for IDD services. Mosaic's data for personal outcomes for people supported shows that people with challenging behaviors was 87% lower when organizations provided each person with continuous and consistent services. The number of emergency department visits for people was 90% lower when people participated in the life of their community. The number of injuries for people was 60% higher when people had direct support staff turnover within two years. Mosaic's current turnover rate is approximately 80%. The ability to have shared living rates linked to CPI will allow us, as providers, the opportunity to continue to expand and enhance these high quality services. We will also be able to positively impact the workforce crisis by offering more flexibility in their job, being able to support their family and the person in service, and also aid them in receiving a livable wage. LB958 is also an efficiency for elected officials, state employees and Nebraskans. All around, LB958 promotes positive outcomes for people with intellectual and developmental disabilities and ensures efficiency. I am available to answer any questions the committee might have at this time.

CLEMENTS: Senator Erdman.

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ERDMAN: Thank you, Senator Clements. Thank you for being here. Of those 160 people that are in shared living, what's the annual, daily, weekly compensation for someone to have someone live in their home?

NATE PANOWICZ: Chairman Clements, Senator Erdman, that's a great question, and I'd be happy to follow up with you on that information. I do not have that at this time.

ERDMAN: Thank you.

CLEMENTS: Maybe somebody else will provide that. And so--

NATE PANOWICZ: It's possible.

CLEMENTS: Thank you for your testimony.

NATE PANOWICZ: Thank you.

CLEMENTS: Next proponent, please. Good afternoon.

SARA BARTRUFF: Good afternoon, Chairman Clements and members of the Appropriations Committee. Thank you for the opportunity to share my testimony today on LB958. My name is Sara Bartruff, S-a-r-a B-a-r-t-r-u-f-f. And I'm the director of financial planning and analysis at Mosaic. Mosaic is a provider for adults with intellectual and developmental disabilities. We have a long 111 year history of supporting people in community settings that was started in Nebraska. Given our rich history of offering home and community based service in the most least restrictive and individualized way possible, we are able to speak confidently about the positive financial impacts of LB958, not only for IDD providers such as Mosaic, yet for the people we support and the state of Nebraska. In comparing the average daily rate for people accessing the more traditional continuous home service against the shared living service model, in the savings, it saves the state 26 to 40%, depending on the tiers of the people served. So how does this impact the state of Nebraska? As Senator Wishart mentioned, this is a cost savings of an average of $18,000 per person per year to serve in shared living. Additionally, overall margins are more favorable in the shared living service model for providers due to more predictability in how shared living providers are paid. This is a win for IDD providers and for the state. When we look at tying the shared living service model to the Consumer Price Index, this allows for the

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service to grow at a steady annual rate in conjunction with the rising cost of living and inflation. For example, in 2023, the CPI increased 3.3%. Knowing what specific increase is coming each year would save IDD providers and the state time from having to debate new legislation with increased rates. Again, another win-win for IDD providers and the state. We also view the shared living model as a key component of solving the workforce crisis. As you know, we have not been able to keep up with Medicaid reimbursement rate increases each year, and it is one of the key drivers to turnover in our field. What we have learned in the 30 years that we have provided shared living in Nebraska is that shared living providers will see financial benefits as well. The average Mosaic direct support professional, DSP, will earn $16.39 per hour, which can translate to less than $40,000 per year of taxable income. Compare that with Mosaic's average shared living provider earning approximately $59,000 per year of nontaxable income. This is a significant financial boost for our workforce. We are finding that in rural communities we are competitive with other industries with the shared living model. We cannot say the same for our traditional waiver group homes. Lastly, the shared living rates range between $62.72 to $228.29 per day less when compared to the continuous home rates. If the increases for shared living are linked to the CPI, this allows providers to have the consistency in planning, as well as ease our stress around if we will be able to cover all future expenses for the service line. Again, this is also financially beneficial to the state to continue to support this important service line, and we hope we can count on your support to pass this legislation. Thank you for listening, and I appreciate all you do to help better support and serve the people in the state of Nebraska with intellectual and developmental disabilities. I am available to answer any questions.

CLEMENTS: Are there questions? Senator Erdman.

SARA BARTRUFF: Yes.

ERDMAN: Thank you, Senator Clements. So I'll ask you this question.

SARA BARTRUFF: Yes.

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ERDMAN: So your testimony said they earn $16.39 an hour, $40,000 per year. If you do $16.39 times 2080 hours, a normal 40 hour week, comes up $34,000, what is the other $6,000?

SARA BARTRUFF: That would be overtime. Our average DSP does work a significant amount of overtime.

ERDMAN: So how much overtime are you allowed?

SARA BARTRUFF: As much as we need--

ERDMAN: OK.

SARA BARTRUFF: --because we are very short staffed.

ERDMAN: Thank you.

CLEMENTS: Senator Dorn.

DORN: Thank you, Senator Clements. Thank you for being here. I think you said in your commentary $228 per day when you par-- that's the continuous home rate.

SARA BARTRUFF: It's the--

DORN: What does somebody have to-- what-- tell us what that person's like that gets a continuous sum.

SARA BARTRUFF: That is going to be in a high risk tier situation. We don't have very many individuals that would be receiving that. So I would say the average would probably be somewhere around $150 a day, less, that we would be seeing for a group home, or excuse me, for a shared living rate versus a group home rate.

DORN: Compared to the shared living in the continuous home, what, what's the percentage of each, maybe, if you have an idea? I mean--

SARA BARTRUFF: I, I can speak for Mosaic in-- Currently, we're serving 160 people in our shared living service, and we are only serving 17 people in our continuous group home.

DORN: OK. Thank you.

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CLEMENTS: Still trying to get a handle on all of these amounts. What is the $59,000 a year?

SARA BARTRUFF: That is what our home providers that provide the shared living service, that is the average wage that they make in nontaxable earnings.

CLEMENTS: So that would be somebody who has one of your clients living--

SARA BARTRUFF: Correct.

CLEMENTS: --in their home--

SARA BARTRUFF: Yep.

CLEMENTS: --would be getting $59,000. How can it be nontaxable?

SARA BARTRUFF: It is a nontaxable service. 1099, no 1099, just--

CLEMENTS: It's got an exemption.

SARA BARTRUFF: An exemption, yes.

CLEMENTS: I see. All right. The-- let's see, you're talking, talking about a possible 3.3%. This, this bill does not provide any increase immediately, but it would be--

SARA BARTRUFF: Yes.

CLEMENTS: --starting--

SARA BARTRUFF: Correct.

CLEMENTS: --in the future. Just a minute. Asking for-- what are the daily rates for continuous home? Do you know what the daily rate is, can you tell us?

SARA BARTRUFF: I, I know the, the current daily rate that on average we are receiving for the shared living service is around $242 a day. And for our group home, it is $290.98 per day per person.

CLEMENTS: A group home?

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SARA BARTRUFF: In a group home setting, yes.

CLEMENTS: $290?

SARA BARTRUFF: $290.98.

CLEMENTS: OK. And so the shared living daily rate is what?

SARA BARTRUFF: The average that we are currently receiving is $242.14.

CLEMENTS: Oh, oh is that this-- that's continuous home.

SARA BARTRUFF: The $290.98 is for the group continuous home. And then the $242.14 is for our shared living service.

CLEMENTS: Is there a difference between continuous home and shared living?

SARA BARTRUFF: Yes.

CLEMENTS: What is the difference?

SARA BARTRUFF: So shared living is the service that's provided in someone's home, whereas the continuous group home service is provided in a group home setting where you are going to live with 2, 3 other individuals and have staff come in and take care of you, it's much more restrictive.

CLEMENTS: OK. Let's see that? We are seeing on, on your testimony, rates between $62 and $228. What's the $62?

SARA BARTRUFF: That is going to be your basic tier. So I was comparing the tiers of services. So we-- there are five different tiers of service. Shared living services has one set of rates. And then the continuous group home has another set of rates. Our particular mix of services just--

CLEMENTS: Based on the need--

SARA BARTRUFF: Based on the needs of the individual client.

CLEMENTS: --of the client. I see. Very good. Thank you.

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SARA BARTRUFF: Thank you.

CLEMENTS: Senator Dorn?

DORN: I think Senator Erdman had a question, I don't know if he still does.

CLEMENTS: Senator Erdman?

ERDMAN: No.

CLEMENTS: Seeing no other questions.

SARA BARTRUFF: OK.

