[LR467]

The LR467 Select Committee met at 9:00 a.m. on Thursday, October 7, 2010, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LR467. Senators present: Tim Gay, Chairperson; Kathy Campbell; Jeremy Nordquist; Tanya Cook; Galen Hadley; and Heath Mello. Senators absent: Lavon Heidemann. []

SENATOR GAY: We're going to get started with the LR467 interim hearing. We're going to run from 9:00 to noon and then from 1:00 to 4:00, and I think most of you, we're going to hear from AARP, the Nebraska Hospital Association, and the Med Center this morning, and then Appleseed also this morning. If we're going to break that up, I think what that is, is about 45 minutes for AARP; the Hospital Association, 45 minutes; and the Med Center, about 45 minutes; and Jennifer Carter for Appleseed, about 15 minutes. So to be respectful of all those people that are either going to be behind you, we'll try to watch that, and I'll try to keep track of that too. We have senators with us. I think...Senator Heidemann called and he won't make it today, but I think Senator Mello and Nordquist are here but are coming...I don't know, so. But I'm Senator Tim Gay, and we'll make introductions starting with our legal counsel. []

MICHELLE CHAFFEE: I'm Michelle Chaffee, legal counsel. []

SENATOR HADLEY: Galen Hadley, senator from Kearney, 37th District. []

SENATOR COOK: I'm Tanya Cook, the senator from Legislative District 13 in Omaha. []

SENATOR CAMPBELL: And I'm Kathy Campbell, senator from District 25, east and northeast Lincoln. []

LISA JOHNS: Lisa Johns, committee clerk. []

SENATOR GAY: All right. All right, with that we'll...let's get to it. JoAnn? Is JoAnn here from AARP? Come on up. And I guess part of today, you know, we talked about the financial aspects and that's always something. But I was kind of thinking about this driving in a little bit. You know, this whole healthcare bill. There are pros, cons, whatever. I mean, whatever your sight is on it, it's been political; it's been whatever the case is. But I think what we wanted to do, and this is kind of a group of a lot of different senators, is to listen. You know, there's probably some strengths in the bill; there's some weaknesses. There's probably opportunities for organizations out there. And then there's the financial situations that we have to deal with too. But as we look at that, I just wanted to keep it open and say, what are those kind of opportunities or those kind of things? So I think that's what we're doing is gathering information. We're going to try to kick out a report that other senators can look at, and when things come up they can reference the report. And we'll throw information...if you want to give us information, as well, it doesn't have to be today but later, and anybody wants to get it to our office, we'd love to look at that and possibly include that in our reports. So, JoAnn, I didn't want to interrupt you, but I probably wanted to get that out before we started, and that carries throughout the day is kind of what we're looking to accomplish here, so. I'm chewing up your time, so go ahead (laugh). []

JOANN LAMPHERE: (Exhibit 1) Good morning. Thank you, Mr. Chair and members of the Select Committee on Healthcare Reform for the invitation to highlight some of the opportunities and challenges that are presented in the Patient Protection and Affordable Care Act. The focus of my presentation--I think you have some of the PowerPoint slides in front of you--why I believe the healthcare reform can take root in the Midwest and the Great Plains in a terrific way that will help achieve better value in your healthcare system. I'll focus on three areas of opportunity and challenges: Medicaid expansions, setting up the exchanges, and the long-term home care increases in the Medicaid program. As AARP staff and volunteers have worked across the United States to help achieve the promise of health reform and to help it take root across the states in all

communities, I'm taken with the thoughtful approach, to date, that legislative bodies in the Midwest and the Great Plains are taking to implementation. I think states in this region can be leaders in constructing sound public policies that will, over time, yield better value for healthcare, reduce the per capita costs of healthcare, and overall improve the health of the state's and the nation's population. It's a historic opportunity. And I'd like to underscore that it is a historic opportunity, so we have to grab those opportunities when they come and do the best we can. I believe that...I work across the United States working with AARP offices in every state, and what strikes me about this particular region of the country compared to many others is that there's a great tradition of civic commitment to social well-being, and you've constructed policies that are sound. They're not, you know, out of bounds. You've thoughtfully experimented with improving the healthcare system. For example, Nebraska is a leader in rural health initiatives and work force development much more than other states. And you've had a thoughtful and respected public/private dialogue over time that has yielded a healthcare system that in many ways is ahead of the curve in the United States. Your state is generally healthy with a generally, you know, very well-functioning healthcare system that works. And so this is an opportunity to build on it and figure out how you can use the federal law to make improvements that you think are a priority for the state. I'd like to highlight a couple of areas of Medicaid that I think affects my presentation today. Medicaid growth in Nebraska has been carefully managed, unlike many other states, and the state hasn't experienced wild fluctuations in spending and wild growth, like other places. Nebraska pays Medicaid providers relatively well compared to other states to assure access to care. Nebraska has learned that it makes no sense to have, you know, Medicaid coverage where people can't get access to providers in a timely way. Nebraska does rely, however, on institutions to care for its elderly residents rather than a broad network of community-based home care to help people live at home with dignity and independence where they would prefer to be. Thankfully, at least until the current election cycle, the 24/7 news cycle coverage of healthcare reform has died down and folks can now roll up their sleeves and get to work. We can figure out how to make the new law work in our businesses, in our communities, in our families, in the state

agencies that we run. And as people learn more about the healthcare law and what it means to them, their acceptance of the law seems to grow. I included a chart of a poll that was done a few months ago that people on all sides of the aisles are, you know, favoring certain elements of this law. And as they learn more they say, okay, well, you know, we can make it work. So the three areas that I'm going to highlight, the first is expansion of Medicaid eligibility to 133 percent of poverty. And for most state agencies, there...you know, they're just gripped with the awesome responsibilities of what this means. I just came from a National Academy of State Health Policy meeting where state officials across the United States were figuring out how do you make these expansions work and what are some of the challenges. And so what many state officials are doing is they're looking at their Medicaid population for each group of...each category of poor individuals. Because remember that the Medicaid program right now doesn't cover all low-income people. It only covers certain categories of low-income people and only up to a certain level of income. And so states are looking at where do they cover in terms of children, parents, adults, other groups, and figuring out what is the difference between what they now cover and what would be covered under the federal law at 133 percent of poverty in 2014. Now 133 percent of poverty is a big leap in many areas, but if you can look at what the gap is and you can figure out how to...the federal law is going to provide 100 percent--90 percent money, FMAP, federal matching--for this expanded population. And estimates are, you know, like $2.7 billion of federal money will come into the state through these Medicaid expansions. There will be the necessity for the state to put up some money, but a lot more money will come in, and so there's a tremendous financial benefit coming into states. Think of it like defense contracting money, that it can, this money, this new money coming in can help improve the healthcare delivery system. It can have a multiplier effect in terms of people being employed in the healthcare sector, and they in their communities then start purchasing services and all kinds of services and things that generate economic activity. So this Medicaid expansion can be a good thing. And for people who have lacked coverage, it will assure more timely access to affordable care. Now, after you look at...and so, how do you get to from where you are now to where you will need to be in 2014? You look at

the categories of eligibility that you have now and figure out what the difference is and what that cost might be to fill in. Then there may be state-only programs that you have under Medicaid that could be eligible for full federal funding. In some states that can end up saving the state a lot of money. You'll need to look carefully at your eligibility systems and your enrollment systems and the processes by which people enter the door to receive Medicaid coverage. In many states, these Medicaid eligibility systems are often antiquated; they're run manually; there's no particular logic. And so the idea of gearing up to 133 percent of poverty and taking in maybe 100,000 more people is an awesome and stunning challenge. And so in your...many states have also begun to think about procurement. What are they going to need in terms of these new systems and how are they going to procure it, and what kind of staff are they going to need? Basically, the Medicaid will need to change from an old, antiquated welfare kind of program that was delinked over, you know, 15 years ago, from welfare to an insurance system. Instead of thinking about covering only the poorest of the poor and only categories of the poorest of the poor, and having people fill out 20-page application forms in order to be able to get coverage, there is going to be a culture change in Medicaid that will be necessitated--and this will take some time--moving from what we have now, to come in the door, get some coverage, and we'll make sure that you get the care you need. Now what are some of the benefits of Medicaid expansions? Because this is a program that so many people love to hate, and other people have...you know, their passion is around Medicaid. But I have seen how systems of care can be designed so that value is generated, so that efficiencies are generated and real improvements in people's lives take place. These expansions will reduce, by large numbers, the number of people in Nebraska that are currently uninsured. I did some research several years ago in several of your neighboring states and interviewed people who were having...who had no health insurance. And, by and large, they were low wage workers, rural residents. They worked a lot on the farms. They were in the agriculture business. They were in the meatpacking business. They were low income, and they didn't get insurance through their jobs and they couldn't afford premiums on their own. If they were lucky and if they could negotiate the system, maybe their children got on CHIP, but they themselves had

no coverage, and many of them were in terrible health. Now, that has to have an effect on productivity. There has to be a business case that can be made for people being healthy, getting the right kind of care, and getting back to work. The barriers to reducing prompt medical care will be reduced with these Medicaid expansions, and state administrative activities will have to be changed--simplifying eligibility rules--because there's simply not enough state workers to do the same thing for more people in the same old way. And there's...in the business sector, the banking sector, all over, business has figured out ways to use IT technology to drive efficiencies, and we're going to have to adopt those efficiencies in the Medicaid program. And if it's done right, these investments can foster delivery system improvements. And what I mean by delivery system improvements is that we may have the best healthcare system in the world and we have the best parts, but if the parts don't fit together, well, you're not going to necessarily have the best system. We don't really have a system of care, and that's what the goal should be moving forward. Like to address the issue of exchanges, because that too is going to be a challenge. And I'd like you to please consider Medicaid in the context of the larger policy objectives for the exchange. The exchange is intended to be a portal which people enter to get...and they will be directed either to get Medicaid coverage or that they would get coverage in the private sector. And if their income is between 133 percent and 400 percent of poverty, they would receive a subsidy, and this subsidy would be in the form of a tax credit that is administered by the IRS. So it's important that these two policy developments don't take place in isolation, that you don't have the Medicaid folks going off doing their thing and the insurance folks going off and doing their thing, because what you'll have is a system that will not be seamless. [LR467]

(Fire Alarm): []

SENATOR GAY: Should we see...Chuck, what do you think? Just sit tight? [LR467]

CHUCK HUBKA: Stay here and let me find out what's really going on. [LR467]

SENATOR GAY: All right, thanks. Sit tight. They'll check with the State Patrol. Can we quiet down? We're going to keep continuing on. Thank you. [LR467]

JOANN LAMPHERE: So a body such as yourselves is an important first step in designing new systems under this health reform, because you, in your different areas of expertise, are coming together and thinking about how does this all fit together. From a consumer's point of view, from a taxpayer's point of view, the exchange is intended to be seamless, that whether or not you have Medicaid for part of the year or a job for part of the year, that you are able to access insurance through this portal. And so behind the screen behind the windows, a lot of systems will need to come together. The exchange can be viewed as a continuum. On the one hand, you have exchanges like Massachusetts--heavily regulated. On the other extreme you might have a state like Utah which is much more intended as what I'll call a "Travelocity" of health insurance. And so policymakers across the United States are thinking about what kind of exchange do we want. And they have several different areas that they're grappling with. For example, how much authority should the exchange have to set standards and negotiate rates? Should the exchange just take any premium level and product that the insurance companies offer? Or should the exchange have the authority to go back and forth like large purchasers do to drive better value, to say can you do a little better on the quality? Can you do a little better on the cost? And it's important to think about the authority of the exchange to drive value, because if the exchange is bringing more people in to have insurance, and that insurance is not constructed in a way to drive better value...(Security notification--false alarm)...if it's not constructed in a way to drive better value, the promise of health reform won't be realized and there will be great inflationary pressures--more people are seeking care and premiums are going to go up, and there's going to be nothing that the state can do to kind of hold that down. There's going to need to...if you look at page or slide 9, there are different areas that you might want to think about as you are constructing an exchange in Nebraska that would work for people in the state. And I'm assuming that ultimately you may want to design...you

probably would want to design an exchange within your state. Several states I visited said, well, you know, let the feds do it; this isn't what we want to do. And then they come back and say, do we really want the feds running the exchange in our state? And the answer is typically no, that people want to take ownership of that. So that's going to be a policy decision that you'll need to make. What AARP is very eager to have is that the exchange is what we're calling "useful," that it's not just another thing. That it really...(Security notification--false alarm)...that it brings in enough consumers that it's large enough to be meaningful. If you just have a couple of hundred people in the exchange, it's not going to do anything to improve the healthcare market. Useful. That it has to be something that consumers and small businesses can easily access and use, which means that there must be initiated a culture of problem solving, a culture of can-do. A problem? Let's fix it and learn as we go along rather than keep people out. And it meets...(Security notification--false alarm). You probably have constituents who have experienced the hardship and pain of losing their insurance through situations over which they have no control: a death of a spouse, spouse ages into Medicare, they get divorced, they lose their job, their hours are put down. That is part of our economic life right now. And the intent of the exchange is to give people the security, so that whatever their situation changes, that they will be able to have secure coverage that doesn't end when their circumstances change. And so making that real is very much involved in the policy decisions going forward and the IT systems that you develop. So that's going to be a pretty exciting, challenging area for policy development. The other area to think about is what kind of products should be sold on the exchange and should there be some standard product, because it's very hard for consumers to discern the differences between multiple products that are offered. And even in Massachusetts where they did a good job of constraining the number of products, people were still confused about the differences between one and another. So if you're depending on consumers...you know, we say consumer choice, but consumer choice isn't meaningful unless people understand the choices that they are being given. Effective outreach is going to be important and clarity in what that particular product is will be important. Now the insurance companies have been--in the individual and small-group market--have

