[LR363 LR373]

SENATOR JOHNSON: Senator Stuthman is here. So I think everybody who is going to come probably has. He was actually looking for a safe haven, in case you wondered (laughter). At any rate, I think all of us here around the table this morning were kind of thinking that, gee, this is like old home wake or a family reunion. So many good people that I think are around this table, but in the audience as well. And let's continue to work together. And so let's explore what we have for the future. And let me first say this is for LR363 introduced by Senator Erdman, and Senator Gay will actually fill in for Senator Erdman this morning. The rest of the people are around the table, there's Senator Howard, extreme left; Senator Hansen; Senator Stuthman, as we mentioned; Erin Mack; got Jeff Santema just to my right; Senator Gay; and Senator Pankonin; and then Senator Erdman is not able to be here now this morning. So let me read what our charge is. It is the interim study to identify powers and duties of the Department of Health and Human Services; to prioritize programs and services; and to examine funding of programs and services. Senator Gay, welcome. [LR363]

SENATOR GAY: Thank you, Senator Johnson, members of the committee. Good morning. I hear Senator Erdman couldn't be with us because his wife hopefully is having a baby soon and he wanted to stay close to home, so he asked me to introduce this for him. And as you all know as members of the committee, LR363 was our top priority of legislative resolutions. When we looked at what we were going to do this year, it was unanimous that this was the number one resolution prioritizationwise because what we're going to do hopefully in the next two days is, as Senator Johnson had mentioned, kind of identifying categories, the statutory powers and duties of the department, and prioritize the programs and services administered by the department. But also we want to know, we want to indicate the amount of funding necessary to adequately fund each program or service and identify those programs and services which would not be funded if the 2008-'09 budget was first allocated to each program and service in the order of priority at its adequately funded level. And then recommend nongovernmental

alternatives for the administration and funding of such nonpriority programs and services. So what we're asking the department to do in short is tell us as we go into the future what are we good at, what could we be better at, what maybe due to funding we can't do, but we need to look for some alternatives. So I'm excited. We wrote a letter, Senator Johnson and I, to Chris Peterson. We had a discussion and we kind of talked about what we wanted to hear, what we thought the committee wanted to hear, and they've prepared I'm sure very well for that. So I think as we go forward and we discuss these items, it gives us a great springboard for those of us who will be coming back to looking at the future and say, hey, here's what we want to do, here's how we can help. And this letter actually...and I know with working the committee for the past two years, we do want to help them succeed. We have disagreements, but in the long run we want to help them succeed. So I think this pulls us all together, gets us all on the same page. Publicly we go out as the department gets to say, here's what we're about, here's what we're trying to do. So I think it's a win-win situation for everyone, and we're excited to hear from the department. Thank you, Senator Johnson. [LR363]

SENATOR JOHNSON: Thank you. First up is the Chief Executive Officer, Chris. Welcome. And let me tell you what we are planning on doing is after each presentation is that we would then go immediately to a public comment and so on at that point in time so that there is continuity with each one. So we'll try and after each presentation, then talk about that presentation before we go onto the next one. So Chris, welcome. [LR363]

CHRIS PETERSON: (Exhibit 1) Good morning, Senator Johnson and members of the HHS Committee. My name is Chris Peterson, C-h-r-i-s P-e-t-e-r-s-o-n, and I'm the CEO of the Nebraska Department of Health and Human Services. And it really is a pleasure to be here with you. It kind of gets this churning again as we move towards January and a new session. But I want to say that the relationship that we have with this committee has been outstanding and we very much appreciate that. I know sometimes--sometimes--we're often a challenge because there's so much going in on

our department that you sometimes get blindsided with things that are happening. But we hope to overcome that to some extent, but again communication is always an issue. And so we hope to continue the back and forth that we have. Let me explain to you just about the book for a second. This will be filled up as it goes through because each division director as they come up will hand you the packet for their specific issue and their specific division in the notebook. What we have in the first part is the LR363, followed by your agenda, followed by our agenda, and what we'll be covering in these different parts. So if you could turn to the part that says "Chief Executive Officer", that's where we'll start. For the audience we have the PowerPoint. And first of all let me start out by thanking you for passing LB296. That has really allowed us to do some things that we were not able to do before. I think you heard the testimony about the original reorganization that happened back in 1996, and that the next step was never able to be accomplished. And so with the work of the Governor and you and the Legislature, we were able to achieve that. And the number of goals for that reorganization are listed there and number one is accountability. I think you visited with the Governor. I visited with all of you. But we need to know who's doing what and who's responsible for what. That's just how systems work. And so I think we've achieved that with the structure that is there now. We spent many hours with the Governor as well as with senators talking about what the core responsibilities of the division are, and there are six of them. And each division now has a director that's actually able to spend specific time in that division and focused just on the responsibilities of that. Second is our efficiencies, and I think Senator Gay talked about that. What are we doing that maybe we could be doing better or not doing or changing how we do it so that we're able to achieve efficiencies--no duplication of services, no wasted man hours, things like that and we have found many of them of those as we've gotten into our first year of the reorganization. Accessibility in an organization of any size you want to be able to know who you go to. We've got a Web site up that at least people are going to know who the CEO is and who the division directors are and they can start out right there. Budget transparency, again, this is more of challenge in trying to simplify a system as complex as ours. But our goal is by the end of the year that we will be able on our Web site to

have the actual budgets under each of the divisions so that you can see where the money is going and how it's being spent. Because of how money is set up, as you all know by subprograms and things like that, it's a little complicated. So we want to make sure our numbers match on the Web site as they match with the Legislative Fiscal Office, and we're working towards that. And again, clarity. What does the department do? What is our role? What are our core responsibilities? We included in this packet towards the back the 900 statutory powers and duties. And I'd like to thank Jeff specifically. He started this project I think two years ago and laid them all out. We have been tasked with a lot of things. Some of those are result of the combination the five agencies originally. But also we continue to have things and duties added to us. There are 900-and-some of those and it has been updated with new names and the new duties since the reorganization. The next shows the new organizational chart. And the one thing I want to tell you is that I believe we have excellent people and they're here in the audience. I think you've worked with many of them. They are just outstanding. We're very, very fortunate to have the directors of the divisions that we have. They're experts in their field. They have experience in managing people, they have experience in government, they have experience in business. They have a variety of interests and backgrounds. And as a group, they are awesome to work with. They're busy people. They're very, very busy people. And one of the things we had to do going in here was build the infrastructure which was not there. That was probably what I would consider the most time that we spent going into the first year of the reorganization was making sure that there was an underlying infrastructure, that we aligned out budget programs with divisions. We didn't have a contract process. When the reorganization happened when I first took over services, I would have contracts come to me and--we still do, piles of them. They weren't electronically put in (inaudible) there was a no sign off by legal, there was not sign off by finance. And so we've implemented just that so that we know when a contract goes out what it's for, how long it's for, who it's been reviewed by, does it meet all of our legal benchmarks that we have to hit. So just doing that alone, who should be reviewing the contracts, at what level does the director review, what dollar amount, just little things like that that took a lot of time and a lot of discussion, but is

something in the floor of any organization that you have to have. We also for the first time have a COO. Bob Zagozda, he's our Chief Operating Officer. Bob has a financial background. He's worked with Arthur Anderson. We was with the University of Nebraska Medical Center in Clarkson during the change there. He has extensive background in billing and IT because, as you're aware, we have three huge IT projects. We have N-FOCUS, which does all of our eligibility. We have the MMIS, the old one and the new one coming on. And then we have charts which provides the resources for our child support. Bob has experience in all of those and is just doing an outstanding job. Under the six divisions, we have behavioral health: children and family services, developmental disabilities, Medicaid and long-term care, public health, and veterans homes. And those truly are the core responsibilities of the agency, even going back to when the original reorganization happened. The date on this list is July 1, 2007 because that's when we actually started the reorganization. And the reason that date is important is because of those numbers of employees under there. Every day we have a different number of employees--people leave, people stop, we bring in part-time, we have contract. Do you mean full-time equivalence, part-time equivalence, contract, warm bodies, empty spots? So what we decided was on July 1, 2007, these were warm bodies. That number, again, changes everyday, but roughly that's about the size of each of the divisions. Scot Adams has the regional centers. As you're well aware, LB1083 changed the whole role of the regional centers and behavioral health services across the state. Scot has a long background with Catholic Charities and has done an excellent job with that. Division of children and family services, Todd Landry. Todd has been in the news fairly often lately and he has done an outstanding job. In fact, I talked to him, I said, you know, after all of this media attention it's going to be kind of quiet going back to just the normal day-to-day work. But he assures me that's not the truth. Developmental disabilities, John Wyvill. Somebody asked John if we had told him what he was getting into, had he took the job. And I said, yes, we did, we actually sent him the newspaper articles. he knew what it was and I respect him even more for that because came into a real mess there. Medicaid and long-term care, Vivianne Chaumont. Vivianne has the expertise. And if there's one thing I would say to anybody,

and I actually got the chance when I was in Rhode Island because they had me come out and testify about the reorganization because they said when you pull up on the Web site government reorganization, Nebraska pops up first. And so NCSL asked me to go out and talk to Rhode Island about the reorganization of their department, they want to go exactly to what we're doing. And I said one of the challenges that any organization has, has to do with the complexity and the overall largeness of Medicaid. You need someone with expertise in Medicaid. Vivianne has that. She's an attorney by profession, but also as the Medicaid Director in Colorado. Now, Vivianne I did lie to. (Laughter) she was living in Arizona at the time, and I told her that the weather here was always in the seventies, and she still talks about that. Dr. Schaefer, you have all worked with Dr. Schaefer. She is just an outstanding spokesperson for public health and has taken the division of public health I think to recognized national attention, especially through the bioterrorism pandemic flu pieces. And John Hilgert, John actually wear two hats. He's also the director of the division of veterans affairs which is upstairs on the fifth floor, and then he's down with us on the third floor and we keep very close track of his time. No, that's not true. John is a veteran himself and just an outstanding representative and advocate for the veterans in the state of Nebraska. Looking at the core responsibilities, as I said, we've spent a lot of time on strategic planning. When all the directors first came on, they did strategic planning in their divisions, and then we met with the Governor to come up with what the priorities are for 2007 and 2008 calender years. This is our main work, this is what we do, and this is what we are putting out time and effort into. The first is accelerate reform of the state's child welfare system. Let me say, if you have questions at any time, please stop me and if I can't answer it, we'll bring someone up here to can. Accelerate form of the state's child welfare system, we actually started this several years ago with the Governor's initiative. We have, as you know, per capita the largest number of children in out-of-home care. And the goal is to reduce that. We are on the second phase of initiatives. The second one we are working in cooperation with the Chief Justice, as well as the Foster Care Review Board to look at those children--I'm smiling at Senator Howard--looking at those children who have been in out-of-home care for a longer than two to three years. Improving the state's

performance on the federal government's CFSR review in 2008. We've had the review. No state has passed it yet. We know we have not passed it either, but we have not received our formal response from the feds on that. We're still discussing with them the results of that. Complete behavioral health reform, and one of the things I wanted to put in here is this is LB1083. And this is a significant step because in essence, behavioral health reform will never be completed because we get different challenges, different populations all the time. But LB1083 was the promise that a certain amount of money would go out to the regions, and that money has gone out. And so I think that that is quite a huge step. Integrating children's behavioral health services into the division of behavioral health. Children's behavioral health services in the system are across three divisions. There are some dollars that go to the regions for children's behavioral health. There are some dollars that are through children and family services. The majority of the dollars come through Medicaid, and those are the services that children who are eligible for Medicaid get. And so we wanted to find one place for that to rest, and that is in the division of behavioral health because in essence, they're the experts on what the services should be. We've had some help with that, with the SIG grant, the state infrastructure grant that Nebraska received. And there's ongoing work with that with a large group of advocates to kind of finalize that and get it set exactly what the role of children's behavioral health services in BHHS should be. One of the others is to continue to slow the growth in Medicaid expenditures to ensure future sustainability of the program. You certainly know what those hard choices are. We had a bill about that just this last year in looking at some of the reductions that were a result of the recommendations of from the Medicaid reform council. Any time that services are impacted those are hard decisions, but there's only three ways to impact Medicaid. You can address the rates we pay, the people we serve, or the services we provide. That's it, and Medicaid is where the large dollars are. And it's true because of the hard choices that you and the administration have made. That gap that we see has been reduced. But it's been reduced from $800 million to $400 million. There's still a gap there. And so we continue to look at insuring the future sustainability and our budget recommendations will show that. Yes? [LR363]

SENATOR GAY: Chris, I've got a question for you. When you're talking these top ten priorities, some of them are fairly broad. [LR363]

CHRIS PETERSON: Yep. [LR363]

SENATOR GAY: Are we going to get into the specifics of those? And you do have benchmarks that say if I complete like a checklist of things? [LR363]

CHRIS PETERSON: Yep. [LR363]

SENATOR GAY: Okay. [LR363]

CHRIS PETERSON: Yes, we do on some of them continue to slow the growth of Medicaid expenditures. Those basically will be financial benchmarks that will show, accelerate the reform of the state's child welfare system. We track that through a couple of things, the Compass Network which shows how things are moving through the courts as well as just our numbers, state wards. What I'll show you as we get into it is our monthly indicators that we actually track on show the number of people in our programs, the dollars spent, where the trend lines are going. Implement the new Medicaid compute system, the MMIS. This is how Medicaid pays its bills. Our system is very old. The Legislature approved a new system coming on, and the direct priority is there, is on time and on budget and so far we are doing that. The bid went out. We have a vendor. We're moving forward in the time line and with the dollars that we have been appropriated. Provide quality of care at the stat veterans home. That's always ongoing. You're well aware of what happened with the Thomas Fitzgerald home. We have now moved into the Bellevue, the Eastern Nebraska Veterans' Home and, John...I'm going to let John explain to you how well the surveys have gone. But with his enthusiasm and hard work on the staff, we have really improved the care there. Operate the veterans homes at or near full capacity. Again, one of the things we'll talk about is the challenges

we have with staffing. Our veterans homes are a good example of that. And so while the goal certainly is to get to full capacity because that's how your revenue comes in, we will not do that unless we have the staffing to maintain the quality of care that we need there. So one hinges on the other. Improve the quality of care for Beatrice State Developmental Center residents. This is an ongoing issue. You're all aware and some of you serve on the commission to look into the BSDC issue. As you know, we have a settlement with DOJ. We do not with CMS. CMS is the federal agency that has the dollars. And at this point we're under termination letter that if we do not meet the standards of participation, they will remove around $24, $26 million of federal funding. We have filed an appeal on that and we will have a hearing before an administrative law judge on I believe November 20 in Omaha. We have hired out sight council. I think some of you have met him, Tom York (phonetic), from Philadelphia. And we are moving forward with that, along with wanting to have talks with CMS. We have had a preliminary talk with them. Certainly our goal and everybody's goal is to resolve this in the best possible manner. And that's what we're focused on. And the realign the public health programs. One of the things that Dr. Schaefer is very focused on is importance of public health to the state of Nebraska. Sometimes with all the programs out there it becomes a maze, but I think she's brought great clarity and transparency to that as well as strong leadership. I'm not going to spend a lot of time on the activities because the directors will be going through these. But in essence what we wanted to show you in 2009 some of the things that had been accomplished. These are prioritized in what the directors believe are their priorities in terms of what's been accomplished. We have an administrative services organization which for the first time goes across three divisions because the same kids that are being served in Medicaid are being served in behavioral health are being served in children and family services. So we've put out a bid and we have one vendor now that's managing that system. That's a large step for the organization to think of itself as a system as opposed to separate units. We've implemented the children's behavioral health plan as a result of LB542. I believe a copy of that is on our Web site. If you'd like a hard copy, we'd be glad to get that for you. That is the result of legislation and resulted with us looking at the Hastings Regional Center,

removing the services that are there, and making a capital construction request for a new facility. Continue the adult behavioral health reform forensic admissions. These are...the forensic admissions are the ones that you've read about in the paper where a person is in a jail. They've been found not responsible by reason of insanity, and NRRI, or they need to have an evaluation and they need to be at the regional center. We have a waiting list for those. We have been working with the judges as well as the regional center so that when that happens, there's not a lengthy amount of time between the time they're in the county court or in the jail before they get in the regional center for their evaluation. So integrate the regional centers with community-based system, and then a new Web site which Scot will walk you through on that in terms of how to find services and your own personal health information. Division of children and family services. Again, the ASO across the divisions. Again, the children's behavioral health plan because that again takes in Medicaid, children and family services, and behavioral health. Probably the one that you've heard the most about is ACCESSNebraska on-line application. For the first time, those forms are on the Web site are able to be pulled down. Long term, we'll be going to all eligibility on the Web site. Reduce the state wards to 6,000. We've come down from a high of 7,000...I'm looking for... [LR363]

_____: April of 2006, 7,800. [LR363]

CHRIS PETERSON: Seventy-eight hundred, down to... [LR363]

_____: Sixty-six hundred. [LR363]

CHRIS PETERSON: Sixty-six hundred, that's the lowest we've been in years. And I will tell you the one thing that's remarkable about that is we're not seeing recidivism, they're not coming back into the system. Implement in home services reform and implementing performance-based contracts to child welfare. Todd, again, can talk to you about that. Division of developmental disabilities. We have made significant progress in moving people into community-based services. We have also got the DOJ settlement that we

have four years to implement and have an independent monitor on site right now. We've reorganized the DD service delivery. Before in the previous organization the service coordinators who actually called on the DD clients and reviewed the plans were not under the director of DD. They are now. They have moved over. They're under John. He has the complete system now. Again, revising regulations for accountability to security ongoing. Medicaid began the development, as I told you about the MMIS. We're on budget. We're on time. We have a vendor. We have staff. We're rolling. PACE is a new program, as we're all aware of. The largest cost we have in Medicaid, and the growing cost has to do with long-term care. And this is a new project that I'll have Vivianne explain to you in greater detail. ASO again there. One of the things also that Vivianne is taking a lot at is all of the rate methodologies, what we pay providers, how we pay. Is it cost based? Is it negotiator rate? And so there's a variety of different processes in place that she's looking at, hospital rates, physician rates, nursing home rates, so on and so forth need a good foundation when we make our budget request what we're basing that on. The money follows the person grant. Nebraska was awarded this. What this means is people that are required to be in an intermediate care facility for the mentally retarded, and ICF/MR, if we move them out into the community, we will get enhanced funding for that. The goal is to have everyone who moves from BSDC out there to receive that enhanced funding for a certain period of time. You all were here for the autism Medicaid waiver. We're required by statue to implement that and that is on time. And then the extensive care coordination, another service Vivianne can explain in greater detail. Public health, become a trusted source of state health information. And I would tell you that I believe that we are. I think that when we have the news releases that go out or when we have press conferences about that, the information that we collect through our public health departments, through out staff is second to none. We do an excellent job with that, and Dr. Schaefer is an excellent spokesperson for that. Again, the Critical Access Hospital-Health Technology is a grant that she can discuss. The division of veterans homes pilot management clinical and financial software. This is another one of those infrastructure things that just wasn't there before. This is a way for all of the all of the veterans homes to be in sync with each other in terms of how we are

billing, what are our clinical standards that we're holding each of the veterans homes to and measuring quality of care. And we finally have an agreement on what the software is and we've got it piloted. So that's a huge step. It's been six years, I believe, in getting there, but we got it started. And that ties into the integrative processes for billing and collection. Believe it or not, each veterans home was doing it a different way. Organization operation. Again, reorganizing the finance functions. This is where we're trying to get to the clarity and the transparency of the budget. Implement KRONOS timekeeping departmentwide. We didn't even have the ability to get overtime broken down by mandatory and voluntary, we've now started that. It's in the 24-hour facilities now, and it will go across the whole system. And then establish the special financial projects team. Some of the things that we found is that we do not have good accounting principals in place. We have worked out an arrangement with the Auditor that when they come over to do the single statewide audit or any special audits we meet with them, either myself or the director of that division and the Auditor. We're there for the exit of surveys, but one of the things we found is the Auditor either audits or helps you, you know, trains you. He can't do both. And so we need to have our own on sight person that goes out and takes a look at the programs ourselves to make sure that we are following sound financial practices, the billings are coming in when they should have, what are the red flags that we need to have in place so that we don't find ourselves in situations like we did at the beginning of the reorganization when money was not being put into the account that it should have. [LR363]

SENATOR HANSEN: Chris? [LR363]

CHRIS PETERSON: Yeah. [LR363]

SENATOR HANSEN: What is KRONOS timekeeping mean? Is that an acronym for something or... [LR363]

CHRIS PETERSON: You know, I don't know what KRONOS stands for. It's a

timekeeping system that people clock in and clock out. So when they come in, when they get into their computer, then it will start keeping track of the time that they're on the job. Right now I believe in the 24-hour facilities, they call. Is that right? [LR363]

_____: Right. It's a phone-based before PC-based clock system, clocking in and clocking out system. Right. [LR363]

CHRIS PETERSON: Right. [LR363]

SENATOR HANSEN: Okay. Thank you. [LR363]

CHRIS PETERSON: Yeah. Here again, these are some of the progress that achieved. As I told you about the contracts now are in the new system, they didn't used to be. We have reduces the number of state wards. We've implemented LB1083. All the money is out in the community. And I tell you, 800 is huge, 400 is still huge, but that's a significant drop in insuring and working towards the sustainability of Medicaid. MMIS, again, on time, on budget. Service coordination, and I believe I talked about the others for you. Any questions on those? Okay. Challenges. Obviously you're all aware, and we've had meetings about it and with you and talked to you, our staffing levels are overtime in our recruitment and our retention. We compete with everybody else for the same limited number of staff. In some of our homes, we have the ability to maintain the census there. But in some we don't. At the regional centers, they're committed to the regional center. We have to have those beds, so we need the staff there regardless of the problems we have with recruiting and retention. We have a variety of strategies that we have implemented, and for the first time we are seeing some reduction in our overtime. What we want to do is start creating a pipeline so that we're kind of growing our own. We're working with the community college. I believe we make a presentation to them on November 7 about trying to create a link with the community colleges in our facilities and provide kind of on sight training while they get their education. In addition, we have the Employment First program. Those are people that are receiving an ADC check and

they need to have so many hours of work project during the month. We're trying to connect the two with those so that we basically have the job there. We train them on that at the same time they're going through the Employment First program. [LR363]

SENATOR HOWARD: Chris? [LR363]

CHRIS PETERSON: Yeah. [LR363]

SENATOR HOWARD: Under these challenges with recruitment and retention, are you looking at the new case management training? Does that fit into this? We've talked about this many times. [LR363]

CHRIS PETERSON: Yes, yes, yes, yes. And I believe Todd will talk to that when he's up there. You can answer it now if you'd like. [LR363]

TODD LANDRY: I can answer it now, if you like. We have now moved towards statewide limitation of the six-week training program instead of the former six-month training program based on the results of the pilot. So yes, that now is moving into statewide implementation based on feedback of our staff, as well as the outcome that we receive from the pilot project. [LR363]

SENATOR HOWARD: What about the graduate school, working with the graduate school for the new worker training? [LR363]

TODD LANDRY: As far as the new worker or the (inaudible) program? [LR363]

SENATOR HOWARD: Both. [LR363]

TODD LANDRY: On the (inaudible) program, if you were aware, we work for a federal grant if to implement stipends for our staff at either a bachelors level or a masters level.