CLEMENTS: Thank you.

SARA BARTRUFF: Thank you very much.

CLEMENTS: Next proponent?

ALANA SCHRIVER: Good afternoon, Chairman Clements, members of the Appropriations Committee. My name is Alana Schriver, A-l-a-n-a S-c-h-r-i-v-e-r, and I'm the executive director of the Nebraska Association of Service Providers, which is the state membership association for home and community-based providers supporting people with intellectual and developmental disabilities. Our members employ thousands of people statewide. We empower individuals with IDD to reach their fullest potential and enable their family caregivers to remain in the workforce. Ensuring supports and services are available for Nebraskans with IDD is a responsibility of the state. Home and community-based service providers partner with the state to provide these essential services at a fraction of the cost of state run institutions like Beatrice State Development Center. According to a recent public records request, the average cost to support an individual at Beatrice State Development Center in 2023 was $380,574. The average cost to support an individual at a home and community-based service provider was $87,854 annually. So the cost savings for the Nebraska taxpayer as a result of this partnership is tremendous. Every year, home and community-based service providers and stakeholders such as myself come before you with bills to increase provider rates in order to keep pace with the rising cost of doing

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business. The cycle's routine and time consuming, as Senator Wishart mentioned, for both sides. With this bill, we have the opportunity to explore another option, tying provider rates to the consumer price index. We realize Nebraska has not been keen on this idea in the past, and that's why we're proposing to start with only one service code, the shared living providers, in order to prove the efficiency and effectiveness of an automated rate adjustment based on inflation. Other states are bringing forth similar bills this year, and Minnesota has already made it official. Minnesota takes the average inflation rate over their two year budget cycle, and rates are automatically adjusted across the board for IDD provider services. I've included the section of the statute there. State leadership time is freed up to focus on other issues. Our providers can shift our advocacy energy towards growth and industry innovations rather than coming back begging for solvency year after year. This bill attempts to resolve a recurring issue instead of just kicking the can down the road. Let's move on from the endless rate debates and explore real solutions. So, as my colleagues mentioned, the reason shared living is so important as this model is becoming more and more common due to the ever increasing difficulties of staffing a 24 hour group home with direct care workers. On the second page, I've included data from Ancor's annual Direct Support Professional Workforce Survey. This highlights, highlights how pervasive staff shortage has become nationwide. The shared living provider model utilizes subcontractors rather than employees, so this frees up the provider staff to focus on other services such as supported employment, which is helping people with IDD secure competitive, integrated jobs in their communities, and thereby also lowering the cost of the state to support that individual. My time is up, so I will turn it over to you if you have any questions.

CLEMENTS: Are there questions? Seeing none, thank you for your testimony. Next proponent?

EDISON McDONALD: Hello. My name is Edison McDonald, E-d-i-s-o-n M-c-D-o-n-a-l-d. I'm here representing the Arc of Nebraska. We're Nebraska's largest membership organization representing people with intellectual and developmental disabilities and their families. We support LB958 to provide long term sustainable provider rates. We must pay people who work with those with disabilities adequate pay. Every year we have to deal with provider rates as they fail to keep up with

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inflation. It's time to make this a permanent, dynamic tool that is reflective of the current need. Currently, providers have to come back every year and ask again for an increase because if rates don't keep up with inflation, it's effectively a rate cut. They also have to make guesses about what to do, what the Legislature will do, and frequently put down money to serve individuals in need if they're-- even if they aren't sure they will recoup it. It's time we stop making guesses in dealing with CEOs who have to fill shifts. In particular, with the minimum wage being tied to inflation, this is absolutely necessary for all rates. Frequently, the status quo has been subjective, but we need to look at making it objective. We need to tie all rates. This bill just does SLPs. And I think it's a good test case. But eventually we need to look at all rates to CPI to ensure long term dependability. Those rates need to be high enough above minimum wage to ensure they can attract people to this sometimes difficult work. We've seen 150% be a good standard. We expect that the federal government will be requiring that at least 80% of CMS funds go to direct care staff. This, plus the minimum wage increase being tied to inflation after 2025, means that we know these funds, these funds will go to direct care staff that need it. This progress needs to be tied to thoughtfully alleviating the waiting list of 500 people per year. To provide some more background. I've included, in my testimony, I'm not going to read it all out to save you all time, but I'm just going to point to a few of those graphics to give you a better sense of the DD system. One, the Table 8 walks through our priorities. That's how people enter the DD system. You can see if somebody's in an emergency situation, it's $134,000 per year. They're coming in at a lower tier. That means that we're able to really put in quality care and avoid much more costly expenses. The second chart shows, and I think we talk about DD rates, we talk about the waiting list, but the waiting list is only 3% of the problem. We currently serve 17% of people with intellectual and developmental disabilities, but there's another 80% out there who are getting nothing. And then on the last page, you can see our graphic of our resource map that maps out every provider across the state. And I think in terms of geographics, that's huge. I know I went on a drive one time and went 1,100 miles and would have only crossed one provider. I think that we need to protect our rural communities and protect people with disabilities. Please move this forward.

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CLEMENTS: Thank you for your testimony. Any questions? Senator Erdman?

ERDMAN: Thank you for coming up. Am I missing something? So if, if, in fact, there's $40,000 a year in taxable income and $59,000 a year in nontaxable income that's $99,000, and that's about the same costs as putting them in a home, isn't it?

EDISON McDONALD: So, we're probably looking at different sets of numbers in the chart that I handed you was from fiscal year 2018. So that's why those might not jive up. And I see Director Green behind me. He may be able to talk a little bit more about what those numbers look like now.

CLEMENTS: Other questions? Seeing none, thank you for your testimony. Next proponent for LB958? Seeing none, is there anyone here in opposition? Good afternoon.

TONY GREEN: Good afternoon, Senator Clements and members of the Appropriations Committee. My name is Tony Green, T-o-n-y G-r-e-e-n, and I am the Director for the Division of Developmental Disabilities with the Department of Health and Human Services. I'm here to testify in opposition to LB958, which would require DHHS to adjust reimbursement rates for shared living services based on the Consumer Price Index. I acknowledge the laudable intent behind ensuring fair compensation for Home and Community-Based Service providers, particularly shared living providers, as outlined in the bill. However, I wish to speak to why tethering reimbursement rates to the CPI is not in the best interest of Nebraska's HCBS system. In addition to the inequities this would create, this approach raises concerns about fiscal responsibility and challenges our commitment to maintaining a streamlined and efficient services. LB958 specifically targets shared living, a distinctive service setting within our Residential Habilitation service line. This service is a subcontract arrangement between agencies and individual independent contractors who share their homes with participants. The subcontractor model does not require agencies to pay benefits, overtime, or other expenses associated with employees. The current rate buildup for this specific service, and all others, include costs for the delivery of direct care, front line supervision, the administration and oversight of the service. Agency providers in this service pay the subcontractor a portion of the payment that's received by DHHS, with the remainder

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kept by the agency for their own expenses. Adopting a piecemeal approach where rate adjustments are mandated only on a specific rate, or specific service, impedes our capacity to address the system as a whole and ensure that resources are utilized to support the areas of greatest need. This service currently has few, if any, limitations on individuals or providers willing to serve. In fact, new provider enrollment specific to this service has increased 29% in the last three years for agencies that subcontract with shared living providers. Also, there's been an increase of 44% over the last three years of new shared living providers. Additionally, tying HCBS reimbursement rate to CPI might inadvertently contribute to unsustainable budget growth. The CPI, as a broad measure of inflation, inadequately captures the unique cost dynamics within the Nebraska's HCBS sector. Finally, it's unclear in this bill if the CPI derived rate increase is meant to be incorporated into, add to, or be in place of other HCBS provider rate increases this session or into the future. We request that the committee refrain from advancing this bill to General File, and I'm happy to answer any questions on this bill that I can.

CLEMENTS: Are there questions? Senator Erdman?

ERDMAN: Thank you. Senator Clements. Thank you for being here, Mr. Green.

TONY GREEN: You bet.

ERDMAN: So one put in a shared living environment, how much cheaper is that than to having them in a normal care system, care house?