been able to compete because they've been able to be one step ahead. They can risk select, and they do it very well. But the intent is that the insurance companies will be competing on how they drive better value, not risk selection, and the state can be an important conduit in making that happen. Let's go back to Medicaid, because, after all, it's about the healthcare delivery system. And there are many parts of Medicaid that are in the law that are intended to improve healthcare delivery, and I'd like to highlight them for your consideration so that perhaps you would be interested in applying for some of the grants or using some of this money to achieve the state policy objectives that you have initiated. One of them is health homes, also called medical homes--and I understand that Senator Gloor sponsored a medical home initiative, and perhaps what is in this new law can help build on that initiative and expand it. And there are many examples around the country, such as in North Carolina, that have built community cares, and over time the states and provider entities have partnered to focus on healthcare issues of greatest concern. They've shared information back and forth and built something that now is not just for Medicaid, but also Medicare is coming in. I mean it really is a partnership. And so that potentially could offer great promise in Nebraska. There are initiatives for healthy lifestyle grants. There's research going on about bundled payments. We're all familiar with the problems in the fee-for-service system, where the intent...you know, you get paid more if you deliver more services. And that has been inflationary and that has led to waste and that has led to overuse of the healthcare system. So learning how to pay differently, bundling payments for doctors and hospitals for a particular patient for over a period of illness may be a way to help slow down cost increases. And, of course, there's unprecedented investment in many areas in the healthcare work force. And given that this is of great interest to you, we'd be happy to bring more information about work force initiatives, both for physicians, nurses, allied health professions, home-care workers and whatever, in this new law. And so I'd encourage you to keep your eyes open for funding opportunities. I know it's been a challenge for some state agencies. They're saying, "We don't have the staff to apply for all these grants." But, you know, if you figure out what your priorities are, you may really want to make a difference. And the other is, is using your positions of

leadership to foster change in communities. Because a lot of the promise of the law is not just what's in the law, but it's what has been learned as the law has been enacted, and I'll give you one example. The Dartmouth folks have showed great variation in healthcare utilization across the United States by procedure with no rhyme or reason. There's no rhyme or reason about why some people in some parts of the country are getting this and some parts are getting this, and it's led to, you know, excess costs. One of the studies indicated that more than 20 and less than 25 percent of Medicare beneficiaries who were in a hospital--they're discharged--and the next month they go back into the hospital. Now think about that. I mean, that's like how does that happen? And what happens is people are discharged into the, you know, into the community. There may not be good discharge planning; there may not be a good hand-off with physicians or whatever. Meds might not be right. But whatever happens, they're discharged; they go home. They're suffering; they're scared; they're hurting, and then they end up back in the hospital. Now the hospital is not necessarily a great place to be, especially when you're old, given, you know, medication errors; given, you know, some of the standards of quality in some hospitals. And so people are realizing, like, we need to do a better job of transitioning care. And so the word "transitional services" has become quite popular, moving between the acute and the long-term care sector or moving between the hospital and home to assure safety and to assure good quality care. So that's an example of using leadership to (inaudible), okay, what are we doing in our community? How are we kind of trying to improve this? I'd like to turn to the third area of great interest to AARP which is the expansion of home and community-based services. Now, why is Medicaid home and community-based services so important? Medicaid is the architecture. Medicaid provides the framework by which long-term home services and supports are delivered. Many people privately pay for home care, somebody to come in and help with their spouse or their parent or whatever, but it is the Medicaid program that really provides the framework and the system. And so...(Security notification--false alarm). Now healthcare reform, this law is about so much more than covering the uninsured. The Patient Protection Act lays the groundwork for a wide-ranging continuum of care improvements and establishes a better framework for

care coordination and integration across providers and settings. Now many of you have spouses or parents or grandparents who are shouldering the overwhelming responsibility and sometimes burden of caring for their loved ones, and they are providing the bulk of home care in this state, as in every state all across the United States, free. They're providing it free. And so the intent is how do you support that? How do you provide help for them so that they can continue to shoulder the responsibilities? And every indication is when states do that, when they expand and improve their home care services, that people continue to provide the support that they have to their loved ones. And it's so important to AARP because study after study, poll after poll, year after year, anyplace we go, nine out of ten people really prefer to live in their home--or let's call it a homelike setting--their home. They want to be independent, and their biggest fear is becoming a burden on their spouse, on their family, and they don't want to lose their independence and they don't want to get poor, and they're really scared. They want to live at home. And so if a state takes the jump, and it is taking a jump like it feels sometimes like jumping off a diving board, to expand home and community supports--and we're talking about helping people with their bathing, getting dressed, eating, supervising medicines, doing all of that--that it is money well spent. And, in fact, if you look at the distribution of Medicaid spending in this state that goes to institutions rather than at home, you'll see overwhelmingly the bulk of money goes to institutions. And they are fine institutions and many of them deliver terrific quality of care, but people, our older residents, our families, would like to live at home. So how can we move this system to something that works better for people? Because I would submit to you that it's a cost-effective policy decision to make, that Medicaid dollars spent on home and community-based services can support nearly three adults and individuals with disabilities, on average, for every one person in a nursing home. That's good return on your money. And then also it's been demonstrated by credible research that states that invest in their home and community support networks can slow their rates of growth in the Medicaid program. It does require some up-front, you know, pay attention, a little bit of investment, but over time it will bend the cost curve in long-term care spending. There are two provisions under the new law that I'd like to highlight for you. There are

several others, like Money Follows the Person, but the two are the Balancing Incentive Payment Program and the Community First Choice. The State Balancing Incentive Program is a grant program that increases the federal Medicaid matching rate by 2-5 percentage points more than what the state currently gets if they move from a certain percentage provision of home care services to a greater percentage. Now the federal regulations are still being developed to figure out how those calculations are being made, but I think it would be safe to say that Nebraska could get at least 2 percentage points more on the federal Medicaid matching rate when there is a change in the balance and moving a higher percentage of spending to home and community-based services. That's something that should be considered. It's time now to look at that and then lay the groundwork for possible balancing incentive payments, because in order to receive those payments a state would need to make structural changes. There would need to be a common assessment form that all the actors who are involved in home care would be using the same assessment form. There would need to be a single point of entry, and that means that everyone, whatever their disability level, whatever their source of coming in, whether it's ADRC or AAA or, you know, another agency, that there would be a single point of entry into the system. And then there would be what's called conflict-free case management which has still to be decided what that means. Now, Nebraska started a single point of entry through the ADRCs last year, and so that's something to build on, and so you're getting there. And so you've got the groundwork. You've got the possibilities of showing the federal government that you indeed could take advantage of this Balancing Incentive Payment money. The other is the Medicaid Community First Choice option which is a new state plan option. What I mean by a state plan option is that each state has a Medicaid state plan, and you just change your...there's now a new possibility, a new program that you can include as part of your state option which is to provide home and community-based attendant services and supports. And that money could also cover coverage for certain transition costs--has to be offered statewide; there can't be any more waiting lists; and the home attendants would help with activities of daily living and instrumental activities of daily living and health-related tasks and so forth. And that program will begin next year. Now, here

again, there is an incentive. The federal government will pay a 6 percent federal incentive on their matching rate with no end date to have that, and sometimes that's what people need. They need home attendants. And there has been a reluctance in many communities to really pursue growth of home care in terms of serving the elderly population. There is some fear, some trepidation that maybe the elderly can't quite live at home; they need a little bit more. And I would submit to you that there are quadriplegics who are on ventilators who are being cared for at home. Certainly our older, beloved family members could be. And this community, this Medicaid Community First Choice option requires that services be provided in the most integrated setting--"make available services regardless of age or disability"--would be run...it would be established with a council, a development and implementation council, and there would be quality reporting data that would be required. And that seems reasonable because you want to make sure that money is well spent and that quality services are delivered. So I've highlighted for you three areas of opportunity and challenges with the health reform law: (1) Medicaid expansions; (2) setting up exchanges; and (3) expansion of home and community-based services. And I think it's possible for all of us working together to achieve the promise of health reform that our good senators and congressmen work really hard...it was very difficult to pull this law together, and that probably is one of the reasons why it looks the way it does, but such is the nature of the democratic process. And there are challenges right now. The economy is bad, particularly in some states. There's a lot of public anxiety about spending, and spending more money. Although the intent of this law is to change the cost growth curve so that costs increase more slowly than they have over time, there are state budget shortfalls and people are retiring from state service, and states are figuring out how to overcome that. Sometimes they're depending on trusted staff in universities and other institutes to help pull grant proposals together. There's aging infrastructures, IT infrastructures that really require some study. In some states there's, you know, efforts to nullify the law and, of course, there's always uncertain leadership and will. But what I found in working with state governments on health reform over I guess now 25 years of service, is that when there is leadership, when there is a political will, when there is real interest on the

part of improving healthcare in the state and improving healthcare delivery, and making life better for, you know, the families and communities and taxpayers that we love so well, great things can happen, and I encourage you to be open to the possibilities, and I pledge that AARP will work with you and help provide information as you need it as you're moving forward in your deliberations. Thank you. [LR467]

SENATOR GAY: Thank you, Dr. Lamphere. There's a...I guess on that and I apologize at the interruptions and a little late start. But I'm wondering, you covered so much, and those are some opportunities to look at. What I wanted to say is probably, you know, you could have a whole day's discussion on what you just talked about...the ins and outs, and the policies are still being developed. But just...appreciate you coming to, I know, to come here and speak to us for this time. But there's a certain point...do you think you could get...I'm sure you probably will...more in-depth opportunities as this thing rolls out a little bit? We've got two years kind of coming, and your Nebraska office does a fine job of keeping us informed. But those are kind of things, as we follow, are you going to make...create opportunity...bring opportunities, I assume, but on that...I don't want to get into too many questions because like I say, I don't think we could cover it well enough. But what I would ask probably is that you make some kind of opportunity for senators to attend and I know...I think they will. It's still early, but our session starts in January. I think it would be very good because some of those options you had talked about. I know there's incentives from the federal government, but also that's cost on the statewide. But I think in order to really talk about that, you need to hash it out and say what's the positives and negatives of doing something like that and where are we at. So what I don't want to do...I want to stick to our time line. I would open it up for questions, and I will for our esteemed colleague, Senator Hadley, one question. [LR467]

SENATOR HADLEY: Just a quick question, right, Senator? (Laugh) [LR467]

SENATOR GAY: Okay, a quick one because we got a... [LR467]

SENATOR HADLEY: Dr. Lamphere, thank you for being here. I admit I'm, you know, kind of a slow learner, at times. This seems very complicated. [LR467]

JOANN LAMPHERE: Yes, sir. [LR467]

SENATOR HADLEY: What is...what can AARP do to help our citizens understand this? Because I am very worried that if we have trouble understanding it and trying to put things together and such as that, that the person sitting out in O'Neill, Nebraska, is going to just shake their head and say, I don't understand it; I'm not going to have any part of it. What can we do...what can AARP and the state of Nebraska do to try and make sure that the citizens of Nebraska understand what's happening? [LR467]

JOANN LAMPHERE: Well, I'd like to ask Mark if he'd like to...could I ask Mark to... [LR467]

SENATOR HADLEY: Sure. [LR467]

JOANN LAMPHERE: ...because he is the associate state director for advocacy to...you might want to say something. I know that AARP nationally has made it...it is our highest priority now that the law has been enacted to educate our members and the population. And we have spent millions and developed all kinds of educational materials, and we're sponsoring sessions all around the United States, but you could speak more deeply about what you've been doing. [LR467]

SENATOR GAY: Hey, Mark, why don't you come up because we are taping this and then...sort of just state, so we can keep track on our record, state your name and... [LR467]

MARK INTERMILL: I think the challenge is to try to simplify the complexity of it which is a challenge. AARP has put together a number of fact sheets about different parts of the

healthcare reform that we're distributing as broadly as we can. We are having some forums across the state. Last week we were in Grand Island, had about 85 people come out to hear about some of the...how healthcare reform might be implemented and what it might mean for people. We are looking for other opportunities. We would be interested in...if one of you would be interested in working with us to set up something in, say, Kearney. I would certainly be interested in doing something like that. But we do have...it is a large task. It is a complex legislation...piece of legislation. But it is accessible if you...it's hard to figure out how to do it, but I think we have some good tools that we can use to help people sort through those options. [LR467]

SENATOR HADLEY: Thank you, Mark. [LR467]

SENATOR GAY: Thanks, Mark. And that's...I guess Senator Hadley asked that question, why I said, I think it's important going...you got two years. The scary thing of this is how do you eat an elephant basically? A piece at a time. But you got to do it quickly. This two years is not a long time, and I think that's what's scaring most policymakers. You've got so much uncertainty between executive branch...now the elections and all these things going on. But that's what...that's the challenge where maybe you can help for senators, alone, because if...you need to understand it to then convey it...good and bad. I don't...whatever your side is on that, so I'd ask for your help, and you guys have always been very good as far as helping out. [LR467]

MARK INTERMILL: And that just reminds me of something we should have thought to do but didn't think to do, and that's to put together a packet of our fact sheets to get to everybody on the committee...just, that provide a one-page overview of different aspects of healthcare reform of particular interest to AARP members, so we have some Medicare issues involved. But we would be happy to do that. [LR467]

SENATOR GAY: If you get that to our office, we can get that out so... [LR467]

MARK INTERMILL: Okay, great. [LR467]

SENATOR GAY: ...with that, though, I want to keep moving on, if we can. Thank you very much, again, Doctor, appreciate it. Thanks for coming and good information and...and other. Also contact information for you, Dr. Lamphere, do we have that or could we get that? [LR467]

JOANN LAMPHERE: Yes, I'll make sure that you have that. [LR467]

SENATOR GAY: Just give it to our clerk and then we'll pass that around, too, or Mark can get it to us, whatever format you want. But we'd love to have you back sometime and in a longer setting maybe where you can discuss some of these things. [LR467]

JOANN LAMPHERE: We'd be delighted to help you out, and I would be happy to come back and work with you and your colleagues. Thank you so much. [LR467]

SENATOR GAY: All right. Thank you. All right, thank you very much. You bet. With that, keep moving on. Bruce Rieker is here from the Nebraska Hospital Association, and topics Bruce is going to cover is implementation considerations and that time line we had talked about for patients and payers and delivery system reform and the quality, the wellness, work force issues, reimbursement and revenue. So got a lot to cover in 45 minutes, and we have your packet here. [LR467]

BRUCE RIEKER: Okay. We'll do that in 45 minutes... [LR467]

SENATOR GAY: Well, you can't do it all in 45 we know, and we know where to find you, Bruce, all the time so. [LR467]

BRUCE RIEKER: (Exhibit 2) No. I know that this is...(Laugh). Well, I was hoping that I'd get invited back after testifying today and things like that. But yes, my name is Bruce