I'm still waiting to hear from the feds if were successful in receiving that grant. And so we're hopeful of that. If not, we will look for other ways of being able to implement that. The second phase of that, we agreed with the schools to social work (inaudible) program and second on the training program after they have a chance to implement and see how the (inaudible) training program will be implemented. [LR363]

SENATOR HOWARD: Thanks. [LR363]

CHRIS PETERSON: Obviously the challenges are CMS survey potential loss of funds, the reform of the in home and out of home services, and these are two proposals that Todd can talk to you. You are well aware, we have more children in out of home placement than we do in home placement. Obviously we want to reverse that trend so that we try to keep the children at home. That changes how we contract the whole way that HHS has contracted before is different with the in home proposal than it's ever been before. Instead of managing a variety of contracts, we put out an RFI for just one in each region, and then that contractor is responsible for subcontracting to make sure that the flow is seamless. Fiscal sustainability of Medicaid. As I said, in order to maintain the growth or insure the sustainability of the program, there's only three ways to do it: the services you provide, people you serve, or the rates you pay. You're well aware that Mercer...had a report by Mercer which is up on the Web site that recommended at-risk managed care model, which means that there are networks created. And then similar to what you do with your insurance, you have approved provider group that you would go to. They also recommended one contractor for behavioral health. And they also recommended, as you're probably aware, we have managed care right now for physical services for Douglas, Lancaster, and Sarpy County. They recommended going statewide with that, that there would be access there, and have a network of providers there then also. That would have two HMO models instead of just the one we have now. MMIS, it's a challenge. It a success and a challenge both. Each time we make one of the benchmarks, it's a success. Looking forward to the next one. It's a challenge. It's ongoing. It won't be up and running until July 1, 2011. So we've got to keep moving on

that all the way through. Implementation of the DOJ agreement. As I said, we have a federal monitor on sight that was agreed upon both by DOJ and ourselves. It's an independent monitor. We have four years to implement. In our budget request, we have a request for $2.5 million to put into place, the management team that we need there, as well as other supervisory roles. And then obviously just keeping up with the demands of technology in the healthcare system. Questions about any of that? One of the things that we have been able to do is take some time and step back and look at trends, and also to look forward in terms of strategic planning. And this kind of falls into what Senator Gay said in terms of what are we doing well, what are not doing well, what should we be moving forward to. Departmentwide, we're going to implement oversight of privatized services through performance-based contracts. Now, what does that actually mean? One of the things that you hear about that we don't do well is we don't have contract oversight. You'll also hear well that many times we don't do services as well as a private provider can. And so we want to look at working in collaboration. Two things: If we have a provider who is providing the services and we go the privatization route, we will make sure that we have contract oversight there and that we will have the ability to monitor that on an ongoing basis. A perfect example is the transportation contract that you've heard about. And I think we came in and briefed the committee about that. How is the department able to guarantee the safety of the people that we serve if we actually have a contract with the private provider? And so what we're looking at is making sure that we have in that contract requirements and standards that we have to have, as well as the ability and the benchmarks to go in and measure for sure that they're actually doing the services that they're supposed to be doing and they're of the quality that they should be. That's a significant shift. The Legislative Performance Committee, we had a hearing about this I want to say about a month ago, and that was one of the findings they had was that the department needed to have better oversight. And so that's our goal, that's a push we're making. [LR363]

SENATOR HOWARD: Will that include looking at this in a pilot program rather than implementing it statewide until you really develop the ability to do that? [LR363]

CHRIS PETERSON: That's 2010. (Laugh) so we will be starting... [LR363]

SENATOR HOWARD: So 2010 is what? [LR363]

CHRIS PETERSON: Yeah. We've started already. Todd has already started that with some of the child welfare contracts already that they are performance-based. So fiscal year 2010 is you would start by July 1 of '09, which is next year, and then throughout that year we would be working on it. [LR363]

SENATOR HOWARD: In terms of pilot projects. [LR363]

CHRIS PETERSON: I'm not sure if I would classify them as pilot projects. What I would... [LR363]

_____: I think we're going. [LR363]

SENATOR GAY: Chris, I've got a question. When you talk about this oversight and working with providers, I talked to some of the providers. How much...I know we have to say here's what we want to get done, but how much feedback is there? How do they stay in touch with those providers? When we're delivering services, it's not like I'm producing a product, it's an ongoing process in a way. But how are you staying in touch with these people? Oversight is one thing, but also we need to work with them. I mean how is the communication back and forth maintained? [LR363]

CHRIS PETERSON: That's an excellent question. And one of the things that I will tell you, no matter what we're doing, it's not enough simply because we're so big and there's so many providers all across the state and communication is always a challenge. Invariably there will be someone that didn't know about it, wasn't able to attend a meeting, didn't hear about a hearing. And so we're going to use the web a lot. We meet

on a quarterly basis with the Nebraska Hospital Association and the CAFCON and NABHO providers their representatives there. And we have an agenda and we walk through many of those questions there. In addition, Todd has, children and family services, has a partners council that he meets with on a quarterly basis also. And I believe behavioral health has one in November, they meet in November. And DD...(inaudible) John? Medicaid actually has two. There's a Medicaid reform council, and then there's actually a Medicaid... [LR363]

VIVIANNE CHAUMONT: Advisory committee. [LR363]

CHRIS PETERSON: ...advisory committee. John probably has the most regular meetings with his...I want to call it VHST. [LR363]

JOHN WYVILL: Yes, (inaudible). [LR363]

CHRIS PETERSON: Yes. So we have groups that meet on a regular basis. But we're going to always have to add to those, especially if something new comes along, we'll have to have to have special abilities, special abilities to pull groups together. But right now, yes we do I think, in all of the divisions have a way to, maybe not enough, certainly can do more, but there is a way to work in partnership with them. [LR363]

SENATOR HOWARD: Well, along with keeping with Senator Gay's question, will there be benchmarks built into this, time frames, periods of evaluation to see what progress is actually being made? [LR363]

CHRIS PETERSON: Yeah. One of the things I want to say specifically, we are not going to jump into anything. We've spent way too many times putting out bush fires, if we'd have just taken a little step longer. So when we talk about implement oversight of that, it's going to be a long educational process. And any ideas or anything you hear, suggestions you can help us with, you certainly are one of the group that we're going to

be talking with before we go forward with anything. And so I'd like to hope that we have everybody in the ground floor that are stakeholders. But if we don't, then when we present it to you at least you're aware of it, if somebody comes to you. We don't want to leave anybody out, invariably we will just because we're large and somebody's not going to hear about it. But we will try to do it in a thoughtful, educational way. And I certainly take to heart what you're saying now. It will be even more thoughtful than it would have been. Okay. Behavioral health, again, implement full performance-based contracts. And again, some of this is already happening. This is not that the providers have never had to have standards or performance measurements. These are certainly things we haven't been as good as we can be at in having the benchmarks, in having the evaluations. And so to do this, this is really kind of a huge step for both us and them because we can implement it, but then we've got to be sure we've got a way to monitor it. You can implement all you want, but if you don't have anybody out there monitoring to see what's actually happening. So this is easily a year and a half long project. Develop behavioral health system of care. We have found that one of the challenges that we've had is we talk about completing behavioral health reform, part of the reason we never will is because we find new challenges. People have a dual diagnosis. It's very hard to find placement for them. And so we don't have the answer to this one yet, but this is one we have to come up in with working with our providers because if they're not mentally ill or dangerous to themselves, they can't be in the regional center. But if they're hard to handle, a provider is going to have concerns about taking them on. So these tend to be a challenge with us providing a provider outside of the regional center system. Suicide prevention program is one that Scot is working on with other groups as well as integrating behavioral health interventions throughout the criminal justice system, and I'll let him go into greater detail with those. Again, this is the implement out of home services reform. This is a very huge undertaking. If you have seen the pyramid where we actually shift from out of home back to more children being served home, it changes how your providers, it changes the services that you are prioritized for funding. This is significant change in the way that Nebraska has done business with children in the child welfare system. [LR363]

SENATOR HOWARD: It would seem like this would be a real opportunity to look at what the deficit is in terms of the families that have utilized safe haven. [LR363]

CHRIS PETERSON: Absolutely, absolutely. Complete the full implementation of ACCESSNebraska. This again is one that...and we've gotten great support with this from advocates across the system because people don't have to take time off from work or get a babysitter. The challenge of this is making sure people have access to a computer, but we believe that we've got a good plan in place and moving forward with that. Reducing state wards to 5,500. That just speaks for itself. What a challenge that will be. And again, full performance-based contracts throughout the division of children and family services. [LR363]

SENATOR STUTHMAN: Chris. [LR363]

CHRIS PETERSON: Yes. [LR363]

SENATOR STUTHMAN: We're reducing the state boards, is that your plan to eliminate some of the state wards that are...I mean, take them off of state wards or not get as many into the state, you know, accepting the new ones, you know? The thing that I'm concerned about is for people to get services a lot of times they have to, you know, relinquish their tie of the kid and make them a state ward. If we could eliminate that portion of it, that would help greatly too. [LR363]

CHRIS PETERSON: That's an excellent question, Senator Stuthman. I think it just kind of was a good lead in for Todd when he gets up here. [LR363]

SENATOR STUTHMAN: Okay. [LR363]

CHRIS PETERSON: I can give you the short version of it, which is we're looking at both,

and his in home reform touches on that exactly. Would that be an accurate way to put it? [LR363]

SENATOR STUTHMAN: I think so. [LR363]

CHRIS PETERSON: Yeah, so... [LR363]

SENATOR STUTHMAN: But if he's going to touch that a little bit later, fine. [LR363]

CHRIS PETERSON: Yeah. He will, everything, the preconference hearings, all of the work with the judges, Through the Eyes of a Child Initiatives, all of those. [LR363]

SENATOR STUTHMAN: I think, you know, I feel it's most important if we can keep them out of becoming a state ward is the most important thing. [LR363]

CHRIS PETERSON: Yes. [LR363]

SENATOR GAY: Chris, I've got...early you said it was 6,000. Is it 5,500? [LR363]

CHRIS PETERSON: Now we're in the year 2010. [LR363]

SENATOR GAY: Oh, okay, I'm sorry. [LR363]

CHRIS PETERSON: Yeah. It continues to go down. We're continuing... [LR363]

SENATOR GAY: All right. Thanks. [LR363]

CHRIS PETERSON: Increase the community-based provider accountability. Now we're in the division of developmental disabilities. I think we've all heard the discussions with the commission and certainly that is something that the providers will work with us on

too. We have excellent providers out there and we can certainly put the pieces in place, the people whose loved ones go into the community can have all the security that they have that they need. Evaluate the distribution of services, making sure that people that have developmental disabilities are getting the right amount of services at the right time at the right place. And then as you're well aware of, LR156 is ongoing now, and that will have recommendations both for rates, as well as the waiting list. And so this one is probably a little vague simple because we're not sure what the LR156 will come out with, but we know it's something that we'll have to address in the year 2010. You might notice that there's a theme here with MMIS. This is probably a $60-some-million project. It is one of the things that will provide greater accountability as well as just faster service, better service. PACE, again, that a proposal to help reduce the number of people having to go to a nursing home level of care. Implementing the preferred drug list of purchase pool was a bill that was passed I believe last year which will allow us to join into a preferred drug list of PDL as well as a pool to help reduce the costs of drugs to our Medicaid population. And again, again, money follows the person as people move into community services. We want that enhanced funding to go with them. [LR363]

SENATOR GAY: Chris, I've got a question. [LR363]

CHRIS PETERSON: You bet. [LR363]

SENATOR GAY: On the MMIS that's so important to everybody, how exactly are you implementing that and who's in charge of that? [LR363]

CHRIS PETERSON: The vendor that we have is Forethought, and they are...we have the two groups, the Forethought people and then our people that are working on it are in the Golds Building right now. And beyond that, my technical ability is zilch. It's a huge system and either Bob or Vivianne could talk to it. We could do it now if you'd like. [LR363]

SENATOR GAY: I wondered in general. I don't need the specifics. But you have a dedicating group constantly working on this thing for the next... [LR363]

CHRIS PETERSON: Absolutely, yes. 24...yeah. They're full-time staffed to the MMIS system. [LR363]

SENATOR GAY: And then how will you update us? Just through the budget or how...you're obviously going to keep us informed if...hopefully nothing goes wrong, but big project like that. So... [LR363]

CHRIS PETERSON: Yeah. You know, that's a good question, Senator, how we would keep you updated. We meet, we have a steering committee that the budget sits on the CIO, chief information officer of the state, myself, Vivianne, our IT people. That's a good question how we can update you on a regular basis about, you know, even having maybe some of the Forethought people over to talk about it. Let us think about that, get something to you. [LR363]

SENATOR JOHNSON: Chris, one of the things that Jeff suggested is when you get down, let's just have Bob come up for just a few minutes and talk... [LR363]

CHRIS PETERSON: Great. [LR363]

SENATOR JOHNSON: ...so that people know who he is and what he does a little bit better than what we do now. [LR363]

CHRIS PETERSON: That would be great. He can handle the last part then. Again, implement the software of all the veterans homes. Some of these are continuations of the activities that we've started that are just...they just take a while to do. And then operations, evaluate and enhance the work environment and culture, evaluate the

recruitment retention and training methods. We have to be state of the art in being a place of employment. People need to want to work for state government and we don't have that culture there right now. And so that's one thing we have to instill. And in order to do that, we're probably going to have to bring somebody in to do that. I think John Hilgert will talk to you about what they're doing with the veterans homes. We have a meeting with some people in Omaha that actually have done this before going across all types of work environments, situations. But this needs to be really a focus for next year. This year was kind of getting us in order, shaking things out, getting the reorganization, people getting new job classifications, lots of things. The next year has to be focused on how do we keep people in state government. Our workforce is aging. And we anticipate over the next three to five years we're going to lose a significant amount of them. So succession planning for us, getting people into the pipeline, those are things that we have to address in a much more aggressive way. DAS has a new personnel software that's going to come out hopefully we know is going to help a lot with our recruitment just in eliminating a lot of the pieces that we have to do now that take a lot of time just organizing and fast time getting people into our employment pool. And then obviously the support services. ACCESSNebraska is going to be huge in how it impacts us because it's a large IT job on top of offices and things such as that. 2011, partnering with local resources for behavioral health services while the money is all out there now, that we have moved the money out. We realize that there are still many, many gaps and many concerns that are being relayed to us. And so we want to make sure that the local providers, as well as the behavioral health, the state are in collaboration and cooperation, working to fill those gaps. And there are a variety of them. We're in the process right now of working with the regions on the new dollars that came out. But I think we have to be very aware that the money is out in the system now, and that the state and the local providers need to have a close relationship in how those services are being provided. Expanded implementation of contract oversight. Again, this is a theme, a goal you're going to see, who's doing what or how are they doing it and how are we making sure that it's being done. Behavioral health, collaborate with corrections on forensics. This is one that I have met with Scot on this to some extent, but this is one I'd

leave him to give you the details on because it's pretty interesting, it ties in with safe keepers and the Department of Corrections and the jails and everybody. So it's a pretty fascinating activity. As well as implementing the managed care statewide. And I want to take some time on that. The Mercer report, as I explained to you earlier, is one that we just got in, and it talks about that if we're going to maintain the sustainability and keep a handle on the cost of Medicaid, we have to implement managed care statewide. And that's different than and ASO. An ASO is an administrative services organization which we have now that's doing behavioral health, children and family services, and Medicaid. They're not at-risk. The state still is, but they are the ones that based upon the medical necessity of the need determine whether that service is going to be paid for by Medicaid or not. Okay. But they don't have the risk. This would be an at-risk managed care entity, and it would in essence create a network of providers across the state exactly like what we have right now with the physical health in Douglas County and Sarpy. We have managed care with behavioral health right now. That's what Magellan does, but it's not at-risk. Okay. This is. This means that we would put out an RFP, we would look at a vendor to implement that, and then they would be the one that would be responsible for the services for the Medicaid population. [LR363]

SENATOR HOWARD: Can you give us an example of what would be considered at-risk that would be outside the Magellan contract just to help get a better perspective of what you're thinking? [LR363]

CHRIS PETERSON: What an at-risk contract means is that you put out a proposal for vendors to come in and it's capitation, which means that you pay a rate to them or you pay a price to them, and then they manage that whole system. And it's similar to just how an insurance company would work that you have a network of providers, and those are the providers that the clients would go to. And based upon their evaluation, it would be whether that services was approved at that level, if it was medically necessary at that level or not. So I'm not sure how else to explain it. Maybe Vivianne could...is that close? [LR363]

SENATOR HOWARD: Would it be a delegation of the decision making, is that what it comes down to based on their network of providers and the need? [LR363]

VIVIANNE CHAUMONT: Well, they would...I don't know what you mean by "delegating the decision making," they would approve on certain levels of care, and they would approve certain services, but we have that now. I mean, we have private (inaudible) services now. The Magellan currently does that with the administrative services organization, they approve (inaudible). [LR363]

SENATOR HOWARD: I know that. What would be the difference. [LR363]

VIVIANNE CHAUMONT: That there would be at-risk for all of the services. You pay them an amount and within that amount, they have to provide all the services that the client needs. We can pay them an amount and it isn't sufficient to pay for all the services the client needs. They're at-risk for that amount as opposed to the state being at-risk. [LR363]

SENATOR HOWARD: So basically they are for-profit, which is what they've always been. So they can either come out ahead or behind on this sort of arrangement. [LR363]

VIVIANNE CHAUMONT: We have the same system right now, the United contract for physical health is an at-risk physical health contract. [LR363]

CHRIS PETERSON: And I think what we'd like to do is provide you with the Mercer report on it. Again, if we're looking at a $400 million gap and we want to ensure the sustainability of the program for the people who need it the most, this is the way that we believe we have to go. And I know you'll have lots more questions about that over the next day and a half. Children and family services, open secure facility for violent youth.

This is our capital construction request. As I've explained earlier, when the children's behavioral health report came out, there is a facility right now on the Hastings Regional Center for our chemical dependency youth that actually come through the YRTC, and then they go to the Hastings Regional Center and they're provided the substance abuse services there. That campus is going to be closed. What this would do then is it would...by this time hopefully if the capital construction request is approved by the Legislature, we would have the construction in place and we would be able to open the secure facility for violent youth, as well as the chemical dependency. We do not have a service for violent youth right. Originally the facility that is in Omaha that's under corrections was supposed to be what's called a "level 5" for violent youth. But that facility was changed to them went under the control of corrections and is for adolescence that are charged with adult crimes. This would be for us, adolescence who have been adjudicated to us that have violent criminal histories behind them. Right now they're challenged to find a place for. We have them at the YRTC, we have some of them with other providers. But this would be a secured facilities for them. It would be in conjunction with the substance abuse with out of sight and sound, I believe. Am I correct? [LR363]

TODD LANDRY: Correct. There would be no commingling of the populations, but the underlying infrastructure of things like laundry, food prep, etcetera, would be shared without any commingling of the youth in order to gain the efficiencies for the project. [LR363]

CHRIS PETERSON: So it addresses two issues that we're seeing, which is the growth of the violent youth as well as the need for extra substance abuse, chemical dependency beds. [LR363]

SENATOR GAY: So on that, it'll be in this budget coming up then is what we should be watching for because you're ready to open it, you want to open it in 2011. You're talking about behavioral disorders and many of these kids too. Isn't that the... [LR363]

CHRIS PETERSON: They're tough kids. I'm going to turn to Todd for that. [LR363]

TODD LANDRY: Right. What we have proposed in our capital construction request is a collocated facility. One for the chemical dependency treatment needs of youth parole from YRTC-Kearney. We currently have 40 beds at the Hastings regional campus to serve those paroled youth. Our proposal is to expand that slightly to 48 beds. The other portion of the collocated facility would be the secure facility for violent youth. Those would be youth who are violent, very aggressive, and who are not amenable to treatment. And so the purpose of that is to provide a secure setting for them, for the staff, as well as for the community until those youth can become amenable to treatment that would (inaudible) move back and be treated in the community or at the YRTC as appropriate. [LR363]

SENATOR HOWARD: And what's the projected number of beds? [LR363]

TODD LANDRY: Twenty-four. [LR363]

SENATOR HANSEN: Chris, would I ask Todd a question? [LR363]

CHRIS PETERSON: Absolutely. [LR363]

SENATOR HANSEN: On our tour last year, HHS tour, we toured a facility on south 13th, 14th Street in Lincoln. How does that facility compare to what you're wanting to build in the capital request? [LR363]

TODD LANDRY: Yeah. That facility in Lincoln is the Lancaster County detention facility. So that facility is for short-term stays of use on a detention basis. Usually they're by court order or for an initial law violation, not intended to be long-term placement. [LR363]

SENATOR HANSEN: And you're looking at a long-term placement then. [LR363]

TODD LANDRY: These could be longer term placements. Certainly in the chemical dependency program the average stay is four to six months. Those are not highly violent or highly aggressive youth. Those are youth who are amenable to treatment and are paroled from YRTC-Kearney. For the secure sight, it could be a relatively short duration period. That would be our ideal. But there may be some youth who need to be there for a significantly longer period of time. [LR363]

SENATOR HANSEN: Thank you. [LR363]

SENATOR HOWARD: And you're looking at this on Kearney's campus. [LR363]

TODD LANDRY: The location has not been named for this project. What we have indicated in our capital construction project is that it would build on state-owned property. And so we're not anticipating having to purchase property for that. But the exact location has not yet been determined or proposal. [LR363]

SENATOR HOWARD: And we do still have the campus here in Lincoln, don't we? The original? Thank you. [LR363]

CHRIS PETERSON: Again, reduce state wards. We're down now I believe another 500, and revise the physical layout at the YRTC-Kearney. This is another capital construction proposal for a dormitory style beds that are with the YRTC now. And this would allow them to fall more closely with the modality of treatment that we have there instead of just the open air dorms. And then again... [LR363]

SENATOR JOHNSON: Chris, what do you have now? [LR363]

CHRIS PETERSON: Yeah. This will take care of what we have now. [LR363]

SENATOR JOHNSON: Yeah. Explain to the group if you would what you have now. [LR363]

CHRIS PETERSON: Yeah. When you go to the dorms right now at YRTC-Kearney and you walk up, it's just a huge open area of beds. And then there's two, I believe, two areas in the middle or one area in the middle for people to watch. This will change that and put in partitions so that there's more privacy that will follow more closely the modality that we have with the treatment of the youth at the YRTC. And Todd can explain a little bit better. It's just that you're not going to have this huge open air where the cots are just laid out. [LR363]

SENATOR JOHNSON: Right. Yeah, and we can get to him later when he talks, but wanted to make continuity here. [LR363]

CHRIS PETERSON: Again, implement managed care statewide. And you are certainly going to hear, this is not going to be everybody is thinking this is the greatest idea in the world. The one thing I want to tell you, the GIO just came out with a new update on where Medicaid is going to go. And it's even worse than what we had anticipated earlier. Managed care has changed certainly over the last couple of years. The state had a managed care contract that was not successful. But I do believe that right now if we're going to look at the sustainability of Medicaid and the fiscal resources we're going to have in the next however many years, right now Nebraska is almost in a little bubble because we have not seen the crisis hit our state that other states have. There's only about five of us that have done that. If the economy...and that's for several reasons, we have a good economy. Medicare has picked up the drugs. And in essence, the whole concept of managed care has to take in account that those could change like that. And one month's bills for us is about...Vivianne, $40 million, one month's bills? [LR363]

VIVIANNE CHAUMONT: Well, it's $1.6 billion for the year, so it's $100... [LR363]

CHRIS PETERSON: However you divvy it up. So all of the things that have kept our program good and sustained and actually showing a downturn, we're still $400 million with a gap. And if we look then at the projections that are coming out and the resources of the state...it would be nice if the economy stays the way it is. But if it doesn't, then we have to find ways to sustain the services for the people who need them the most. And that's what this would allow us to do. And again, you'll hear more about it from us, you'll hear more about it I'm sure from people that provided the services before. Certainly it's going to be a large discussion item. We cannot maintain the integrity of the system should we fall upon harsh times or less resources than we have. Developmental disabilities, it's just a continuation of LB2010, moving towards implementing the DOJ settlement and moving people successfully to the community. Medicaid, I think the only new one on there is implementing 100 percent electronic claim submissions, which would be a significant...we're pretty high, but it's not there completely. And then implement a nursing facility reimbursement methodology. As I said, Vivianne has moved through. We're looking at different ways of how the rates are set, how costs are provided, whether it's cost-based, reimbursement, rate setting, there's a variety of ways to look at that. And public health is continue the development of electronic system. We have a small pilot, and one of the things that we always look at is health data, patient information, and how that is successfully transmitted. Veterans home. Again, the census and quality of care and the same thing with operations, improving the culture, helping with recruitment and retention. Questions? [LR363]

SENATOR HOWARD: You had a lot of information you had to deliver. (Laugh) you might want to take a break. One of the things that Senator Stuthman brought up earlier was his interest in a program that would keep kids from coming into wardship. And the first bill that I got passed, LB264, was for the early intervention services for infants which I think has been very effective and kept kids from coming into foster care. But even more important, kept kids from...babies from being hurt. In trying to process this

with the safe haven issue and all the things we're looking at, I'd be real interested in knowing your feelings or your thoughts on a program that would run tandem to that for older kids to help families in time of crisis, services that they could access without the child becoming a state ward. [LR363]

CHRIS PETERSON: Okay. I think that when Todd talks about what we've already implemented, there's some significant things there. One of those that comes to mind immediately is the preconference hearing that the judges have implemented, which is Judge Vanpola is the one who brought it to my attention, which is if you could get everybody together ahead of time and prevent people from getting into the system, then it's hard to get them out. So I think the in home care services the whole contract that Todd has created addresses just that issue. [LR363]

SENATOR HOWARD: The difficulty is when people are in a time of crisis with their youth, they want immediate service to address what's going on. And we want to keep people from reaching the point where they strike out, where they do something that in the heat of the moment that if they had the opportunity to take a step back, they wouldn't do. [LR363]

CHRIS PETERSON: And I think one of the things, Senator, that we've certainly talked about through the whole issue with safe haven is that the state is not just the quickest, fastest answer. There are a variety of nonprofit organizations, many of which you donate to, that provide those services, in addition to churches, in addition to families and friends. I was just visiting with somebody about going back to my high school reunion and talking about where people ended up. One of my friends is now a nurse for a congregation, and she actually goes out and when people come back from a nursing home, she's there to help them get ready. That's not provided by the state, it's provided by the church. All the dollars that go to United Way. There are a variety of organizations out there, several whom, you know, came on with us when this first happened--Boys Town, Cedars, 2-1-1--for people to access. Education is a key. There's no doubt, and

my kids are 29 and 31, there is no doubt that everybody at some point has a time when you don't truly know what to do. The people that we're seeing, they have children that are quite complex and a challenge. And so it's certainly what our goal is to...and they were all Medicaid, I think for the most part, have all been Medicaid eligible. [LR363]

SENATOR HOWARD: Which is an interesting piece. [LR363]

CHRIS PETERSON: So the services have been available for them, and that's why we're sending out the letter telling them how to access them. These children are Medicaid eligible, which means that opens up the door to behavioral health services that might not be there, you know, for other people. And so we need to educate them where to go if they're eligible for Medicaid. If they're not, there are many organizations out there that would be a benefit with parent counselling, with respite, with family support, things like that. And so part of it is obviously, part of it is education, part of it is a support system whether it's a family, a church or an organization. And then the children that are adjudicated to us that become state wards, those are the ones that the state truly should be involved with. But we should use some of those other services that are out there first. [LR363]

SENATOR HOWARD: Well, and I think you and I are saying basically the same thing. I feel we have a responsibility to be proactive on this issue. That really is the best way to assist families who are going through a tough time and to keep kids out of the system. [LR363]

CHRIS PETERSON: One of the things I'd really like to do right now is I'd like to have Todd come up and talk because he has lived and breathed this for I'm not sure how long, and he's been an expert spokesperson. And he's been involved in all of the discussions. So... [LR363]

SENATOR PANKONIN: Chris, before you leave I'd like to just add, from going...