TONY GREEN: Senator, great question. I can follow up and get you the exact rates. So let me explain kind of the-- I think there was a question about the differences though. So can-- residential habilitation is one service in the CMS, CMS taxonomy of a 24 hour residential service. There are then in Nebraska three delivery methods of that residential habilitation. You have the continuous home, which is the model that was described where it is shift staffed with employees of an agency. You have the shared living model, which is what we've been talking about here, which is the subcontract to an individual or family who is providing care in their own home. And then you also have a host home model. We don't see this as often anymore,

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but it was where the live-in caregiver was actually a paid employee of the agency instead of an independent contractor. So there are three ways that agencies can deliver that 24 hour residential service to individuals. Within that model, there are tiered rates based on the individual's assessed need that range, we call them like a basic tier, intermediate, high, advanced. And each of those have a different funding level that moves up as your needs increase. The, the rate buildup between a continuous home, which is the shift staff group home versus the shared living model, has many of the same factors that are in there. So there's the wage to the direct carer or the contractor, there is administration, there is oversight. The missing piece that would be in the rate buildup for shared living is generally in what we call ERE or the employee related expenses, because they're not paying benefits, overtime, in those things. So you do see a lower rate in shared living. And, I can get those exact rates to you, but I would agree that they're probably equivalent, to what Ms. Bartruff showed you from Mosaic.

ERDMAN: Thank you.

TONY GREEN: Yes.

CLEMENTS: Other questions? Senator Dorn?

DORN: Thank you, Senator Clements. Thank you for being here, Director Green. I have a couple questions. One is, I call it piggyback on one of the questions asked earlier, Senate Erdman. The lady asked question to, and I think, I don't remember what the organization she was with. They had about 10% of them were in the home, continuous home or whatever. Is that a normal percent or what do you see in your-- compared to the other models, is about 10% of the patients or whatever you call them in that continuous home base?

TONY GREEN: If you're just comparing the shift staff group home to the shared living model, what's the percentage of the population in each of those? You know, Senator, I can also follow up and give you an exact figure of what that looks like today. In, in previous conversations with our, our data folks, where we were looking at this last year, we were around-- it's over 50% are in the shared living model versus the shift staff group home. And I would-- I would imagine, based on the figures I gave you about the increase in

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agencies coming forward to deliver this service, in addition to the the 44% increase in folks coming-- families or individuals delivering the actual-- becoming independent contractors, there has been a, a rapid growth of this service over the last several years. There's nothing today that prevents agencies from moving people out of the traditional paid employee shift staffed continuous home over to the shared living.

DORN: Is that-- when you say nothing-- excuse me for asking this question too--

TONY GREEN: It's OK.

DORN: But, I mean, that is a decision based on DHHS, or that is a decision that they, based on criteria, get to make?

TONY GREEN: It is an individualized decision. So I would say it's not even really the agency. It is-- it is at the participant level that, that that decision would be made between them and their guardian, whether they want the continuous home model or the shared living provider model.

DORN: And then one last question yet, based on your comments here. It says-- and this one I wanted to ask you to explain this one, "additionally tying any HCBS reimbursement rate to the CPI might inadvertently contribute to unsustainable budget growth." How do you control, or what do you use the model to control budgets now?

TONY GREEN: Well, I think that's a-- so now we-- any rate increases that, that the department would be bringing forward are generally done when we might have a rate study that you mentioned earlier, or we get too far off of the existing rates. It's a requirement of, of CMS. These are Medicaid funded services that the states must, in their waiver applications, address the adequacy of their rates. And so--

DORN: Yes.

TONY GREEN: --that is always done in your renewals and any subsequent amendments that you do with your waiver. My comment to inadvertently having unsustained budget growth is because that number would be so unpredictable. And, and you could perhaps at the local level have decreased costs. Right? So let-- what we'll use an example of if the

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state came in and said we're going to lower training requirements, or we're going to lower some regulatory expectations that might decrease costs for providers, that wouldn't be taken into consideration if you-- if you arbitrarily tie it to CPI.

DORN: Thank you for answering the questions. Thank you.

TONY GREEN: You're, you're welcome.

CLEMENTS: In the past, how often has the DD rate been changed?

TONY GREEN: I did not bring that with me. I can-- I can tell our, our--

CLEMENTS: Is it two years or three or--

TONY GREEN: No, they, they have been increased over-- every year in the last few years. So our most recent substantial increase, during Covid, we increased the DD rates to include shared living by two-- no, not shared living, but all of the services, in total by 26%. Shared living received a 19%.

CLEMENTS: Then we had testimony that a shared living provider can receive $59,000 of tax free income.

TONY GREEN: Yeah.

CLEMENTS: How does that work?

TONY GREEN: So it, it's the, the, the exemption that is given, it is, is similar to foster care. It's the same exemption at the federal level that, that, that-- it's a hardship payment, so it, it becomes exempt from, from taxes.

CLEMENTS: All right. Any other questions? Thank you, Mr. Green.

TONY GREEN: You're welcome.

CLEMENTS: Anyone else in opposition?

DORN: Is, is our $12,000 exempt because we're hardship also?

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CLEMENTS: I heard that. Seeing none, is anyone wishing to testify neutral? Good afternoon.

JOE VALENTI: Hi, Senator Clements, Appropriations Committee. My name is Joe Valenti, J-o-e- V-a-l-e-n-t-i. I, I just want to clarify a few numbers that I know Senator Erdman will appreciate this, probably. So Alana mentioned some costs for BSDC, and as you may know me from the past, I'm very much a proponent of BSDC. And she did quote correctly that the cost averages for BSDC in 2023 was approximately $380,000 per individual. There's 77 individuals there today. And she did quote correctly that the average cost for the community right now, give or take, is around $87,000 per individual. So the only thing I want to-- I do want to clarify is right now in the community, there are 49 individuals being served, and Mr. Greenwood [SIC], Director Greenwood have to define exactly what that-- what the term is for the rate. But they are costing also over $380,000 per individual for those 49 individuals living in the community. So the reason I clarify that for you is because, as you go into appropriations, you know, you're in the middle of the biennium now, but when you go into it next year, BSDC will come up again. But there are 77 individuals there. And I would suggest to you, and I, I'm not an expert on this, but if we-- if we try to serve those same 77 individuals in the community, which they wouldn't fit in the community, because right now the providers are not accepting that high risk individual into the community, but if they did, the cost would be the same. It would be $380,000 or whatever the right number would be at that point in time when they got accepted into the community. So, BSDC does get hit often. I tend to try to pay a lot of attention to it because our son is there. And it is a high cost, but it is the same cost that our son would cost in the community would be $380,000. And right now, again, one more time, there are 49 individuals in the community being served at that number. And that's from the Office of Public Records. So that's not me just guessing it, that's from the Office of Public Records. I'll be glad to answer any questions.

CLEMENTS: Any questions? Thank you for your testimony.

JOE VALENTI: Thank you.

CLEMENTS: Anyone else here in the neutral capacity? Saying none, Senator Wishart?

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WISHART: OK. Well thank you. I will be quick to close since I know we have two more bills, but a couple of things I did want to point out. First of all, this is-- this is in no way, this legislation is in no way saying that shared living is the only solution for people who need care with developmental or intellectual disabilities in this state. Beatrice State Rehabilitation Center is very important for, for individuals who have high need of care, as are other different forms. So I just want to be, be clear on that. The reason I brought this legislation specific to tying sort of the cost of living increases that people experience with sort of these-- this rate increase, is that we are talking about families. So Nebraskans who are welcoming an individual into their home, and when the cost of living goes up, these are contracted employees and their cost of living goes up. The food that they put on the table, the gas that they use to take this individual around. And so I think actually this is a really good test case for us to look as an Appropriations Committee as to how we could find a more sustainable way to fund rate increases and specifically focus it on a, a type of service that we have seen now reduces the overall cost Nebraskans, in terms of our investment in providing care, and also provides a home-based situation for somebody to live in and, and, and thrive in. And, you know, being a-- having fostered a kid before and welcomed a little kid into my home, I know what it feels like to welcome someone into your home. And I know there are a lot of Nebraskans who, as we can hear, are growing, a growing number of Nebraskans who want to welcome an individual, have the capacity to welcome someone into their home. And I think it does behoove us to look at how can we create a cost of living increase that ties to what it's costing for basic needs to go and support these Nebraskans who are extending their home to somebody who's in need and saving the state money. So that's really what I'm looking to do with this legislation. And then lastly, Senator Erdman, I talked to Mosaic about-- the, the terms are very confusing, but the $40,000 per year taxable income, that is for a group home paid staff. So that's for a more facility base paid staff, it's my understanding. And the $59,000 per year nontaxable income is for this shared living, this family who is bringing somebody into their home. So they're actually making, you know, close to $60,000 a year to bring someone into their home, which also supports, then, that family as well. So I think it's a win-win solution, and we should incentivize it with legislation like this.