Rieker. That's R-i-e-k-e-r. I'm vice president of advocacy for the Nebraska Hospital Association, and it's truly my honor to be here before you. This is probably one of the most important presentations I've made or will make to the Legislature in the four years I've worked for the hospital association. We're talking about...well, the biggest reform to healthcare, the impacts to our hospitals, as well as the patients we provide, the people we employ. On the lighter side, as we were preparing for this, Michelle and I were working through what I was supposed to talk about, and she gave me the challenge, or she challenged me to show up at this hearing with the blueprint to implement healthcare reform. I told her already, and I gave her a copy of it, but the best I could do right now was print her copy in blue, and so that's her blueprint. But the way I look at this or the way we look at it from the association is that the Legislature, especially this Select Committee, is probably the trauma team that's going to deal with implementing healthcare reform. You have a patient that has many vital organs, a skeletal structure that was involved in probably a very severe car accident, or for some reason this patient came to you, and no matter what you do, you're faced with all sorts of trauma in this particular patient. Treating one vital organ affects another one. You need to figure out which one you're going to treat first in order to save the healthcare delivery system. And I'm not trying to cast a dark light on this, but it is absolutely doable, and we believe that, you know, putting this all together is a doable thing. But there are so many working parts and so many critical decisions that we have to be careful about, you know, which organs we treat first and how we put it all together and make sure that at the end of the day the whole organism or the whole patient survives. And so with that, to give you an idea or, you know, to outline what's in the packet of information that we provided you, first behind tab 1 will be my PowerPoint and we'll go through that in just a moment. Behind tab 2 is a summary of provisions for the healthcare reform bills that were signed into law March 23 and March 25 of this year, at least those that our hospitals deem significant to us. And as the previous speaker, you requested of her, if ever, and we will be trying to make appointments with all of you, but if ever you would like to walk through this either individually or in a group, we would be more than happy to drill down deeper in each of these issues to let you know how that works. Appreciate so many of you who

came to our healthcare reform symposium on August 31. Behind tab 3 are some excerpts from our community benefits report that we did...that's the most recent one we have which is 2009. It's based on 2008 data, and this will give you some of the vital signs of at least part of what are the moving parts as far as where we go from here that will affect access, quality, and what sort of services our community hospitals can provide. Recently adopted by the healthcare or excuse me, the Medicaid Reform Council, their report is behind tab 4, and we'll talk about a few things in there. Tab 5 is the Milliman report. Tab 6 is the Kaiser Commission. Tab 7 is the checklist. We've given this to several of you before, but this was prepared by the National Conference on State Legislatures, and we think that it's a very good list to help all of us walk through implementation of healthcare reform. And then an implementation time line that was prepared by the American Hospital Association is behind the last tab. And Senator Mello is not here, but he gave me a bad time for that one. He says, I almost went into shock when I looked at that. There's so many colors and so many things going on that...and I think it's just reflective of how many moving parts there are. So with that, I'll move into our presentation. [LR467]

SENATOR GAY: Bruce, you just wrote our report for us so (laughter). Thank you. No, appreciate it. It's a lot of good information. [LR467]

BRUCE RIEKER: (Laugh) Well, that was our goal. We wanted to give you as much information as possible but as succinctly as possible, and we will probably augment this from time to time, but this is the core of what we're going to be working from for our members and from, you know, implementing healthcare reform. We have a...on a side note, we have a policy development committee that's made up of roughly 30 representatives from our various hospitals, and so many portions of healthcare reform have been discussed, and they and we as an association, just like you, are constantly looking for more information. You know, there's so many unanswered questions, so many regulations and rules yet to be developed that we are constantly educating them as well. But this is also something that we've provided our members or will be, and it's

on our Web site too. Okay. As you had said, my...overall, my assignment was to talk about access, quality, how it affects some of the moving parts, the financing of healthcare. I think that it's fairly well known by everyone. I mean, our first slide here that...healthcare reform expands Medicaid. The goal is to get more people insured whether it's...you know, they raised the eligibility 133 percent of the federal poverty level, so there will be more people that will be eligible. It's still too early to tell how many of whom will participate in that. You know, Kaiser has their estimates. Milliman has their estimates, and I'm not here to pick apart any of those studies. I think that they bring all, you know, all of them bring good information to the table, and part of it's going to be on how human behavior reacts. It's also going to be affected by employers. Some employers may drop coverage, and then how that affects uncompensated care or charity care that our hospitals provide is yet to be determined as well, but we'll talk about that in a little bit. Even admittedly, healthcare reform as enacted and scored by the Congressional Budget Office says that the goal is to insure an additional 32 million people by the end of the ten years that it's implemented. However, there will still be 21 million people that will be uninsured if it all works as they had planned. So another side note, these two bills that were enacted that constitute healthcare reform are roughly 2,200-2,300 pages, and as we try to sift through everything, and I think this is a fair assessment, it's somewhat scary. But I have heard people in Washington talk about, for every page of law there will be a thousand pages of regulation between state and federal governments, and I believe that. So we're looking at millions of pages of regulations for all of us to find our way through over the course of ten years. And so there's a lot of unknowns; there's a lot of provisions in healthcare reform that say that the Secretary of HHS shall do this or is mandated to do that. But we have some unknowns and they affect our business decisions as to how hospitals will operate and deliver care. Okay, some of the payment policies that have been put in place by healthcare reform is a Medicare update factor reduction. Part of healthcare reform, and this is...it was front and center for us...I don't know whether it made it to your radar screens, but hospitals agreed to a $155 billion reduction in Medicare reimbursements over ten years. That's a national number. Nebraska's number, when it's all said and

done, as far as we can calculate right now will be about $850 million that we will have reductions in payments because of the cuts to Medicare. But to break it out, Medicare update factors for Medicare Part A and B, that will be reduced by about $690 million over ten years. Some of these cuts have already started to take place, and that's another interesting cash flow or business component for our hospitals. The Medicare cuts start...they started on September 23, I mean, and they will be implemented in a stairstep procedure. However, the requirements for bringing more people on and getting them insured, for the most part, doesn't take place till 2014. So we're taking some cuts up front, and it's still going to depend on how many people participate in those particular programs to see how this works out. There's some productivity offsets, I mean, or mining deeper into this particular issue, for inpatient and outpatient hospitals, rehab facilities such as Madonna, inpatient psychiatric facilities, long-term care hospitals, and skilled nursing facilities, that there will be beginning in 2012 an estimated productivity reduction of 1.3 percent of the Medicare reimbursements. Additional reductions for those facilities will range, starting in 2010 already, but start with an additional .25 of a percentage point in 2010 and 2011, increasing to .75 of a percentage point by 2019. So all of these things, and I'll talk about this a little bit later, but they lead towards a negative Medicare margin. I want to make sure that as we go through this, I'm going to be talking about these reimbursements as compared to costs. Okay? Not our charges, not something that would be a retail price or something like that, but these are comparisons to cost. So these will be some reductions that affect our margins. Disproportionate share hospitals: Nebraska gets about $30 million a year from the federal government to help with the disproportionate share hospitals, and what that is, is those hospitals of ours and it depends on the year, but somewhere between 25 and 30 hospitals throughout the year get payments to help support hospitals that provide a disproportionate share of care to Medicaid patients. So if they are above the state average, those hospitals get a little bit of assistance from the federal government to help offset some of the losses that we incur for providing care to Medicaid patients as well as Medicare. There's a $75 million reduction over ten years for that particular program. The federal government has justified or concluded that 25 percent of those payments are

empirically justified, but 75 percent of them will probably be reduced as people come on board and we have more people insured. Medicare home health agencies will receive a $71 million reduction over ten years. It cannot exceed...it will be phased in over four years, excuse me. It will begin in 2014 and those reductions cannot exceed 3.5 percent per year. On the up side, there is a rural home health agency add-on that provides 3 percent add-on payment for home health services provided to Medicare beneficiaries in rural areas. So there was some recognition in healthcare reform that there needed to be some help in rural areas, and that's one area that they did talk about, you know, enhancing some payments to providers of that particular service. Healthcare acquired conditions: This used to just apply to Medicare, but healthcare reform now applies it to Medicaid, and what this does is that for those hospitals that are in the lowest 25th percentile in the country, they would be penalized 1 percent of their Medicare payments for healthcare acquired conditions. Now this is different than the readmissions issue that the previous testifier talked about, but we'll step right into the readmissions. We anticipate or project that the readmissions penalties for Medicare will constitute a reduction of $21 million in revenue of, once again, over ten years for our hospitals. And what this is...and this is one of those that it's very hard to predict because we don't know if the Secretary is going to say that readmissions will be applied to hospitals in the worst 25th percentile or the worst 2 percent or what it may be. But based upon the numbers, we can figure out how much is going to be spread across the country, and we have tried to estimate that our hospitals would be reduced $21 million. Although we'd like to say that we never have any of these readmission occurrences, they will happen and there's the potential that some of our hospitals will fall in that. There's also the potential that none of our hospitals would fall, and it's not a state-by-state analysis. It's a national average, and we're measured against other states. The great thing about what we have going on for us is that we are truly by CMS standards a high-quality, low-cost state. So there are some things that work in our favor. Hopefully, we don't incur these readmission penalties, but there's a chance that it would. Initially, they will be applied to only three conditions--heart failure, heart attack, and pneumonia. In 2015, they will be expanded to chronic obstructive pulmonary disease, coronary artery bypass grafts--I'll

just say PTCA on the next one because I'm not a doctor either. I love these, you know, multiple syllable words, but percutaneous transluminal coronary angioplasty (laughter). Yeah. How did I do? Let's see, and then somewhere down the road, the Secretary has the ability, the authority to apply that to all readmissions. Now here's something that we want to point out. This isn't a per case by per case penalty, okay? If we have a hospital that, for some reason, whatever it may be, they have a small number of patients they treat, but they fall into that category for one quarter is what we're anticipating is how they're going to rank this, our hospitals will be penalized for all of their Medicare reimbursements. So this penalty that would apply, whether it's 1 percent in 2013 or up to 3 percent in 2015 for all Medicare discharges...I mean if they fall in that category, that's...I mean, it's going to severely hurt them. Now, the plus side is that, you know, it pushes us to have better quality, no doubt about it. So there are, you know, pros and cons in this one, and we want to definitely recognize the incentives for getting better at what we do, so that the AARP folks would like to be at a hospital. We want...yeah, if you need it. Okay, I won't talk about Medicare reimbursements anymore, or excuse me, the readmissions. There's also a value-based purchasing program that would allow hospitals and other providers to come together to hopefully put together some sort of model of purchasing that shows efficiencies and would allow all of those providers to share in any savings that they may generate for the Medicare program. There are hundreds of demonstration programs. I'm at the top of page 7 now, but three of them that our members are not ready to say we're ready to go after any one of these grant or demonstration programs yet, but they're also not ready to rule it out. We have so much to do to get information to them, but as we do our due diligence to figure out, you know, which ones may prove worthy of us trying to go after these demonstration programs. Sometimes they're going to require a partnership with the state, but bundled payments--they're going to have a grant program in up to eight states. Pediatric accountable care organizations...this one is of high interest to a couple of our hospitals--Boys Town and Children's Hospital in Omaha. Both of them are very interested in this as far as doing their due diligence to explore this, and then emergency psychiatric projects. If any of you would like a list, and I think I sent it to Michelle, but if

any of you would like a list...we have a 107-page document of all of the grant opportunities, those funded and unfunded, in the healthcare reform that we would be happy to share with you. Okay, Medicaid. How is it affected in quality by healthcare reform? By 2014, the Secretary must establish a Medicaid quality measurement program for adults, and 2011 they have to identify and publish priorities; 2012, publish the initial core set of adult health quality measures; and then 2013, to develop a standardized format for reporting. On the next page, page 8, there are five Web sites that, you know, for your reference, that if you would like to look or research what is out there for quality measurements as well as charges for hospitals, things like that, those are some that are very good resources: "hospitalcompare," maintained by HHS and CMS; "statesnapshots" maintained by the Agency for Healthcare Research and Quality. There's the "Dartmouthatlas" organization; the Joint Commission which surveys some of our members but not all of them; and then our hospital association also has an NHA "carecompare" Web site. Now, what does all this mean for hospitals or for Nebraska's hospitals? I've talked about some big numbers, but I want to give you a frame of reference as to what that may mean for us. We have 86 member hospitals. Sixty-five of them are critical access hospitals with 25 beds or less. Usually their employment is somewhere between 100 and 200 people. And then we have 21 hospitals that would be classified as PPS hospitals. They're the larger hospitals: Good Samaritan in Kearney, all of the Alegent hospitals; well, practically all the hospitals in Lincoln and Omaha would be in that category; and then your larger referral centers across the state, all the way out to Scottsbluff. We employ nearly 45,000 people. We treat or care for more than 10,000 people per day. We have earned income of over $2.1 billion, and that's a 2008 number, and we have revenues of nearly $4.5 billion. I think that it's important to also point out that, yes, hospitals are providers, but they're also consumers. You know, our number one outlay of money is for wages and benefits. Slightly over half of all that we do is in wages and benefits. We also purchase more than half a billion...our hospitals collectively purchase more than half a billion dollars of health insurance coverage every year, not healthcare, but health insurance coverage. We buy insurance, utilities, information technology, and transportation. Now, on page 10, and this document may

be a little bit hard to read, so if you went to tab 3 there's a larger version of it. The second page...but these are our community benefits. And as you can see, if you jump down all the way to the bottom line for...and these are 2008 numbers, our members or at least the 69, and at that time of the 85 members reporting, said that our total contributions exceeded $1 billion. You can see right above that is we incurred bad debt of $175 million, and as far as total community benefits, $827 million. But what I want to draw your attention to is some of the premises of healthcare reform if we go to the top left side. If everybody is insured and adequately insured, theoretically, we should have no charity care. There are some that would tell us that that would go away completely. I will submit to you, that's not going to go away, okay? The number may fluctuate. It may get lower; it may get higher, depending on how many people stay covered or those that elect to pay the penalty and go uninsured and then present themselves to our hospitals for care. And as you probably all know, we're subject to EMTALA, the Emergency Medical Treatment Active Labor Act that says if they present themselves to the emergency room, we have to provide a medical screening and treat and stabilize them if they need emergency care before we ever ask about their ability to pay. So those are just some of the things out there. Unpaid costs of public programs: Medicare. Okay, we do not make money. This is compared to cost. Okay, we're losing this amount of money providing care to Medicare, and that is nearly $380 million per year. Medicaid is $134 million per year. And then we have other public programs which add another $12 million per year. You know, down at the bottom, we have subsidized healthcare services, and some of you have heard me talk about these. But these are things...these are services our hospitals provide, knowing that we're going to lose money. And I'll submit to you if you ever see a specialty hospital that opens up for any one of these, I will be shocked because all of these--emergency trauma care, neonatal intensive care, behavioral health services, palliative care, women's and children's services--all of those things we know we are providing them to the community knowing we're going to lose money, but we underwrite those through revenue from other services that we provide. Okay, bottom of page 10, back to the PowerPoint. Our current reimbursements from public programs, I already...I gave you the numbers...the gross numbers. But Nebraska currently, our

hospitals are reimbursed at 84 percent of our costs, so we have a negative 16 percent margin on Medicare. Currently, we have a negative 24 percent margin with Medicaid, and depending on what happens with the state budget, if we receive a 5 percent cut, theoretically, that margin will moved to a negative 29 percent. So, you know, once again, we know our responsibility, but we just want to share with you what this means to us financially. I talk about...we can't look at...okay, Michelle asked me to talk about access and quality and things like that. The money is going to affect which ones of these we can provide and which ones we can't, so I don't want to make this look like it's in a silo and we're just talking about money. This will affect access. It will affect, you know, as these numbers go up, which ones of our hospitals provide the services and which ones may cut them. [LR467]