[LR363]

CHRIS PETERSON: Oh, I didn't think I was going to get to leave. (Laughter) I was just going to slide out of there for a while. [LR363]

SENATOR PANKONIN: First of all, you and your staff haven't been here two years and kind of get on the front of the reorganization and your role and whatever. But all of you have worked hard. I personally appreciate it, but I think the state appreciates the hard efforts of you and your staff and all the department heads. And it's been amazing the things you have taken on. And hopefully this reorganization is taking hold and going to be very successful and a pattern for other states. As the discussion moves on to what we've been talking about and what Todd is going to talk about, I made this comment to someone today. I think we had unintended consequences with safe haven, but I don't necessarily think it's a bad thing. I think it has brought to the forefront that people are in trouble, people are desperate. And we can talk about the education piece which is important so they do know, but I look at it and I actually have been pleasantly surprised maybe that I've had contact with. I haven't been down here for about five weeks, but just in general have said we didn't realize there was this big of problem for families and children. And I think this is a time to, because of the unintended consequences, to look at this with more focus and to see how we can help our state, help our children, help our families. Chris, you made that comment of you know we've all been parents. Senator Gay has got younger children. My children are more your age, but we've all gone through times when our kids are having tough times. And whether we're Medicaid eligible or not, just the resources that are there. So I think this is time that because of this has brought out how can we make it better for our state, our citizens, our families, and also knowing that if we can help on the front end, it's going to save people not only the emotional toil, but on the other end. One last comment is we have been fortunate economically that our state has had a better go here this last couple of years. But we're not going to be immune from it, and I think it's going to put more stress on families and overall mental health because of people that are struggling. And so we saw this in the

farm crisis in the mid-eighties and things likes this. But we're going to have more of this, there's no doubt. And so we need to as a department be prepared for that of how we can get on the front end of that as well. [LR363]

CHRIS PETERSON: Thank you. [LR363]

TODD LANDRY: Well, good morning. We certainly have had, as Senator Pankonin indicated, some unintended consequences as it relates to the passage and implementation of LB157. And I know that all of your are probably going to be participating in the currently planned special joint hearing on November 13. And so I'm sure we can get into more details at that time or repeat some of this information. I believe that your comments, Senator Stuthman, are right on the mark that you made a little bit earlier in that to the extent that we can safely keep kids out of the system, that is clearly going to be a benefit in my opinion not only for the state, but more importantly for the youth and their family. Much of what we have done over the past two years within the department in implementing the safety intervention system and implementing our in home contracts are specifically designed to provide earlier intervention techniques for those children so that they don't have to become escalated in the system and need higher levels and usually more expensive levels of intervention, whether those be in out of home placements in psychiatric residential treatment facilities, or some other kind of high level of detention, for example. So that is certainly something that we believe in. Senator Howard, you're exactly right. We have implemented the home visitation contracts in four communities across the state, and our intention is to continue those. That's included in our budget proposal that we have put forward on September. Certainly that is an example in my opinion of one of the prevention tools that we have in our state. Part of my presentation that you'll see tomorrow, one of the pieces that we illustrate is a triangle or a pyramid join the full continuum of care, everything from prevention to early intervention, to higher levels of care, all the way up to the proposed secure care facility that we've included in our budget proposal. The key aspect of that pyramid to recognize is that at the bottom layers of that pyramid, particularly on the

prevention side, that is where you have the greatest involvement of nongovernmental resources. The prevention piece is where most of our nonprofits thrive and spend much of their time focusing on. It's where many of our churches and synagogues and other faith-based organizations spend a lot of their efforts on doing. The prevention piece is really where the community plays a huge role top play there. As it specifically relates to the 19 youth who have been left under safe haven at hospitals since September 13. Chris is also correct in that saying that eight out of ten of those, 85 percent of those were eligible for Medicaid and in most cases were receiving Medicaid services. So I know that there has been some feedback from the community saying that the Medicaid eligibility rate needs to be changed or to have more services or have increased eligibility. If we look at the data from the 19 cases, that would not be the case. Those were already eligible and receiving Medicaid services. So it was not an issue of access to services or ability to pay for those services. In my opinion, in most of the cases that we've seen, and we'll get into more detail at the November 13 hearing, in most of the cases that we're seeing it instead was a situation where the results that the parent and the family were looking for were not necessarily being achieve fast enough, and they reached a point where they felt like someone else could do a better job than they could. How we fix that question I think is a very different question than a question about how do we increase resources or make resources available. I think there is a key question there that we need to address. Part of it is education an up front, part of it also is education to these families so that they have a better understanding of knowing how to access the services and knowing that sometimes these services are not as we as a culture tend to want immediate quick fixes. Many of the issues that we're dealing with and that these families are dealing with and that many families are dealing across our state and country are dealing with are longer term chronic issues that are going to take repeated interventions, repeated tries at changing different ways of getting the desired results. And They may be different when the child is 9 versus when the child is 16 or 17 years old. That I think is a bigger challenge. [LR363]

SENATOR HOWARD: I'm sorry. I don't mean to interrupt you. Don't you feel when a

family feels that they're physically in danger, the child is physically in danger, there's some safety reason...I'm thinking of the grandmother who woke up with the child standing over her with a knife and she was scared to death. That really is not amenable to tomorrow's counselling. That's a situation where a person feels they need immediate action. [LR363]

TODD LANDRY: And I can appreciate that. What I can tell you is that based on our review analysis and law enforcements involvement in these cases as well that none of the 19 kids were in any immediate danger of being harmed. Now that is not just our opinion, that's also has been the opinion of law enforcement and the county attorneys, etcetera. Now, does that mean that a child can certainly become very violent and aggressive at times? Certainly children and youth, particularly older youth, can do that, but younger youth can do that as well. In those situations of immediate jeopardy of safety and issues of harm for a family, I do believe that in many of those cases that's where our families may have to pick up the phone and call 911 as they have done for many years and say, I've got an out of control crisis situation that I need immediate law enforcement or police involvement. That is very, very different from a situation where I'm not getting the results I want, my kid is running away, my kid is not obeying my instructions, he/she is not coming home when he's supposed to and I'm tired of dealing with this and I want someone else to do it instead. I think every case is unique and individual, and so we have to look at them uniquely and on an individualized basis. But what I'm seeing so far is that in vast majority of theses cases, these are not situations where there was a question of ability to pay for services. It seemed to be more of a question of how quickly results were being achieved. [LR363]

SENATOR HOWARD: I would think... [LR363]

SENATOR JOHNSON: If I could interrupt for a second, and I like our interplay that's been going on here. But I don't want to convert this to a safe haven hearing. We have many other things to go over in the next two days, and we actually do have time set

ahead for hearings on this specific thing. So one more question, and let's try and move onto something else. [LR363]

SENATOR HOWARD: Todd, I would just caution you that one of the risks that we have as a agency, Health and Human Services, is that we have to be careful not to minimize the problem. We like to think things will be addressed through counselling or family support or situations. But clearly we should learn a lesson from last December that there are situations that we cannot simply refer to counselling. [LR363]

SENATOR GAY: Joel, I've got one thing. [LR363]

SENATOR JOHNSON: Yes, certainly. [LR363]

TODD LANDRY: I'm sorry, but I have to say I think that referral to the situation in December doesn't have anything to do with these situations. That may be an area we just simply have to disagree on, Senator. [LR363]

SENATOR GAY: Todd, I've got a question and you don't need to answer it right now, but tomorrow when you speak to us. And Chris had talked to us about recidivism rates. What I want to know, and like I say you can wait until tomorrow, what you're doing to make sure when somebody...ongoing services that are now completed and they're out of the system, but they're on the fringe and one little thing could put them right back in. Talk tomorrow about what you're doing, if anything. [LR363]

TODD LANDRY: I will be happy to. I think that's an outstanding point in the piece that to be very honest with you has not been a big part of our service area in the past or our contracted services, and we can speak very, very directly to that tomorrow. [LR363]

SENATOR GAY: Okay. Thank you. [LR363]

CHRIS PETERSON: Oh, did you have something, Senator? [LR363]

SENATOR STUTHMAN: I just have a comment, more or less. I just think with the events that have happened with LB157 and the drop-offs, I think we can make a very positive affect on this by being able to utilize what we have in place already with no more funding, but making them available, utilizing the 2-1-1 system. I have tried to call the 2-1-1 system and it's not working, it's not working at all. And I think just the fact that it's very visible at this time, I think there's a lot of people that really support what we have done, that there is a need for people to get services. But there are services, but they need to have the access to them and almost immediately I think, you know. I've almost got to the point where I have an ear infection already because of the fact of answering the phone so many times. But it's just unbelievable how many people say, you know, there is a need out there for something there. But we don't want to have a separation at the hospital. That's what I think we've got to make sure of that. So I think I would just like to announce I did an interview on the Dr. Phil Show and I listened to the taping of the whole show. That is one we need to listen to of people, you know, other parts of the country that are in situations, very demanding situations where they needed help and couldn't get help. So it's going to...I will let you know when that will be aired. So that was very interesting. [LR363]

SENATOR PANKONIN: Oh, we get to see Senator Stuthman on the Today Show (laughter) and now Dr. Phil. We have a national expert here, Todd, use him. [LR363]

SENATOR HOWARD: He's our celebrity. [LR363]

SENATOR STUTHMAN: I really didn't plant it that way (laughter). I wanted to save a little baby from being in the dumpster. [LR363]

SENATOR HOWARD: Be sure to let us know when that comes out. [LR363]

SENATOR JOHNSON: And the fact of the matter is I used to be an old quarterback and I know when to hand off the ball. (Laughter) [LR363]

CHRIS PETERSON: If I might just say a couple of things, follow up. I served on the HHS committee. It's a very hard committee to serve on because there are a lot of needs out there, there always are. Our agency is not an easy agency. We typically are dealing with people who are at their very most vulnerable. And there aren't a lot of avenues left for them anymore. They've gone through support and they don't have a lot of options out there. But I think it's my responsibility as well as my directors to ensure that the people who are getting the services are the ones that need it the most, and that those services are going to be there when they need them. And so we look at all of the issues, and that's what we're looking at here in our strategic plan is I hope the economy stays great, but I'm not going to count on that. And there are a variety of things in here which is contract oversight, working more with local resources, managed care, they're not easy and they're not popular. But even on a good day I'm looking at a $400 million gap, not that I'll be here to see it, but I certainly can't let it continue to grow at that rate. As I've served on this job, I wake up at 3:00 in the morning. And as I talk to my directors, they have started that 3:00 in the morning wake up too. It's because you don't want something bad to happen to somebody that you're taking care of. And so I will tell you that there's probably no group that had bigger hearts than those setting behind me. But we also have the fiscal responsibility to maintain our programs. So on that little soapbox, I'll be quiet. Yes. [LR363]

SENATOR HANSEN: Senator Johnson? [LR363]

SENATOR JOHNSON: Tom, go ahead. [LR363]

SENATOR HANSEN: Chris, one thing that I haven't seen on your PowerPoint was anything due to the licensure, and I know you handle licensure a lot. Is there a trend toward on-line renewal of licensures? And I'm sure there's now, but is there a trend

toward more of that? Because I've been contacted with some people out in the western part of that state...central part, where I'm from, that they think that it costs about $1,200 to come down to Lincoln to get a two-day renewal of their license. That's loss of time on the job, loss of time, you know, take the time to come down to Lincoln, get the motel rooms and all that stuff. It's HAZMAT training. Is some of the contact that I've... [LR363]

CHRIS PETERSON: You know, that would not be one that I'd have the knowledge of. I know Dr. Schaefer probably does, but if she doesn't, she's up next after we have the public comment, between then and now I'm sure we can get...(recorder malfunction) [LR363]

(Recorder Malfunction--Some Testimony Lost) [LR363]

SENATOR JOHNSON: ...trying to get away from is that we are going to go through all of these different areas and that's why I didn't want to get us involved too much with the safe haven type of thing at this point because it will come up in due time here and so on. So I want to try and keep it semiorganized here. So... [LR363]

SENATOR GAY: Joel, I have one... [LR363]

SENATOR JOHNSON: Sure. [LR363]

SENATOR GAY: ...one question, general. Chris, this is a general management question. You're a very large organization with a lot of responsibilities, but how is the interaction? How do you interact with these department heads and the Governor and explain so we're not in silos,... [LR363]

CHRIS PETERSON: Uh-huh. Absolutely. Oh, thank you. [LR363]

SENATOR GAY: ...that we're working together. But what's a daily or weekly or monthly

routine for you? [LR363]

CHRIS PETERSON: That's a great question. We meet with the Governor on a monthly basis. We're his favorite agency so he likes to meet with us often. (Laughter) And so we...and we go through everything there, every division. We talk about, you know, trends. As I said, one thing that the reorganization has given us that we haven't had before is the ability to not just do crisis management. We have the time to look at/pull statistics together, look at trends, see where the gaps are, kind of analyze the complaints that come to us either from senators or from stakeholders or providers and figure out how we can do that within the resources we've got. We've never had the luxury of doing that before, truly. So we meet with the Governor. Usually during the legislative session we meet with him twice a month, but on the off-season we meet with him once a month. I meet with my directors on a regular basis every Monday for two hours and at that point, those are our...we talk about things that have happened with them, we talk about things that go across divisions and how to handle those. We're all in the same general area so it's...if there's an issue, like when we were putting together...I'm trying to think what we were just working on, oh, overtime, talking about overtime, I was able to just pull a director in right off the...out of their office. So that happens on a daily, actually hourly basis, so there's really not a time that someone isn't aware of something else that's going on. In addition, I meet with the directors themselves on an individual basis for at least an hour every week. They meet together, I follow all of their schedules so I know what the discussions going on are. There is just a tremendous amount of interaction. The one thing that they have picked up on very quickly is you can't touch one part of the system without it affecting somebody else. So if there's a change made in transportation and Medicaid, it impacts immediately all of those people out in the field who are getting that transportation service. And I will tell you that this group works very well together in making sure that number one, number one rule, no surprises, no surprises. And so I think that's how we work, with trust and collaborativeness and communication. That's the biggest challenge, senators, the communication, even between us. [LR363]

SENATOR JOHNSON: Chris, I'm going to ask Bob to come up and join us for... [LR363]

CHRIS PETERSON: Very good. [LR363]

SENATOR JOHNSON: ...just a minute and nobody knows who he is and...but so why don't you come up and tell us just a little. This kind of impromptu on my part here,... [LR363]

BOB ZAGOZDA: Sure. Oh, no problem. [LR363]

SENATOR JOHNSON: ...but it seems to be appropriate. [LR363]

BOB ZAGOZDA: Could you go back to page 3, Mike, or not? Yes. Bob Zagozda, it's B-o-b and the last name is Z-a-g-o-z-d-a, COO for the Department of Health and Human Services. Mike is going to put back up on the screen the first org. chart you saw. We can take a quick look at my areas again. I'm responsible for legal services, finance, human resources, communications, legal services, and support services, the blue box on the right. Basically, operations provides the basic business functions for the agency so divisions can focus on the services that they provide. So basically, the divisions are my clients, and so we provide the basic business infrastructure for them. In addition, I probably do a lot of...plenty of special projects for Chris, including I'm kind of the main liaison with DAS and with the Auditor's Office, the APA's Office. We've done a lot of special projects this year, including we've been, you know, doing an ongoing project with improving collections. As Chris mentioned, that I originally worked at Arthur Andersen back when that was a really good thing to have as a credential. But those areas, at least at that point in time were 547 people. I think we're down a little bit closer to 500 now. We have some big projects, as you can imagine, because I have IS&T, so we have the MMIS system include my people, all the ongoing big three...or the other two big systems, plus we'll have significant involved...the ITS&T area will have

significant involvement in ACCESSNebraska and in the vets home software project. So we have some big, big projects going up that are utilizing lots and lots of resources from the IS&T area. A lot of the things that you see for DHHS issues and problems are also shared by me, for example, staffing recruiting and retention. It's, you know, the HR area is certainly instrumental and fundamental in helping the divisions fix those problems. So I get involved in many of the business-type issues that happen at the agency level. I've been...my background, as you well know if I worked at Arthur Andersen, was, you know, in accounting, but I've done lots of administrative things, including, I think Chris mentioned, I joined Clarkson Hospital two months before the merger started with University Hospital at the Med Center, which was about a two-year process before we actually came together and had designed things from scratch. It's very interesting that coming in where I have at the reorganization of DHHS is that there's a different kind of an energy that a reorganization generates that I can remember having the same kind of feeling during the Nebraska Health System merger days that just the process of going through and looking at things, you know, in some ways it's overwhelming, in some ways it's refreshing because you can take a fresh look at things. You can turn things around and make things...at least how they make sense to you or have opportunities for improvement. So as Chris mentioned, we have a very collaborative relationship, usually on a one-on-one basis. It's very "formal." We all sit within several yards of each other. If I need to know something, I walk in somebody's office and ask. Of course, meetings are a little more formal, but we have great access. We have a great working relationship between all of us and that certainly helps the process of going through the DHHS reorganization that we've had in the last year. Otherwise, I'd be happy to answer any particular questions that you have. [LR363]

SENATOR JOHNSON: Okay. Any questions of Bob? [LR363]

SENATOR GAY: I've got one. When you have...each division, does it have a finance director then reporting to you, so Scot has a finance director specifically to him or are you overseeing all of them? [LR363]

BOB ZAGOZDA: No, I'm overseeing all of the... [LR363]

SENATOR GAY: Is there a specialist in each division? [LR363]

BOB ZAGOZDA: Yes. [LR363]

SENATOR GAY: So if we want to find out where some savings is or where the money is going in... [LR363]

BOB ZAGOZDA: So for...I'll give you an... [LR363]

SENATOR GAY: ...Children and Family Services... [LR363]

BOB ZAGOZDA: Yeah. For example, in the finance area there's a budget group of approximately six people... [LR363]

SENATOR GAY: Yeah, in each division or... [LR363]

BOB ZAGOZDA: ...and each of those people has a division that they work with on a regular basis, same thing in the accounting/payment processing side. There's probably 13-14 people in that area. They have people that they work with regularly in each one of the divisions so they get to know what's going on and get to know what their issues are and get to know who in the specific divisions do those same types of things that they need to interface to get things done. [LR363]

SENATOR GAY: Thanks. [LR363]

SENATOR JOHNSON: Bob, thank you very much for the impromptu... [LR363]

BOB ZAGOZDA: Thank you for the opportunity. Appreciate it. [LR363]

SENATOR JOHNSON: Chris, do you want to finish up or anything further that you were thinking of as you were sitting there? [LR363]

CHRIS PETERSON: Actually, I just appreciate the opportunity. Again, as I said, we spent the first year kind of building the infrastructure. We've had the opportunity to learn how to work together well and do some strategic planning. This is the direction that I believe we need to go and certainly to ensure the sustainability of all the programs that we provide right now. And so would welcome any comments, suggestions, arguments, discussions, anything along those lines throughout the next couple of days. We've put a lot of stock in our relationship with the Health and Human Services Committee and try to have it collaborative, and finally just get to the point where we agree to disagree. So be it, but at least we'll do it with openness and honesty and trust. [LR363]

SENATOR JOHNSON: Well, I guess the one thing that's... [LR363]

CHRIS PETERSON: Yeah. [LR363]

SENATOR JOHNSON: ...kind of stuck in my thinking here as we've gone on this morning and I think it's worthwhile mentioning it, President Clinton as on the Tonight Show here a day or two ago and they asked him, isn't this just a horrible time to be coming in to be President now in January. And his answer was, oh my goodness, no; what an opportunity to do good. And I think this is where we're at now with the reorganization and the other things, is what an opportunity all of us have to really make a difference. And so, you know, I see that in the department and in the reorganization change and, you know, I think it's extremely important that we maintain that mentality that is building. [LR363]

CHRIS PETERSON: Okay. [LR363]

SENATOR JOHNSON: So with that,... [LR363]

CHRIS PETERSON: Thank you. [LR363]

SENATOR JOHNSON: ...what do you say we take just about a ten-minute break and then...oh, Jeff is saying do you want to take a ten-minute break now or do you want to have the public comment and then take a break. What? [LR363]

SENATOR STUTHMAN: Public comment. [LR363]

SENATOR HOWARD: Yeah, let's have public comment. [LR363]

SENATOR JOHNSON: Okay, all right. You're not as old as I am. (Laugh) [LR363]

(WOMAN): I am. I've got to take a break. [LR363]

SENATOR STUTHMAN: You might need (inaudible) before I do. [LR363]

SENATOR JOHNSON: So the vote is to go ahead with the public comment, so let's go ahead. And again, during the year we've kind of had a rule of five minutes. I'm not going to hold anybody to that or anything like that, but let's try and be very specific and to the point and not just go on and on. So let's make our comments meaningful, if we could. So with that, I don't think that there's any pro or con here. It's kind of all helpful testimony. So whoever wants to be first, let's come on up and comment about what has happened so far or, if you prefer, there may be people here that want to talk about specific things as we go through comments here and maybe that would be more appropriate at that time. So is there anybody that wants to comment about what we've talked about in general so far here this morning? Ah! [LR363]

SENATOR PANKONIN: Seeing none... (Laughter) [LR363]

SENATOR JOHNSON: Seeing none, the...let's come back in about ten minutes and we'll go on from here. [LR363]

BREAK []

SENATOR JOHNSON: Go ahead and get going. Well, can we all have a seat, and let's go ahead. Talking about getting older, it kind of reminds me of something that my father-in-law said was you can tell where you're at in life by the food that you eat because you start out with liquids and then progress up, and pretty soon you're eating dorm food and then you get married and your wife learns how to cook better and better so there's a period in there where you're kind of really eating high on the hog and so on, and he says, but start worrying when you're back to dorm food. (Laughter) At any rate, Chief of Public Health, etcetera, if you would like to join us. Good to see you looking healthy, etcetera. [LR363]