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CLEMENTS: Other other questions. I think the testimony was about $242 per day was the rate for shared living?

WISHART: It ranges. It ranges from--

CLEMENTS: There-- I know there are the levels of--

WISHART: Yeah. The average for Mosaic is about $150. Around that.

CLEMENTS: Oh, all right. And-- so that gives you. It's $54,000 a year, so the-- that's-- the shared living is going to be higher than that. But the, the Mosaic company is going to make-- they've got to, to have some revenue above the $59,000. I was trying to get to what the difference is for their administration.

WISHART: I think their-- the rate that they receive is around $240. And then the average per day rate for a family who is bringing this individual into their house is around $100-- $150.

Unidentified: It's around 78, 70%.

CLEMENTS: 177?

WISHART: 78%. It's around 78% what the family, what is contracted.

CLEMENTS: OK. And so 22% to the provider.

WISHART: Yeah.

CLEMENTS: To the organization.

WISHART: And all the supports that go around making that family situation a success.

CLEMENTS: All right. Thank you. Any other questions? Seeing none, thank you. We have position comments for LB958. Proponents, 9. Opponents, 1. Neutral, none. That concludes LB958. Next we have LB1376. Just-- Senator Riepe, just wait a minute while the room clears.

CLEMENTS: All right, now we'll open the hearing for LB1376. Welcome, Senator Riepe.

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RIEPE: Chairman Clements and members of the Appropriations Committee. My name is Merv Riepe, it's M-e-r-v R-i-e-p-e. I am the senator from District 12, which is Metro Omaha, including Ralston. I am here today to introduce LB1376, a bill requesting funding for LB204, which concerns Medicaid pharmacy reimbursement distribution fees. LB204 was brought to me by the Nebraska Pharmacists Association, and was passed on General File last week. LB1376 seek, seeks to appropriate $6 million to the Department of Health and Human Services for Program 348, specifically designed for increasing the Medicaid dispensing fee for pharmacies owning six or fewer pharmacies. This funding is essential to ensure LB204 can fulfill its objectives. Understanding the context of Medicaid pharmacy reimbursement is vital. With the transition from fee for service to managed care in 2015, there have been significant shifts in the reimbursement mechanisms. LB204, supported by funding from LB1376, aims to rectify these disparities, including concerning dispensing fee component. Drawing from the Iowa law model, which established a dispensing fee of $10.38 for Medicaid patients, LB1376 proposes a similar approach to enhance reimbursement rates. This measure is crucial, especially given the declining number of independent pharmacies in Nebraska. A chart has been presented to you, illustrates a concerning trend of closures impacting both rural and low income communities. LB1376 serves as a potential financial backbone for LB204, enabling us to fulfill our commitment to preserving access to essential pharmacy services for Medicaid recipients across Nebraska. By providing the necessary funding, we pave the way for fair and equitable reimbursement practices. Those seated behind me from the Nebraska Pharmacists Association will be able to delve deeper into the details and financial realities of this program. I urge your support for LB1376. This bill is not just about funding. It's about investing in the well-being of our local pharmacies and their preservation. Thank you for your attention, and I welcome questions.

CLEMENTS: Are there questions from the committee? Will they have a number for how many pharmacies there will be for less than six branches? So we know who that applies to?

RIEPE: I don't know. Mr. Chairman, what the remaining number will be that would be impacted by this reimbursement. I am a-- I am told that I believe it was the number of 19 closed in last year, no-- of the local pharmacies.

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CLEMENTS: And just for-- to prepare the others, we're going to want to know how many prescriptions will be expected to be filled so that if we don't use $10.38--

RIEPE: Yes.

CLEMENTS: --we know what the cost is--

RIEPE: Yes.

CLEMENTS: --per dollar of increase.

RIEPE: OK.

CLEMENTS: So we'll, we'll defer to the testifiers.

RIEPE: OK. OK. Thank you. That's, that's an incri--critical number to have, the multiplier times $10 or whatever it is. OK.

CLEMENTS: Thank you, Senator Riepe.

RIEPE: Thank you sir.

CLEMENTS: We'll now ask for proponents for LB1376.

MARCIA MUETING: Good afternoon.

CLEMENTS: Good afternoon.

MARCIA MUETING: Senator Clements, members of the Appropriations Committee, my name is Marcia Mueting, M-a-r-c-i-a M-u-e-t-i-n-g. I'm a pharmacist, and I'm the CEO of the Nebraska Pharmacists Association, and a registered lobbyist. Thanks for having me here. I appear before you today to address our request for funding for an increase in prescription dispensing fees. LB204 was heard before the Health and Human Services Committee last year. Prescription reimbursement is based on two components, the cost of the drug, and then a dispensing fee, which is supposed to cover the overhead costs to provide the medication. In January 2008, and this sounds like a little bit of a broken record this afternoon as I hear the other bills, a report was issued-- Nebraska Medicaid requested a dispensing fee cost of dispensing survey. And that, that was performed based on 2006 numbers

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,and the cost of dispensing in 2008 was determined to be $10.18. There were no adjustments to dispensing fees based on that cost of dispensing survey. When managed care was implemented in 2015, a dispensing fee of $4.65 was offered to independent pharmacies with six or less locations, only under fee for service. The managed care organizations were allowed to negotiate a lower dispensing fee. But what I've learned from pharmacy, pharmacies that the negotiating is, is a take it or leave it contract. Pharmacies have not received an increase in reimbursement in 22 years. In fact, they have actually received cuts in reimbursement, not only to the cost of the drug, but the dispensing fee as well. And Senator Riepe was talking about the number of independent pharmacies in Nebraska. In 2010, it was 239. In 2023, it's 140. That's a difference of 96 [SIC]. 96 independent pharmacies across our state have closed between 2010 and 2023, in 13 years. LB204 is going to establish a medicaid dispensing fee of $10.38 for-- on all prescriptions, fee for service, managed, managed care, doesn't matter, to independent pharmacies with six or less locations. LB1376-- excuse me, LB204 is currently sitting on Select File. We asked Senator Riepe to introduce LB1376, since we did not know at the start of the session whether we'd be able to have LB204 considered on its own merits. LB204 also directs the department to perform a cost of dispensing survey, and surveys every two years, to provide for any necessary adjustments. We are awaiting a revised fiscal note for LB204, which will identify the cost to the state of just of increasing the dispensing Medicaid-- or excuse me, Medicaid dispensing fee to $10.38 for independent pharmacies. We are aware that the fate of LB204 is dependent on funds available after the budget process has been completed, and on spending priorities established at that time. If the committee elects to include funding for increased dispensing fees through the biennium budget adjustment process, we'd recommend the funding be based on a dispensing fee of $10.38 to pharmacies with six or fewer locations, as proposed in LB204. It's important to know that we are not asking for reimbursement to independent pharmacies for them to profit. This is a breakeven cost of the medication, plus cost to dispense. For these reasons, I hope the committee will advance LB1376, and I'm happy to answer any questions that you have.

CLEMENTS: Are there questions? Senator Dorn?

DORN: Thank you, Senator Clements. I, I guess that the, the managed care fa-- or the, the groups are allowed to negotiate. Is it just with

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the independent ones or is it, I call it all pharmacies statewide. For example, at Walmart.

MARCIA MUETING: All pharmacies statewide. They can negotiate a lower-- a lower cost of dispensing and a lower cost of reimbursement.

DORN: Have, have, have they-- when you talk about the rate in here, then, is that all pharmacies or is that it just the independent ones that have that specific rate? Do you know, I guess, yeah.

MARCIA MUETING: Well, I want to be clear. When, when we introduced LB204 last year, I actually asked for $10.38 for a dispensing fee for all prescriptions for all pharmacies across Nebraska. That's the cost to dispense. I don't know why it's OK to say we're not going to cover your cost. I don't know why that's OK to say that. In some negotiations with DHHS, they've made it clear that-- and I don't-- I don't know that our state can afford to pay all the pharmacies adequately. So we were asked to somehow limit the, the budget for the cost of dispensing. And we looked to our independent pharmacies first, they're a safety net. And a lot of these are-- well, these are single owner businesses that are supporting our-- the infrastructure of Nebraska. They employ a lot of people. So do the chains. I would advocate-- I would advocate for everybody to get an increase in the cost of dispensing fees. But in 22 years we haven't had an increase, and I thought, let's start with the independents. They're the ones that are closing. They're the ones that are really struggling.