SENATOR GAY: Bruce, I don't want to ask too many questions, but you talked... [LR467]

BRUCE RIEKER: No. [LR467]

SENATOR GAY: ...about quality. If you increase quality, there's a disincentive if you don't. Is there an incentive? You said Nebraska and probably other Midwestern states have better quality. Do you get bonus money if you have better quality compared to, I don't know, a state that's bad? Is it just a penalty and no reward? I mean, stick and carrot thing kind of... [LR467]

BRUCE RIEKER: It's...in federal government terms, there's a bonus, okay? And how they word it is, we'll take 3 percent away from you, but then if you get it right we'll give you 2 percent back, and that's your bonus. I mean, that's how they wrote it in...it's written into the legislation that way is you get a bonus on some of these quality measures. Now, as far as Nebraska and several states around us...I mean, Nebraska isn't alone. I mean, a lot of Midwestern states are in this category, being high quality, low cost. There's a geographic disparity debate in Washington, and it was not included

as part of healthcare reform even though we wanted it to be. But basically, it comes down to your small states are taking on your big states, and the big states get reimbursed better because of the mechanism that...the way it was started and how the reimbursements grew in the larger states versus here. They had a...what shall I say, a greater growth, so they actually are reimbursed better on these government programs than our smaller states, and that is something we continue to try and fix, and that's going to take some people at the federal level such as the rural caucus and other folks on Capitol Hill to stand up and say that there needs to be fairness in that. But that's something we're still pushing for. I mean, to us reform is not done. There's a lot of things that we're still working on to try and improve. For the sake of just information on the top of page 11 and the bottom I shared with you what the mandatory and optional services are covered under Medicaid. And then provider rate, and all of this comes from the Medicaid Reform Annual Report that was submitted to the council and approved last week. But you can see that, you know, the reimbursements back in 2005 for hospitals were 3.8 percent and now we're down to .5 percent, so the gap between the cost of providing the services and what we're reimbursed is widening. On the next page, and there's a larger picture of this in the Medicaid Reform Annual Report behind tab 4, but if you look at the outpatient...this is Nebraska Medicaid and CHIP Vendor Expenditures, you can see that outpatient hospitals and inpatient hospital reimbursements accounted for 22.2 percent of all of the Medicaid expenditures of that--what was the total here?--$1.7 billion. So we're talking about, you know, $338 million. But that isn't where the story stops for us. We also have some physician payments for those physicians we employ. We have some dentists on staff, so we receive a small part of that. Forty of our 86 hospitals own nursing facilities, so we have a little bit of that. Now, I am not able at this time to tell you what the aggregate percentage is, but for the sake of discussion, we're going to estimate, or we have estimated that probably 30 percent of all those payments come to hospitals, okay, of all the Medicaid expenditures in one way, shape, or form. I mean we start with 22.2 and then with the other services we provide or are affiliates, it's probably in the neighborhood of 30 percent. I'll come back to show why that's important to us. There's some Medicaid projections. I know that we've talked

about those in hearings past. Now to summarize a ten-year impact, I already talked about the Medicare reductions of $854 million, and there's a summary there. But the fourth bullet under the Medicare reductions: Our margins for Medicare with healthcare reform are expected to increase from a negative 16 percent to a negative 39 percent by 2019. Most of that reduction, not all of it, but most of that reduction will come from these cuts that I've already outlined--the productivity rebasing and additional penalties, readmissions, but not all of it. There are rules and regulatory changes that are always coming down from CMS that change our reimbursement rates, but this is a number that we did not come up with. This was done with the help of the American Hospital Association, helping us project where we're headed. But you can see that that gap is huge. You know, when you have negative margins, no matter how many people you treat, you're not going to make it up in volume, so, you know? Then I know that there's been a lot of discussion or some about who's right, the Kaiser Commission or the Milliman study, and both of these studies are included in your book. But if Kaiser is right, at their lower participation level which they estimated at roughly 57 percent of those who become eligible for Medicaid will participate, which is the national average, as I understand it, for participation of those that are eligible, this is what it would cost the state. It would cost the state $106 million, and the federal government, as the previous testifier talked about, picks up the greatest portion, 100 percent the first couple of years, and then after that it goes down to 90 percent. But overall, the federal government picks up about 95 percent of that. So the total expenditures in Nebraska would be close to $2.5 billion. If their enhanced participation fiscal impact is correct--once again, this is Kaiser--and this is an estimate of roughly 75 percent of all the new enrollees and those currently eligible would participate, the state would have to come up with $155 million, and the federal government would contribute or share the cost of $2.7 billion for a total of $2.886 billion. Now, if Milliman is correct, and as far as their numbers go, between the two, for the most part, I would say that their estimates of the numbers of people that would be affected are fairly consistent, so I think, you know, they're fairly squared away with regard to how many people would be eligible. Now how many people participate is where they differ, but Milliman's mid-range participation fiscal impact, and has been put

out in the media, the state would have to come up with $526 million and the federal government would contribute nearly $4 billion, so total expenditures would be $4.5 billion. Now if we have 100 percent participation, you can see that the grand total would be $6.26 billion would come into the state...well, it would be part of the state Medicaid reimbursements. That is a lot of money, and, obviously, there would be some General Fund revenues generated from that kind of money going to providers and providing treatment. But for us as hospitals, where we have negative margins, as these numbers go up, we incur more losses. Okay? Yes, we have more people that are covered, and depending on their behavior and whose projections or assumptions you want to say are right, yeah, Medicaid expansions will increase the number of insured, but it will also increase the costs of our unpaid public programs. Now, if we do...we hospitals get a 5 percent provider reduction in the upcoming budget, we'll have this potential margin from costs of a negative 29 percent. I've already talked about the Medicare reductions. Then on page 16, Medicaid's impact on the community hospitals, earlier I'd said that we estimated that the total Medicaid expenditures for hospitals would be roughly 30 percent. If we take that and we apply Kaiser's lower participation model, the low end of the range, Nebraska's hospitals' additional unpaid costs of Medicaid over the next ten years would be an additional $300 million. Now, if we take Milliman's full participation model, the top end, our additional unpaid costs would be $767 million. This is on top of those other numbers that I showed you in the community benefits program. So bottom line, or the estimate, the range of between Medicare and Medicaid, the portion that Nebraska's hospitals will have to absorb will range over the next...this is additional, not...compared to the current...or it's not including any of the current Medicaid expenditures, our 86 hospitals will shoulder the burden of somewhere between $1.15 billion and $1.62 billion in unpaid care. That's the end of my presentation. [LR467]

SENATOR GAY: It's a bummer to end like that (laughter). Anyway, yeah, do we want just a few questions for Bruce? And then what I'd like to do is let's give him a few questions if you have any; if you don't, that's fine. Then we'd take a little short break, come back at 10:45, let everyone in the audience and us stretch their legs, grab a

coffee, do whatever you got to do. Is there any questions? [LR467]

SENATOR CAMPBELL: I just have one (inaudible). [LR467]

SENATOR GAY: Okay, let's start with Senator Campbell. [LR467]

SENATOR CAMPBELL: Senator Cook, I want to draw your attention under tab 4 to page 12. Bruce has it in his report, too. But one of the questions that you had asked at a previous hearing was, if we had not had the actual healthcare, if we weren't sitting here looking at that issue at all, would we have projected that Nebraska's Medicaid costs would increase? The answer is yes. However, the chart will tell you that from the initial projections that we looked at in 2005 to what we are looking at now, that curve has come down, so it's not as steep of an increase but we still would have seen an increase. [LR467]

SENATOR COOK: All right, thank you. I'm going to dog-ear that page. [LR467]

BRUCE RIEKER: I like those kind of questions (laughter). [LR467]

SENATOR CAMPBELL: You would (laugh). [LR467]

SENATOR GAY: Senator Nordquist. [LR467]

SENATOR NORDQUIST: Just in general, Bruce, with all the...I know there are regulations pending, many to come out yet from HHS, just kind of your thoughts on, you know, we see these ranges of fiscal impact studies and we've seen them in other states, and one in Maryland showed a positive. There's been the range all across the board. Just kind of your thoughts on trying to pin down a number now and how difficult that is with everything in flux. [LR467]

BRUCE RIEKER: It's very difficult. I mean, the definite that we have is we know what Medicare is going to do. But as far as pinning down a number, I mean, outside of the public programs, let's say that you have somebody or individuals that are not eligible for Medicaid, not eligible for Medicare, I mean we've been talking about public programs here, but based upon the way the insurance reform is structured, you know, it's going to be a very interesting test of employers, those that provide that employee or, you know, employer-provided healthcare, especially in a time of recession, to maintain that particular benefit. And if a business to stay in existence says to their employees, well, here's your choice: We can provide you health insurance coverage at a cost to you and your family of $10,000 per year, or we could drop the coverage and we give you $6,000, $7,000, $8,000 a year increase in salary. You know, what's that employee going to do or what are those employees going to do? Well, yes, they are obligated to go out and buy insurance, as healthcare mandates, but if they don't, they can pay a very small penalty in comparison and not have any insurance whatsoever. And so we're still trying to figure out...and I don't know how to estimate people's behaviors and business behaviors in this economy. You know, how many of those people are going to become uninsured, and then when we have the potential, that they still come to our hospitals? I mean, once again, I want to be clear, it's not everybody who comes to our hospitals we have to admit them, I mean, but if they have an emergency situation, we do that. And we're obligated to do that. But so, it isn't like we're going to have to take everyone, but if they allow their health to get so poor and they have been going without insurance, then when the cost of care comes to us, it's very high. To try and give you a very real example of access, without any of this right now--and I don't mean this against the dentists that I'm about to talk about, I truly understand their business decision--but in Chadron there are four private, practicing dentists. Not one of them will take a Medicaid patient. Now, one of the things that happens in our hospital up there is that people's dental health deteriorates, it gets worse, and then they present themselves to our emergency room for that oral care. Well, our hospital up there was losing so much money on those, they hired their own dentist and now they're hiring a second dentist because we'd rather lose a little bit from Medicaid and take that hit rather than taking all

of the uncompensated care in emergency rooms. There are lots of providers out there, and I don't want to speak for the physicians or the dentists or anybody else, but there are going to be some real business decisions that they are going to make to say we're not going to do this. And then...and we already have some of our hospitals, some of the providers, physicians, physician assistants, things like that, are starting to turn to us and say, this is difficult, this is hard to do. In order for us to continue doing this, you as a hospital need to help make us whole. And so there's lots of pressures on the various parts of the system. [LR467]

SENATOR NORDQUIST: Yeah, I understand. Sure. [LR467]

BRUCE RIEKER: So I can't give you a hard and fast estimate, but, you know, if the participation is correct, I am very comfortable that our range is very accurate as to whether Kaiser is right or Milliman is right, we're somewhere in that ballpark. [LR467]

SENATOR NORDQUIST: Yeah, sure. And I guess it's up to you if someone else has a question. [LR467]

SENATOR CAMPBELL: No, I don't. [LR467]

SENATOR NORDQUIST: Just kind of systemwide, get your thoughts on this. If we get people coverage and we can't predict people's behavior, as you said, and they start seeing primary care physicians more and they establish a medical home and get the preventative care they need, the reduction in emergency room utilization, and therefore, need, there's a potential there for a reduction. Has the national association or anyone run any models on how, I guess, the model of hospitals today could change in the next ten years shifting some of those resources out of emergency room utilization to other aspects of healthcare, I guess? [LR467]

BRUCE RIEKER: Yes. Go ahead. [LR467]

SENATOR GAY: Hold on one minute. I'd like to get a break in here, not to do that, but that could be a...that's a very good question, but that's a...I don't know if we know where that is. [LR467]

SENATOR NORDQUIST: Well at least if they've done any studies or anything. . [LR467]

BRUCE RIEKER: The answer is yes and I'll get that information for you. [LR467]

SENATOR NORDQUIST: Okay. [LR467]

SENATOR CAMPBELL: That would be great. [LR467]

SENATOR GAY: Yeah, thank you very much. Let's do this, let's take about a five-minute break and come back at 10:45 and we'll listen to the Med Center. [LR467]

BREAK

SENATOR GAY: All right. Well, we'll get started again, and I know people are still out and about, but they'll be making their way back. We're going to hear from the Medical Center, and they've got three speakers. And when the speakers come up, it's Steve, Darwin, and Dr. Harrison, when they come up, if you could introduce yourself and then spell your name out, too, for the record. I've been...my fault, I should have asked that earlier, so we can keep it...because it's being taped and they can find their way on the tape who is speaking. But we'll start out and we'll go to probably 11:30, maybe even a little longer if there's time for questions. [LR467]

STEVE PITKIN: We're going to attempt to keep our presentation brief... [LR467]

SENATOR GAY: Well, I know, and then maybe that will give us some time for questions

and a conversation too. [LR467]

STEVE PITKIN: ...so that you can ask a few questions. [LR467]

SENATOR GAY: But we'll get started and go ahead. [LR467]

STEVE PITKIN: (Exhibit 3) Okay. My name is Steve Pitkin. I am the assistant dean for the University of Nebraska Medical Center, College of Nursing on the Kearney campus. Additionally, I also currently am chair of the Center for Nursing and you will see references to that in my testimony. Darwin Brown from the School of Allied Health and Jeff Harrison from the College of Medicine will speak after me. Basically, what my comments are going to address today is work force and educating the work force. Nebraska has three major groups who are gathering work force data. The problem is that the data usually gets collected and then sits in a database. It never gets pulled out and analyzed so that we can provide stakeholders and legislators, etcetera, an analysis of all this data. And in order to be effective in meeting the problems of the shortages in the various disciplines, we've got to have data, first of all, collected, and then, most importantly, we have to analyze it and feed it to the appropriate people who need that information. And I have proposed a way here in which that could occur. Currently, the University of Nebraska Medical Center has a health professions tracking service that tracks both individual professionals and also...or organizations that are licensed to provide care. The weakness of the health tracking service is that it is not always accurate, and they use a survey method where they survey institutions and also providers but they don't get an accurate response rate. The Nebraska Department of Health and Human Services has the licensing database. The limitations of that database are that there's only limited data collected. And then the Nebraska Center for Nursing has worked with the Department of Health and Human Services. We have been able to add an additional survey that gathers appropriate information and then marry it to the licensing database. That way our data is accurate, complete, and we can make policy, we can recommend policy to policymakers because of that. Essentially what I'm

proposing is that DHHS be allowed to work with these other providers who are currently doing it so that we get better, accurate data so that we can address the shortages before they become a big issue. And that would be looking both at institutions that are providing health services and individual providers; particularly, we're interested in the primary care providers across the state. The Nebraska Center of Nursing recently began using GIS which is data and you can layer data on maps, color coded, etcetera. With GIS Cloud, which is now available on our Web site, anyone can go in and access our databases and build that so that they don't have to always call. They can get the information immediately. Now that's just in the beginning stages, but we see it growing. There are constantly national reports coming out telling us that we need to change the way that we educate health professionals, change the modes that we need to do that. And the University of Nebraska Medical Center has been responding to these reports. As a result of that, colleges and schools at the Medical Center have revised curriculums; they're starting to use learner-centered teaching strategies and delivery modes to educate the students. We are providing students with interprofessional education opportunities and we anticipate that those opportunities will be growing. We've been doing it for about three years now and we are participating in a national consortium that is working with that. Additional things that have happened that contribute to all these changes being able to take place was the addition of the College of Public Health which met a major need in Nebraska. The Sorrell Center for Health Science Education serves more than just medical students. It serves nursing students, medical students, and also allied health students in a variety of disciplines. Another thing that the Medical Center has done recently is enter into a public/private partnership in two areas. The one that you probably are most familiar with is when we worked with citizens in the northeast region to open a new Paul and Eleanor McIntosh College of Nursing. The thing that is unique about that is, here we have an opportunity where a community college and a major university work together to meet the needs of a region. And citizens in the northeast region now will be able to take coursework in nursing, starting with the nurse's aide and running all the way to a Ph.D. in nursing. We think that's an innovative model and it should be used in the future looking at other issues.