JOANN SCHAEFER: Oh, you have no idea how good it is just to be here, just to be alive. All right. We're going to talk about Public Health. I'm Joann Schaefer, J-o-a-n-n S-c-h-a-e-f-e-r, M.D. I'm the chief medical officer and the director of the Division of Public Health and I want to show you our structure here. Chris referred to this in her testimony, how we realigned our programs and it's got us a significant amount of national attention about this. I interviewed with several magazines, including Governing and also the CDC took note that we switched one of our main components to a life health services unit or life span health services unit so that we could follow people along the stages of life. In Public Health, we have a lot of regulatory responsibilities and that is primarily on the left, and then you have Public Health responsibilities that come into protection, some of the vulnerable populations that we serve, the data that we collect and the fact that we have services and programs that follow the span of life. So in that life span health services unit, the CDC has switched their way of thinking as well and we

just mirrored that here and I think we were the first state to do that. But basically, we have preconception health, we have pregnancy health, we have health of the newborn, health of the infant. Then it goes into adolescent health, then it goes into women's and men's health, and then we get into elder care. So if you...if we look across the life span, that helps us organize our messages, our programs and everything that we do according to the life span that somebody is in and it's just a unique way and a new way of doing business. Our Public Health support unit is the division that deals mainly with data, and that's one of our priorities and you'll hear me talk about that in a moment. And then our community health planning and protection unit that's up at the top, that is where we get a lot of federal grants, a lot of federal dollars that come into the system, and our job is to coordinate them and put them out to the communities, and some of that has to do with protection. Our bio security grants, bioterrorism, our pan. flu, our strategic national stockpile grants, all of those fall within that realm as well as things like our office on minority health and health equity and making sure that we're doing the things that the grants tell us to do in a coordinated fashion by putting them all in one unit. We tried to make our organization structure, when we realigned all the public healths, to meet for...formed to meet function, so people who, if you put people together who do similar functions all day, there's an efficiency that comes to it and there's a lot better collaboration. And we found that with all the federal grants that we manage, if we divide them in the right way and put them together, they are much more efficient in taking care of the populations, much more efficient in working with the local health departments, which are extremely valuable partners of ours out there. If you look at our funding structure over all, you'll note that it's about $132 million. Just a little over $13 million comes from General Funds, so it's a little bit less than 10 percent, or about 44 percent cash funded and about 46 percent federal funded. And that is the structure of our funds within the department...or the division. Sorry. [LR363]

SENATOR PANKONIN: Dr. Schaefer. [LR363]

JOANN SCHAEFER: Uh-huh. [LR363]

SENATOR PANKONIN: When you...you know, obviously, operations, I think I know what that is, that the aid is...what would that... [LR363]

JOANN SCHAEFER: What is the example of that? [LR363]

SENATOR PANKONIN: Yeah. [LR363]

JOANN SCHAEFER: On the General Funds in the aid, that's community health centers primarily and the money that we send out to that, and then some smaller things like housing opportunities for people with AIDS and then our renal program, our organ donor program, those wind up being in the general aid. And then we have the cancer and tobacco prevention funds, which wind up being in the cash aid. [LR363]

SENATOR PANKONIN: Okay. [LR363]

JOANN SCHAEFER: And then the remainder of that is in the federal funding, and our programs like that are WIC, some of the federal funds that we draw down and send out. [LR363]

SENATOR PANKONIN: Okay. Those are part of your department. [LR363]

JOANN SCHAEFER: Yes. [LR363]

SENATOR PANKONIN: Okay. [LR363]

JOANN SCHAEFER: If you look at the numbers that we serve, we do a lot of business with folks across the state. In fact, if you throw water in the mix, we really literally touch every Nebraskan. But 495,000 licenses or credentials are issued pretty much on a yearly basis. Some of those are multiple. Some people hold multiple licenses or...and

credentials. We've done, on a yearly basis, about 5,000 investigations of professionals. That's the complaints that go in to doctors or nurses, tattoo artists or cosmetologists, as well as investigations into food stamp and Medicaid fraud. [LR363]

SENATOR GAY: Dr. Schaefer,... [LR363]

JOANN SCHAEFER: Uh-huh. [LR363]

SENATOR GAY: ...I've got a question on that. Do you want us to wait or ask you questions... [LR363]

JOANN SCHAEFER: No, ask me questions anytime. [LR363]

SENATOR GAY: On the Beatrice committee, we talked...Helen was talking, Helen Meeks, talking about some of the investigations they're doing. How many people are in that department? And I was...when we were doing investigations, I was somewhat concerned how few we had, quite honestly. That sounds terrible to say, but how many people do you have doing those 5,000? [LR363]

JOANN SCHAEFER: Oh goodness, you know what, I need to get back to you on the exact number but it's somewhere around 46 total for all of those. [LR363]

SENATOR GAY: For all of those. [LR363]

JOANN SCHAEFER: So in the professional occupations and licensure, I believe there's about 12 to 13. And then in the nursing home, you know, the surveyors, which are also investigators but they're not in that 5,000 group, that's a whole other set of surveys and investigations that they're doing, there are four in developmental disabilities and then I'd have to get back to you on the number for nursing homes. Those are surveyors on a different side. So these are the investigations that if a person who has a license in state

has a direct complaint based on them, that's the number that we're doing, that and the food stamps and Medicaid fraud. [LR363]

SENATOR GAY: But under your department, though, you also investigate Beatrice and... [LR363]

JOANN SCHAEFER: That's right. [LR363]

SENATOR GAY: ...places like that. [LR363]

JOANN SCHAEFER: And that's not in that 5,000. [LR363]

SENATOR GAY: Okay. But I guess to file in the memory banks for the future... [LR363]

JOANN SCHAEFER: Sure. [LR363]

SENATOR GAY: ...is, as we say we need more community-based services, the protections of those, when we send them into the community, I'm not so sure five people can effectively do that for the safety of those citizens. [LR363]

JOANN SCHAEFER: Sure. [LR363]

SENATOR GAY: So that's something in the future. How you're going to address that question and how you would work with John Wyvill or any other department is somewhat concerning because that's been a main contention, as Senator Stuthman and I would tell you. It's a concern. [LR363]

JOANN SCHAEFER: Yes. [LR363]

SENATOR GAY: So that would be something in the future to make sure we are properly

staffed. [LR363]

JOANN SCHAEFER: Yeah. Absolutely. To continue on with the people that we license, there's about 10,000 more environmentally related licensed--water well drillers, asbestos, lead cleanup, there's a whole host of them in there; 13,000 people per year on the commodity food supplemental program as well, so 13,000 families that we assist with food; and 12,000 women are screened every year with Every Woman Matters Program; 7,000 are served on the maternal/child health side; and 1,700 are screened for colon cancer. Our goal is...we have a grant for that through the CDC. We are one of just a handful of states that got money to increase the screening rate and the reason was is because we have a very high incidence of colon cancer in our state and a very low screening rate and a very low vegetable consumption rate. We've only gone up, I think, from 48th to 46th in our rate of eating fruits and vegetables, which is one of our preventive strategies for colon cancer. Our goal is to get 5,000 screened for colon cancer by the time that grant is out. It was a several... [LR363]

SENATOR PANKONIN: And who qualifies for that, Dr. Schaefer? What are the targets, target? [LR363]

JOANN SCHAEFER: Folks who have family histories of early colon cancer, over the age of 50, and then symptomwise... [LR363]

SENATOR PANKONIN: Okay. [LR363]

JOANN SCHAEFER: ...as their provider. So we've hooked in with the provider community so that they can be screened and, you know, to be able to do that number and get colonoscopies. And, you know, we've actually, in that group that we've screened, we've saved several from colon cancer already by removing polyps before the time, hypoplastic polyps that would eventually gone on to turn into colon cancer. And these are folks that either didn't have insurance coverage or didn't have insurance

at all that needed the colonoscopy, too, as part of their screening of preventative health. [LR363]

SENATOR JOHNSON: If I can give Nebraska just a little boost here for just a second, there has been a doctor in Omaha by the name of Henry Lynch... [LR363]

JOANN SCHAEFER: Absolutely. Professor of mine. [LR363]

SENATOR JOHNSON: ...who actually was one of the very first people to notice the history link in families regarding colon cancer, and there are now actually a couple of colon cancers named after Dr. Lynch. There's a Lynch I and a Lynch II, believe it or not. [LR363]

JOANN SCHAEFER: That's right. [LR363]

SENATOR JOHNSON: So anyhow, Nebraska has been kind of at the head of... [LR363]

JOANN SCHAEFER: He also discovered the link between breast... [LR363]

SENATOR JOHNSON: Yeah. [LR363]

JOANN SCHAEFER: ...and ovarian cancer... [LR363]

SENATOR JOHNSON: Yeah. [LR363]

JOANN SCHAEFER: ...and worked...did a lot of work on the breast cancer gene itself. So, yeah, we're really blessed with some brilliant people out there. And we have 74,000 persons who are fed on WIC. That's the Women, Infants and Children Program. Those are federal dollars that come in. If you look in general about Public Health, we have three primary responsibilities: prevention through the screening test and then the

behaviors that we try to prevent. We have injury prevention programs, you know, trying to get people to wear their seat belts, proper childcare, child restraints; and then a whole host of things, getting more fruits and vegetables, activity, nutrition. All of those things fall into our preventive strategies. And then protection, by ways of making sure that the water is clean and safe to drink, bioterrorism and pandemic influenza strategic national stockpile, all those things that would protect the public should we have an event of such magnitude. And then when you get into the regulation of the entire healthcare system, when you consider that we license all the professionals and then we license and inspect and go out on complaints on any healthcare facility that's within the state, including the hospitals, surgical centers, nursing homes and assisted-living facilities, and the state owned and operated facilities as well. And then our third role is education, which we spend a lot of time on, obviously directed at those prevention and protection measures. And in that, you know, we do a lot of focus on the data that we have available at our fingertips and data is a huge priority for our area to work on and I'll touch on that in a bit. [LR363]

SENATOR GAY: Dr. Schaefer, on that protection, on the pandemic flu, the health centers bought a lot of...what's the antibiotic? [LR363]

JOANN SCHAEFER: Tamiflu. [LR363]

SENATOR GAY: Yeah. Anyway, did they ever correct the problem where they were going to have to dispose of all that, or can they reuse it? [LR363]

JOANN SCHAEFER: They did extend the shelf life. [LR363]

SENATOR GAY: To how long? [LR363]

JOANN SCHAEFER: They extended it to ten years, so we'll have...we'll have those more and, you know, we'll have them longer than the expiration date that was printed on

the bottle, after they did several studies to test the actual stability of the drug in the bottle after the expiration date. You can't do that with most meds. Why, wouldn't want anyone to take home from here that it's okay to take expired meds, but in this particular case they had done enough chemical studies on it to feel secure that we could extend the shelf life of those medications, including our own state stockpile. [LR363]

SENATOR GAY: And how much did we spend on those? [LR363]

JOANN SCHAEFER: $658,000, I believe. [LR363]

SENATOR GAY: Okay. So it goes till when? Ten years... [LR363]

JOANN SCHAEFER: You know, I can't remember the actual date. [LR363]

SENATOR GAY: So we're good to go for... [LR363]

JOANN SCHAEFER: We just...for a number of years. [LR363]

SENATOR GAY: ...six or seven. [LR363]

JOANN SCHAEFER: Yeah. We try to think of it as our insurance policies, that we're good to go if we have a pandemic in that period time. If it happens after, we're going to have to readdress it. So these are the priorities for our division and I'll go into some detail on them. Becoming the trusted source of health data, a lot of people rely on our data and we have a ton of it, but we tend to be data rich and analysis poor. And if we can open up our data streams to people so they can use our own data and help us with the analysis, the state will be better off as a whole. And we do analysis on specific requests and we have a certain number of reports that we generate each year, but there's so much more that we can do. We're working on rolling out a Web query system so that eventually...my vision is that you could go on and you could type in the county or

counties, the disease and the age group, and you could find out, you know, what the incidence of that particular thing was within those counties. This would help unburden the local health departments from having to do such data collection and their own data mining. They'd have it. We already have that information so we could pass that out to them. Creating a culture of wellness based on four things: prevention, screening, testing; nutrition, proper nutrition; activity, increasing physical activity around the state; and then stress management--those four cornerstones of wellness. I believe we are at a tipping point in our state on the whole idea of wellness because everywhere I go now around the state people are doing things on wellness. Corporations, large and small businesses are participating in wellness, and I'm going to talk about that in a little greater detail in a moment. Addressing health disparities within our resources, currently we have a requirement that all the grants that we have that are coming, that we get money for and that are going out to the communities, we want them to address, look at, and be aware of the health disparities in their region. And in order to get those dollars, they have to acknowledge what those disparities are and a way that they're going to improve that. We've never had such a requirement within the division before. We've had grants that go out and look at disease X, but they've never looked at why there's such a disparate difference between the black population and the white population, mentally ill and healthy. They've never looked at the disparities within them. So now we have that requirement because we really need to put the money out there in the communities and the places where it needs it most, and we also need to stop doing some of the things that haven't turned out a decent result. After several years of funding certain programs, if they're not turning out the outcomes that we want, it's time to stop those and shift and do some new thinking and get different things out there with the same dollars. [LR363]

SENATOR HANSEN: Dr. Schaefer. [LR363]

JOANN SCHAEFER: Yes. [LR363]

SENATOR HANSEN: Could you elaborate on some...or give some examples of those

programs that should be cut? [LR363]

JOANN SCHAEFER: Sure. Well, one of the concerns that we have right now is when we go out and work with a community, we don't look that the infant mortality rate is necessarily higher for one, for African Americans versus white versus Hispanic children. We don't look at all of those with all the grants that we turn out to that community, in that it's important that, if we're talking maternal child health dollars, preconception and prenatal health dollars, when they go out, that they take into account that those outcomes are worse. So if they're not putting money towards those, we're making them address those issues by shifting the funds that they would to the total and making sure that they have part of those funds going to addressing those specific needs. [LR363]

SENATOR HANSEN: Thank you. [LR363]

SENATOR GAY: Dr. Schaefer, to follow up with Senator Hansen's question, are you...you work with the county health departments, right? [LR363]

JOANN SCHAEFER: Yes. [LR363]

SENATOR GAY: Okay. The same thing goes for those, the question I had wrote down but now is a good time to ask, I guess. How do we coordinate what the county health departments are doing with the funding they receive? They receive from tobacco settlement funds. Is that correct? [LR363]

JOANN SCHAEFER: Uh-huh. [LR363]

SENATOR GAY: But do they also get grants and things from you? [LR363]

JOANN SCHAEFER: Lots, yes. [LR363]

SENATOR GAY: How do you know whether in our county that they're doing the right thing? They're made up of county commissioners and citizens... [LR363]

JOANN SCHAEFER: Sure. [LR363]

SENATOR GAY: ...in the counties that have merged together, and Senator Stuthman I think was on the board too. But how do you know that Platte County is very effective, which I know they are, versus Sarpy County, versus Dodge County, let's say? How do you coordinate what they're doing, or don't you? [LR363]

JOANN SCHAEFER: Well, we have very specific outcomes that are measured. One of our grants alone has 186 outcomes that can be measured on it so that we know how people are doing. And if we're not seeing areas of improvement in certain ones, then we go after that at their annual or semiannual review. We have many contracts that are for direct deliverables and direct things that have to happen in order for them to receive payment, so a lot of our coordination is very tied in with the local health departments. Many of our funds go directly out to them. Most of them go direct. Some of them are now starting to become competitive. Because the funds are decreasing from the federal side, you can't fund everything just a little bit. You actually have to just make the grants, you know, the dollars...make a program work well and that means not funding some and funding others. So as we've gone through some of the competitive process, that's been difficult for some of the local health departments but they understand our rationale of why we're going that way and there's only so much of the federal money to spread around. The federal guidelines on all of our grants and the outcomes that they expect are pretty stringent. I can't think of a grant that we have that has less than 50 outcomes tied to it, that are tied to it and things that we are specifically required to do. So if we're required, that gets passed right on to the local health department. [LR363]

SENATOR GAY: If, say, you talked about something, 50 outcomes or 186 did you say? [LR363]

JOANN SCHAEFER: A hundred and eighty-six in one grant. [LR363]

SENATOR GAY: I guess here's my...you have limited resources, especially if you're a small agency... [LR363]

JOANN SCHAEFER: Sure. [LR363]

SENATOR GAY: ...and we have 186 outcomes. I mean shouldn't we narrow that focus a little bit? [LR363]

JOANN SCHAEFER: It would be wonderful if we could, but they're federal dollars so they come...it's federally driven. Those are the measures that we are stacked up. [LR363]

SENATOR GAY: So we're basically a conduit between the federal grants... [LR363]

JOANN SCHAEFER: Very much so on many. [LR363]

SENATOR GAY: And then on the... [LR363]

JOANN SCHAEFER: On 46 percent of our funds. [LR363]

SENATOR GAY: ...on 46 percent. So, I mean, that...I always wondered. It just seems like they do a lot of things and I'm not criticizing. [LR363]

JOANN SCHAEFER: We do. Sure. [LR363]

SENATOR GAY: I think they do some good things, but I always wondered. It's like, man, how can you do so many things and be effective at it and how we control that. But

that is something maybe, I mean, good luck and that, but we need to... [LR363]

JOANN SCHAEFER: Well, on the federal level, we're very fortunate too. We're a very well-respected state and they frequently refer to Nebraska's ability to get things done and with unbelievable coordination. We're very well-known for that. So, you know, we do have a voice when it comes to the CDC and HHS with the funding mechanisms that they have, and we have been able to change things for not only our state but all states just by speaking up and questioning the validity of some of the things they're asking us to do. The 186 sounds like a lot, but when you break them down into groups, while they are a lot, they're all good and it's hard to look at one thing that you'd want to toss out when there are several million dollars backing up those 186 things that they want you to do. So we do do a lot. In fact, in the powers and duties that you have, if you look through that, I actually counted one day, we have 444 powers and duties just in the Division of Public Health, and the next one is Children and Family which has 215. So we have the lion's share of the powers and duties, according to HHS, largely based on all the things that we regulate. But there are many programs and many things that we do out there that we're directed to in statute. To go on, coordinating a media and education plan, this just gets into our coordination with the local health departments, particularly, and community organizations. You've all heard probably eight different ways of how you're supposed to get physical activity in every day, even though the guidelines do change. This...that's just one example of why we need to coordinate, so that we don't say five times, five different things to a population when we're trying to talk to them about cardiovascular health. We need a coordinated message that goes out, and a lot of that has to be coordinated on a daily basis with different topics that come up so that we aren't saying something different than what the locals might be saying. Because it's just confusing to patients, providers, to everyone if our messages aren't a little bit more clear of what we actually want people to do. Providing budget transparency, knowing where every dollar goes, and we've put a lot of time into that, into our division and making sure that we understand and we actually overlay the budget on top of our org. chart so we understand where the General, Cash, and federal funds are and what

programs they're paying for so you can dig that down. And our goal is to have that available on the Web for people to see. Progress that we've made in Public Health: Gathering all the data in our division to begin working on that Web query system, we're testing our different computer or Web-based systems now and will be bringing that up over the next year or two, and that just gets back to our vision of being a trusted source of health data and the ability for people to be able to look up various sorts of data on-line. We rolled out our immunization registry without General Funds used or needed and this has been a long-time project. Through, you know, very strategic planning of our federal funds we were able to get this system in at minimal cost using our federal funds. The entire computer system was obtained through Wisconsin when they developed things. When you develop things with federal funds, you can't charge another state for using them, so they were kind enough to let us use their immunization registry and we took some of our federal funds and "Nebraskatized" it and put some of the things in there that we wanted too. This does immunizations from cradle to grave. Entire spectrum of immunizations can be put on there. We've uploaded our registration, our immunizations that have already been in the old register that we had that was just about ready to break. It was being kept together with duct tape and wire, but we got through. We got that data uploaded into the new system and all the free clinics are using this currently, including our travel clinic which services people who travel outside the United States. In addition, we're rolling that out for free to the private providers, so any doctor's office can use this. Now the schools love this because they'll have the ability to look up immunizations on-line. As a practicing physician back in the day, I can tell you I spent a tremendous amount of time in August and September with my staff digging up immunization records on the patients and faxing them to the schools, because the schools did not have access and the child could not be admitted without the proper immunization record. So we hope that this will help tremendously and we are starting to train the private docs, anybody who is interested. The private doc already has an electronic medical records system. We can just set up a link so as they put their stuff in it just gets downloaded into the system automatically on the back end so they have to do nothing other than enter it on the front end, and then it's in there and parents can

look up their own children as well. We recently... [LR363]

SENATOR JOHNSON: Could I ask you a question about that? [LR363]

JOANN SCHAEFER: Uh-huh. [LR363]

SENATOR JOHNSON: Because, you know, I think the electronic medical records is one of the great things that could be accomplished in this country, and we have a long way to go. But I remember Michigan on this, by putting in an electronic medical record, went from last as far as percentage of kids that were immunized to first. And with that being the case, though, is how are you working it out with the previous privacy legislation, HIPAA regulations and all of that? [LR363]

JOANN SCHAEFER: Uh-huh. [LR363]

SENATOR JOHNSON: Is that coming together or is it still an obstacle? [LR363]

JOANN SCHAEFER: Well, it's still an obstacle out there for some of the parts of the electronic medical records system, and I don't pretend to be an effort in that area at all, but I know that there's a committee that's working on that. We still have a grant for privacy standards, setting up privacy standards in the system as a total. Nebraska holds one of the grants for that. But the immunization registry is something that people can easily sign consent for and allow that information to be on there, and it's been very, very well accepted. Just as a parent, I remember having to look every year for the immunization records and I could never remember where I filed it (laugh), so this will be really handy for people to be able to pull up their own child and print it off and take it to the school. And if they forget, then the school can also look it up. We recently obtained a $500,000 grant for two years on preconception health to at-risk populations. This gets back to looking at some of our infant mortality issues that we have, that again I'll mention in a moment, but the whole idea is healthy body, healthy baby. It will be a

tremendous help for us to do some planning and outreach over those areas. We obtained competitive federal grant for $725,000 for five years to further our work on activity and nutrition. As you know, obesity is growing at a rate that is going to cause us significant problems in the healthcare system. Continue on, we provided technical assistance for the Governor's Wellness Award to companies. When we had announced that award, we offered the technical assistance. Within the week we had over 120 companies quickly call us and ask us for information on how they could develop a wellness program within their company, and these are companies that were as small as ten people to several thousand. There are two different awards. One is for basically meeting all the criteria of having a wellness program. They get the award. It's good for three years and then they have to reapply and recertify that they still have those things, that they are available to their employees. The second award is to the company that is actually showing a return on their investment or they're seeing the decreases in their health costs or there's a decrease in the smoking rate or they're actually meeting some of the outcomes that they set out to do with their wellness program. We handed out over 38 of those awards or just 38 of those awards in the last month and a half and that's been really exciting to see. And, of course, Lincoln Industries here has been recognized nationally by the Department of Health and Human Services and by the CDC as one of the leading organizations. They were one of three companies to receive this. Corporate wellness was actually developed in Nebraska and it's a Nebraska owned thing that has taken off across the country. [LR363]

SENATOR STUTHMAN: Dr. Schaefer. [LR363]

JOANN SCHAEFER: Uh-huh. [LR363]

SENATOR STUTHMAN: When you make the statement "award," is that just a plaque or something like that, or is there... [LR363]

JOANN SCHAEFER: It's a certificate that they could hang and the business has actually

approached us about having a state level recognition for the wellness program, which we thought was a great idea because many of the businesses. While they have a wellness program, they can't afford to have the accrediting agencies from the national offices come in and do that, but they want to be able to show that they are doing something for wellness. And there are some good things going on out there, companies that have been able to go a year without any back injuries, construction companies, because of the wellness programs that they've put in place, everything to decreasing weight, smoking, diabetes, medications, you name it. It's been an amazing turn around for them. So, yeah, it's a nice certificate that they can hang and we actually had one company that asked for a duplicate so they could put one in their corporate office in another state and one here locally to show that they were doing wellness. [LR363]

SENATOR STUTHMAN: So there's no monetary reward. [LR363]

JOANN SCHAEFER: No monetary reward, no. [LR363]

SENATOR STUTHMAN: Okay. Thank you. [LR363]