DORN: No. Thank you for that explanation.

MARCIA MUETING: Sure.

CLEMENTS: Any other questions? The current dispensing fee is $4.65 for those you're talking about? Is that right?

MARCIA MUETING: Well, it's in the-- in the fee for service population, and only 99% of the pharmacy claims are being paid for-- 99% of the pharmacy claims in Nebraska are covered under managed care. So only 1%--

CLEMENTS: Of Medicaid.

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MARCIA MUETING: For only 1% of our independent pharmacies are receiving that dispensing fee. Otherwise it's less. In fact, the fiscal note from LB204 from last year indicated that the dispensing-- average dispensing fee across the board in Nebraska was like $3.88, well below the cost of dispensing, as determined by a survey from the department from 2008. So, it's been a long time. And we don't come before you every year, we haven't been here in a long time to even ask for an increase. So I think this is really important.

CLEMENTS: How many pharmacies are there that have less than or equal to six locations?

MARCIA MUETING: I don't have that number for you, but I will get it.

CLEMENTS: How many claims do you think you would have, how many prescriptions would you fill in a year's time?

MARCIA MUETING: I think that was in the fiscal note for LB204, the number of claims paid last year.

CLEMENTS: And so the $6 million is going to provide how many services?

MARCIA MUETING: I would have to-- I'd have to go back and look at LB204. But we calculated that it would increase the dispensing fee on an average of $7.

CLEMENTS: And, you-- It was mentioned that we're waiting for a fiscal note from someone, that someone is right here, that someone is asking me how many pharmacies are there and how many prescriptions are you going to fill?

MARCIA MUETING: OK.

CLEMENTS: And so you're not going to get that information till you provide it from your organization should have those numbers. And maybe somebody else behind you will have that.

MARCIA MUETING: I'll have to request those numbers from Medicaid.

CLEMENTS: All right. Well, thank you for your testimony.

MARCIA MUETING: Sure.

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CLEMENTS: Next proponent? Good afternoon.

BRYCE WALKER: Hello. Chairperson Clements and members of the committee, my name is Bryce Walker, B-r-y-c-e W-a-l-k-e-r. I'm a pharmacist and member of the Nebraska Pharmacists Association. I'm here today to testify in support of LB1376. I have worked at the Kohll's Pharmacy in Lincoln at 27th and Vine Street since I graduated pharmacy school in 2017. Kohll's pharmacy has five locations in Nebraska and one in Iowa, and employs a more than 140 people. Kohll's offers vital health care services including medication packaging, long-acting antipsychotic injections, respiratory services, medical equipment, and a delivery service. I would love to be able to just focus on providing excellent patient care, but more and more of my attention has to be on the reimbursement we receive, otherwise we would not be able to remain in business. Kohll's Lincoln Pharmacy is in a lower income area and serves a high number of Medicaid patients. About two years ago, we stopped carrying certain expensive brand name drugs when we realized Nebraska Medicaid reimbursement for these drugs was less than the cost of the drugs. This cost doesn't include the many other expenses involved in dispensing prescriptions like labor, supplies, and utilities. Some prescriptions through Medicaid are, are profitable for us to fill. However, when we take into account all of these costs, it, it can be a net loss. We don't have this issue with the Kohll's Iowa Pharmacy because Iowa's Medicaid reimbursement, like the vast majority of most other states, is over 100% greater than Nebraska's. Local independent pharmacies like Kohll's have difficulty negotiating an adequate reimbursement rate from the massive corporations that serve as pharmacy benefit managers for Nebraska's three Medicaid managed care organizations. The difference in reimbursements for the same medications across MCOs could be hundreds of dollars. LB1376 would help to protect independent pharmacies in our state through securing a more fair and reasonable dispensing fee. Kohll's is considering moving the Lincoln location further south to an area in a higher income part of town. This would decrease the amount of Medicaid prescriptions we fill and prevent us from dispensing prescriptions at a loss. Many pharmacies in low-income neighborhoods across Nebraska have closed. These closures impact Nebraska's neediest residents. The situation is particularly dire for Medicaid patients with mental health diagnoses, which, when left untreated, results in increased emergency healthcare expenses, which significantly increases

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costs to Nebraska taxpayers. Two weeks ago, we had a Medicaid patient come in needing a long-acting antipsychotic injection called Abilify. We were losing more than $100 on the medication due to the low Medicaid reimbursement rates. The patient needed the shot, so I made the decision to administer it despite the loss. Few pharmacies have pharmacists with the expertise to give these types of injections. I mean, obviously, a mail order pharmacy would not be an option for this patient. If Kohll's chose not to take the loss and dispense the much needed injection, this patient would have great difficulty accessing this medication. If Medicaid updates their reimburse-- their reimbursement, including the dispensing fee, this would allow us to continue serving patients like this that we see every day. Increasing the professional dispensing fee for prescriptions through Medicaid would allow Kohll's and other independently owned pharmacies to continue serving patients in need. I urge you to support this bill and help keep pharmacies in low-income areas open, provide excellent care to Medicaid recipients, and save Nebraska taxpayers money. Thank you. I welcome questions.

CLEMENTS: Are there questions? What percent of your Medicaid scripts, or what percent of your scripts at 27th and Vine are Medicaid?

BRYCE WALKER: Sure. So probably at our location, between a third and 50% of the prescriptions that we fill are, are for patients who are covered under Medicaid. Probably closer to 50%. I could get the exact-- closer to the exact number for you, but--

CLEMENTS: It's close to 50%?

BRYCE WALKER: It's, it's probably about 50%.

CLEMENTS: All right. Do you-- do you know how many Medicaid prescriptions a year Kohll's fills?

BRYCE WALKER: I could get you the exact number, but we, we do probably fill, on average, between 250 and 300 prescriptions a day. And if 50% of those are for patients on Medicaid, I, I could do the math of it.

CLEMENTS: Senator Dorn?

DORN: Thank you, Senator Clements. Thank you for being here. Explain that part where you say, in Iowa, the Medicaid reimbursement, like

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many other states, is 100% greater than Nebraska. What do you mean, is that for the prescription part? Is that for the fill thing, or is-- or explain that.

BRYCE WALKER: Sure. So the, the professional dispensing fee in Iowa is, is greater than what Nebraska is. I, I believe Marcia said ours was an average was about three, $3 and something cents, and Iowa's is, is more than $10. And so, I believe--

DORN: So it's the prescription fill part of it that's 100% greater.

BRYCE WALKER: Yes.

DORN: Maybe somebody else will answer that too. Thank you.

CLEMENTS: Then, on the cost of the drug itself, you mentioned one drug that you lost $100, that some drugs you have a profit on a Medicaid fee?

BRYCE WALKER: Yeah, yeah, some of them. We don't lose on every single prescription. But if you, if you take into account the other costs associated with just doing business, really it can be a net loss.

CLEMENTS: Very good. Thank you for your testimony. Next proponent? Well, seeing none, we will anticipate getting some information from the Pharmacy Association. Is anyone here in opposition to LB1376? Seeing none, anyone here in the neutral capacity? Good afternoon.

RICH OTTO: Good afternoon, Chairman, members of the committee. My name is Rich Otto, R-i-c-h O-t-t-o, testifying in a neutral capacity to LB1376 on behalf of the Nebraska Retail Federation and the Nebraska Grocery Industry Association. I'm here to testify, because the retail pharmacy industry supported LB204 as originally-- as originally introduced. But the committee amended that with AM1418, which restricts the reimbursement increases to pharmacies with six locations or less. I realize the committee didn't hear LB204, it was in HHS, but we were not given the opportunity before the bill advanced to register our opposition to the committee amendment, AM1480-- AM1418, so I wanted to mention that today. The six pharmacy or last number can be found in HHS regulation, but we find it arbitrary and not particularly rational given how many pharmacy customers are served by retail pharmacies, which have many more locations. It seems like this was an

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effort to avoid giving a windfall to large pharmacies, which would only be the case because they fill the most prescriptions. But this change also fails to include medium sized companies, even one indepe-- independently owned retail pharmacy headquartered here in Lincoln. It also completely discounts the fact that some independent, independent pharmacies actually form groups where they're offered similar pricing structures to those of medium sized pharmacies. But since individually each of these owners have fewer than the six locations, they would qualify for the increased reimbursement. While we don't love the idea, the increases in reimbursement will go to the pharmacy-- those pharmacies only for now. But the plan is to increase reimbursement to all pharmacies after the survey is complete. We would probably suggest a tiered system or a sliding scale. We'd be open to that. We understand that that's probably where the department would push it. Most of their opposition was to the chains getting the increase when they feel that they have negotiated under managed care. Again, we're willing to work with this committee or the body to make it work for all parties. Happy to answer any questions you might have.