Another place where we have partnered, the College of Nursing at the Medical Center and Methodist College of Nursing along with RWJ and major providers of long-term care have joined together in matching a grant from RWJ. Through that we are working with the employees in the long-term care facilities to raise their level of education and raise their leadership abilities. It will be a few more years before we will be able to see the full effects of that, but we have run one group of leaders through, and all of the people who participated in that specialized program have been certified nationally and we think that's really important. The other thing is, is we think it will encourage people to continue their education so that we have better educated people working in the facilities. The conclusions that I think are important. First of all, we have the tools for the database. Let's get the people together, get them working together, get DHHS authorized to do what we need to do so that we can produce data in a quick way that it can inform policymakers. In terms of education, some things that we need to be doing is to continue getting money, grants, etcetera, both public and private, and work in public/private partnerships in order to educate our work force and to increase their level of expertise. We need to do that in a way that allows us to work in the rural areas and to educate students as close to home as possible, because we know that if we educate students in the rural area, they have a greater tendency to stay in the rural areas. And we need to do...we will probably be using a lot of distance technology in order to accomplish that, and the Medical Center has a long history of doing that, in particular, the College of Nursing. Another thing that I would ask is that we look at being able to increase the number of people who apply for licenses, either agencies or individuals, to do that entirely on-line. By having them do that, that immediately dumps the data into the database; we don't have to go back and clean it. It allows us to get reports out quicker, and I think that is essential for us to be able to then predict the shortages and to come to you and say, we need to target. Some examples at the Center for Nursing is looking at using the GIS software--and this could be used for any of the health professions--is we can take a look at the age of the professionals who are working in a particular region, and then go to that region and work with them to get them to go into a public/private partnership to get students from their region into a health work force

program in the state of Nebraska, and hopefully one closer to home. I would be willing to answer any questions that you have following my other... [LR467]

SENATOR GAY: Is there a...well let me ask...let me ask you one right now. I think the best way to do this...you're all going to cover something a little different? [LR467]

STEVE PITKIN: A different aspect, yes. [LR467]

SENATOR GAY: So we don't have you back and forth, back and forth, and we're kind of actually making good time now because I've pushed and pushed, let's do this. Let's ask a few questions to the speaker here while they're fresh in your mind for five or ten minutes or whatever we need to do, and then we'll do it that way, so then you won't have to come back up again. [LR467]

STEVE PITKIN: Oh, okay. [LR467]

SENATOR GAY: Because you covered a lot of things and I'm sure there's a few questions. I've got one. Do you have one, Senator Nordquist? Go ahead. [LR467]

SENATOR NORDQUIST: Yeah, just...you mentioned give DHHS the authorization they need. Do you know what's preventing them from having the authority to... [LR467]

STEVE PITKIN: The issue is getting them to add the work force surveys to the licensing when the people renew their licenses, and the same with the agencies. The Center for Nursing has a supply-and-demand model for nursing now. It's been up and running for three cycles. We are just ending a cycle where registered nurses are renewing. The quicker we can get that data, the quicker we may be able to say what the effect the recession has had on the nursing work force. So it's those kinds of things. [LR467]

SENATOR NORDQUIST: Okay, thank you. [LR467]

SENATOR GAY: I've got a question for you. Earlier we talked about when AARP was discussing the expansion here, and going through my mind is, "And how are we going to do this, because of our shortages?" And anyone on the committee or, I think every senator has heard that. We've got a shortage, but I know the Health Committee has been really aware of that. I like your idea of one central depository of information because probably anyone here would say, I get bombarded with so much information; how do I keep it straight? But the Medical Center being a great resource for Nebraska, so if we had that, we could then decide, under what you're saying, is where the student is going. What worries me sometimes is when we want to expand programs, I expand a program, they get educated at the Med Center, and then all of a sudden they end up back in Boston or wherever the case may be. But a lot of good Nebraska youth growing up here, or anyone else who wants to come here, I think once they come here, they would stay here, but those incentives and those kind of things. So do you envision something, if we train them we can track them better through this repository? [LR467]

STEVE PITKIN: Yes. [LR467]

SENATOR GAY: How would that work, I guess? Be a little more specific. [LR467]

STEVE PITKIN: Okay. We would have to add to the groups that are currently collecting data. I can only speak to nursing because I'm not familiar with how other disciplines are doing that. But the schools of nursing in Nebraska have to file an annual report with the state Board of Nursing. By using the data that they file, we know what the pipeline is going to look like for the next five years, because they have to tell us how many students are currently enrolled, how many students were admitted, at what level they are. So we constantly have data. I think that would be relatively easy to get other schools in Nebraska in other disciplines to report their data to the data center, and it can be included in the reports that are submitted to the policymakers. [LR467]

SENATOR GAY: So, all different nursing colleges. I saw like even ITT just opened one,... [LR467]

STEVE PITKIN: Yes. [LR467]

SENATOR GAY: ...the governor. So they would have to...what would we do? Pass legislation? [LR467]

STEVE PITKIN: By law they have to file a report. [LR467]

SENATOR GAY: Yes, put it in there. And then how many students, I guess, you get into a program and you see in the pipeline in 2010 we have X amount of nursing students by 2013. Some may have dropped out, left, whatever. So what you're saying is that we would have a more accurate...how long is this span when you enter to be a...? And I'm going to keep it to nursing. [LR467]

STEVE PITKIN: Okay. An ADN program, you're looking at two years before they're into the work force. A BSN program, you're looking at four years before they can be in the work force. Advanced practice, most of the advanced practitioners says it takes two years of graduate education before they preenter the work force in a new role. All those things that you just mentioned have to be reported by all the nursing schools on an annual basis. So we can adjust the model if we need to, based on the reports that are submitted to the Board of Nursing. [LR467]

SENATOR GAY: Senator Campbell. [LR467]

SENATOR CAMPBELL: I want to go one step further from Senator Nordquist's question. Has UNMC requested in writing from the department to do what you need? [LR467]

STEVE PITKIN: That has not been done yet. [LR467]

SENATOR CAMPBELL: Okay. So no...they haven't been asked to do anything, so if our committee decided to make that request. It has not been made. [LR467]

STEVE PITKIN: It could be done, I think. [LR467]

SENATOR CAMPBELL: Okay. The second point was that in our budget deliberations we have talked with them about maybe getting a list of all the student programs that we now fund through the Legislature, particularly, in the health and human services, to see if we can start drawing those all in one place to track them. [LR467]

STEVE PITKIN: I think that would be possible. And I think that group of... [LR467]

SENATOR CAMPBELL: Yeah. So we have some idea of the effect, over the course of time, of the money that the Legislature has put into that. [LR467]

STEVE PITKIN: Yes. Um-hum. That's all possible with nursing. Now the other disciplines, it would take some additional work, but we got the Center for Nursing model which has worked through a whole lot of those issues, and it's working for us and we were able to produce data. Now, that has been analyzed, broke down, analyzed, and with recommendations. [LR467]

SENATOR CAMPBELL: The last is, have you identified any of the pilot projects or innovative programs that we could apply for to put the database from the federal health reform? That may be a question I need to ask Mark when he comes up, if we've identified...because the list is so long, there's no... [LR467]

STEVE PITKIN: Briefly, in my testimony, I identified some of the disciplines that I thought we should start tracking. Is that what you're asking me? [LR467]

SENATOR CAMPBELL: I'm just seeing if there's some national pilot through the national health reform that would help us. [LR467]

STEVE PITKIN: Okay. The Nebraska Center for Nursing is a member of a national consortium of nursing work force centers and we share our data with them and then there's where being...efforts are being made to create a national center for nursing work force data so that the feds have a better idea of how to target their requests for proposals for areas to grow. [LR467]

SENATOR GAY: So, Senator Campbell, what you're saying too is if...this has been a problem that you can't just ignore with the budget problem looming; there's opportunities through the federal health care act that we may take advantage of, but I'm sure that will probably be presented. [LR467]

SENATOR CAMPBELL: That's what...and we can ask Mark that question when he comes up. [LR467]

SENATOR GAY: Yeah. But, yeah, that's a real opportunity probably that we should explore. Any other questions? Senator Hadley. [LR467]

SENATOR HADLEY: Thank you, Senator Gay. Steve, thank you for coming from the wonderful town of Kearney. Just as a side, the School of Nursing out there shared the building with the College of Business and Technology... [LR467]

STEVE PITKIN: Galen's office used to be down the road. [LR467]

SENATOR HADLEY: ...so whenever I needed healthcare, I just walked down the hall. I was healthy. Steve, this is a question I'd like to ask all three of the presenters, so I won't repeat it for the other presenters, but, you know, in the Legislature we hear a lot about

scope of practice and we have discussions whether it be dental assistants, dental hygienists, I mean, you just name it, we've had scope of practice issues, in fact, APRNs and pharmacists. Are we hurting ourselves by having these kind of little...what I almost call turf battles over scope of practice when it comes to giving healthcare to rural parts of Nebraska? Maybe it's an unfair question. [LR467]

STEVE PITKIN: You've put me in an untenable position here, Galen. [LR467]

SENATOR HADLEY: Oh, okay. [LR467]

STEVE PITKIN: So here's what I'm going to do, I'm going to answer it as an individual. Yes, I think we have. One of the things, very early on, Nebraska was set up so that all health disciplines had to compare themselves against medicine. That has led to turf battles beyond belief, and not only is it just with medicine, it's with all the other groups fighting over scope of practice. All of the national reports call for revision of scope of practice, and it's opening up scopes of practice so that patients can receive the best care in the best situation. And my personal belief is that we should decrease the amount of scope of practice issues, open it up. And it wastes tons of time, tons of state employee time, state legislators' time, association times, getting everything ready trying to advance that. I think there are some ways in which we could facilitate that process and get out of those wars. The Med Center, obviously, is much more interested in educating the students and getting them to appropriate placements in the state of Nebraska rather than fighting turf wars. [LR467]

SENATOR HADLEY: Okay, well, I just...Pam from...the assistant dean from...was here, gave us some very startling numbers, that 20 percent of the counties do not have an MD; a shortage of nurses across the state; retirements; some significant number of healthcare providers retiring in the 10 to 15 years. And so I think we need to be looking at...maybe a little more inventive ways, because I worry that we have...we're getting a system that allows people to get healthcare, but if we don't have healthcare providers,

what have we done? [LR467]

STEVE PITKIN: I concur. [LR467]

SENATOR HADLEY: Thank you, Steve. [LR467]

SENATOR GAY: All right. We'll have that last... [LR467]

STEVE PITKIN: Thank you. [LR467]

SENATOR GAY: ...thank you. [LR467]

DARWIN BROWN: (Exhibit 4) Good morning. My name is Darwin Brown, D-a-r-w-i-n Brown. I represent the University of Nebraska Medical Center. Good morning again and thank you very much for this opportunity to address the committee. Again my name is Darwin Brown. I'm a clinical coordinator at the University of Nebraska Medical Center's physician assistant program in the School of Allied Health Professions. I'll focus my comments today pretty much on the Patient Protection and Affordable Care Act on rural healthcare with an emphasis on the role of allied health work force and delivery of that care. The current conditions of rural poverty, a limited rural health work force--especially of primary care providers, an aging population with poorer health status--particularly in rural Nebraska, and disparities in minority health outcomes, create both significant challenges to the delivery of, and the absolute need for, accessible, affordable, high quality care to citizens of rural Nebraska. According to a report by the Rural Policy Research Institute, many of these provisions of the Affordable Care Act can and may serve to promote this actual outcome. You've heard from many presenters over the last couple of weeks about the issues and needs and shortcomings of rural Nebraska, both in healthcare and work force issues, and so I'm not going to belabor that any longer at this point in time. You can look at my testimony if you have interest in that. The provision of the Affordable Care Act requiring healthcare coverage for approximately