JOANN SCHAEFER: We received last year 88 percent of our over 37,000 reports of communicable diseases electronically. Now hopefully we'll get that to 100 percent, but I can tell you not too many years ago we were doing this all paper. This has a tremendous impact on the health of Nebraskans and I'll tell you why. When we get those reports, when you have a culture that's growing out at a hospital on somebody and it comes out E. coli or 157:H7, that comes to us and immediately we know to take action on that, get in touch with the local health department. We need to find that patient. We need to interview them and see where they've been eating. This is what can lead to food recalls and/or food alerts so that people won't eat the contaminated food. It happens. Salmonella is another example, listeria is another example, and campylobacter. Those are bugs that we look for on a regular basis. The sooner we catch them, the sooner it's reported to us, the sooner the local health departments and

we can do a joint investigation and figure out where that is coming from and hopefully save lives. We received a perfect score on our pandemic flu planning and this was a third party that did this, Trust for America's Health, which was a phenomenal score to get. We were only one of a few states that got that. And then by the CDC we have a passing score, an above-average passing score for our pan. flu plan, and right now we have 88 percent on our strategic national stockpile plan. And all those are really good and they speak to the efforts that we've gone in protecting citizens, should any of these events happen, maintaining a constant state of readiness. Even though the headlines have gone away and the worry in most citizen's minds have gone away, we still have a constant state of readiness that we're held accountable to. And they have put out some of the pan. flu money in a competitive way and we obtained four of those grants to work with. At risk populations are the most vulnerable populations that are out there and we won a lot for our state because there weren't that many of them. And for Nebraska to get four of them, it really spoke highly of the work that we're doing. Our rate of deaths from cardiovascular disease has declined from 377.6 to 288.9 deaths per 100,000 in the population, which is good, but we still have a long way to go. It's our number one killer and it deserves our attention. You can credit most of that difference to our increase in medical technology and the fact that we have a really robust EMS system for the most part that can get people to the hospital quickly when they're suffering from chest pain. When you look at the fact that less than a quarter of Nebraskans have had their cholesterol checked, adults, and less than...or and 20 percent of the population has hypertension that's untreated, that is concerning for our future cardiovascular health, and then you combine that with the obesity rate and you can understand why we don't expect that rate to stay low for long. Next is our low rate of infectious disease. We're ranked 12th best in the country for that, which just shows that we're pretty good at keeping things healthy and clean and, you know, for 8.1 cases per 100,000, that's pretty decent. We purchased 106 AEDs. Those are automatic external defibrillators. As you know, they've saved the life of one of your former colleagues this past year. Eleven were purchased for the State Patrol to place in the visitor sections across the interstate, because we've had many Nebraskans and visitors hit those visiting stations in cardiac

arrest and we put those AEDs out there to help facilitate them in getting back to a normal rhythm, if that's their issue, until EMS can arrive to help them. This gets to some of the on-line issues. Eighty-six percent of our physicians renewed on-line for the first time this year. This past month, in October, we have...they all had to do it by October 1, including me, very quick, on-line process. We roll in a new profession as our budget allows each year because it takes awhile for us on the licensing information. We have to build the computer, a company has to build for us the computer screen that has all of the necessary questions that we ask and puts in the information for that licensee category. So every year we do a new category as our budget allows and it's done, too, on demand--who wants it, who will use it. We've had problems where we've rolled in professions before and less than 2 percent of them renewed on-line because they didn't have access to computers, so we stopped doing those and we're doing the ones where we know that there's demand for it. I can't think of any situation where someone would have to come down and spend two days here trying to get a license, because we do everything by phone or paper otherwise and we'd be happy to mail people. But if there's somebody that's having that hard of a time getting a license, I want to know about it because it should not be that way. It's either by paper and phone and fax, or on-line for some. Not all professions are on line but each year we pick up more of those and the trend is to get everybody on-line eventually. Our immunization rate is something to celebrate, although I'd like to see it at 100 percent, these are children, to have all the immunizations by age 2. The national rate is 77.4 percent and we're currently above the national average. In fact, we're always in the top five. I think we're number two this year so we're doing pretty well on that. The higher the better. I think our immunization registry will help, as Senator Johnson pointed out, with increasing that. So here are some challenges that we have. Infant mortality is at 6.5 percent, this was in 2006, compared to 5.4 in 2003, but our current preliminary data for 2007 is 5.5, and that's total over all. It would be 5.3 for white babies and an astounding and embarrassing 13 for African American babies. So we have a lot of work to do in the African American community to change infant mortality rates. They are twice the norm, more than twice the norm. The best state is Washington with an infant mortality rate of 3.2, and so that's

the national benchmark. The national benchmark that's set is whoever best state is at the time, and that happens to be Washington with 3.2 per 1,000 live births. So we have a ways to go on that. Another health disparity issue is that blacks experience 85 percent more premature death than whites. That's all-age adjusted as well. We can do better than that and so that's the reason for the focus on our grants. Obviously, no one person or HHS is going to fix that problem. That takes a lot of community collaboration and healthcare system collaboration to fix that. We have a high prevalence of binge drinking at 17.9 percent of the population, and those are adults, particularly young adults in their early twenties. We've launched a campaign, working with Nebraska Education Television, to address that issue and do some campaigns around sporting events to just bring the awareness into the issue that we have with binge drinking. [LR363]

SENATOR STUTHMAN: Dr. Schaefer. [LR363]

JOANN SCHAEFER: Yes. [LR363]

SENATOR STUTHMAN: That 17...18 percent of the population, what do you mean by population? State's population, college population or...? [LR363]

JOANN SCHAEFER: That's adult. [LR363]

SENATOR STUTHMAN: That's adult population. [LR363]

JOANN SCHAEFER: That's the young adult population, young adult population that it is...it's an issue. [LR363]

SENATOR STUTHMAN: Of an age bracket is where you're really taking that. [LR363]

JOANN SCHAEFER: Pardon? [LR363]

SENATOR STUTHMAN: You're taking an age bracket then... [LR363]

JOANN SCHAEFER: Yes. [LR363]

SENATOR STUTHMAN: ...of a population. [LR363]

JOANN SCHAEFER: Yes. [LR363]

SENATOR STUTHMAN: Okay. [LR363]

JOANN SCHAEFER: Sorry. That should be clearer. [LR363]

SENATOR JOHNSON: Nineteen to twenty-five or something like that or... [LR363]

JOANN SCHAEFER: Pardon? [LR363]

SENATOR JOHNSON: Nineteen to twenty-five or something like that? [LR363]

JOANN SCHAEFER: You know what, don't quote me on the age group but it's something like that. And so that's the area that we're focusing on for, you know, that college age group and precollege age group. [LR363]

SENATOR STUTHMAN: Thank you. [LR363]

JOANN SCHAEFER: Another public health challenge for the state is limited access to prenatal care with only 70 percent of women receiving adequate prenatal care. That is one of the indicators or why we have the struggles that we do with infant mortality rate. This is not an insurance question. This is a first trimester care question. Even those with insurance do not always seek care in the pregnancy within the first trimester, the first three months, and that is a culture change, an educational issue. It's a provider

availability issue. Some providers don't see patients until after their first trimester is completed and that they're healthy, but that is a time where we need to get in and intervene and make sure that we've addressed any risk that the patient has in that first trimester so we can keep them healthy throughout their pregnancy. But unfortunately, not all women know that it's important to get in before their first trimester. Many of them believe, on surveys, that it's okay to wait till after the first trimester because that's when the real work in the pregnancy is done, but actually there's an incredible amount of importance to that first trimester in identifying risk and increasing the health of the mom and the baby over all. We have a high prevalence of obesity, increasing from 11.6 in 1990 to 26.9 percent of the population in 2007. If you throw in the overweight category as well, that leaves our population with greater than 65 percent overweight or obese. This is a significant issue for the pediatric population as well. We are seeing adult type II diabetes in children where we normally can see that just in an adult. This does not speak very well for our future cost in healthcare and the quality of life that folks may have as they start getting some of the debilitating diseases that are many times associated with obesity and being overweight. Deaths from cancer are 41 percent more prevalent among blacks than whites even though the incident rates are approximately the same. That gets back to a delay in diagnosis, insufficient treatment or improper treatment. We have some work to do in health disparities, there's no doubt. And we're not...this isn't unique to Nebraska. It is a national issue, but we have...we have things to focus on here. With that, I'd be happy to take any questions. That's the end of my comments. [LR363]

SENATOR JOHNSON: Yeah. Senator Stuthman, go ahead. [LR363]

SENATOR STUTHMAN: Dr. Schaefer, thank you for your presentation. [LR363]

JOANN SCHAEFER: Yes. [LR363]

SENATOR STUTHMAN: The concern that I have with the public...the health

departments, and I have one there in Columbus, a federally accredited one, is that I visited with the director there and she said her mental health calls or patients that she sees has gone up 46 percent this last year, with no additional funding, and she says it's a real struggle to see that many patients. And I think the patient number is up to like 2,500 for this year on the mental health. [LR363]

JOANN SCHAEFER: Oh, goodness. [LR363]

SENATOR STUTHMAN: And it's probably because of, you know, economic times and stuff like that. But she's really concerned with that amount of an increase and not being able to get any more money. But they're doing it. They're making it. They're surviving. [LR363]

JOANN SCHAEFER: Yeah. Absolutely. [LR363]

SENATOR STUTHMAN: And I don't know what they can do to get additional funding or what we can do to try to curb that mental health situation. [LR363]

JOANN SCHAEFER: Yeah. You know, we look at the same issue and it is very difficult. There's isn't additional funding out there federally through our programs that come down to the federally qualified health centers or the community health centers for mental health specifically, although some of that falls into Scot's area and he may be able to answer that question a little bit better than I can. You know, we would like to do everything that we can to prevent some of the crises that people find in their lives and bring in some of that. One of the issues that we have is a shortage of healthcare professionals within that area. There's no doubt that all across this spectrum we need...there are needs for primary care physicians and folks in mental health and medical schools aren't pumping them out like they used to in the past. There's a tremendous, speciality driven mentality in not just the medical schools but the students themselves in not wanting to seek those as areas and fields, so we need to get in there

and help them see that it's a rewarding career. But that's a community effort trying to address some of the professional shortages that they have. [LR363]

SENATOR STUTHMAN: Thank you. [LR363]

SENATOR JOHNSON: May I just touch on one little thing and I have some people that are interested in this? And things are pretty well taken care of in Lincoln and Omaha areas this way, but outstate I hear concerns, and what it is, is it's...I know you talked about the potential for disasters and so on and there are groups of medical reserve corps and so on but they have a tough time organizing and doing things successfully, like training exercises and so on. For instance, I've heard that there was one that was going to take place in the Hastings area and the...if they have it, everybody is basically on their own, even though they're in a training exercise to help the state and fellow citizens, and yet there is no access to any insurance if they would be injured in an accident while they're undertaking these efforts. And I heard rumor that the Hastings people contacted four insurance agencies and basically said, no, there's no way of doing this with the structure that we now have in the state and so on. So we can talk about this more privately, but I wanted it to be part of the record because apparently this is a concern for developing medical reserve corps. And I'm not talking just physicians. I'm talking the whole gamut for disasters that we might have in this state or certainly Katrina has got all kinds of examples how this can be done well or done poorly. And so maybe we can talk further about this another time, but wanted to mention that. And then one of the other things that comes to mind this way is that there are communities that are now experiencing significant troubles getting EMTs. Been a great volunteer organization over the years but, for whatever reason, now having trouble recruiting and retaining EMTs so that there's places where they're short. And so again mention this for different things that we might do to stimulate this industry, if you will, that how can we help them. And just a off-the-cuff illustration is can we make the EMTs a nonpaid state employee so that they might be available for the insurance that the state covers, with them paying the bill, or their county, or city, or whatever, or village? These are the

different types of things that I wonder if we can't find someway of addressing these problems because they're there and I suspect that it's going to get worse rather than better. So maybe we might want to spend a little time on that. And then just one last thing I wrote down here. I was at a function the other night and, you know, we're talking about rates of this and that and so on, and there were two statistics that were mentioned, is that there are more suicides--and this was in the United States and I suspect it's a higher number with us--there are more suicides than there are homicides by almost a 2:1 margin. And the other aspect of it was that the average life expectancy of people with mental illness of significance is 25 years less than the average American, pretty big numbers that I don't think that we're much aware of but, when it comes to public health, something that would be nice to attack. [LR363]

JOANN SCHAEFER: I am not aware of a 2:1 suicide to homicide rate. Actually, I'm shocked if that is actually the case for Nebraska, but we can certainly look at that data. [LR363]

SENATOR JOHNSON: Yeah. I would guess it would be higher than that. I mean, we... [LR363]

JOANN SCHAEFER: I... [LR363]

SENATOR JOHNSON: ...we don't have many homicides for our population except in very localized areas and so...but this is somebody quoted it nationally at a big meeting. Be interesting to look into it, I guess. [LR363]

SENATOR GAY: Yeah, I remember that. Dr. Schaefer, I have a question for you. [LR363]

JOANN SCHAEFER: Uh-huh. [LR363]

SENATOR GAY: What is your coordination, if any, with Building Bright Futures' agenda that's going on in Douglas and Sarpy County? Are you guys helping at all or are you involved in that at all? [LR363]

JOANN SCHAEFER: We're not specifically involved in that. They've asked us for data, basically, so we've given them whatever data sets that they've asked for based on their population. Some of their data they don't have because OPS doesn't participate in the youth behavioral risk factor survey. So they have District 66 and Millard, but we don't have OPS and so some of that very data that they want is just not available. They've not participated in the survey for a number of years, so we hope to change that in the future. But, yeah, any data that they want, that's what we've been there. [LR363]

SENATOR JOHNSON: Any other questions? Gwen, you look like you got one that you want to ask. [LR363]

SENATOR HOWARD: No, I think you've asked everything. (Laughter) [LR363]

SENATOR JOHNSON: Okay. Thank you very much. [LR363]

JOANN SCHAEFER: All right. Great. Thank you. [LR363]

SENATOR JOHNSON: Okay. It's a quarter of 12:00. Let's do this. Let's give people the opportunity again for any public comment and then we'll break for lunch and come back probably at 1:30 pending. Have somebody? Great, come on up. Is there anybody else, by the way, so we...? Okay, great. [LR363]

MARTY FATTIG: Good morning, Senator Johnson and members of the Health and Human Services Committee. My name is Marty Fattig, M-a-r-t-y F-a-t-t-i-g, and I am a rural hospital administrator down in Auburn, Nebraska, and I'm also a member of the Rural Health Advisory Commission, appointed by the Governor. I'm serving my second

term and it's a real privilege to serve on that committee and also to work with you folks as well as the Department of Health and Human Services on a regular basis. We actually work very closely with the department (sic) of Rural Health, obviously, and Dr. Schaefer there and Jackie Miller when Dr. Schaefer is unable to attend. Just a couple of things I'd like to address with you and I'm sure you're aware and that is that providing healthcare in Omaha is different than providing healthcare in Kearney, which is different than providing healthcare in Valentine or Ogallala or Scottsbluff. And the big issue is personnel. We are embarking on probably the largest healthcare work force shortage this country has every seen and one of the main focuses of the Rural Health Advisory Commission is focusing on this rural health work force shortage and trying to alleviate some of that. We have two excellent programs in place--the rural health loan...the loan repayment program which works with, you know, students while they're in medical school or another medical type of degree--behavioral health, dentistry, other things--to help pay their medical...their education expenses while they're in school. We also have the loan repayment program which has been very successful. If a student will agree or a provider will agree to practice in a rural area for three years the state has a pool of money that they give them. Right now we're awarding $17,500 a year for a physician, a dentist, or a doctor level mental health provider, and half that for the master's level folks if, in fact, they can get an equal match from their community, which means the community has a vested interest in making this work as well. The big problem with this thing, of course, is funding, as with everything else, and we realize that you folks have a real balancing act to perform with meeting needs versus maintaining a budget. And I think any of us in business have that same issue. One of the things I'd like to mention to you is that the proposed budget that is...right now that has been proposed for the coming year is that we will have a $33,103 decrease in the amount of money that we get from General Funds for the next year. That's essentially two scholarships or loan repayment program recipients that we will not be able to fund. We also...we were very fortunate in the last year to get some money from...I believe it was Mark that had a lawsuit settlement and we were able to get some funds for the next few years over that to...from that to help fund student loans and loan repayment program awards. We were

also given cash spending authority so we could spend down our cash funds, and those cash funds come from one of two sources. First of all, we have to have cash spending authority in order to give the community match money back to that recipient. We also get community...or cash funds from those people who default on either of the two programs. Those monies go into the cash fund and then we can award those. The problem is, is we're spending down those cash funds pretty rapidly and we're going to need some sort of funding to keep this whole...these programs going. One of the...when the graduate level mental health students were added to the loan...to the student loan program, we were given $240,000 in additional cash spending authority to fund that. Well, if we don't get some additional funds, in about two years our cash funds will be gone and I don't know how we're going to fund these additional behavioral health scholarships without some additional funding. So we just want to impress upon you the importance of continued funding for these programs. They are one of the only advantages that rural Nebraska, I mean very rural Nebraska, has to attract a provider who has amassed tremendous debt getting through school, one of the only advantages we have in rural areas to compete with the cities. And with that, I would answer any questions. [LR363]

SENATOR JOHNSON: Marty, I've got one quick one. [LR363]

MARTY FATTIG: You bet. [LR363]

SENATOR JOHNSON: We attempted to fix a fault that had been found with the repayment program, that if you cancelled out then the interest or the penalty was so high it was discouraging... [LR363]

MARTY FATTIG: Yes. [LR363]

SENATOR JOHNSON: ...the people from going into it. Has that seemingly been corrected? [LR363]

MARTY FATTIG: That seemingly has been corrected, yes. At one time the penalties for drop...for dropping out of the program were so severe that nobody would apply for it, so now we at least have people back applying for it. We had applicants come in, in June, and we had some outstanding applicants come in that are from rural areas, want to return to rural areas, and I think will make outstanding providers in these rural areas. [LR363]

SENATOR JOHNSON: Great. Arnie. [LR363]

SENATOR STUTHMAN: Marty, are you aware of other rural states, do they have a shortage like that? What type of programs do they have, or is it more attractive at other states, or how are we comparing? [LR363]

MARTY FATTIG: Some of the states...some of the states do have other programs that are more attractive, but it's not because of the...it's because...mostly because of the tax advantage that they receive in those other states. Right now, the way our loan repayment program is set up, these folks get $17,500 times two, so $35,000 a year, and then when they get awarded that money, it becomes subject to federal income tax. Because it's subject to federal income tax it is also subject to state income tax. So they end up sending--you do the math--that percentage back to Washington and I don't think that's what you folks had in mind for us to do with the money you awarded us. [LR363]

SENATOR JOHNSON: How do you correct it? [LR363]

MARTY FATTIG: First of all, we have been working on correcting this Senator Johnson and one of the things that we've been working with is working with our congressional delegation in Washington, and they come to us and say, have you corrected this at the state level; we said, no, we haven't. And they said, when you correct it at the state level then we'll have some clout to correct it at the national level. And we're currently working

with several other states, there's about 18 states that are in the same boat we are. Now, see, if we would outline our program exactly like the federal programs are, it would be tax-exempt at the federal level, but in order to meet the exact needs of this state we've augmented that plan quite a bit. And it really does help meet the needs. For instance, on a federal program, you have to practice full-time in a medically underserved area. In Nebraska, we allow a provider to practice part-time in a medically underserved area. Now does...and I don't know this to be true, but would Mullen or Hyannis need a full-time physician? Probably not, but one three days a week is of tremendous value to those folks. So if we can get, say, a North Platte physician to go to Thedford or Mullen, you know, for a couple of days a week, if we can get a Scottsbluff physician to go to Hyannis, things work. But then that makes the loan or the loan repayment program subject to federal income tax. [LR363]

SENATOR JOHNSON: Yeah. [LR363]

SENATOR STUTHMAN: Thank you. That was good information. [LR363]

SENATOR JOHNSON: Okay. Any other questions? Sure, Dave. [LR363]

SENATOR PANKONIN: Senator Johnson, thank you. Marty, just I'm assuming, when you say the budget has been cut, it's your budget? Money comes, you said General Fund, but is this from the Department of Health and Human Services? What area for this program? [LR363]

MARTY FATTIG: I can't answer that. [LR363]

JOANN SCHAEFER: Public health. [LR363]

MARTY FATTIG: Public health, yeah. [LR363]

SENATOR PANKONIN: Was it Public Health? Okay. [LR363]

MARTY FATTIG: I'm sorry? Yeah, the experts are here. (Laugh) [LR363]

SENATOR PANKONIN: So, Dr. Schaefer, is there a reason or do you happen to know why or what? [LR363]

JOANN SCHAEFER: Just to meet the budget criteria that we have. We are 10 percent general funded. There aren't too many places where you can decrease General Funds within the division itself, so many of the programs have to take a hit. [LR363]

SENATOR JOHNSON: I don't know if this is the time to ask it, but I'm going to ask it anyhow. If you were to tell us what are the greatest shortages in rural areas, and I, you know, heard such good things about what you're doing down at Auburn with the various programs and so on,... [LR363]

MARTY FATTIG: Thank you. [LR363]

SENATOR JOHNSON: ...but across the state, what are the greatest shortages of workers? [LR363]

MARTY FATTIG: One of the most critical shortages might surprise you, in rural areas, and that's going to be dentistry. The average age of our dentists in rural communities is around 60. To try and recruit dentists back into these communities is going to be extremely difficult and, of course, oral health is extremely important to overall general health as well. Physicians are short. It all starts with physicians. You know, when you start talking about general physical practice of medicine, it all starts with a physician, so we have to get those in place and then the allied health professionals, laboratory workers, x-ray workers. Nursing is always a huge problem, but if you can get the other things in place it makes it easier to attract the nurses, PAs, yeah. [LR363]

SENATOR JOHNSON: Okay. But nurses themselves are... [LR363]

MARTY FATTIG: Are quite short. [LR363]

SENATOR JOHNSON: ...where are they at in relation to the others as far as the shortages are concerned? [LR363]

MARTY FATTIG: Nurses make up the largest number of healthcare workers in the state and in the nation, so their numbers really stand out with you. But the nurses, generally, are running anywhere from 12 to 15 percent short in areas and it becomes extremely difficult to recruit these nurses to rural areas for various reasons, unless they're raised there and understand, you know, why we like to live in rural areas, which, of course, I do. I was raised in Senator Hansen's area and I've always been in a rural community and love it. [LR363]

SENATOR GAY: Marty, out at the rural health conference, we are working on that bill you talked about. We had a meeting and... [LR363]

MARTY FATTIG: Uh-huh. [LR363]

SENATOR GAY: ...we're kind of drafting some legislation now... [LR363]

MARTY FATTIG: Oh great! Appreciate that very much, Senator Gay. [LR363]

SENATOR GAY: ...actually, so we've followed up on that. [LR363]

MARTY FATTIG: Great. I will talk to your aide. [LR363]

SENATOR GAY: So if you have any interest in getting involved... [LR363]

MARTY FATTIG: You bet, I certainly will. Thank you for that. [LR363]

SENATOR JOHNSON: Yeah, Tom. [LR363]

SENATOR HANSEN: One quick one. You were talking about a North Platte doctor going to Mullen three days a week or two days a week or whatever, but if that doctor gives a prescription to that patient, then they have to drive to North Platte to get the prescription filled. [LR363]

MARTY FATTIG: Exactly right. Big problem. It's a big problem. So pharmacies are a huge issue as well. [LR363]

SENATOR HANSEN: Pharmacies are huge, yeah. [LR363]

MARTY FATTIG: Yeah, it is. And pharmacists are quite short as well. And again, some of the federal programs have hurt that in rural communities. Medicare Part B has really, really taken...has really placed a hit on some of these rural pharmacy providers. [LR363]

SENATOR JOHNSON: Yeah, I was aware that in several smaller communities, and some of them not too small, by the way, that the pharmacists had really looked at that was a business that, for their retirement, they would sell their pharmacy. They can't sell them. [LR363]

MARTY FATTIG: Yeah. Can't give them away. [LR363]

SENATOR JOHNSON: There's no buyers. And...but any other questions around here? This is one of the things that stuck in my mind that you mentioned. I did not realize that dentists were one of the big shortage areas in rural areas. [LR363]

MARTY FATTIG: They really are. [LR363]

SENATOR JOHNSON: Gee, it would seem to me that in these smaller communities of 1,000 or more in population, the best thing that anybody would do for their dental health is to add fluoride to their water, huh? (Laugh) [LR363]

MARTY FATTIG: Exactly right. I think that's been proven, Senator Johnson. [LR363]

SENATOR JOHNSON: Okay. Marty, thank you. [LR363]

MARTY FATTIG: I just want to say... [LR363]

SENATOR JOHNSON: Sure. [LR363]

MARTY FATTIG: ...how much of a pleasure it has been to work with you over the years, Senator Johnson, and I really appreciate all you've done for the... [LR363]

SENATOR JOHNSON: Well, we've got a great committee with great staff and so we thank you for those comments and we'll try as a group to keep making things a little bit better. [LR363]

MARTY FATTIG: Thank you very much. [LR363]

SENATOR JOHNSON: Thank you. [LR363]

MARTY FATTIG: Appreciate it. [LR363]

SENATOR JOHNSON: Okay, anybody else here this morning? Otherwise, let's break and plan on coming back 1:30 and we'll go from there. [LR363]

BREAK []

SENATOR JOHNSON: Go ahead and get started for this afternoon. We're still on LR363 for the Health and Human Services Committee. This morning we went through the report of the chief executive officer and the Division of Public Health, and so this afternoon we start with the Division of Veterans' Homes and then finish with Medicaid and Long-Term Care. So let's proceed with the Division of Veterans. Thank you very much for coming. [LR363]