CLEMENTS: Senator Dorn?

DORN: Thank you. Senator Clements. And, and maybe I missed it earlier on when you talked about it. The, the Department of Health and Human Services, they gave the authority to, I call it the managed groups to negotiate. Am I correct in that statement?

RICH OTTO: Yes. So we switched is-- as was mentioned, in 2015, we switched over to managed care.

DORN: Yes.

RICH OTTO: So a lot of times you see the number on the dispensing fee. That, that's not accurate. I think if you looked at the fiscal note of LB204, I think it was less than 1,500 prescriptions were actually paid that fee for service amount. So in theory, you sh-- the fee-- the fee for service is accurate of what it should-- does cost pharmacies to dispense. But it's not what we're being reimbursed at, and chains are being reimbursed at maybe a dollar, probably less.

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DORN: So-- and I mean, I'm asking this question, probably it's a stupid question, but what if we don't have no pharmacies and nobody's gonna dispense nothing--

RICH OTTO: Well, that--

DORN: --then what?

RICH OTTO: Exactly. I mean, we see the trend. You know, PBMs have pushed mail order, all these other things that have hurt independent pharmacies. I don't want to discredit the closures or any of that. All of the previous testifiers were correct. But we need to incentivize locations. We need places where people can go in, get shots, have care, all of this. And the unfortunate thing is that we had to cut costs. But there is also a portion where the six or less, if a chain has eight, they're actually incentivized to close two locations. So it is concerning that this doesn't accomplish the goal of having more pharmacy locations. I think in the current state of Nebraska pharmacies, it is true that very few are opening new locations and that very few are going to hit that seventh location. But if a chain did have six, they would definitely never open a seventh.

DORN: Thank you.

CLEMENTS: Senator Dover.

DOVER: You know, you made a comparison as far as you wouldn't be incentivized. But many pharmacies sell much more than-- just, I mean, they, they have other products, that was like-- but-- so it probably does it nearly as much as far as the money they're making off of selling the prescriptions and stuff. But what percentage of it-- I, I know it's a strange-- it's a probably tough one to answer, but what percentage of profit comes from the lack of dispensing fees versus, versus other, other moneys made? And I'm obviously familiar with my Walgreens type store, where they're selling a lot of other things, and they have the pharmacy. But I mean, maybe they're making enough--

RICH OTTO: Right.

DOVER: --on the other side not to shut the store down.

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RICH OTTO: Sure. And that, that has been proposed before. I don't know the exact breakdown. But many have argued that pharmacies like Walgreens or those should take a loss on, on prescriptions being filled because they can make it up by buying something else. I completely think that's ludicrous, to think that we should be saying that pharmacies should be able to take a loss leader on prescriptions--

DOVER: Yeah, no, I didn't mean that--

RICH OTTO: --just because they're making--

DOVER: --I just was wondering-- I guess, when you made the statement that maybe they would just shut down and shut the location down, that be saying that-- that would be saying that there's no profitability on the other things they were selling, because--

RICH OTTO: Well--

DOVER: --maybe, maybe the other products do justify having a-- having a pharmacy there selling other products.

RICH OTTO: Sure. I think if a store, if they had stores that were on the verge and just barely profitable, that getting to that sixth location would make each of those locations more profitable and may justify the closure, is my point.

DOVER: All right. Thank you.

CLEMENTS: Any other questions? Seeing none, thank you for your testimony. Anyone else here in the neutral capacity? Seeing none, Senator Riepe, you may close.

RIEPE: Thank you, Chairman Clements and members of the committee. I would like to respond, and I'd like to thank everyone that's testified, regardless of their position. I'd also like to say that I would not describe the request that's in front of you today as a windfall for anyone. I think that our purpose in amending this down to the six pharmacies was that we sought to cease pharmacies closing, which is often a sole pharmacy in a given community. I'd also-- while I was a finance major in school, I was not an actuarial scientist, so some of the numbers I will give you. I took, with my trusty number

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here, I took the $6 million that we're requesting, divided 10,000-- $10.38 into that. And that comes up to 578,035 prescriptions. And that would amount to 4,128 per independent, independent pharmacies in terms of the numbers of the prescriptions. There are a total of 140 of the pharmacies that are-- that are in the count, that are under the ownership of six pharmacies. With that, I think that is the kind of clarification notes that I wanted to make. I would seek to answer any additional questions.

CLEMENTS: Are there questions? Seeing none, thank you, sir.

RIEPE: Thank you. Thank you to the committee.

CLEMENTS: And we have position comments for the record on LB1376. Proponents, 3. Opponents, none. Neutral, 1. We're ready to open a hearing for LB1078. Senator McDonnell, welcome.

McDONNELL: Thank you, Chairman Clements and members of the Appropriations Committee. My name is Mike McDonnell, M-i-k-e M-c-D-o-n-n-e-l-l. I represent Legislative District 5, South Omaha. LB1078, which seeks to increase the-- in rates paid to child welfare providers who perform work on behalf of the Department of Health and Human Services and the Office of Probation Administration as offered in the bill. The aim is for a 5% increase. As drafted, the bill incorrectly referred to current fiscal year. But I am distributing an amendment that corrects the error and implements it in '24-25 fiscal year. You can also see in the, the fiscal note there is a separation also. Let me first start by thanking the committee for its support of child welfare increases in the budget last session. Although the committee included a 2% increase, the Governor chose to veto the additional funding. Instead, the administration did implement a rate increase for all services and provided a one time larger increase for selected services using un-- unspent ARPA dollars that had carried over. After some discussion as to whether or not an effort should be put forth to override the veto, a decision was made to respect the Governor's commitment to providing the increase using ARPA dollars, primarily because the larger increase for critical services that impacted rural providers was absolutely needed, and the risk of jeopardizing the loss of those additional amounts was too great. At the end of the day, then, providers did receive the rate increases, but through the spending of ARPA dollars, and the department had

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access to and, and, and not via base rate appropriations in the budget. I note all of this today to help underscore the importance of maintaining those rate bases that were not General Fund supported, particularly as the Legislature moves into the next biennium. At the very least, the one time ARPA dollar increase needs to be maintained moving forward. I also ask the committee to consider building on the work we did last year, by providing an additional rate increase for providers without ongoing, and the intentional investment providers will continue to struggle to meet the needs of the children and the families they serve. Ensuring that the providers are able to provide the appropriate levels of care and the attention to the children is critical to our success and the future of these kids. There are a few providers here to testify that can talk about the challenges they face making ends meet and ensuring adequate staffing. I'll let them speak with, with their-- with their real world experiences. Again, if you look at the fiscal note, the amendment that was handed out with my testimony, it has to do with fiscal year '24- 25. If you go to the fiscal note and look at the second page, it specifically talks about, if the bill was meant for fiscal year '24-25. So please refer to that part of the fiscal note. I'm here to answer your questions.

CLEMENTS: Are there questions?

McDONNELL: I will be here to close.

CLEMENTS: All right. Ready for the first proponent, please. Good afternoon.