220,000 Nebraskans starting in 2014 will improve access to care for Nebraskans, particularly the poor in rural areas. The key concern remains, however, will there be sufficient providers to deliver that care. The expanding number of insured and aging population requiring chronic disease management, and a renewed emphasis on primary care will significantly increase the demand for physician assistants, physical therapists, medical nutritionists, and highly skilled laboratory and imaging technologists. One strategy for expanding access is to increase the primary care providers. These providers are generally defined as medical doctors in family practice, general internal medicine, and pediatrics. Federal primary care Health Profession Shortage Area designations have not considered mid-level providers such as physician assistants and nurse practitioners as primary care providers. However, in Section 5501 of the Affordable Care Act defines a primary care practitioner as an individual who is a physician with a primary specialty in family medicine, internal medicine, geriatric, or pediatric medicine, or a nurse practitioner, clinical nurse specialist, or physician assistant. In many primary care practices, the presence of PAs and the nurse practitioners allow patients with routine health problems to be seen more promptly. Nurse practitioners in primary care in the state grew by 9 percent during the last 10 years. Currently, 33 percent of nurse practitioners work in primary care in almost 60 different counties in the state. The number of physician assistants in primary care has grown by 4 percent over that same time period, with 50 percent of PAs in Nebraska practicing in primary care. The 2007 data identified that PAs and nurse practitioners in primary care increased the state's overall primary care work force by approximately 40 percent. The inclusion of PAs and nurse practitioners as primary care providers is critical for Nebraska to meet the anticipated demand for health services, as PAs and nurse practitioners play a significant role in providing primary care, especially in the rural areas. Research shows that physician assistants and nurse practitioners, working in collaboration with physicians, deliver high-quality care in a cost-effective manner that results in excellent patient outcomes. Approximately 60 percent of the total healthcare work force is comprised of professionals in allied health fields. The UNMC School of Allied Health Professions comprises 11 educational programs that's described in the

colorful tri-fold handout you've been given. According to the Bureau of Labor Statistics, it projects increases in work force demand over the ten-year period 2008-2018 for all 11 UNMC professions, ranging from a low of 9 percent for dieticians to a high of 39 percent for physician assistants. Relative to these national work force predictions, we need more detailed work force data on allied health professions in Nebraska to understand more accurately the characteristics and geographic distribution of allied health work force and where the specific needs exist. We do know, however, that 10-20 percent of allied health professions in Nebraska are older than 55 years of age. In the next ten years, 25 percent of the clinical laboratory specialists, or medical technologists, will be eligible to retire. Currently, only two laboratory professionals enter the field for every seven that retire. When approximately 70 percent of clinical decisions are based on laboratory results, a shortage of laboratory professionals could have a significant impact on the quality and timeliness of patient care. Interprofessional education is part of the solution for the work force shortages. Interprofessional education is defined as students from two or more programs learning together with the goal of promoting collaborative practice. Interprofessional education has been shown to increase a student's understanding of systems thinking and quality improvement processes, improve professional relationships and identity, and increase collaborative teamwork. Improving teamwork is perhaps the most beneficial outcome overall, given that the root cause of approximately 70 percent of medical errors can be attributed to poor communication and problems with coordination between team members. Some conclusions and recommendations: First, Nebraska has a number of existing programs that can help address the work force shortages. The federal health reform law offers opportunity to expand some of these programs. We also anticipate that there will be many opportunities for pilot programs and demonstration projects that could benefit Nebraska. As the opportunities for pilots and demonstrations projects are announced, UNMC anticipates exploring new alternatives which may also include some state participation. Interprofessional education holds considerable promise and should be a required part of health professional education. UNMC is currently developing and assessing interprofessional curricula and teaching methodologies. Questions remain about the

interprofessional education however, and there has been little, if any, federal funding currently to look at educational outcomes and research in this area. It must be recognized that the intended outcomes of interprofessional education will likely challenge supervisory requirements and reimbursement patterns, and these will need to be examined to keep pace with the new delivery of models. The Affordable Care Act also provides for the establishment of community-based interdisciplinary and interprofessional teams to support primary care practices within hospital service areas, as well as establishes the Independence at Home Medical Practice Demonstration Program, to test models of care that use physicians, nurse practitioners, and physician assistants to direct teams and reduce expenditures and improve health outcomes. A nurse practitioner or a physician assistant may participate in or lead a home-based primary care team. Nebraska will need to develop and evaluate new models of care to determine if they deliver lower cost, higher quality care. The Rural Health Opportunities Program, which you're all familiar with, also offers early admission to health profession program for students interested in returning to rural practice, and has been shown to be a successful model for increasing the rural health work force. RHOP began in 1990 and has produced 323 graduates; approximately, for which 40 percent are allied health professionals. Last year, the UNMC School of Allied Health increased its RHOP slots by approximately 70 percent, but the pipeline is still long and these students' total numbers of participants still remain relatively small. Increasing enrollment in allied health professions programs is another strategy for addressing work force issues. UNMC's enrollment in allied health programs in both physical therapy and physician assistant increased by 25 percent last year. The UNMC PA program received $924,000 in federal funding to support students pursuing careers as physician assistants from the $30 million allocated for the expansion of physician assistant training under the Affordable Care Act. These funds provide for student scholarships and educational support as well. Scholarship and/or loan forgiveness programs for students entering other allied health professions and/or choosing to practice in selected geographic areas of Nebraska may also prove to be valuable in the development of an allied health work force to serve Nebraska. Finally, whenever you increase students, you need to increase faculty and

clinical sites as well. Allied health professions faculty are in the same situation as nursing faculty, they're few and far between, and that is certainly a limiting factor when it comes to increasing student populations. Secondly, clinical sites in our state are also a significant issue. Incentives might need to be thought of as far as providing clinical sites for educating the increased number of students--medical, physician assistants, PA students--who need the same type of training to learn their capabilities and skill sets. Finally, creative programs, developing new partnership, and truly out-of-the-box thinking will be required to address these issues in the future, and the university is certainly, I think, well poised to do that. Thank you for the opportunity to comment on some perspective of allied health here in the state of Nebraska. The school is certainly committed to its mission which is to train highly qualified allied health professionals to serve all Nebraskans. Thank you for your time. [LR467]

SENATOR GAY: Thank you. Are there any questions? I've got a question for you. When it comes to the funding for...to keep professionals in the state, we do some tuition funding...anyway, is...again, these programs are fairly long, they change, now we have too many of this, too many of that. Would you say in all these professions we're under...you said for every seven that might be retiring, we're taking two in? [LR467]

DARWIN BROWN: For the Clinical Laboratory Science folks. [LR467]

SENATOR GAY: For that particular thing. [LR467]

DARWIN BROWN: Correct. Correct. [LR467]

SENATOR GAY: When I look around, I look at, like, PTs, physical therapists. I know several of those are...they seem to be a growing profession. But when you look at all these 11, is there a time where you can...we only have limited funds to give to certain scholarship programs, and we do it for doctors or whatever, if you targeted certain ones for a few years, and others--I know that's hard, because once you get funding, you want

to just keep it. But sometimes we don't have that and we need to be more strategic on where we're going to place our education dollars. So on the tracking, when the prior speaker was talking about nurse tracking, you track those fields fairly closely for the state, or just the Med Center? I mean, who else is doing this? Just the Med Center? [LR467]

DARWIN BROWN: Just the Med Center. [LR467]

SENATOR GAY: Okay, so when you track that, I guess, if Clinical Laboratory Sciences, it sounds like there's a huge need for that, so if we wanted to direct people, that program lasts how long from entry to exit? [LR467]

DARWIN BROWN: The CLS program is currently after a...it's a baccalaureate degree, so they can enter the program after three years of college, and graduate with a bachelor's degree, so four years total, from in to out, after high school. [LR467]

SENATOR GAY: And is there training afterwards that they have? [LR467]

DARWIN BROWN: No, it's all done during that year of training. [LR467]

SENATOR GAY: Okay. So Nuclear Medicine Technology and Computed Tomography and basically CT, those are four-year programs? [LR467]

DARWIN BROWN: No, those are, again, and I speak a little bit out of ignorance, those are not programs I'm directly involved with, but they range from bachelor degrees to certificate programs, which mean they can take kids out of high school after a year or two of college and train them and give them a certificate for some programs. [LR467]

SENATOR GAY: Oh, okay. [LR467]

DARWIN BROWN: And then others will require a bachelor's degree and further training. It just depends on the specific program you're looking at. [LR467]

SENATOR GAY: Okay. So when we're doing that, so these pilot and demonstration programs, the ones that I've been looking at, usually require the state to do a lot more. It's not just free money, here you go. [LR467]

DARWIN BROWN: Right. [LR467]

SENATOR GAY: Have you found any ones that are, in particular, that you thought were, oh, that's really attractive? I know it still has to come through the state. [LR467]

DARWIN BROWN: Sure. Sure. And, you know,... [LR467]

SENATOR GAY: But anything that struck you as, like, wow, that would really work here? [LR467]

DARWIN BROWN: Not that we have...not that I have individually tracked myself. And again I'd refer back to probably Mark or the university to have some better insights on what programs they think might fit our current situation. Getting back to your earlier question about tracking information,... [LR467]

SENATOR GAY: Yeah, how do you move the money. [LR467]

DARWIN BROWN: Yes. I think getting back to Steve's comment of having a centralized location that can track students, where they're at in the pipeline and what the expectations are for future needs, is kind of critical importance for Nebraska, a kind of a centralized work force capacity situation. How the state then decides to fund areas that are in need or perceived to be in need, I think, then becomes your decision on where issues lie at. I think it's incumbent to you to have accurate information to make those

decisions on where maybe to place the money in the future. But currently in our Allied Health Programs, we do not have a way of tracking globally the students who are in or that out. I think each program does a nice job on their own, but there's no centralized area for all that information to be housed. [LR467]

SENATOR GAY: We probably need that. Senator Hadley, did you have a question? [LR467]

SENATOR HADLEY: Yes. Darwin, thank you for being here. So that I just didn't put Steve on the spot, I'd like to ask you a question, because we do, the Legislature, we're constantly hearing scope of practice issues. [LR467]

DARWIN BROWN: Sure. [LR467]

SENATOR HADLEY: And a lot of them deal with rural areas. Any thoughts that you have? [LR467]

DARWIN BROWN: Well again, I will have to plead the Fifth and answer as an individual and not on the university's behalf at this point. Scope of practice is a sticky wicket and a slippery slope for everybody. We as physician assistants are trained and expected and by law work under the supervision of physicians. So that is where we're tied to as far as our ability to work out in communities and rural health areas as well. The turf battles that occur over the years to carve out your niche and to develop these skill sets you need to practice at the level of your capacity, I think can be difficult and are just that, are turf battles. And again, it becomes I think incumbent upon the state Legislature and policy and procedures to make decisions on what they think is in their best interests and the communities' best interests to provide the level of healthcare you feel is necessary for its population levels. If that requires some change in scope of practice, that's your decision. And I think we've got plenty of folks around the table that would be glad to give you information for pros and cons on all levels of that. But I think those are certainly

thoughtful ideas that, again looking at out-of-the-box kind of solutions that might be necessary for some period of time to kind of get the coverage you're looking for in the areas that need it most. [LR467]

SENATOR HADLEY: Thank you. [LR467]

DARWIN BROWN: How's that for a dodge? [LR467]

SENATOR HADLEY: Well, no, I...I appreciate...I think it was a very good... [LR467]

SENATOR GAY: No, it's a tough situation, yeah. Just getting an opinion, yeah. [LR467]

SENATOR CAMPBELL: I just want to make a comment, just because Senator Hadley is bringing this up. I did have an interim study on scope of practice and have met with the State Board of Health and then the subcommittee that really works with the scope of practice. And the general consensus is, yes, we need to do something, but it is a bigger project. And so it was really a matter of given the fact that this committee was going to start work and what did we know from national healthcare and what do we need to have in place for 2014, we decided that I would reintroduce the interim study and we would probably move that work to next year. But, Senator Hadley, almost everyone that has visited with me has said we need to tweak the system. We need a system, but we need to tweak it. It's been too long, before it's...that it's not been reviewed at all. Sorry. [LR467]

SENATOR GAY: No, I think it's...get into it... [LR467]

DARWIN BROWN: Right. I'm mean, you still want to have qualified licensed individuals out there and some way of controlling that, exactly. [LR467]

SENATOR HADLEY: Absolutely. Quality care. [LR467]

SENATOR GAY: Public safety. Yeah, just the safety of (inaudible). [LR467]

SENATOR CAMPBELL: So we are going after it. [LR467]

SENATOR HADLEY: Good. Okay. Thank you. [LR467]

DARWIN BROWN: Good luck. [LR467]

SENATOR GAY: All right. Well, thank you very much. [LR467]

DARWIN BROWN: Other questions? [LR467]

SENATOR GAY: We appreciate it. [LR467]

DARWIN BROWN: Thank you for your time. [LR467]

SENATOR GAY: Thank you. [LR467]

DARWIN BROWN: I'll introduce, by the way, Dr. Jeff Harrison, from the university, as well, family practice clinic. [LR467]

SENATOR GAY: All right. Thank you. [LR467]

JEFF HARRISON: (Exhibit 5) Hello, I'm Jeff Harrison, H-a-r-r-i-s-o-n. I'm the assistant dean for admissions in the College of Medicine and I direct our rural family medicine residency program, as well as our family medicine residence program at the university. I guess (inaudible) because we've talked about scope of practices. Well, I'm sort of representing the rural physician work force. I think almost everybody who practices realizes if we don't have a multidisciplinary team of nursing, allied health, and

physicians, we don't have a quality rural work force. So I'm going to jump ahead and answer your question before I even start. [LR467]

SENATOR HADLEY: Okay. Thank you. [LR467]

JEFF HARRISON: Because I know it's coming and it is a huge issue and so much emotion gets into it. You know, this is my silo and this my turf and I want to expand it. And I think as we look ahead, the only way to really provide the answers we need is really a multidisciplinary team approach. And whatever the medical home model ends up being, somewhere in that you're going to have to have physicians, allied health, nursing, and everybody working together. And the challenge will come back to you to figure out how do we define that and put it together. But you've said the magic word. We've got to do something where patient safety is involved, how do we best take care of the citizens of rural Nebraska. And the devil is always in the details. [LR467]

SENATOR HADLEY: Absolutely. Thank you. [LR467]