JOHN HILGERT: Thank you, Mr. Chairman, members of the committee. My name is John Hilgert, J-o-h-n H-i-l-g-e-r-t. I, as Chris Peterson said, I wear two hats in state government. I'm the director of the Nebraska Department of Veterans' Affairs, as well as the division director of the Division of Veterans' Homes for DHHS, and in that capacity, I'm testifying before you today. (Laugh) The flow chart is one that...it is restarted in July 1 with the reorganization and we have been busy creating, creating a division with the emphasis on serving veterans in the Nebraska Veterans' Home Division. The four administrators that you see up there: Howard Googins is in Eastern. Ginada Hostetler in Grand Island, Norfolk is Jerry Eisenhauer, and Western Nebraska is Lonnie Starke. We have new leadership in all the homes within the last year and a few months. It's a wonderful team. We're forward thinking. We're progressive. I did write some notes on this slide because earlier today you heard about the communication and, Senator Gay, you asked about the management, overall management structure, and I wanted to tell you how wonderfully accessible both Bob Zagozda in Operations and, most of all, our CEO, Chris Peterson, is to the division directors. I have never been without counsel when I've asked for it and accessibility seems to be a hallmark. I was telling Senator Johnson, this is the reorganization that we had hoped for some years ago. The appropriation is right up there. It's all operations. There's no aid. Cash, federal funds, the federal comes from per diem. By and large, the cash funds come from the sliding scale fees that we charge, or maintenance charge of our members. We have, as I said, four state veterans' homes. The Eastern Nebraska Veterans' Home, we just moved into

it last July, well, a year ago July, and as I reported to you earlier, we...our first inspection there was deficiency free. The Grand Island Veterans' Home is our largest. The Norfolk Veterans' Home, which is approximately six years old, and the Western Nebraska Veterans' Home, which there's a component within our capital construction budget regarding that facility. [LR363]

SENATOR HANSEN: John. [LR363]

JOHN HILGERT: Yes, sir. [LR363]

SENATOR HANSEN: Excuse me. You say you have 506 members. Can you give us how many there are in each one? [LR363]

JOHN HILGERT: Yes, I can. The last slide that you have in your booklet and...is it's called the Division of Veterans' Homes waiting list but it, indeed, sir, answers your question about the current census. [LR363]

SENATOR HANSEN: Good. [LR363]

JOHN HILGERT: This was...this chart is kind of hard to read but it is available on the Internet for the general public. This is part of the emphasis that our Governor has placed on accountability and clarity and transparency. We update it weekly and it was initially put together to address the question of waiting lists and demand, if you will. But as you see, there's quite a bit more information than just that on this chart. So although you have a copy here, it's updated weekly on the Internet for the public and yourselves. [LR363]

SENATOR HANSEN: Thank you. [LR363]

JOHN HILGERT: You bet. [LR363]

SENATOR PANKONIN: John, just a quick question... [LR363]

JOHN HILGERT: Yes, sir. [LR363]

SENATOR PANKONIN: ...on why the state is in the veterans' homes, why we do this activity. Is it by statute? Is it by federal... [LR363]

JOHN HILGERT: There's no mandate, but it is by statute. Our oldest veterans' home is...and this is not a beginning of a terrible long story but...(laugh) [LR363]

SENATOR PANKONIN: No, I know. No, but I'm curious about the history of why. [LR363]

JOHN HILGERT: My colleagues are probably groaning right now... [LR363]

SENATOR PANKONIN: Right. Okay. [LR363]

SENATOR HILGERT: ...because if you want the history, I can give it to you. [LR363]

SENATOR JOHNSON: Yeah, John, we're interested. Go ahead. [LR363]

JOHN HILGERT: But, you know, the first veterans' home did start in 1887. It was a Soldiers' and Sailors' home. [LR363]

SENATOR PANKONIN: Sure. [LR363]

JOHN HILGERT: It was the place you go. In fact, there was statute up until just a few years ago that you had to help raise the food and do the work around the facility unless you had doctor's orders and you were on sick call. And over time that became, that

concept became, what is now a professional assisted-living and skilled nursing facilities. We...let's see, Western Nebraska is the old Hiram Scott College dormitory, primary domiciliary, and we're going to be working on that a little bit. Eastern Nebraska is the brand new facility that used to be...there used to be a home at 156th and Maple in Omaha called the Thomas Fitzgerald Veterans' Home. It was made reference to earlier today. This is the new facility, brand new. And then we have the...the Grand Island is the oldest. That cornerstone was laid by Governor Thayer, a Union veteran by the way, General Thayer, in 1887. And then the Norfolk used to be part of the regional center campus and about six years ago they developed and built a new facility in the present location. [LR363]

SENATOR PANKONIN: So it's kind of by tradition? Not every state does this. [LR363]

JOHN HILGERT: I'm not sure if all do it or not. There was...when I first came to be Nebraska Department of Veterans' Affairs director in 2001, on November 22, there was some states that did not have veterans' homes. Since then, that list is shrinking considerably. There may be four or five that don't at this point. Almost all states, the vast majority, have veterans' homes, some have several. [LR363]

SENATOR PANKONIN: And most of them are like ours, partially federal, partially state funded? [LR363]

JOHN HILGERT: They all operate on a similar model, although almost every state is just a little different. They all get...the federal government helps in 65 percent/35 percent match, federal's being 65 percent, 35 percent being nonfederal funds, for the construction. And then there's a per diem support system whereby we apply to the federal government based on our population in eligible veterans for a per diem to help our operational cost. That is the operational federal input on the budget slide some...a couple times ago. That's what...that's where that money comes from, from the federal government. Our veterans that are eligible to get, for example, free pharmaceuticals

and so forth from the V.A., we access all the benefits that we can and we're doing more on that, by the way. But it's a federal-state relationship. In exchange for that per diem and helping construct the homes, we get the pleasure and honor of a yearly inspection by our USVA surveyors and I can certainly...I'll certainly reference that later on. But it's a federal-state partnership and it is by state statute that we operate these. [LR363]

SENATOR PANKONIN: Okay. Thank you. [LR363]

JOHN HILGERT: Our priorities: quality assurance and improvement of member care; ensure proper staffing levels for quality member care. We're doing monthly internal reporting. We have a lot of internal monitoring controls. We are using those to identify trends, direct educational training topics such as member falls, pressure ulcers, staff turnover, pain management, and weight loss. It is a interesting...part of the creation of the division was that we are accumulating a lot of reporting mechanisms to maintain and improve our quality and I think that we compete favorably with state and national averages and where we do come up short we're able to focus and zero in. In fact, under the topic of falls, we track falls per occurrence, not per member. In other facilities, they've chosen to do member. So if we have one person have 28 falls, it's going to show 28 falls, because we need to be able to identify that risk and to care plan accordingly and respond to this individual. So I'm very proud of the way that our leadership has bought in to our internal monitoring systems. Additionally to the internal monitoring systems concerning quality of care, we've also had internal systems developed for HR reporting by department to see what their retention is, see how...what positions are advertised, so we can always have a view to what exactly the needs are and what's happening within the facility. Another report that we've generated and constructed is a construction report. Let's prioritize what our construction needs are, our maintenance needs, things that are beyond our operational budget, and let's prioritize them. In fact, we color-coded them just to make it easier. We had the color red for a federal survey identified deficiency. We have blue for a Fire Marshal deficiency--water, I guess; better than the red. And then you have orange, which are deficiencies that we

ourselves identified that could be identified by a surveyor or an inspector but they have not. So we are more harder on ourselves than I think our surveyors are because we want perfection. We are going to keep on striving for perfection. [LR363]

SENATOR GAY: Does the state also come in and survey us? [LR363]

JOHN HILGERT: The state comes in certainly as need be, as in response to certain reported events. Also every five years the state comes in and does a thorough survey. Eastern Nebraska, of all places, a brand new facility, they had their federal inspection come in from the U.S. VA surveyors. Now the U.S. VA is divided into three big groups: the National Cemetery Administration--a shameless plug for the groundbreaking we had a few weeks ago in Alliance, Nebraska, for our first State Veterans Cemetery; the Veterans Benefits Administration, which you so kindly gave me a fifth state service officer--another shameless plug, sorry Chris; and the last is the VHA--that's the relationship we have with our veterans' homes, the Veterans Health Administration. But the VDA also checks us out sometimes to look at our member accounts and so forth to make sure that the drawdowns are correct and so forth. And Howard Googins is over in Bellevue--he's Nebraska Veterans' Home--had the U.S. surveyors came in. Then within a week he had the VDA, U.S. VDA came in; then he drew luckily and got the state surveyors to come in for their five-year inspection; and then we had our friendly Auditor show up. So we had probably within ten days so many people walking around, and Howard needed a vacation after that and he was unable to take one because his second in command took off and went on vacation. But we have a lot of people looking over our shoulders, as well as 140,000 Nebraska veterans that see these facilities as their own. We have a volunteer base that's extensive and they come in and out of our facilities. And, folks, veterans aren't shy about telling you when they see something wrong or they perceive to see something wrong. And those are sometimes just as good because you cut the cards and you have to track down every comment, and it makes our system real healthy. So we welcome the extensive inspections that we're getting. I will share with you also since you do have some knowledge of the Thomas Fitzgerald

Home, the federal inspectors came in and they did find a deficiency. The consistency of our puree was not quite the same consistency that they had anticipated. So I just can't say enough. It's not about us here in Lincoln; it's about our staff and our line staff that have bought into this, that are proud of their jobs, that perform great, great service for our members. You don't pass a survey because you had an organizational chart or you issue some directives. You pass a survey because you have good employees who are committed to doing good work, and we have that, by and large, and we're very, very proud of them. Without them we would not have been successful as much as we have been. One of the other priorities is to operate at or near full capacity. That, of course, is dependent upon our ability to staff. We will not have a capacity that overextends our staff. We had some issues, as you know, in Grand Island Veterans' Home within the last year, where we had a large population and we were not able to staff appropriately. We had a high turnover. We had a hard time retaining staff. So what we have done and you heard, we had to cease admissions temporarily. What we did is if you had five or six departments, let's say, and you have a capacity of 266, it makes no sense to have one department staffed for 266 and another department only staffed for 180. You need to staff to census. So what we did is we held off on the admissions. We established a baseline and we staffed for that amount. Then we staffed for 20 over. We are currently staffed for 200 members. The census in your packet is approximately 190. As we approach 200 we will then start staffing for 220, and then in that way we will be able to, through our revenue of our members and the lack of needing agency staff--we haven't had agency staff since I believe August 17 or July 17. No, we're done. Our mandatory overtime has diminished remarkably. We have been able to schedule in advance with full schedules with no holes. Obviously, you still have call-ins, you still have vacations and so forth, so there are still some issues and more work to do with voluntary overtime, but what we've done is we have staffed for the census that we have, and our staff is always a little bit before the census so we have the census following our ability to staff. And we've been able to maintain on budget and remarkably reduce our mandatory overtime, which has helped our retention which is--it just snowballs. As quickly things can spin out of control in long-term care or in any 24/7 care facility, they can get back

into control with decisive leadership, and that's what we've had in Grand Island. The March of Progress. The compliance with regulatory agencies, I've touched on that some moments ago regarding our survey readiness. One of the benefits that I've been able to enjoy was to have a systems clinician devoted to the Veterans' Home division and her name is Pat Moeller. She comes from the private sector and was a systems clinician for over 40 facilities at one time. So she has the ability and the experience, works extremely well with all of our administrators and is very close to me, and we are able to maintain a 24/7 survey readiness. Some veterans in the audience may remember the term "combat readiness." Well, this is something that our administrators can understand, that a lot of our veterans understand. We want to be ready all the time. We started doing mock surveys, and those are...it was kind of fun because we asked the administrators one time to go through your facility, and we want you to look at...here's all the things that you're going to be graded on in the federal survey and we want you to see and identify where the deficiencies are before the federal surveyors come in. Oh, well, you know that's proactive. It makes a lot of sense so they did that. Well, then we had another team come in and did another survey to not only compare what they found but to compare what the administrator found and compare those two--why did we miss some things, you know. And it's always learning, it's always getting better. You know, you train yourself to make sure you're seeing all of the aspects that you need to. It's not to successfully, obviously, have a successful survey, but also to provide that high quality of care that our members deserve and are entitled to. We've been so successful, in fact Grand Island Veterans' Home, the United State Department of Veterans Affairs said we just had the best survey in 12 years at that facility. We even had some folks test the light sockets, which I thought was kind of amazing. I didn't know this was one of the things they looked at, at some point in time. When you pull a cord out of a light socket you ought to have a certain amount of resistance, and you can measure that resistance. Our folks did. Our maintenance folks at the Grand Island facility are wonderful, as are our other departments. So, in fact, VISN 23--back to the U.S. VA chart again, the three parts of the U.S. VA. The VHA is divided into 22 VISNs--Veterans Integrated Service Networks. We are VISN 23. And I know that I just said there were only 22 but, hey, you

know everything has to be confusing, right? Well, the VISN 23 is made up of the Dakotas, Nebraska, parts of Kansas, Minnesota, parts of Wisconsin, and Iowa. And our systems clinician from the state of Nebraska, pat Moeller, was invited to go to Minneapolis, the VISN headquarters, and to give a talk and a briefing on survey readiness to everyone else. In fact, very informally--and you know, here I am testifying--but it was an informal conversation, but they also inquired to me whether we could have some arrangement where our team can go inspect the U.S. VA. We're getting good at it. We're improving. Are we perfect yet? Nope. We're getting there because we have committed staff, we have a plan. Acuity-based, our administrative, we continue to work towards consistency of implementation of the division processes, procedures, and management of division expenditures. The acuity-based staffing, that's another interesting deal here. They implemented the changes to provide better staffing-to-patient ratios and manageable levels of acuity-based care. What that means is that, for example in Grand Island again--Grand Island has had a lot of attention in the last 12 months--if you put the color green, and this is what we did, green for the lowest acuity, red for the highest acuity--green, blue, yellow, red--and laid out the floors of the facility and you assigned and you saw where each room was identified and every member was assigned a color based on their level of acuity. I kid you not, it looked like the Partridge Family bus, it was so...what you had to do then is staff for the highest acuity everywhere. At the same time you have a staff shortage? At the same time where we're hiring agency staff? Huh-uh. We were able to...we had a wonderful opportunity. We moved our secure dementia unit from the third floor of the Phillips Building down to the one-level, ground-level Anderson Building. We decided to put some of our most vulnerable and high-maintenance individuals, if we ever had a fire or a tornado, off the third floor where they were onto a ground floor. We used that opportunity to move, I believe, 18 additional members, and we were able to now have our floors by acuity. So on a high-acuity floor you staff high. On a lower-acuity floor you staff low. You have an 8:1, 6:1 ratio on a high-acuity, whereas a low-acuity in like assisted living, you could have 1:20, 1:30, as far as staff tech IIs and so forth. So part of our labor shortage was not...you know, there's a lot of elements to it. But, you know, like the Serenity Prayer,

let's change the things that we can, and acuity-based staffing was one of those changes. [LR363]

SENATOR GAY: Hey, John, does that...when you look...I assume you guys talk amongst yourselves, but would...and maybe I'm comparing apples to oranges here, but when you look at the Beatrice facility could the same concepts apply and then talk to John on these things? [LR363]

JOHN HILGERT: Certainly, John Wyvill...obviously he, I'm sure he looks at everything. He's aware of what we've done. Have I followed through to see how things were implemented or not implemented and so forth? No, I have not, but I can assure you John Wyvill is extremely attentive and is very eager to look for any and all information and best practices to do what's best at Beatrice. But I haven't followed through, Senator. I can't answer it. [LR363]

SENATOR GAY: Yeah, and I'm not questioning him, John. He's doing a great job. But that just sounds like some good practices, and if you're excelling in these things...and now CMS is probably a lot different the way they're going to do their surveys, but I'm just saying some of these good ideas probably, if you share them and they go back and forth... [LR363]

JOHN HILGERT: Well, and that's why Chris has her...you know, she mentioned on Monday, we have two-hour directors' meetings where we share our best practices, and we've been able to learn some things regarding staffing and staff retention from John Wyvill. So it's a healthy exchange. [LR363]

SENATOR GAY: Well, for that...we're having that hearing on 24-hour facilities coming up. I don't know if you're going to be at that; I assume you will. But I'm just saying... [LR363]

JOHN HILGERT: If you don't want me to be there, Senator, I won't. (Laugh) [LR363]

SENATOR GAY: No, I think it's...but I think some of the problems are common though that we're going to experience is the staffing levels. You know, these are stressful jobs that no matter where you go...but, I mean, in all these facilities we have staffing levels and we have probably some of the same common problems. [LR363]

JOHN HILGERT: I think there are some very obvious similarities and there's some obvious differences. My population tends to be older, tends to be male by and large--a vast majority male which is different in other long-term care scenarios. I'm dealing with veterans and the majority of veterans are male. But there's certainly some similarities and some differences, but we do communicate and we'll be there, obviously, on the committee. And following along that though is another element, is consistent staffing. When I come into a veterans' home...let's say my dad is there--my dad passed away in 1980 so I'm just using it as a hypothetical--and I go in and say, well, how's Dad doing? I don't want someone to say, well, let me look at the chart. You know, I want the nurse or the staff tech II, our CNAs or med aides to be able to say, oh, are you John? Bob speaks of you often. I know he's really looking forward to you coming here today. As you know, he had a little bit of a cold last week but he feels pretty good now. I want our staff to be able to communicate to our families ahd interested parties about the folks that they care for. Consistent staffing provides that. It also provides that caregiver to say, well, Bob's lost weight; we've better act on it. If you're off and on, off and on, and you rarely see the individual, there's not a lot of consistency. There's a lot of rotation, you have this agency staff coming in, you don't have the same level of care, I believe, that you would if you had state employees and consistent staffing. Also you can identify, for example if you have a lot of call-ins in one area, what is the issue in that area? Is it supervisors? Is it management? Is there someone...or do we need to intervene? Is there more reeducation that's needed? Are there med errors? We are able to track not only the fact that there was a med error but you can start looking into why, again with an eye towards getting that quality up and doing the necessary retraining. So consistent

staffing is a committed decision that our division is going towards. Is it fully implemented in every neighborhood or pod or floor or ward throughout our division? Not yet. It will be this year. That's what our goal is. Our challenges: ensure the proper staffing levels. That's a constant and that takes a lot of work. It takes a lot of work because you need to know...certainly you need to know who you're serving, what the acuity is, changing acuity. You need to reduce the overtime. We've made great strides at reducing the mandatory overtime, especially. Again, agency staffing; we're done with agency staff in Grand Island. We still have some in Eastern Nebraska. We've had for seven or eight years, as well. But Brenda Knutson, our director of nursing, and Howard Googins, they have plans and they are committed to being free of agency staffing at Eastern Nebraska. They have a lot more competition for staff in Bellevue than elsewhere. In fact, there's another 200-bed facility coming in on, I believe, Fort Crook Road. I think they're building one in Bellevue which will again put more pressure on keeping our staff. Compliance with regulatory agencies. I've talked about that; that's our 24/7. That's a constant that we need to do in long-term care. Technology...and Chris was spot-on. Six years ago in December 2002, there's was a decision to get a computer software program for the veterans' homes. Well, I came on board and I saw the decision in December, and I said, well, that's only seven months, and then I saw the year and like, oh, oh, seven months and four years. What we needed to do was to strike out--and you've enabled us to do this, LB296--is, as a division decide what our needs, decide what we need. And we are implementing some software--we have been able to absorb the cost, we have not asked for additional funds for this--that will help us in our management, our business practices and our clinical care. Our in-service training programs, obviously when we...with our reporting systems that we have with our attentiveness to our surveys, it's easy to identify training regimens and programs. We are going to be buying-in as a division to a new culture change training opportunity that is coming our way. It is called LEAP, and LEAP stands for Learn, Empower, Achieve, and Produce. And we need to further empower our employees. You know, our success right now is because we have empowered our staff and our accountability, but we also use different opportunities to direct our educational training. It's not so in just reaction to

different dictates or regulations that come down the Internet. But we had an instance where a family had a, I think, less than superb experience with the end-of-life event of their loved one. Did we have in place...? And one of the things that happened, they got a bill. They got a bill for something two weeks after the individual expired. Do we have protocols in place that interdisciplinary that react to certain events to make sure that the...? It's basic customer service, and that's one thing that I can't stress enough. We have worked very hard over the last year getting our quality where it should be, and it's always been there but we've now quantified it and are able to track it. We've worked very hard with our employees and for our employees to try to make the environments the best that they can be. We have one of the best missions in the state: To care for America's heros. We think that's an attractive job and we need to support our staff. Now we need to also start looking beyond the home confines and looking at the family members, the POAs, the healthcare power of attorneys, and making sure that customer service is a priority and that we're accessible to those who interact with our homes. It's an exciting time and I will say this, that we've had, one home at least existed for over 120 years now. What allowed us to be where we are was LB296. We are able to focus on a mission now. And we had good people in the past, hard-working people, people who worked extremely hard, but the reorganization has allowed us to focus on these areas, and I'm sure the other directors can speak to this as well, but I've been in state government and I was an observer of DHHS for six years prior. So I'm excited about the change that has taken place and the direction that it's going. I would be more than happy to answer any questions that you might have. [LR363]

SENATOR JOHNSON: ~th. [LR363]

SENATOR HANSEN: The way I look at the records, I mean you have 725 employees at present, whatever the date was there, with 506 members. That's 1.4 staff per member. How does that compare to the private sector? [LR363]

JOHN HILGERT: What I would do is I could get that for you. What I'm going to do

though is that I would like to converse with you about if you gave me what a staffing ratio is for assisted living, what my staffing ratio is compared--or the division's not mine--staffing ratio with the private sector, I could get you that information. A nursing unit to nursing unit, a secure dementia unit I can perhaps get that. We have more staff than other places. A veterans' home is not simply a--with no, I don't want to be disparaging it, but we have a little bit different components than the private sector. I think we offer more services. We're not simply trying to provide a base service, but we're trying to not only provide a service to these veterans but we're also honoring their service. We also have the issue that my population is predominantly male. It takes more hours to shave. A male population, you know there's different aspects to the population that I serve that adds more hours. I can break that down and I can get you that information. I think we compare very favorably. I will also observe that I can't work short. My mother is in a facility which I won't name. They work short; I don't. I have to maintain a certain staffing or I will call in...and unfortunately we've had to do mandatory overtime in the past and of course we're trying to eliminate that altogether, and then the extreme measure of calling in agency staff. But unlike some of the private sector, we can't work short. They can. But I will get you that information so we're doing apples and apples. [LR363]

SENATOR HANSEN: The other qeustion I would ask, how are you going to address the Alzheimer's members in the Western Veterans' hospital since they're in the general population? I mean, are you going to address it, I hope? [LR363]

JOHN HILGERT: Yes. You know, yes, I've been before you before. You had that tour and that did not go unnoticed. You identified the need that has been there for some time for a secure dementia unit. And as you can see through our capital construction request that was submitted September 15--they went online, I believe the 18th, Jeff--there was a capital construction request for a secure dementia unit at the Western Nebraska Veterans' Home. We did two things with that request. We also took the opportunity to take the idea, is to take 30 assisted-living beds, and as you know, our assisted-living

beds at the Western Nebraska Veterans' Home are basically the rooms that were the old Hiram Scott dormitory rooms. They're very small. You probably saw that when you went out there. We're going to take 30 of those small assisted-living beds and convert them into 15 competitive larger assisted-living beds that would better serve couples, etcetera. So we don't want to, of course, decrease the capacity, so we're going to increase by 15 beds, so we are going to maintain the same number of, quote, beds, at the facility and add to our secured skilled unit, our secure dementia unit, which would be very, very helpful and address that need spot-on at the Western Nebraska Veterans' Home. And as you can see from the waiting list, the Western Nebraska Veterans' Home under the Alzheimer's heading, has none, because we do put them in the general population. We try to serve them the best we can. The secured dementia unit at the Western Nebraska Veterans' Home will allow us and enable us to provide that service specifically and for that population and it would be a great benefit. So we've exactly responded to what the last time I was here I believe that you had talked about, but through enlarging the assisted-living, making those more competitive, and providing for a secure dementia unit and you'll see that in our capital construction. Yes, Program 915 which was handed out.. [LR363]

SENATOR HANSEN: Thank you. [LR363]

JOHN HILGERT: Thank you, Senator. [LR363]

SENATOR JOHNSON: Anyone else? John, thank you. I guess you've said the most encouraging thing here today whether you realize it or not, and that's that the reorganization is working. That makes us all feel good, and you've seen both sides so it means a little bit more. [LR363]

JOHN HILGERT: It's not a question in my mind, Senator. Thank you. [LR363]

SENATOR JOHNSON: You bet. Thank you. Well, do we have any public comment on

the veterans' homes? I see none and I guess we don't need to have a break at this point in time so let's just proceed and I'll suspect it will take a little longer here on the next section anyhow. So the Division of Medicaid and Long-Term Care. [LR363]

VIVIANNE CHAUMONT: Ready? [LR363]

SENATOR JOHNSON: (Exhibit 2) So that I don't forget something, we have a letter here from the Nebraska State Independent Living Council that fits appropriately here and we want to make sure that that gets included in the record. so excuse me but that way I won't forget. Anyhow young lady, welcome. [LR363]