RYAN STANTON: Good afternoon, Chairman Clements and members of the Appropriations Committee. My name is Ryan Stanton, spelled R-y-a-n S-t-a-n-t-o-n. I'm the CEO of Compass, a family service provider based out of Kearney. We're-- I'm also the president of the Nebraska Alliance of Family and Child Service Providers. We're an association of child welfare providers who individually contract with DHHS to provide child welfare services to thousands of families all across Nebraska. I'm here in support of LB1078 and want to thank Senator, Senator McDonnell for introducing it. We appreciate you and several others on this committee for advocating for the provider community over the years. As many of you have repeatedly heard over the years, providers serving in counties outside of Douglas and Sarpy Counties went without any rate increases for services other than foster care

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from 2010 to July of 2019. In fiscal year 2021-22, we did receive a 2% increase in each year. Then, in January 2022, specific services received a temporary increase through June of that year. In addition, beginning in January of '22, DHS transitioned case management in Douglas and Sarpy counties from Saint Francis Ministries back to the state. Then, in fiscal year '23, in order to allow much needed and much utilized services to continue to be available to families, rates for several services were increased by about 17%. I know that sounds significant, and it is. However, I do want to note two things. One, despite the increase, the providers that were serving Douglas and Sarpy County experienced a decrease in the reimbursement rate for some of the services because the state reimbursement rate was still less than what they were receiving from Saint Francis. And then, two, the drive time rate, which is the money that we get paid for driving families those millions of miles all across the state to services and visit, visits actually decreased from that temporary six month increase in '22. And then for fiscal year '24, providers received a 3% increase. In addition, specific services received an additional increase using ARPA dollars. Which brings us to today. Currently, the rates for many services have not been reviewed for over 15 years, and new services continue to be considered in request by DHHS. Please-- let's see here. Just trying to cut out some of my testimony here. What we're seeking is a fair and predictable method for determining rates and rate increases with contract language that hol-- holds the both the provider community and DHHS accountable. To that end providers des-- providers desire annual rate increases equal to the rate of inflation, or maybe a cost of living increase. Any above and beyond increase would need to show objective evidence to its need. In the meantime, we continue to deal with inflation and the always increasing cost of doing business. We'll continue to come and beg for dollars to help serve the state's most vulnerable citizens. Again, thank you so much for hearing our plea, and I'd be happy to answer any questions.

CLEMENTS: Are there questions? Seeing none, thank you for your testimony.

RYAN STANTON: Thank you.

CLEMENTS: Next proponent? Good afternoon.

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ASHLEY BROWN: Good afternoon. Thank you, Chairman Clements and the members of the Appropriations Committee. My name is Ashley Brown. I'm the president for KVC Nebraska. And I'm also-- KVC Nebraska's a private nonprofit organization providing a wide variety of services to individuals and families across our great state.

CLEMENTS: How do you spell your names?

ASHLEY BROWN: Sorry.

CLEMENTS: Go ahead.

ASHLEY BROWN: Ashley Brown, A-s-h-l-e-y B-r-o-w-n. I also serve as the president for the Children and Family Coalition of Nebraska, otherwise known as CAFCON. CAFCON is a nonprofit association comprised of 11 organizations that provide child welfare and other services to Nebraskans in all 93 counties. I'd like to start by first thanking Senator McDonnell for introducing LB1078. I'd also like to thank the committee for its support for an increase in child welfare rates last year in your budget proposal. Unfortunately, we're here again, and it is just as critical that you consider another rate increase for child-- for child welfare rates this session. To continue a positive impact and positive outcome for children and families in the child welfare system, the first step is making intentional investments so that systems and services of support in our state are appropriate and effective. There's no question the best way to prevent system involvement altogether, strengthen families and communities, and facilitate safe and timely return of children to their families is through a well equipped, well-trained workforce. Continued increased challenges in the ability to offer an adequate and competitive wage and supportive work environment to the child welfare workforce results in instability for the most vulnerable children and families served by our system. Over the past few years, employers statewide have seen wage increases and competition for employees has been high. That's an understatement. And not only did we see that firsthand, but our industry's reliance on state reimbursement rates leaves us in a really unique and challenging situation related to meeting employee need and ensuring we have adequate staff to serve children and families. CAFCON members value a strong and productive public-private partnership. We're grateful for the collaboration between the public and the private system over the years. It remains critical for this to

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continue, and it must be paired with a commitment for future adjustments and plans, as Ryan mentioned, on how we set and review child welfare rates. Without providers-- without us as providers receiving these rate increases and having a predictable model, we're continuously at a disadvantage in terms of planning for workforce needs, hiring employees, and training and retaining, retaining them. For this reason, we continue to ask for your support and rate increase-- increases as you-- as you construct your budget. Thank you for your support on LB1078. Happy to answer any questions.

CLEMENTS: Are there questions? Senator Erdman.

ERDMAN: Thank you, Senator Clements. Thank you for coming.

ASHLEY BROWN: Sure.

ERDMAN: I noticed all those CAFCON members on that last, back page.

ASHLEY BROWN: Yes.

ERDMAN: Are any of those west of Grand Island?

ASHLEY BROWN: Some of us have-- Yes. I can say-- I can speak for my organization specifically. We have employees and support families in the Scottsbluff area.

ERDMAN: You do?

ASHLEY BROWN: I can't speak exactly for every agency, but I can tell you there's a lot of satellite offices and employees. So we are in-- we are serving all 93 counties.

ERDMAN: OK. Thank you.

ASHLEY BROWN: Yep.

CLEMENTS: Other questions? Seeing none, thank you for your testimony.

ASHLEY BROWN: Thank you.

CLEMENTS: Next proponent, please? Good afternoon.

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ANNETTE DUBAS: Good afternoon, Senator Clements and members of the Appropriations Committee. My name is Annette Dubas, A-n-n-e-t-t-e D-u-b-a-s, and I am the executive director for the Nebraska Association of Behavioral Health Organizations, otherwise known as NABHO, which represents 58 organizations statewide. We include community mental health and substance use disorder providers, hospitals, regional behavioral health authorities, and consumers. We would like to thank Senator McDonnell for introducing LB1078. Many of our NABHO members who provide behavioral health services for children and families are also involved with the child welfare system. We believe rates that support behavioral health services and child welfare services go hand in glove. They are a part of a comprehensive system that addresses all the components for children and families. Child welfare providers are those front line workers. They're responding to families in crisis, and they see children when they are at their most vulnerable. They are serving families who are struggling with mental illness and substance use disorders. And if you look at the numbers, those are, are pretty high, whether it's the, the parents or the caregivers or the children themselves. They support foster families. They work hard to reunify families and keep them together. They also provide adoption supports. But all too often, the trauma that these children and families are dealing with, be it physical or mental or both, is at the root of the mental illness and substance use disorders. And that's where our behavioral health community comes in. So as I listen to my members and these other providers, it seems that they are doing whatever it takes to make sure that these kiddos and their needs are being met, be they physical needs, emotional needs, educational needs, or mental needs. As in the behavioral health world, retaining and recruiting workforce is a challenge. These are high demand, high stress jobs with heavy caseloads. Increasing reimbursement rates for these services won't solve the problem, but it will certainly help them be much more competitive with their wages and keep services available. Increasing reimbursement rates will provide needed support for this system of care, and caregivers who help children and families live healthy, happy and productive lives. It's an investment well worth it for our state. I'd be happy to answer any questions.

CLEMENTS: Questions? See none, thank you for your testimony. Next proponent? Good afternoon.

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CHRIS JONES: Hi. Good afternoon. Thanks for having me. My name is Chris Jones, C-h-r-i-s J-o-n-e-s. I'm the advocacy director for Nebraska Children's Home Society. I'm testifying in support of LB1078, and thank you so much for your votes and your support during last year's legislative session, when we did provide a rate increases despite a Governor's veto. Our statewide nonprofit has three core programs, family support, foster care, and adoption. Many of the services we provide are unique to our expertise in the areas of permanency planning and post adoption, relative and kin supports, and lifelong connections. In your packet, you have a copy of my testimony, the NCHS financials, and a fact sheet about a recently terminated contract for Family Finding, a service included in LB1078. Last year we came to the committee, like others, to express our need for rate increases. At that time, we were privately subsidizing between 30 and 77%, or $1.4 million, in private dollars for our state contracts. The situation's only gotten worse. This year we're projected to spend upwards of $2 million for-- in private dollars for these contracts, which is not sustainable. Additionally, we received notice last week that a service we've been providing statewide since 2015, Family Finding, will end May 1st. Since contract renewals and delays are frequent and anticipated when working with the department, we've been working in good faith since October without a contract, and collaborated for most of last year with the previous administration on how to modify and expand that contract. The rationale given for the ending the contract is that it's no longer in statute, citing a pilot that ended in 2019, and the department is planning to bring the service in-house and add DHHS employees. The contract termin-- termination affects ten NCHS employees, their families, and hundreds of individuals and professionals connected to the service facing disruption. Just to hit a couple of my high points in the testimony, and you have the full copy in front of you, this loses a private match, which is, since last July, $179,000 worth of our private dollars. So in a fiscal note, you'll see the state dollars and the federal dollars, but you often do not see the other side-- or the full picture, which is to include the private matches also, which were able to help ensure the program success. 71% of the kids served in this program last year are-- were outside of Lincoln and Omaha. So we served 253-- or 257, excuse me, last year. And 71% of those were in greater Nebraska, where licensed foster homes and other formal supports are sparse. There's a significant return on investment when

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we connect kids and-- who are languishing in foster care with relatives and other kin supports. Excuse me. Due to the department's ongoing and persistent challenges with vacancies and workforce turnover, this will result in case stagnation and poor outcomes for children and families. A case work-as-usual mentality undermines progress. I see my, my light is up and I have just a few more paragraphs left if the committee has time.