JEFF HARRISON: I think we will be much farther down the road and we can get out of the turf silos. Unfortunately, I'll speak personally, it's the physicians that tend to be the bigger barrier to that, sometimes for good reasons, sometimes for less honorable reasons. That being said, I'll move to my testimony and I'll certainly come back and answer your questions. I'm not going to repeat a lot of the numbers you know, but I do want to take a little different spin on it in the area of physician work force. If we go back to our own report, we have about 3,400 practicing physicians in the state. We know 28 percent of those practice rural. And we also know that in the next five to ten years, a third of those are going to retire. Doing the math is, we have a 300 physician work force shortage coming in the next ten years and we've got to replace that. And that's going to be a challenge because there's several factors in there that, again, I'll go a little bit out, that I think we want to talk about. The most likely young person to practice in rural Nebraska is somebody who is from rural Nebraska, who goes to a state institution, who

has got a service orientation. I mean, we know that. That's national data; it's been reproduced state after state. That's who we need. That's also the most rapidly declining demographic in our 63 rural counties. The 19- to 30-year-olds is the fastest declining group. So the very group we need to come in and fill our needs is also, from a population standpoint over the last decade, getting the smallest. We've talked a lot about primary care, both Darwin and Steve have mentioned that. And why is primary care the answer for rural Nebraska? On average, for a family physician, it takes a population of about 2,500 people to take care of a full-time provider. It takes about 3,500 population for an internist. It takes about 10,000 for an obstetrician. It takes about 16,000 for an orthopedic surgeon. When you realize we have 20 counties with less than 2,500 people, we can't have a specialty-based work force taking care of rural Nebraska. So why doesn't everybody go into primary care? And it's simply money. You know, the kids out there look at money. On average, you come out $150,000 to $200,000 in debt. Primary care physicians, on average, make about half of what specialty-based physicians make. So as you become a specialty-based physician, you really can't go to rural Nebraska because you don't have a big enough population basis to have a viable practice. So we're sort of battling that on the front end, coming in, of, you know, how do we get kids out there. Well we've done a few things and I'm going to move out of the gloom and doom here for just a little bit and talk about the programs that we've done over the last 20 years, which sounds like a long time. But we...Nebraska has had some of the most innovative and successful rural pipeline programs in the country. This came back from actually the Legislature funding the RHEN Program back in 1990, the Rural Health Education Network, which was really a public/private partnership to try to increase rural healthcare work force. And it wasn't just medicine, it was the entire system. Darwin had mentioned the RHOP Program which to me is probably our shining light of a program we've done. We've done that in collaboration with Kearney State...not Kearney State, we'll talk about Kearney-UNK in just a minute. But we've done that with Wayne State College and Chadron State College of recruiting rural high school seniors who we know are the most likely to go back; who we know if they tend to stay institution, they're most likely to go back and practice rural; and guaranteeing them admission into

medical school if they maintain the professional and academic standards we expect. The state colleges have been great in awarding full-tuition scholarships for these kids. Here we are...that's the problem is, that's an 11-year pipeline, but at the 11-year pipeline, you know, we've had a 60 percent success rate in getting these kids back into rural Nebraska; 75 percent stay within the state. And while you might say, 60 percent rural, 75 percent in the state, there are no other programs out there that approach those numbers until kids start coming in later, well into medical school, well into residency. So, you know, realizing that 75 percent of our 17-year-old kids from rural are staying in the state, 60 percent of them are practicing rural, is really pretty phenomenal. The success of that program led us, two years ago, partially based on health demand needs, to developing what we call the KHOP program, the Kearney Health Opportunities Program in conjunction with UNK for very much the same reason. We have success rate. We know we have a need. We have a large, large population from the central corridor of the state who would be interested, who want to go to UNK, who want to stay in the state to train. That program is just getting started and it should be coming to fruition about the time we're really looking at our biggest shortages in the next ten years. We developed a parallel program to that at UNK for nontraditional students. I've sat on the admissions committee for the last ten years, and there's been a large number of older students with degrees living in rural Nebraska who want to come back, become physicians, and go back to their communities. And as the system was set up, there wasn't an easy way for them to go in and get their prerequisites. So we actually developed, in conjunction with UNK, a one- to two-year program for people living out, with degrees, who want to go back, to shorten up that course. They can come in, get their one-year prerequisites that we design, with the idea that they are going to back to the rural communities. That cuts us down to a much more a seven- to eight-year window. Again, not ideal, but I think that's a program that's going to have great success for us as we go forward. Final thing that I...one other...two other good news programs within our pipeline: We started programs back in 1992 called the Primary Care Program and the Advanced Rural Training Program for UNMC seniors. They can come into the program starting their senior year. They received a tuition waiver. Again, for kids who have an express interest

to take care or do primary care in underserved Nebraska--and we also include underserved Lincoln and Omaha communities as successes for that program--we give them a tuition waiver, trying to decrease that problem we have with educational debt. Since we've started those programs, we've had 180 graduate into residency; 75 percent are practicing within the guidelines of our program. Fairly good success rate in the program, that we actually applied for a HRSA grant to try to expand this year--approved, but not funded. But I think there's going to be some more opportunities to see that program get a little larger. Nebraska was one of the first states in the country to have a rural training track. Rural training tracks are known as 1-2 programs. You spend a year in Omaha at a core site; you spend two years--and now we have five rural sites, including Scottsbluff, North Platte, Kearney, Grand Island, and Norfolk. Family physicians as a whole, nationally, 50 percent will practice within 50 miles of where they train. The whole idea being if we trained them in Grand Island, they're much more likely to stay in the Grand Island catchment area; if we trained them in North Platte, etcetera. That program, again, has done exactly what it's meant to do. Roughly 80 percent of those graduates are practicing rural medicine inside the state of Nebraska. So we've had some great successes. And I want to stay a little bit away from, you know, totally the gloom and doom that...Nebraska has been an innovator and we've had partnerships with the private hospitals, with the private communities, the medical communities, and with the other state colleges, and have done well. So how do we keep this going? Solutions are the hard part. But I think it's critical that we continue to build on the successes we have. Strong science programs at Chadron, at Kearney, at Wayne, you know, not only attract the good kids into the RHOP Program, they attract other kids from the region who know they can get into the professional schools and do well. And our kids out of those programs have been at the top of the class; they've distributed throughout. So we have, really, a lot of bright, young people out in the state and the ability to educate them well. So I think we definitely have to keep those programs going. We've got to find the ways to work collaboratively. And what are the pilot projects that are going to be out there? What is going to be the medical home where we can really define what's going to be the role of the physician; what's going to be the role of the

nurse practitioner, the PA, the rest of the nursing staff, the clinical lab folks, to really provide the model care, the most cost-efficient, the most safe for our patients in the state? And I think that's one of the ways we can look at. You know, rumor is...and I'll refer to Mark that there's potentially more money inside the health care reform act to help us expand those programs and make them work. I'll answer questions because I feel like I've talked a lot. [LR467]

SENATOR GAY: All right, any questions? I've got one for you, real quick, if somebody is thinking. You know, I represent the metro area and Senator Nordquist does, Senator Campbell somewhat, and Senator Cook as well, so many of us, but then hear about western Nebraska. And I respect my colleagues out there, but I've heard of...but I always wondered, we're trying to recruit kids out there to come back home. But there's a lot of kids, I think, in the metro areas--I watch this as my kids are getting a little older--to say, you know, what?--my son, he likes fishing, hunting, and all those things. Are you talking to any of the metro kids, I assume, and say, you know what, they want to stay in the state of Nebraska, is there programs like that? [LR467]

JEFF HARRISON: We actually have a program called NU-PATHS for more metro-based kids who, not to go rural, but to actually encourage them and, you know, kids from underserved backgrounds tend to go into underserved care, whether that's rural, whether that's north Omaha, wherever that's at. And so, you know, that's an entirely separate program. One of the things that we've done, and in the interest of time I didn't talk about, every one of our students, wherever they're from, spends three weeks between their first and second year, in a rural Nebraska community. Every one of our third-year students spends an eight-week block in a rural Nebraska community, doing their family medicine rotations. So we do want to get them out there. The problem is, most of the kids from the metro areas meet urban spouses who really don't see any desire to go live in Broken Bow, Nebraska--nice place to visit, but I don't want to live there. And that was one of the theories as we go back to, you know, why have Wayne and Chadron been successful. You're up at Chadron State. You're a Panhandle kid, and

guess who you meet? You meet a nice girl from the Panhandle and, you know, who is perfectly willing to go back and live... [LR467]

SENATOR HADLEY: They're all nice girls from out in western Nebraska (inaudible). (Laughter) [LR467]

JEFF HARRISON: Well, they are. They are. They're all that way. But that's been an ongoing, you know. I don't know if it's social engineering or not, but you know, spouse selection is huge, huge, in where people are willing to go live. And that's a little bit...that was a little bit of the thought processing of why do you train people at UNK, why do we train them at Chadron and Wayne, is you're much more likely to meet people somewhat of a like background. You leave the state... [LR467]

SENATOR GAY: So, well, I guess, just my logic...my logic is this: Papillion-La Vista has created this program where you go and you train and you can...it's a medical sciences program, and you basically go to high school at Alegent. All those kids, there's a certain point though, I graduated personally with a $10,000 loan, and it stunk paying that thing off over the years, but it is what it is. I can't imagine graduating with a $150,000 to $200,000 loan. But if you're a junior or senior, a smart kid, the kids I meet have a lot of their life planned out, and you don't know exactly how life is going go, but they kind of got a good direction. If they would say, listen, I want to go to medical school; here's a way to pay for it, but here's your choices, I think a lot of them would look at it. But you know the science better than I do. But I think a lot of these kids don't want to graduate with that kind of loan balance. [LR467]

JEFF HARRISON: No. [LR467]

SENATOR GAY: And they're willing to say, my spouse...I grew up in Nebraska, I've been there, some kind of thing like that. But I don't know, you can't reinvent the wheel. But it sounds like you're having great success. I just wondered if those programs existed

and...because a lot of...I've got a friend who is a 4.0 at Creighton right now. Could have gone into anything. He did. He went to the Air Force, he's doing an Air Force ROTC--full...he could have done anything. But I don't know if those programs are even available. But there's probably hundreds of kids like that. [LR467]

JEFF HARRISON: Yeah. The Armed Forces have done a nice job of filling part of that role. Yeah, I mean, medical...you know, tuition for an...an instate student from Nebraska, tuition yearly is $26,000. [LR467]

SENATOR GAY: That's a lot, yeah. [LR467]

JEFF HARRISON: That's rather daunting. [LR467]

SENATOR GAY: It sounds like you're doing a good job, though, with those success rates. [LR467]

SENATOR HADLEY: I just wanted to make one quick comment. I have a niece whose goal was always to be a pediatrician, and she graduated from a University of Michigan school, and she's now in her (inaudible). And she said to me, I'm just not sure I can figure out how to pay off my student loans, being a pediatrician in rural Michigan someplace. That's her exact comment. [LR467]

JEFF HARRISON: Yeah. And it's a real issue we've got, and it wasn't...I don't know if that was totally addressed in the health care reform bill. How do you make it viable for a young person to go practice where they want to practice, with that level of debt? [LR467]

SENATOR HADLEY: Absolutely, Doctor. That's very important that we look at that. [LR467]

SENATOR GAY: Over primary care rates in that bill, isn't there's something where primary care rates are higher? They're trying...they understand that. [LR467]

SENATOR HADLEY: They're trying to raise them, right. [LR467]

SENATOR CAMPBELL: They're reimbursing them. [LR467]

SENATOR GAY: Those are being raised, I think. [LR467]

SENATOR CAMPBELL: At a higher rate. [LR467]

SENATOR GAY: Still a long ways to go, probably. [LR467]

JEFF HARRISON: Long ways to go. You are correct, sir. [LR467]

SENATOR GAY: Anything else? Well, thank you so much for coming, Doctor. Appreciate it. [LR467]

JEFF HARRISON: Thank you. [LR467]

SENATOR GAY: Thank all of you. I think we know where to find you and we can talk to Mark or Bob or whoever if we have other questions, so. Thank you all for spending time with us today, and I think we're going to go...Jennifer Carter is here from Appleseed. [LR467]

JENNIFER CARTER: It's not always fun to be the person to cut off UNMC and keep you from lunch, so I'll do my best to be quick. [LR467]

SENATOR GAY: That's all right. Hey, we're right on schedule, so don't worry about it. [LR467]

JENNIFER CARTER: (Exhibit 6) Okay. All right. My name is Jennifer Carter, C-a-r-t-e-r. I'm the director of public policy and the Health Care Access Program at Nebraska Appleseed, and I really appreciate the opportunity to be addressing you today. I also wanted to say I'm just very grateful for how much time this committee is spending on this issue and how seriously and carefully you're looking at what the implementation might entail, and I think it's a really important start to implementation. I wanted to touch base on two things, two main things, which is continuing stakeholder input in this process and a little bit on Medicaid since that's an area we obviously focus on. I think...you've heard a lot of good stuff today, especially from AARP, that I think would cover some of what we were going to cover. For us, in terms of stakeholder input, I think a lot of what you've heard shows already that there is a lot of work to be done over several years, and that has its pluses and minuses. It gives us a lot of time to try to do this correctly, but it also means that some people are waiting longer than they want to be waiting for the help that they are looking for. But really significant decisions are going be made over that time, and I think some large and some small, and we are really concerned about what process looks like going forward, because this is such an important start. But I think what we discovered, what I've discovered listening to this is that there is so much to cover that I think we need some ongoing planning for this. And so we...and I think there's the need for consumer input, in particular. For things like the Exchange which we'd agree with most testifiers so far, that's a really...one of the, if not the most key part of implementation. And how that works seamlessly with Medicaid is also a key part of that. But we've heard the Exchange discussed as possibly something like Travelocity which is just one model and may or may not be the best model for consumers. It also will have a large on-line component and I think that will be true, no matter what, and that can be extremely beneficial. But you have rural Nebraskans and low-income Nebraskans who may not have access to the Internet, or easy access, persons with disabilities, seniors who don't know how to or may have true issues negotiating that. And so I think there are some ways in which consumer input could actually be quite helpful in saying, here's a creative way that I could navigate this

system if we set it up this way or...really also, any Nebraskan may need help navigating this system. It's going to be kind of a brand-new world. And so I think having...thinking about, do we need to have some real live people who can help you. Do we need to not do everything on-line? What does it look like when it's on-line? Is it really easy to get through, I think we'll be really important. And so for that reason, we are really hoping that this committee will consider legislation or a recommendation for a task force or a working group moving forward, and that that task force or working group would have real and meaningful consumer input as part of it, and not just necessarily just one person. Maybe one person from different constituencies. And obviously it also needs to include the Legislature. It needs to include businesses, I think, small and large, with varying perspective. You have to have all the relevant state agencies, insurance. But I really think this is an opportunity to get everybody at the table, and we would just really appreciate if consumers were truly part of that. There are 18 states and the Virgin Islands who have already created working groups or task forces. Some of them have already put out reports on what they think implementation needs to look like. So I would just hope...I don't see that that's part of the plan just yet. I understand that public hearings are part of the plan for the state planning grant that the state just got for planning the Exchange and I think that's great and that needs to be part of the process. But this is going to be a three-year process with lots of little decisions made, and to me, that task force or working group is the group that needs to be hearing from the public as they then make their recommendations going forward, and so. So that's one of the bigger issue that we would love to see addressed, and if we can be helpful in that in any way, we would love to be. In terms of Medicaid, I appreciate a lot of what's been said about Medicaid today and the reminder that this is not only a program that's critical for vulnerable families, but it's actually been designed to deal with a low-income population and the specific challenges and needs of that population. And expanding Medicaid to 133 percent was a much more cost-effective way of covering those families than moving them into the Exchange and trying to provide them with tax credits for private coverage. It actually would have increased the cost of the bill by quite a bit to do that instead. And so, you know, from our perspective, it will be extremely helpful to parents and children.