VIVIANNE CHAUMONT: Thank you. Good afternoon. I'm Vivianne Chaumont, director of the Division of Medicaid and Long-Term Care. It's great to be back in front of you. We'll talk today about all of the programs that Medicaid...that my division runs. I have the smallest division of the entire Department of Health and Human Services with only 156 people. About half of them run the claims--actually work in the part of the Medicaid program that pays the claims. Back in July we reorganized into two prgram areas, acute care programs and long-term care programs. Under acute we have four units and under long-term we have four units. The four units under acute are...the first one does behavioral health, pharmacy and ancillary services. Behavioral health and pharmacy I think are self-ex0lanatory. Ancillary services are durable medical equipment and transportation. The Medicaid claims unit is about half of the staff that actually input the claims that come in and make sure that claims get paid. Operations unit has a program integrity office in it which is the people that do some utilization review, claims, checking of providers to make sure that Medicaid is paying the right amount for the right service to the right kind of provider. They also have the school-based program which is some Medicaid advministrative costs for schools to help with school-based healthcare. They have also a person that keeps track of all the state plan amendments. Medicaid, as you know, is a joint federal/state program and the state plan is basically the contract between the state and the federal government to get federal financial participation

money from the feds. They organize all the audits or responses to the audits and they do a variety of reports. The physical health services unit is basically all the practitioners, so physicians; dentists; chiropractors; the therapists--not behavioral health therapists but physical therapists; and managed care, as well, is there except for the behavioral health managed care. On the long-term care side we have the HCBS waiver unit and we have currently three existing waivers. We have the aged and disabled waiver; the early intervention waiver, which we are in the process of asking the federal government to...we're going to eliminate that waiver and just move the seven children on that waiver over to the aged and disabled waiver. They will get the same services. There will be no change there except that running a waiver is an incredible amount of paperwork that's due to the federal goverment so we're doing that as an administrative efficiency. We have the traumatic brain injury waiver and then we are in the process of inplemeneting the autism waiver. Then the long-term state plan services, as opposed to--these are all long-term care services. There are waiver services and there are the state plan services, and those are the ones we're more famliar with like nursing homes, ICF/MR, the home health services, private duty nursing, and hospice, as well as personal assitance services. The safety and independence supports unit...oh, and the long-term care state plan services also is where the Money Follows the Person grant is currently housed and I'll talk about that a little bit later. Safety and independence supports unit, that's a unit that has basically all of the things that aren't Medicaid in the division, except for that we have moved eligibility, policy making used to be with Todd Landry's unit in Children and Family and we have moved that to the Medicaid division where it makes sense that the Medicaid division established the policy for Medicaid eligiblity. That unit also has a variety of small state programs, medically handicapped children's program, the disabled persons and family support program, the medical insurance for workers with disabilities, and several federal grants. The last unit is also not a Medicaid unit and that's the state unit on aging, and they work with the area ageancies on aging throughout the state and basically pass through federal and state money on aging. They also have senior care options which is a statutory program here where they are the contractors that evaluate the elderly to see if they qualify for a nursing facility level of

care, 65 and over, and that's also the unit that has the long-term care ombudsman who are folks that go out and help people resolve issues in nursing facilities. [LR363]

SENATOR STUTHMAN: Ms. Chaumont. [LR363]

VIVIANNE CHAUMONT: Yes. [LR363]

~AS: You mentioned the autism waiver you're working on. When will that be in place or when is that supposed to be workable? [LR363]

VIVIANNE CHAUMONT: That waiver was submitted July 1 as reuqired by the statute and it's being reviewed by CMS. They have...we submitted everything to them. They have gotten back to us with a list of pages and pages of questions which now we need to respond to. So it's hard to tell when that will get approved but that's what we're working on. [LR363]

SENATOR STUTHMAN: Could it be months, years? [LR363]

VIVIANNE CHAUMONT: Yes, it could be months. [LR363]

SENATOR STUTHMAN: But not maybe years, hopefully not. [LR363]

VIVIANNE CHAUMONT: You know, the way the federal process works is they have 90 days to say whether or not they're going to approve or disapprove a waiver unless they ask you a question. And so they ask you a question and then that stays the 90 days, and then you have another 90 days, and then they ask you a question and then another 90 days. So, you know, they have gotten better about it but I've known waivers that take years to approve. [LR363]

SENATOR STUTHMAN: Okay, thank you. [LR363]

VIVIANNE CHAUMONT: I don't think that is going to happen in this case. Okay, the next is just to give you an idea of the different broad categories that receive Medicaid. Assistance...as you can see, the largest category is children with about 66 percent of our clients are children. About 10 percent of our clients are aid to families with dependent children adults, so basically caretaker relatives of many of these children; the aged would be people over 65; and then the blind and disabled would be people with physical disabilities. These numbers went up from 2007, increased about 2 percent for children, about 1.5 percent for the disabled; decreased about 8 percent for adults with dependent children and, surprisingly, decreased about 1.7 percent on the aged. As a whole, eligibility increased about 1 percent between 2007 and 2008. Vendor expenditures by service. Although I have the smallest division I have the most money. Medicaid is 19 percent of the state budget, so it's a huge chunk of the state budget, and in other states about now it's averaging that Medicaid is about 20 percent of the state's budget--except for evidently the state of Maine. I just read where it's 31 percent of the state budget. From year to year, from '07 to '08 we had increases as a percent of the share of the total in managed care and community-based services and in home health. Those three increased. And we saw decreases in nursing facilities and hospitals, both inpatient and outpatient, which makes sense since we're trying to shift people from institutional settings to community settings, so we would expect to see that. Total vendor expenditures increased about 4 percent from FY'07 to FY'08, and the average monthly cost per eligible increased about 3.5 percent. Those increases because enrollment has been so flat have been mainly due to utilization and increase in rates. Vendor expenditures by eligibility. If you saw the last chart you remember that children were the biggest portion of clients but they are not the biggest expenditure there. Children are cheap--unless you have some and then you know better. But overall...you know, kids are healthy; they tend to be healthy and Medicaid kids tend to be healthy like other kids, so the largest share of expenditures goes in the disabled category, then kids, and then the aged. We saw an increase of about 4 percent...I guess I talked about that already...and the 3.5 percent. Okay, the long-term care services. I almost freaked out

when I was looking at these numbers because they didn't make any sense, and then I realized that the very first, the chart on the left, is actually '08 and the chart on the right is '06, so sorry there. They are backwards. So, no, we did not save $55 million in two years on long-term care services. (Laugh) Nursing facility services are still by far the greatest percentage expenditure of long-term care services although institutional care between '06 and '08 decreased from 63 percent, and so institutional care on this chart would be ICF/MRs and nursing facilities. That decreased from 63 to 60 percent. And community-based payments, which is everything else, increased from 37 percent to 40 percent. So the move to move people from the institution to the less expensive community, the shift which we're trying to do, it's happening. The next slide is...for Medicaid reform, as you'll recall back in 2005 when they did the Medicaid reform, they showed that if you calculated, if you projected out Medicaid expenditures, appropriations, general funds, in 2025 there would be a $785 million shortfall between the general fund appropriation and what Medicaid needed to maintain at the same level. We have now recalculated, three years later, those numbers, and the numbers indicate that there is now a $400 million shortfall. I think an important thing to remember is that I think Medicaid reform has slowed growth. I think it is working. There's still almost a $370 million gap between available funds and costs. And the other thing to remember is that between 2005 and 2008 have been three years of economic good times--very, very good times economically--so that the eligibles have been fairly flat and we've had economic good times. So... [LR363]

SENATOR PANKONIN: Vivianne, if I could interrupt you here for just a couple questions. First of all [LR363]

VIVIANNE CHAUMONT: Sure. [LR363]

~PAN: First of all, on the estimated appropriation available, is that just basically adding the percentage to that? And what percentage is that? Is that a...? I mean, when you say estimated or let's say you say, whoever did this calculation. [LR363]

VIVIANNE CHAUMONT: Let me see if I...sorry. Let's see. They basically updated eligibility criteria in '08, and part of the thing here was that case load was lower as I've said. They...let's see how they did the appropriations. They said population forecast didn't change so they didn't change that. And I think they used the exact same methodology that had been used in 2005 but I don't know what that was is in order to estimate the appropriations available so I'd have to get back to you on that, Senator. [LR363]

SENATOR PANKONIN: Well, I guess one point is we...you know, looking at this chart, between '05 and '08, that's three years when you're looking at 20 years out, or 17, that we've made some pretty good strides, and so hopefully we can continue to narrow that. And I know it can go either way, I fully understand that. But you have to be happy with a trend line over three years. That's a significant narrowing. [LR363]

VIVIANNE CHAUMONT: Yes. [LR363]

SENATOR PANKONIN: And there's so many factors that go into it, it's really, really hard to predict... [LR363]

VIVIANNE CHAUMONT: Right. [LR363]

~PAN: ...but I am pleased to say...I mean, that's over half of what it was. [LR363]

VIVIANNE CHAUMONT: Yeah, I think the measures that the ~L and the ~G came with the Medicaid reform are working. I think that the mistake would be to think, okay, now we're done and we don't have to do anything more, because I think $400 million is still out there and I think that these were also good times, so.... [LR363]

SENATOR JOHNSON: Could you just expand on that just a little bit. What measures do

you think were the most successful? [LR363]

VIVIANNE CHAUMONT: I think the shift to try to get people in community care, I think that's a very important part of it, because you saw the charts where the long-term costs are. I think that's a huge part of it. And I also have to say that the Medicare Part D with the drugs is also part of that decrease, because for dual-eligibles, for Medicaid clients who are also eligible for Medicare, the cost of drugs has been taken away from them from the Medicare program. But I think that institutional, that's the biggest...probably the biggest shift. [LR363]

SENATOR JOHNSON: Have we done all we can in that area? [LR363]

VIVIANNE CHAUMONT: To do that? No, I don't think so. We continue to educate people. I think that's a big part of it. I think a lot of people are not aware of the options that they have in the community and families are not aware of the options they have in the community. If we want to start a discharge program where we work with hospitals to make sure that when hospitals discharge, instead of...you know, it's much easier for everybody in some ways to just discharge from a hospital right into a nursing home. Most hospitals have relationships with specific nursing homes and they just get them out of the hospital into the nursing home, than to work with a discharge planner and with a caseworker to make sure to see if there's alternatives available in the community. And in many places there are. In many places a person can go, you know, if they have a home or a family they can go back to that if you have the support services available to them to help them. So part of that is education. [LR363]

SENATOR STUTHMAN: Ms. Chaumont, what could we do now at this time or in the next few years to hopefully address the fact that it looks like it's going to be that $400 million difference? Can we be doing anything now already, to try to curb that, more than what we're doing? [LR363]

VIVIANNE CHAUMONT: Well, we'll...yes. Yeah, we...yeah. [LR363]

SENATOR PANKONIN: She's got it all figured out (inaudible). [LR363]

VIVIANNE CHAUMONT: I've got all but $5 million of it figured out. No. (Laugh) No, there's all kinds of things that we can do and I think we can talk about some of them as we go on. But I think we have to...I think the biggest point is that we can't stop. We can't say, oh, this is wonderful and now we don't need to do anything further. We need to continue to evaluate the program at every level. [LR363]

SENATOR PANKONIN: Arnie, one of the keys is going to be, since what's happened in the market, my financial advisor Senator Gay says everybody is going to be working until 90 anyway, so we just go from there to you know where. [LR363]

SENATOR GAY: Thanks for that plug. (Laughter) [LR363]

VIVIANNE CHAUMONT: That wasn't a very good plug, was it, Senator Gay? [LR363]

~TG: No. [LR363]

SENATOR STUTHMAN: In other words, you won't need long-term care. You'll only be there one year. [LR363]

SENATOR PANKONIN: Just keep working. [LR363]

~TG: (Inaudible) work force (inaudible). [LR363]

VIVIANNE CHAUMONT: That's right. You know, I think...and I think that we should be proud and happy of the work in Medicaid reform that ~N has done, that you all have done. Because I think Chris mentioned when she was talking about a report that just

came out from CMS, and it came out from the Office of the Actuary, and it's pretty grim I think. It says the report projects that Medicaid benefit spending will increase 7.3 percent from 2007 to 2008--we didn't see that--reaching $339 billion nationwide, and will grow at an annual average rate of 7.9 percent over the next ten years, reaching $674 billion by 2017. That compares with a projected rate of growth of 4.8 percent in the general economy, so Medicaid increasing at 7.9 percent in the economy, or the costs, and that the general U.S. economy increasing at 4.8 percent. And this actuarial study was done before all of this came out. They also say that, as far as state spending is concerned, that they're projecting that state spending on Medicaid will increase by 4.4 percent from 2008 to 2009--we're a little bit lower than that--and that such an increase would be more than four times the rate of growth in the average state general fund. So, you know, we, I think did very well. You all did very well to start this at the time that you started it, and we just need to continue. [LR363]

SENATOR GAY: Vivianne, I've got a question regarding Senator Pankonin's question prior on that estimated appropriation available. Did you say you are going to get us some information on how that was figured? [LR363]

VIVIANNE CHAUMONT: Yes. [LR363]

SENATOR GAY: Is that in that Mercer report or where is this? [LR363]

VIVIANNE CHAUMONT: Our staff...yes, I believe. [LR363]

SENATOR GAY: You'll get us the information though, why this chart is... [LR363]

VIVIANNE CHAUMONT: Yes. I think they just projected the increases in the general fund appropriation throughout, and we would need bigger and bigger increases in order to...but I'll check that for you. [LR363]

SENATOR GAY: To get to...well, the gap is under existing...what we offer now under existing, and then that appropriation available is...I mean that could be anything, couldn't it, because didn't you say it's 1 percent? [LR363]

VIVIANNE CHAUMONT: Yes. If the appropriation is like this and expenditures are like that, there's going to be a gap, and that's what they just projected, the general... [LR363]

SENATOR GAY: Yeah, but I guess on appropriations available is pretty much what you would want to make it available. I mean it would be a goal we're shooting for, right? I'll wait until we get the information and maybe have another discussion. [LR363]

VIVIANNE CHAUMONT: Yeah. I'll get you the information. I'll send that over to you. Okay. This just goes to show that we have been pretty flat as far as eligibles are concerned from 2006 to the projection in 2011. We built the 2010-11 budget requests on a 1.8 and 1.7 percent increase, and we have had very slow increases in eligibility since 2006. Then the program trends and projections is just the average cost that a client costs the Medicaid program in the different eligibility categories. As you can see, the aged and disabled again are the more expensive populations and children and the adults are the less expensive population. I think there's been a decrease in the aged population you see from 2004 to 2008. That would be attributable to Medicare Part D covering the drug costs, so we're not having to pay for those anymore. On the four big, big, biggest line items or the biggest portions of the Medicaid budget as far as services are concerned, our nursing facilities...and I'm sorry the legend seemed to get misplaced there, but the columns are 2002, 2004, 2006, and 2008. You see nursing facilities are pretty steady. Pharmacies is the only service that has gone down dramatically or significantly in any way, and that again is because Medicare Part D came in. We used to experience double digit increases in the pharmacy budget. And for '10 and '11 we've projected the budget based on a 6 percent increase in the pharmacy budget, so that's very significant and that's where those savings are coming in. The next slide is just what

the division's Medicaid request is for the upcoming biennial, and it's for Medicaid funding and SCHIP funding, and it just shows you that the Medicaid funding is matched at about 60 percent federal; the SCHIP funding is matched at about 72 percent federal. In Nebraska, we run SCHIP as an extension of Medicaid, so it's just the difference in how the feds reimburse us as opposed to any other difference in the program. And then we get to program budget that our reductions that are a part of our requests for '10 and '11, and we are requesting a reduction in the increase that we would otherwise give nursing facilities. The budget is...and all of these are for 2011. There is nothing for 2010. All of these...we have requested in the budget a 1 percent rate increase for all Medicaid providers. So in 2009 there would be a budget increase, a 1 percent increase...I'm sorry, in FY'10 and FY'11 there would be an 1 percent increase. The $600,000, this is all general funds, so that would be $1.5 million in total funds. $1.5 million is .48 of the 2008 nursing facility budget, so by 2011 it will be a much smaller percentage of the total nursing facility budget. We have not made any decisions as to how we would take that reduction. We could take it across the board to all nursing facilities or we could focus on nursing facilities with very high administrative costs and take it from them. The next reduction would be to increase the outlier threshold for diagnosis related group hospital. This is hospital reimbursement that we would increase the outlier by $15,000, and this is the amount that a hospital has beyond the regular DRG before an outlier, an extra payment kicks in. So we would increase that by $15,000 so that that would be a reduction in reimbursement. Reduction in indirect medical education for hospitals. Indirect medical education is part of graduate medical education which is a special pass-through payment that hospitals get who do education in their hospitals, like have residents or a university-type hospital. We would...it's based on a formula that uses 72.64 percent. We would reduce that to 70 percent. We would reduce critical access hospital reimbursement from 100 percent of their costs to 90 percent of their costs. [LR363]

SENATOR HOWARD: Vivianne, I'm sorry to interrupt but could I ask a question at this point? [LR363]

VIVIANNE CHAUMONT: Sure. [LR363]

~HOW: These critical access hospitals, would this be...would Creighton in my district be considered one of those? So many trauma people go to this facility. Is this what this refers to? [LR363]

VIVIANNE CHAUMONT: No. A critical access hospital is usually a rural hospital. [LR363]

SENATOR HOWARD: Ah. Okay, thank you. [LR363]

SENATOR JOHNSON: Average 25 beds or less. [LR363]

~HOW: Okay. [LR363]

VIVIANNE CHAUMONT: Reduction in outpatient hospital reimbursement from 82.45 percent of cost to 75 percent cost, again. That's just a formula for outpatient hospitals. Coverage of disability childcare limited to cost exceeding basic childcare. What this is, is in several of our programs, if you have a special needs child, we will pay for childcare. We have been paying the total amount of childcare. CMS has told us and it's kind of commonsense that we should only be paying for that amount of childcare above and beyond what you would be paying if you didn't have a special needs child. So when you have a child and decide to go to work and, say, day care is $100 a week, you would be paying $100 a week for that child. With a special needs child, because they might have nursing needs or different needs, that childcare would go up to $500 a week. Medicaid will reimburse the $400, so the parents would have to reimburse the first $100 like they would for any child, and then we would pay for the $400, the additional $400. So basically CMS has told us that we need to be paying for that which is medically necessary to have that child in day care. [LR363]

SENATOR GAY: Vivianne, I've got a question on that. When you decide what's medically necessary though, who does that and what department? I mean I know you do that but some would have to...all these cases are all different so how do you go about...because we've had a conversation with one of my constituents about reimbursement rates, of course. Well, you know, they're saying we're providing extra than others, but how do you decide that though? It's just an arbitrary decision? There has to be some guidelines we go back to and tell these people... [LR363]

VIVIANNE CHAUMONT: Yeah. The regulations show...have the guidelines for what children are eligible for those places. So that wouldn't change at all, those regulations. [LR363]

SENATOR PANKONIN: Those are federal. [LR363]

VIVIANNE CHAUMONT: There's state and there might be some federal ones too, but our own regulations say, you know, in order to get this benefit, this is what it takes to get this benefit, and so we wouldn't be changing any of those kinds of things. What we would be changing is that we would be calculating what the typical costs of day care. I think we would use the childcare...there's a childcare index or something that says, so in my neighborhood for an infant, day care is 100 bucks a week. So we're going to go to a day-care center and for my infant they're going to charge $500 a week because of the special needs, then we would pay the additional $400. [LR363]

~TG: Okay. And I guess the difference is this: If a special needs is a lot of different things so my needs may be different than the other child's. I guess where is it that I can go and look or where--we can have a discussion another time, we don't need to do it now--that these needs get this much. It takes this much to care for a child with these needs (A) versus a child with these needs (B), versus (C), (D), (E). Because there are going to be different cares... [LR363]

VIVIANNE CHAUMONT: We have just rates that we use, that we calculate the rates. [LR363]

~TG: So there's no differentiation though? And that's where I think there's a discussion we need to have. [LR363]

SENATOR HOWARD: Are you thinking more severe needs versus... [LR363]

SENATOR GAY: Yes. [LR363]

~HOW: ...is more easily cared for needs. That's a good point. [LR363]

VIVIANNE CHAUMONT: Well, I think you were talking about a day-care center. Yes, they have rates. They might have different rates but there are rates, and they're not based on each individual child. In a home we would calculate what that child needs and that's what we would pay. [LR363]

SENATOR GAY: Okay, and is that a state decision or is that a federal decision? It's a flat rate. So what you're saying, it's a flat rate. Federal law says that. [LR363]

VIVIANNE CHAUMONT: No. Federal law doesn't talk about rates...states set rates within federal parameters, but yeah. [LR363]

SENATOR GAY: All right. Sometime I would like to get more information on (inauidlbe) because it's going to come up again, obviously. [LR363]

VIVIANNE CHAUMONT: Okay. The large majorioty, by the way, of disability childcare is in the child's home; it's not outside the home. [LR363]

SENATOR GAY: Oh, it isn't? Okay, that's good to know. [LR363]

SENATOR HOWARD: Well, Vivianne, does the Ambassador provide day care? I know there is a facility in Omaha that does provide out-of-home care. You may have...they've had visits over there. [LR363]

SENATOR GAY: This is an out-of home. [LR363]

SENATOR HOWARD: Yeah, but does the Ambassador provide that? [LR363]

VIVIANNE CHAUMONT: I don't...I haven't heard of the Ambassador having a day-care center. I know of Children's Respite Care Center and Children's World are two special needs day-care centers in Omaha. [LR363]

SENATOR HOWARD: Right, right. [LR363]

VIVIANNE CHAUMONT: I don't...those are only two I know of. [LR363]

~HOW: Well, I know they provide the care but I don't know if they have a day care either. [LR363]

VIVIANNE CHAUMONT: Okay. Let's see, where are we. Okay, number 7 is a premium payment for families whose income is over 185 percent. And this is for children whose Medicaid eligibility is determined without any regard to parental income, and so we would start with premiums at 185 percent up to a maximum of 5 percent of their gross income. That's the maximum by federal law, and I think that around 550 percent of the federal poverty limit, we would be at the 5 percent. A limit of 52 visits per year on outpatient mental health therapy for adults, and then implement a two-tiered payment rate for office and facility-based care by physicians. Medicare currently pays physicians a different rate if they see a client, a patient, in the hospital, than if they see them in their

office. And the reason that they do that is because they say that doctors don't have all of their overhead expenses when they're seeing patients in a hospital that they would when they're in their office, and so that's about $4 million. [LR363]

SENATOR HANSEN: Vivianne, I've heard about that one a little bit out in the country. [LR363]

VIVIANNE CHAUMONT: I thought you might. [LR363]

~TH: I have...even though I'm in Lincoln I still have overhead on the ranch at North Platte and the doctors do too. Whether they have staff there or not, they continue to have overhead there. Is this going to be hard and fast, that part of it? I mean, what is the alternative? The doctors quit seeing Medicaid patients and that's not good for us either, especially in the rural area because we don't have a surplus of doctors. [LR363]

VIVIANNE CHAUMONT: Well, this is...that is our budget request is for that reduction, and while it is true that they would still have the overhead continuing in the office, you pay a physician fees based on their service, and that includes their overhead. So when you're providing a service over here, you don't have the overhead when you're providing a service over here. You do have the overhead so that's the differential. [LR363]

SENATOR HANSEN: That's a hard sell. [LR363]

SENATOR JOHNSON: One of the things, and I'm looking at it a little bit differently, is as we look at Nebraska and there are well over 70 counties that are declining in population and so on, and we worry and try and figure out how to help rural Nebraska, I think one of our considerations has to be that if we get to a situation where we start providing lesser quality medical care in the rural areas, I think it will be a significant deterrent to being able to help the rural areas as you won't get quality people to move to the non-metro areas, and the ones that are there aren't going to stay either. So I think we

have to kind of put this in our thinking some way or other, too. [LR363]

VIVIANNE CHAUMONT: You are correct, Senator, and federal law requires the Medicaid program to ensure that there's access throughout. I would wager that the largest percentage of that $4 million is not in outstate Nebraska, but is in Omaha and Lincoln where you're not going to have those issues. But making sure that we have access to our clients is always a priority and a goal. [LR363]

SENATOR HOWARD: Before we turn the page, just a quick question. You and I had talked earlier in the summer about this 185 percent of the poverty level, and I remember you had said to me at that time that when we talk about a sliding scale possibility, that the department didn't have any way to collect the revenue. And remember, we talked about the autism program, that it was such a small population and such a small amount that could be factored in for that. Have they changed? Do they now have a system where they could collect the payments? [LR363]