CLEMENTS: Are there questions? Would you, you go ahead and just wrap up your comments?

CHRIS JONES: Yes. So it cannot be emphasized enough the impact that decisions like this have on the workforce. Throughout the last 15 years, those who've remained working in child welfare services have experienced a number of disruptions due to contract terminations, program closures, reassignments and other involuntary role changes. To do this work, you have to have the ability to build relationships with families who have-- who have felt harmed by this system or by DHHS in the past. And to-- excuse me. We work hard to build the trust with our own employees as well as the families that we serve. We need legislative partnership to, to continue the groundwork prepared by LB1173 practice and finance models last year. I respectfully ask the committee to commit funding in the budget with the intent of restoring that Family Finding contract, and urge you to support LB1078. And that's it. And there's additional--

CLEMENTS: Are there questions?

CHRIS JONES: --materials in your packet.

CLEMENTS: Let me take a look here. Senator Wishart?

WISHART: So, in terms of the, the private match, when this contract was ended, were there private dollars that were invested into this that can no longer be-- I'm just trying to-- can you tell me a little bit more about what happened during this contract process?

CHRIS JONES: Sure. I'll try to make it brief, but essentially when we had a public-private model in the eastern service area where we had a lead agency through either PromiseShip or Saint Francis, our, our NCHS program was providing Family Finding in all the other service areas of

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the state. And throughout the last year, we've been working with the previous administration on how to expand into the eastern service area and move the service up front further. We've always put in private dollars to ensure the success of the program, to make sure we have manageable caseloads for our team members who we can pay for travel for relatives who are coming from out of state to meet kids that they didn't know were in foster care and reconnect those. So these are dollars that are already spent. So last year-- and the numbers that I'm reporting, the $179,000 in private funds, those are for services to complete the service more fully that is not covered by a DHHS contract.

WISHART: OK.

CHRIS JONES: That helps.

CLEMENTS: How many children did you serve last year? Did you-- I thought I heard you say a number.

CHRIS JONES: Yes. Thank you for asking. We served 257 children last year. The contract is a case rate, a referral by case, which could be a sibling set of six or eight, and it could just be for one child.

CLEMENTS: Oh.

CHRIS JONES: Yeah. So the contract states for 127 referrals, but what ended up being served was 257 unique children.

CLEMENTS: I see. Very good. Any other questions? Seeing none, thank you for your testimony.

CHRIS JONES: Thank you very much.

CLEMENTS: Next proponent for LB1078. Good afternoon.

AMANDA ADAMS: Good afternoon, Chairman Clements and Appropriations Committee members. My name is Amanda Adams, and I am the policy analyst for the Nebraska Children's Commission. You spell my name A-m-a-n-d-a A-d-a-m-s, and I am testifying in support on behalf of the commission for LB1078. The Foster Care Rate Reimbursement Committee was created in 2012 as one of five statutory committees which fall under the umbrella of the commission, and is responsible for reviewing

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and making recommendations on foster care reimbursement rates, standardized level of care assessments, and adoption assistant payments. The committee submits a rate recommendations report every four years based on an analysis of current consumer expenditure data, cost of living adjustments in Nebraska, and cost specific to caring for children in foster care. The committee will submit recommendations in June of this year after reviewing census data from the USDA expenditures on children and families, the Bureau of Labor Statistics inflation calculator, and surveys that we took with child placing agencies across Nebraska. The committee will be recommending a 5% increase this year to all foster care rates and agency support rates, and every year until our next report based on this research that we completed. The last committee report was submitted in 2020, and prepared in 2019, at the beginning of the Covid pandemic, if you hadn't heard about that, and prior to multiple economic changes that have impacted the cost of caring for children. Since 2019, DHHS has increased their rates each year, and the commission appreciates and commends that action. But due to the rate of inflation in recent years, the 2% increase that we previously recommended has not kept up with the cost of providing minimal needs for youth in care. Nationally, the Bureau of Labor identified that in 2022, the inflation rate was 8.4%, and it's estimated that it'll be at least 4% or higher in the coming years. As Nebraska moves forward towards keeping youth in their communities and homes, consideration should be made about the increased resources for high behaviors when determining these rate structures. Youth that are placed out of home are likely to have higher behaviors and needs than previous reporting periods, resulting in increased cost, additional schools-- or school sets, skill sets, and training foster parents and the support staff to maintain these placements. The Children's Commission does not specifically review and research every child welfare provider rate outside of foster care. However, the commission was created to monitor and evaluate child welfare system through collaboration among stakeholders in Nebraska. The Children's Commission identified increasing service array to improve stability within our strategic plan last year, also going into this year. And that requires appropriate reimbursement rates for all services within child welfare, with the purpose of stabilizing the families involved. Given the Rate Committee's recommendations in 2020 and the substantial increase in the cost of goods and services, it's essential to address child welfare provider rates. We saw the impact

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of ignoring these rates specific to the foster care system leading up to the collapse of privatization in 2012, when Nebraska had the lowest foster care rates in the nation. And that's not a path that we can really afford to go down again. We want to thank Senator McDonnell and the Appropriations Committee for your leadership and work on behalf of children and families in Nebraska. Sorry I'm late. But we'd urge you to advance this bill.

CLEMENTS: Thank you. Are there questions? We had earlier testimony that there was a 17% rate increase in 2023. Is is that--

AMANDA ADAMS: That's not specific to foster care, that was a different service rate.

CLEMENTS: That wasn't foster care?

AMANDA ADAMS: No.

CLEMENTS: Oh. OK.

AMANDA ADAMS: So the department has been pretty close to the recommendations that our committee has put out there. And it was not 17% for foster care specifically.

CLEMENTS: All right. That was a-- another kind of service.

AMANDA ADAMS: Yes.

CLEMENTS: All right. What amount was increased in 2023?

AMANDA ADAMS: It was about 2%.

CLEMENTS: How many?

AMANDA ADAMS: 2%.

CLEMENTS: 2%.

AMANDA ADAMS: Approximately, give or take.

CLEMENTS: And 2024 was 3%. Is that right?

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AMANDA ADAMS: There's-- well-- it's 2024 now. They don't-- they don't do increased rates until the summer. So it would be July.

CLEMENTS: And the budget last year, what was the child welfare rate increase? Was there one?

AMANDA ADAMS: Not that I know of. I can't speak to that. I doubt it.

CLEMENTS: I'm being told there was an increase, but it was funded with federal money, with ARPA dollars. Oh, OK. Very good. Any other questions? Thank you for your testimony. Next proponent? Seeing none, is anyone here in opposition? Seeing none, anyone in the neutral capacity. Seeing none, Senator MacDonnell.

McDONNELL: Well, it's been a long day. Unless there's questions, I'll thank everyone for testifying and waive my closing.

CLEMENTS: Senator Erdman?

ERDMAN: Senator McDonnell, one last shot. Thank you, Senator Clements. On the fiscal note you have, on that first page, it talks about in '24, it was $13.8 million, $12.3 million from General Funds, $1.59 million federal, was that ARPA money?

McDONNELL: So if you go back to the fiscal note, as I mentioned in my opening, go to the '24, this bill was meant to be fiscal year '24-25. That's why I handed out the amendment. And back to last year, that was all ARPA money.

ERDMAN: OK.

McDONNELL: To answer your question, but--

ERDMAN: All right.

McDONNELL: --reference that part of the fiscal note.

ERDMAN: All right. Thank you.

CLEMENTS: Are there questions? Seeing none.

McDONNELL: Thank you.

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CLEMENTS: We have position comments for the record. LB1078. Proponents, six opponents, none. Neutral, none. That concludes the hearing for LB1078. That includes-- concludes our hearings today.