VIVIANNE CHAUMONT: No, we have a system that...we currently collect payments on two Medicaid programs, the MIWD program, Medical Insurance for Workers with Disabilities, and for transitional medical assistance we collect premiums, as well. We do have that. I think that what we talked about is that this is an estimate because we currently...if parental income is not required to make an eligibilty determination, we don't have that information so we can't collect that information. And so based on instances where we have that information, we extrapolated the data to see where most of the people would fall, and determined that based on a... [LR363]

SENATOR HOWARD: And the way I remember it was more the actual collection that was problematic. We didn't have a mechanism in place in the computer system to accept payments other than for the autism program. [LR363]

VIVIANNE CHAUMONT: No, we... [LR363]

~HOW: This was probably early June. [LR363]

VIVIANNE CHAUMONT: Yeah, we currently do collect that and we would need to have something in place to aid in this collection, but we currently collect premiums for those two programs, and once autism comes up we will collect that on the autism waiver, as well. [LR373]

SENATOR GAY: And Vivianne, how did you get 52 visits a year on outpatient? What's...why is it 52? [LR363]

VIVIANNE CHAUMONT: We looked at the data and 52 because there's 52 weeks in a year and once a week, and we looked at how many people would be affected by that and it was about 470 people, which was a fairly small percentage of all of the people receiving outpatient therapy. [LR363]

SENATOR GAY: Well, and then it's just...all right. [LR363]

VIVIANNE CHAUMONT: The division priorities, Chris talked about it already. In our division there's two, the MMIS, building it on time and on budget, and continuing to slow the growth in Medicaid expenditures so that we can ensure that we have a fiscally sustainable program. As far as the Medicaid Management Information System is concerned, we are currently operating with a 30-year-old computer system. This new system that we are building will bring updated technology and updated functionality, and will make everyone's life a piece of cake, and so we are very excited about it. And we're building it hopefully so that the way that it's being built is so that it is easy to change, easy for it to be flexible so that when there are changes in the program and new needs, we can be flexible and be able to make policy decisions not based on what MMIS can do, but have MMIS do what the policy wants. And Senator, you had asked how many people we have working on there? Currently, we have 59 state staff; 41 staff from

FourThought Group--when they are at the peak they will have 87 staff there; and we have four staff from FOX, which is the IV&V. [LR363]

SENATOR GAY: And on that, well, a 30-year-old computer system obviously has to be updated and all that, but have you guys run any, like, a return on investment on that or is it just one of those things...and that's hard to do in government because we don't turn a profit but there's a certain point. It's just do you think this will enhance your ability, probably more than anybody, won't it, since you make all these payments and... [LR363]

VIVIANNE CHAUMONT: Oh, it will enhance, definitely will enhance our ability, plus... [LR363]

SENATOR GAY: Yours and Ron... [LR363]

VIVIANNE CHAUMONT: And I think all of that ROI thing was done when they came into the ~L to request the $50-60 million. So, yes, it will facilitate our electronic billing, it will facilitate...yeah, and give us better data, absolutely. And not to mention the fact that your MMIS system has to be certified by CMS, and if it isn't certified by CMS your whole program is not eligible for federal financial participation. So we needed to do this. [LR363]

SENATOR GAY: Yes. So there's very few vendors, I assume, that do this so every state is doing it, obviously, but.., [LR363]

VIVIANNE CHAUMONT: You know, there have gotten to be like two or three big hames in the field, and it's starting to open up again. Nebraska is different because we run our own MMIS system and we are having the contractor build it, and then...and it's a learning process for us, as well, because we will be the ones making the changes to it--you know, adapting it after the build is done--and we will be the ones operating it. [LR363]

SENATOR GAY: So we won't have to pay an ongoing maintenance... [LR363]

VIVIANNE CHAUMONT: Oh, yes, exactly. [LR363]

~TG: ...I mean we'll have maintenance because of the employees but we won't have to have some contract then. [LR363]

VIVIANNE CHAUMONT: Correct. [LR363]

SENATOR PANKONIN: So most states contract the services? [LR363]

VIVIANNE CHAUMONT: I think there are 14--it might be increased to 17 states now--that operate their own MMIS. Chris talked about not telling me about the weather. She also didn't tell me we were in the middle of this--but she says she did. (Laugh) I don't remember it. (Laugh) [LR363]

SENATOR PANKONIN: But besides this thing, as well, if you're telling me that things ought to run more smoothly and we'll have more data, but that's also going to tell me that hopefully it will save us money, too, because it's efficient. [LR363]

VIVIANNE CHAUMONT: I think it will save us money, Senator, because if it's more flexible and it can do more things, then you can do more things like do... [LR363]

SENATOR PANKONIN: Analysis. [LR363]

VIVIANNE CHAUMONT: ...analysis of disease. You can do better disease management, you can do...there's all kinds of things. [LR363]

~PAN: Things that could come from this. [LR363]

VIVIANNE CHAUMONT: That's right. ABsolutely. [LR363]

SENATOR JOHNSON: Okay. Any other qeustions? I want to wake Arnie up there and... [LR363]

SENATOR STUTHMAN: You're not complete because I do have some qeustions. [LR363]

~TG: Unless you're not done yet. [LR363]

VIVIANNE CHAUMONT: I'm not done but I am complete. (Laughter) Okay. [LR363]

SENATOR STUTHMAN: The one question that I have is you, the budget request is planning to be a 1 percent increase? [LR363]

VIVIANNE CHAUMONT: A 1 percent rate increase to providers. [LR363]

SENATOR STUTHMAN: One percent rate increase. [LR363]

VIVIANNE CHAUMONT: Rate incrase for Medicaid providers in '10 and then another 1 percent in '11. [LR363]

~AS: Okay. [LR363]

SENATOR HOWARD: Do you think that's going to be enough to keep them on board with us? [LR363]

VIVIANNE CHAUMONT: Yes. Okay, slowing the growth...oh, where were you? Page 41. Okay, so other ways to slow the growth of expenditures that we are looking at.

Addressing the highest cost populations, which are elderly persons and persons with disability. Again, we're talking about rebalancing the long-term care system from nursing facility from institutional care to home and community-based care. While we do this we also have to ensure that we have a continuum of care in long-term care. I mean what we need to build, what we need to maintain is a system where we can provide not very much support in somebody's home, increasing support in somebody's home, maybe assisted-living, and then nursing facilities and hospice at the end so that there is a place that can address everybody's needs in the best possible way as far as care is concerned and in the best way as far as cost is concerned, as well. Again, I talked about education regarding choice and options in the community. I think that's an area that we need to step up. We also need to improve our assessmwent tools for the need for long-term care, and we actually have a new tool that we have developed that we will be implementing as soon as we can get the regulations promulgated, and we are very close to having those regulations get ready to go through the public process. We need to strengthen services management through public/private partnerships with health insurance entities. That involves getting, for instance, some of the...well, part of it is managed care and then part of it is the enhanced care management that we are talking about, that we just started on October 1. And I was just told yesterday or the day before that the contractor has signed in five people, and what that is, is a program that we're doing where we send a list of names--it's a voluntary program--but we send names of people for whom Medicaid spent more than $50,000 a year to our contractor who then contacts those people and asks them if they would like assistance with their care or with coordinating their care, and that helps to keep down their costs and to give them getter quality of life and better care. Continue shifting behavioral health service delivery from the high-cost out-of-home services to lower-cost in-home services. Just like physical health--keep people out of the hospitals, keep people out of psychiatric institutions or children out of that and into the community; both saves money and improves quality. So the things that we have accomplished and the progress that we're making in my division is...have we talked about the MMIS yet? That is big...a really big, huge project. And we've got the contracts signed and we are starting...we have started the process to get

this built on time and on budget by 7/1/11. Benefit delivery. Benefit delivery: The enhanced care coordination. We have signed a contract. That has started. We signed a new contract with behavioral health administrative services. This is the Magellan contract where for the first time...Magellan used to just be involved in prior authorizing and in taking a look at our out-of-home services, and they are now also involved in our in-home services, as well--so outpatient as well as inpatient. This is the contract that we have done, one RFP, three contracts between the three divisions so that we can...so behavioral health is in this contract, children and family is in the contract, and then Medicaid is in the contract, so that we can better see the continuum of care, especially for children. We have redone the enrollment broker contract, which is the contractor that enrolls new Medicaid clients into managed care when they are in the Lancaster, Lincoln, and Sarpy area. And we are doing prior authorization for new drugs through the Drug Utilization Review Board. Since that has started we have reviewed 100 new drugs. It's a group that if new drugs come in and they are prior authorized, then in six months this group of pharmacists, physicians, and other people look at the drug and determine should it continue to be prior authorized, is it okay to take it off prior authorization, does the prior authorization need to change, and they have done with over 100 drugs so far. And then, like I talked about, the institutional to community shift in the delivery of care. On provider reimbursement we have several studies that are being done. The nursing facility rate study has started. The contractor is going out to three areas of the state to talk to providers and interested stakeholders; is there a better way to reimburse, a better, easier way to reimburse nursing facilities in the state, and bringing in experience from other states to see if there are improvements that can be made in our reimbursement system. Hospital rates, we're about to sign a contract to take a look at that, including rebasing the diagnosis related groups which hasn't been done in awhile, and looking at DSH, GME, and all of the other hospital issues. And then we have been working diligently to look at all our fee schedules, in particular physicians. We have physicians, durable medical equipment, everything. We used to have those rates up on the Internet. They were a formula. And we are changing them to just let the doctors know what the rate is with a number so they don't have to math in order to figure out

what their rate is. We are trying to make life as simple as possible for our providers, because if we reduce their administrative costs we put money in their pocket. Use of technology. We have gone to electronic provider information instead of paper, out to all our providers. We are working to increase electronic billing by providers, and we will have mandatory electronic fund transfers to where we pay providers electronically as opposed to sending them warrants. And then we are looking at a Medicaid card. Currently we send out a card every month to 202,000, to the families--not 202,000--but we send out an 8.5 X 11 piece of paper. So we are going to change that to a card that looks like your regular health insurance card that doesn't have to be sent out every jmonth. Providers still have to call in and make sure that...or check online to make sure that the person is eligible, but it will save a lot of administrative costs in that area, as well. [LR363]

SENATOR HOWARD: What will the period of eligiblity of the card be? Is that like a year's duration? [LR363]

VIVIANNE CHAUMONT: No. The card will not have an eligiblity time period on it, so that the physicians or the hospital or wheover will have to come in. [LR363]

SENATOR HOWARD: So it's more of an identity card. [LR363]

VIVIANNE CHAUMONT: Right. [LR363]

SENATOR JOHNSON: So the provider would run the card just like I take my Capital One or BankAmericard and swipe it, and if there's... [LR363]

VIVIANNE CHAUMONT: And money comes out? (Laughter) [LR363]

SENATOR JOHNSON: But, no, more importantly, no money comes out. [LR363]

SENATOR HOWARD: It's not an EBT card (inauidible). [LR363]

VIVIANNE CHAUMONT: No, no, no, and it's not a slide card. You know that...when we started this project, that's what I thought we were going to be doing was a slide card, and evidently that is not state-of-the-art anymore because everyone is trying to get to Web-based. And so with the new...it will be a little bit different once the MMIS gets built, but currently a physician or any provider has three different ways. They can call, they can get on the Internet, and there's some other thing that they can do to say, okay, ~jtj, is he...he's in my office today, is he eligible? Yes, he is. So they'll still have to do that and they do that anyway. [LR363]

SENATOR HOWARD: Do you see any fraud problems with that, with someone coming in with somebody else's card? [LR363]

VIVIANNE CHAUMONT: Not any more than you ahve with an 8.5 X 11 sheet of paper... [LR363]

SENATOR HOWARD: That we give them now. [LR363]

VIVIANNE CHAUMONT: ...that we give them now and cost of all of that. [LR363]

~HOW: The postage alone would... [LR363]

VIVIANNE CHAUMONT: Yes. Exactly. Okay, the biggest challenge we have in the Medicaid program is the same year to year, and that's making sure that we deliver the best quality care in a fiscally responsible manner so that we can be sure that the program is around for the people that need it. One of the challenges that we have--have we talked about MMIS yet?--is building this huge computer system on time and on budget. I have seven staff that have gone permanently over to work on the MMIS for the next three years, which is seven less staff that I have, plus I have the people...for

instance, the person that runs hospitals has to go over when they're going to do hospitals. So it's a great strain and drain on staff, but it really is an important project that we're all very excited about--not as excited as we will be when it's done but we are all very excited about it. We are going to implement the preferred drug list/purchase pool, which is LB830 from last year. We're working to implement that. Adn we want to look at expanding managed care, and that's the Mercer report that Chris was talking about. We had done a study at the department that shows that capitated managed care--on the physician health side I'm talking about, the three counties that have mandatory managed care. We have two managed care programs. We have shared managed, which is United, and that's a capitated program where we pay them a rate and they take care of providing all of the person's physical healthcare needs under the contract. [LR363]

SENATOR JOHNSON: What are the counties? do you remember the counties, off hand? [LR363]

VIVIANNE CHAUMONT: Yes. I said Lincoln...that's not a county. Lancaster, Sarpy, Douglas, so it's basically the Lincoln/Omaha. [LR363]

SENATOR JOHNSON: Half the population. [LR363]

VIVIANNE CHAUMONT: Yes. So we have that program which is fully at risk, and then we have this program called primary care case management where we pay the doctors to manage the program, $2 a month, and then we have a contractor that's supposed to manage the PCCM program. It's called...and what Mercer recommend...we did the study and we found that we paid...that the most cost-effective way of delivering care was at-risk managed care followed by the PCCM program, and the most expensive way to do it was the fee-for-service where we didn't have anything. And we compared it to the contiguous areas around that because we figured they're pretty equivalent. So based on that information we would like to move to a two...we would like to expand

mandatory managed care to the contiguous counties, which is about 9,000-10,000 people, and we would like to move from a PCCM HMO program to a program where we have two HMOs, both of whom are fully at risk for that. We would also like to explore in other parts of the state, for instance in the tri-city area, if a PCCM program would work there and if there is anybody interested in an HMO program there. And then on the behavioral health side we would like to...we're going to start looking at moving to an at-risk program for behavioral health--one contractor statewide. Again, the need to continue the shift to community care in every aspect, not just long-term care, but delivering care in the community. And then we want to develop a program for all-inclusive care for the elderly, which is called PACE, which is a program I'm really excited about. This is actually a managed care, long-term care program, and the thing that is unusual about it is that the entity that you hire, the contractor, is at-risk for all of the services that a client gets, including drugs, including nursing facility care, including long-term care. And usually it's people who are dual-eligible so they have Medicare and Medicaid. The company gets a premium from Medicaid and a premium from Medicare, and they have then the task of taking care of that person--all of that person's needs. So it's obviously in their interest since they would be responsible for the nursing facility to provide them the services that they need in their home, to provide preventive services because they are at-risk for the hospital services. So to provide the best care possible--and it's not just medical care but things like day-care activities, things like that. To keep people satisfied and happy in the community helps them because they're at risk for everything--for hospice too, you know, at the end of life. It's a program that a lot of the states are moving to. It's an expanding concept. It's a program that there's a very large one in Denver that I'm very familiar with and it's a really good program and it's just a, if nothing else, another choice for people to get their delivery of services. So that's it. [LR363]

SENATOR JOHNSON: All right. Senator Stuthman, did you have... [LR363]

SENATOR STUTHMAN: At the present time I do not have any questions. [LR363]

VIVIANNE CHAUMONT: Excellent. Thank you. [LR363]

SENATOR JOHNSON: Anyone else? Vivianne, I don't see any. Thank you very much. [LR363]

VIVIANNE CHAUMONT: All right. Thank you. [LR363]

SENATOR JOHNSON: And now to finish up the day, how many people have a comment regarding this section on Medicaid and long-term care? I thought surely with...oh, okay...that there would be some people. No, glad to have you. I just kind of expected about six or eight people, at least, to stand up instead of just one. [LR363]

JENNIFER CARTER: I know, as did I, but here I am. Appleseed. We can't help ourselves. [LR363]

SENATOR JOHNSON: Well, welcome. You bet. Welcome. We're glad to have you. [LR363]

JENNIFER CARTER: Thanks. My name is Jennifer Carter, C-a-r-t-e-r, and I'm the director of the Health Care Access Program and the registered lobbyist for Nebraska Appleseed. Thanks for the opportunity to speak, actually, because I know originally I wasn't sure there was going to be time for public comment and we really appreciate that. We just had a few sort of bigger picture points that we wanted to make. One is in terms of the budget and sustainability, and I appreciated, Senator Pankonin, you asking about...I wasn't sure what those projection numbers were too, and so I'll be interested if we can hear about what that is, as well. And part of our concern is that the original numbers and the $800 million projection was based on...our understanding is that's the chart that came from, as Ms. Chaumont mentioned, the 2005 study, which actually was a look back of about 20 years. And so what they came up with was that the average

growth of Medicaid is that it grows about 12 percent a year, which really isn't accurate in terms of how fast Medicaid grows. And there were a couple of anomalies in those 20 years, like the federal government created SCHIP and we decided as state to participate in it. That's a huge expansion that you don't see every year in Medicaid. And even CMS itself, if you're looking to do something as a state, they only look back five years and they adjust for anomalies like that. And so what we have discovered in looking back to fiscal year '06, and I have to give credit more to Mark Intermill at the AARP for this work, was that actually Medicaid has been growing at about 4 percent a year and some of that is before any of those reforms came in. So organically, Medicaid is not growing at the concerning rate that was sort of originally presented in 2005. And so actually I'm curious where, if the 400 is really the amount of the gap we're looking at in 2025 or if it's less than that and what the percentage of growth we were talking about when we got to the 400 number. And I think what for us what is important about that is not so much that we don't need to look at ways to make Medicaid more efficient and to make sure it's sustainable, but there's been a certain sense of urgency that Medicaid was going to take over the entire state budget in not a long time, and that it was driving some of the changes. And for us I think our main point is that I think it hasn't been growing quite as fast and we have time, actually as Ms. Peterson said, that you want to do these things right and I think they're trying to approach it in a slower way now and really figure out what is best for the clients and still being able to save some money. And we are hopeful that--and we've mentioned this in the Medicaid Reform Advisory Council too--we're hopeful that that's the case and that we can stop using the 12 percent growth number which is not accurate and really look at how fast Medicaid is growing. And yes, we want to make it more efficient, and yes, we want it to operate better, but we don't have to...there isn't the same sense of, I think, urgency that might lead us to do things that are not going to be as helpful in the long run. And I also think that we want to make sure that we're looking at the budget as a whole. One of the members of the advisory council, at the last meeting, was talking about the fact that sometimes cuts in Medicaid are not necessarily good for Nebraska taxpayers because what it does is shifts a lot of that just to the private market, so now you're ending up in

the emergency room, now you've got more expensive care at the doctor's office or the emergency rooms, and that ends up in all of our premiums. It ends up draining local communities, and so we have to be really hopefully long-term in our thinking. And I believe that was Steve Martin at Blue Cross/Blue Shield, so I thought he probably knew what he was talking about. And I think we need to just make good choices about where we're spending our money and that actually sometimes spending money in Medicaid might be better for the state; other times not, in Medicaid or other places, because long-term you're going to see savings and the state will be better off for healthier citizens and all of the rest. And actually an interesting point that frankly we had not thought about is not of wanting to avoid innovation because it's going to cost us money now even if it will save us money in the long run, and I think that's an interesting point and I'm not sure what proposals have been...you know, that we've missed anything yet. And I think the investment in the MMIS system is a good example of that. We need to put the money in now so that we have a better functioning system in the future. And one note that we wanted to make too is that we've been really pleased that in this Medicaid reform process, that we are not always seeing eye-to-eye with the department on, we have been really pleased to see that a lot of things that the Medicaid coalition that Appleseed has worked with, they have at least considered and even tried to implement, like the preferred drug list, the home and community-based care waiver, counter detailing on drugs so that doctors are not only just influenced by drug reps--that's there is somebody else who can give them information so they can really be balanced as to what drugs work best, and expanding the 340B Program which is another pharmacy program. So we've really appreciate that. And the main other point I wanted to talk about was this move to managed care, which we're not necessarily opposing. I think it's kind of unavoidable and is being done in most states and can be done right and be helpful for both beneficiaries and save the state money. Our concern is whether...we just...the Mercer report, for us, raised more questions than it did answers, and when I read it I didn't necessarily see it as a full endorsement of moving to full risk managed care, that maybe that was the way to go if a lot of questions were answered, like whether we could actually get more than one managed care organization to come in

and bid and be operating in these places because I think you need more than one in order to have that type of competition so that there would be a place for people to go if one of them is not operating well and we can really see how that's working. Other things in terms of the managed care are, what's the mechanism for oversight and what are we contracting for. Because other states have gotten stuck where they didn't actually contract for all the Medicaid services that they're legally obligated to provide and the state had to continue to provide the other services. What does the contract look like? How are we managing it? How are we ensuring that the access that people are getting under those managed care programs is really working for people? How do we make sure that it's really quality care and that the networks work and the providers are there and happy? And so those are just some of the thoughts that we had on that. And we actually really have seen in a couple of other states, Illinois and North Carolina in particular, are having great success with a primary care case management program. And in North Carolina, it's savings tons of money. They've gotten some award. And I think the difference for us, which I had mentioned also at the advisory council meeting, is that there is a fundamental difference in the orientation of those two managed care programs. Primary care case management is really focused more on the care given to the patient and what's most efficient, how do we do preventative care, how do we make sure people are coming in for their checkups, how do we avoid doing two MRIs when you only need one. All of that actually brings down the cost but we're really focused on the person's care, whereas the managed care...the full risk managed care, necessarily that organization is looking more at its bottom line, and you would hope that it would be driven to also be working efficiently in terms of how it's serving its patients, because that would save it money and then it gets to profit instead of having the risk of having to pay for more care than it got paid to deliver. [LR363]

SENATOR GAY: Couldn't you put that in the managed care contract, some of these outcomes which you're asking about, could be placed in the contract possibly, couldn't it? [LR363]

JENNIFER CARTER: Yeah, that might be the case. [LR363]

SENATOR GAY: Because I do agree with you as far as prevention strategies and some of these other...what's the outcome ultimately is what we're after. [LR363]

JENNIFER CARTER: Right. [LR363]

SENATOR GAY: But I assume in these contracts you can place it in the contract so that's something...I don't know. I'm not expert (inaudible). [LR363]

JENNIFER CARTER: No, I would think so. And I think for us in terms of how we moved to managed care, it's something Appleseed will just be sort--and other members of our Medicaid coalition--I think, monitoring to see how it's implemented. But I think the bottom line is still, there's more of a focus on cost rather than...I mean, just...I think just when you're...if you're the managed care organization and you know you've got a defined amount of income in terms of how you're going to manage this, I think you're a little more focused on costs than maybe you are in terms of it's worth spending this here for the patient's good, and so moving...it's just a little bit of a different orientation and we think it might be better for patients if we're working for more of a primary case management model. With real care coordination centers and a lot more feedback to the doctors, in North Carolina they've had a great success. The providers are apparently happier than ever and they've gotten more providers, and so that's just something that we would like to see the state consider and maybe see this committee consider as we go forward instead of moving fully to full risk. But other than that, the only other--I guess I have a third point that I would like to mention, I'm sorry--is just in terms of the urgency for Medicaid reform that I think we've seen in the past, there's been about 50 regulatory changes to Medicaid within the last year, which is quite a bit, and a not all of them limiting benefits. But we've kind of been doing this fast and furious. And in terms of talking about Medicaid reform, I'm very appreciative that we had this discussion and that we have the advisory council discussions, because it does feel a little fragmented, and a

lot of stuff is happening that is not necessary being overseen by the advisory council or the Legislature. Because only five of those changes came before the Legislature last year, and even the dental one, the regulations we believe have a significant change in them than what was, I think, presented to the Legislature originally, which is mainly that the client and the dental provider are actually responsible for seeing whether the person meets their $1,000 cap. And nobody can figure out how it is that the patient--or even the dental provider. The dentists we're talking to are saying they don't know how to figure out how somebody meets that $1,000 cap, and that we think was a significant change from what just a flat cap looked like, and that came through in the actual regulations. And so we just wanted to...I think there's some...we'd like to maybe see a little bit more coming before the Legislature and the advisory council on some of these substantive changes. But other than that we really appreciate the opportunity to speak with you. And we are working with several groups, and if at any point we can be a resource--you know we'll be showing up anyway--but if we can be a resource beforehand and we'll talk to you as much as possible, we would really appreciate it, because I think, you know, as we move forward we appreciate the chance to be at the table and see if we can do this the best way possible. I'll be happy to take any questions. [LR363]

SENATOR JOHNSON: All right. [LR363]

JENNIFER CARTER: Thank you. [LR363]

SENATOR JOHNSON: No, thank you. Anyone else? Seeing none, let's call it a day on LR363. And Jeff, what time do we start in the morning? [LR363]