And when we're out talking to people, a lot of people don't realize that childless adults cannot get access right now; and exactly how poor you have to be in Nebraska to get coverage as a parent--about 47 percent of the federal poverty level. So we're grateful for that. In terms of the cost of the Medicaid expansion, I think I won't go too much into it, because you've heard a lot of that already. And much has been made about the Milliman report. We agree that it has numerous flaws: vastly overestimating the number of newly eligibles; overestimating the cost per enrollee; assigning costs for provisions that are not even in the law; and failing to account for significant savings. I did want to mention one thing, because guidance just came out from CMS this week. The Milliman report also assumes a loss of prescription drug rebates, but actually...and there was some reason, I think, to be concerned about that before, but CMS issued clarifying regulations that state that the states won't lose...whatever your rebate was, whatever you had negotiated, you will get that, and the rest only on top of that will revert to the federal government. So, I think there's a question as to whether...I would think the report would need to be revised to reflect that we won't see that kind of loss, which I think was around maybe $11 million, something like that. So that's good news. And I guess our main concern is that while I understand that HHS has said, well, we just put that together for a worst-case scenario, it's not being presented as a worst-case scenario. It's being presented and you're being asked to base your policy decisions on those numbers. And so I guess we would just ask that other numbers are considered, as well, and the significant flaws in that report be considered before we make really serious policy decisions based on that estimate. And most importantly, there's a whole lot of benefits, and I think you've heard about that. Even by HHS's own estimates it's over $2 billion expected into our local economies. With this expansion you get a bunch of...you know, over 80,000 people at least covered, and a reduction in uncompensated care, which really is the cost shift to many of us, both providers and consumers. And so I think there's a lot of opportunity there, and I would...I appreciate how carefully you have listened to that and the possibilities of moving forward with that. And I'm happy to answer any questions. We just mainly wanted to talk about the stakeholder input and what the thoughts were for moving forward, because if this could keep...you know, I

think we need to keep doing this kind of thing. [LR467]

SENATOR GAY: Yeah. Jennifer, I would to ask you a question. On those Exchanges, it can be multi-state as well. [LR467]

JENNIFER CARTER: Yeah. [LR467]

SENATOR GAY: Are any other states talking to each other at all? I mean, only...you said only 18 out of the...is anyone talking to each other and saying we're going to do a joint thing? [LR467]

JENNIFER CARTER: That is a good question. I don't know for sure which states are talking, but I imagine several are, because I know, particularly for smaller population states, there is some sense that that might be particularly helpful because you can just pool more people together and then hopefully that brings down costs, but. So I think that that's something to seriously look at and I assume it's something we'll look at with the planning grant. But I don't...I have not heard any specific deals worked out yet between any states. But I'd have to go back...we certainly could go back and see the groups that have issued reports, if they've...I don't know that any state has made a decision yet. [LR467]

SENATOR GAY: It might be a little early for that, too, to get more information. [LR467]

JENNIFER CARTER: I think, yeah, I think it might be. [LR467]

SENATOR GAY: Senator Campbell. [LR467]

SENATOR CAMPBELL: One of the things, Jennifer, that would be helpful as you're looking at other groups, is one of the concerns that I have is that when we go to national healthcare, you have to be able to...the Exchange can also accept applications from

Medicaid. [LR467]

JENNIFER CARTER: Yep. [LR467]

SENATOR CAMPBELL: I mean it has to be...many doors are open to get there. And my concern would be that if you go with other states, do then the states have to agree upon what that Medicaid program would look like? And that question, to my knowledge, nobody has ever really been able to address. So if you could keep an eye out for some of that, that may be the stumbling block to some of the states going together. [LR467]

JENNIFER CARTER: Yeah. [LR467]

SENATOR CAMPBELL: Because I think that states are going to tweak. Well, look at us. I mean, we're in a financial crunch. A lot of the other states have. So they're tweaking their Medicaid program to start with, let alone what it will look like. [LR467]

JENNIFER CARTER: Yeah, right. No, I think that's an excellent point. And I don't know how hard it is to do all of that in the back office so that it is still one portal for somebody in Nebraska. [LR467]

SENATOR CAMPBELL: Yeah, exactly. [LR467]

JENNIFER CARTER: And it's the person who is taking the application who has to know, okay, this is Nebraska Medicaid so they go in this pile, but I'm going to put this private market person in the pool with all the other states. There may be a way to do that so that you wouldn't have to affect...or find some kind of...everybody has the same Medicaid system. That would be hard. [LR467]

SENATOR CAMPBELL: Because the whole idea is to make it an easy access for people. [LR467]

JENNIFER CARTER: Yeah, absolutely, yeah. [LR467]

SENATOR CAMPBELL: But just keep your ear open. [LR467]

JENNIFER CARTER: Yeah. No, definitely. [LR467]

SENATOR CAMPBELL: Thank you. [LR467]

SENATOR GAY: Senator Hadley. [LR467]

SENATOR HADLEY: Thank you, Senator Gay. Jennifer, thank you for coming in. This is probably a question that I should know the answer to and shouldn't be asking. But, you know, earlier, the AARP person talked about the Kaiser report versus the Milliman report versus that. Are these issues that are trying to impact at the federal level or do they impact the state level depending on which of these...you know, if we have an array of reports to use. I guess my question is, how does that...how does that boil down to the state impact? I can understand we're trying to impact the federal because some people want it rescinded or changed or by using worst-case scenarios or not, but how...your comment in here about, you know, the policy issues for the state, how does that change depending upon whether we believe the Kaiser report or the Milliman report or a third report or whatever? [LR467]

JENNIFER CARTER: Yeah. No, actually I think it's a great question. And in some ways I think it doesn't necessarily change, because this is the law; we need to implement it; and I think we need to implement it as best as possible. There may be...as we see more of the regs come out, there may be choices we could make that would be more or less cost-effective. And so, to me, for the state level work it's more about helping us anticipate what that investment is going to look like over the next several years, rather than it doesn't necessarily allow us to chose not to implement or not. So I think that's a

fair point, but I think it helps...I think the goal would hopefully be we could anticipate our costs. And I guess I just also don't want the concern over costs in the future to affect policy choices that we make today, regardless of implementation, on what the Medicaid program should look like or what kind of investments we want to make. Because that's been our concern sometimes in the past. It happened with Medicaid reform. There was an inflated estimate of Medicaid's growth, and I think it's driven, to some extent, choices not to make investments in some programs that we may have been seeing savings today as a result, or similar things that I'm hopeful actually are moving forward, like Senator Gloor's medical home model, which is actually something we can get...I think we mentioned that you can get a very high match starting next year to supplement that. And so those types of investments that you may see, down the line, benefits from, I guess I would hope that these numbers wouldn't keep us from thinking about those kind of investments. But I think you're right. Otherwise, it's about us anticipating our costs, but this needs to move forward and we need to it the best way possible either way. [LR467]

SENATOR HADLEY: Thank you, Jennifer. [LR467]

SENATOR GAY: Any other questions? Senator Cook. [LR467]

SENATOR COOK: Thank you. I have a question about your public education process in terms of your clientele, your typical audience. What kinds of questions are you hearing, or are you anticipating getting from Appleseed's typical client? [LR467]

JENNIFER CARTER: We haven't actually gotten a ton yet on health reform. We're trying to go out and talk to as many people as possible. There's sort of been this odd thing where, after the bill passed, we haven't been able to get much funding. We've looked locally, but we haven't been able to get much funding from our...and we work mainly off grants to just do education work. I think there's the sense that like, oh, well, somebody else is doing the education work, like the Department of Public Health, or

somebody is doing that, so you guys work on something else. And we're trying to say, no, no. A lot of people don't know what's in this and what's coming. And so we have gotten a few questions after the 23rd, when children...you can no longer deny children and new plans for preexisting conditions. We have gotten a few phone calls about that. But we actually haven't seen a whole lot in our intake line yet. I anticipate there would be more and more. In general, we're just getting questions about how does this work, you know, and when we go places, a lot of people are surprised about what the basics are of the bill. [LR467]

SENATOR COOK: Thank you. [LR467]

JENNIFER CARTER: Yep. [LR467]

SENATOR GAY: Anything else? Perfect timing. [LR467]

JENNIFER CARTER: Oh good. [LR467]

SENATOR GAY: Thank you, Jennifer. Appreciate it. [LR467]

JENNIFER CARTER: Yeah, thanks. [LR467]

SENATOR GAY: Let's for lunch and come back at 1:00. Thank you all for coming. Appreciate it. It's good information. [LR467]

BREAK

SENATOR GAY: All right. Well, we'll get started. We got this afternoon some more information coming. I know we've got some folks from the university, Creighton University, are here to speak, to start off. And then Topher Hansen, Joni Cover, the Center for Rural Affairs, Friends of Public Health, Nebraska Academy for Family

Physicians, and the Nebraska Medical Association. So there's plenty of people coming in this afternoon. We'll start with Creighton University. I know they're here. If you can come on up and we are taping these just for reference, so if you could state your name and spell it out for the...it helps the clerk decipher what's going on later when they come back and go through the tapes. Thanks for coming. [LR467]

DONALD FREY: Senator Gay, fellow senators, I really appreciate the opportunity to be here, and I'm Dr. Donald Frey. The last name is spelled F-r-e-y. I'm the vice president for Health Sciences at Creighton University. My background, essentially, is that I was a family doctor, and a rural family doctor. It makes me a little bit unusual in the vice president for Health Sciences world. Most the time people who are in this position tend to be highly subspecialized. I'm one of the few people who started their career as a rural family doctor, and some how, someway wound up in a position like this. My duties at Creighton, essentially, are to be responsible for the School of Medicine, the School of Nursing, the School of Dentistry, and the School of Pharmacy and Health Sciences. I came to Creighton in 1993 as chair of the Family Medicine department; was chair of Family Medicine for a number years before taking this position a year ago. It was not my first trip to Nebraska though. I spent a year from 1989 to 1990 at Clarkson Hospital, getting their family medicine residency program up and going. Was able to do that. Had an offer to go back east for awhile, which I took, but I was very, very confident that program was going to do well, because before I left, I was able to recruit an outstanding family physician from O'Neill, Nebraska, that most of you know, Dr. Dick Raymond to come down to Clarkson and take over that program. That program has done very, very well, much more because of his work, quite frankly, than mine. I'd like to visit with you just a little bit about Creighton, the situation at Creighton, and how health reform and the Affordable Care Act may impact upon Creighton and the work that we do at Creighton University. Creighton University, we are what some would term a safety net hospital. We care for a number of folks who have difficulty financially, many of whom are uninsured, many who are on Medicaid as their primary form of insurance. As a hospital, Creighton University Medical Center, and a delivery entity, Creighton Medical

Associates, that cares for a large number of indigent patients, we are what is sometimes termed a disproportionate share, or "dispro" as the slang goes, hospital. That means that we were able to secure additional dollars through the Medicare program because we care for a number of uncompensated cases. As I think has already been described here, the disproportionate share mechanism goes away under the Affordable Care Act. The reasoning for that, and the logic behind that, is pretty straightforward, and that is, if in fact the bill does successfully cover many people who currently are uninsured. In fact, many of the dollars that otherwise would have come through the disproportionate share program, will now come through the insurance entity that will cover these folks in a newly insured environment. I wish I could be 100 percent confident that that might happen. I realize that there are a lot of slips between passing an act of this sort and actually getting it done and accomplishing it. And given some of the comments that have been made in terms of people who may oppose this in the future, I'm, frankly, concerned that the disproportionate share may go away but the corresponding increase in the insured may not, in fact, be there. That would be very, very difficult for us. We're not going to turn anyone away. As long as our doors are open, as long as we're a part of the community, we will continue to see every patient that we can, regardless of their ability to pay; we will continue to care for them. We do provide a significant portion of uncompensated care. That's a part of who we are and that is a part of what we will continue to do. However, for us, Medicaid revenue is a significant issue in our ability to keep our doors open and in our ability to continue with the work that we do. That's important, certainly from the standpoint of the care we provide, but it's also important because at Creighton University, obviously, we have a second mission, and that's to produce healthcare professionals. We are an institution that--I didn't come up with his term, but it's been used--we are an institution that adds to Nebraska's "brain gain." There are states that worry about a brain drain; Nebraska has a "brain gain." There are significant numbers of health professionals in this state practicing delivering care who otherwise would not be here had they not come to Creighton to go to school. Can I give an example? I'll give you a very close-to-home example. Dr. Joann Schaefer, the state's Chief Medical Officer, born and raised in southern California, most likely would not have

stepped foot in Nebraska, but instead she came to Creighton University to medical school. She did her residency training in the specialty of family medicine at Creighton University; joined our faculty; and then answered the call to the state to participate in state government; is now the Chief Medical Officer. That's just one example. There are also Creighton graduates practicing, not only in Omaha and Lincoln, but in places like Valentine, Superior, North Platte. Throughout the state there are hundreds of professionals. And that's just the physician side. Obviously, nurses, dentists, physical therapists, occupational therapists are throughout the state. We are able to do this partly because of the tuition dollars that our students pay, but also because of the revenues we're able to generate, much of which is through the Medicaid program, and that has a significant impact on our ability to continue. We do know that if Massachusetts can be used as a model, and the Affordable Care Act oftentimes has been compared to the Massachusetts plan, there will be an increased need for healthcare professionals in the future. A lot of emphasis has been placed upon how many more doctors are we going to need. And frankly, doctors get all the attention. The reality is, we'll need increased numbers of nurses. We'll need increased numbers of other health professionals, too, as we head toward the future and the needs of insuring more of our population. The other aspect of what we do is we do a significant amount of research. And certainly the program which uses dollars from the tobacco settlement is very important in terms of our research. Research has an obvious payoff--you know, we make new discoveries; we impact on people's lives. But that's just part of it. Research also has a significant role to play in bringing those professionals to the state and in keeping the medical school open. Being able to do research is a significant factor in attracting outstanding faculty members--the people who taught Dr. Schaefer, the people who taught the other graduates who are out in the state practicing now. These are people who came to Creighton partly to teach but also because of the research opportunity as well. All these things that I'm mentioning obviously we share with our friends down the street at the University of Nebraska Medical Center. All those are the same factors. Unlike the University of Nebraska Medical Center, we don't receive state funding to do these things. And if you all had a whole bunch of money just to spread

around and wanted to give us some, I wouldn't turn it down. But at the same time, I recognize the very real economic circumstances that all of you are wrestling with right now. And I can tell you right now, I'm glad that you folks are doing that--I know I couldn't--and I'm very appreciative of the work that you're doing. As we look to the future at Creighton, certainly we're going to continue to see every patient that comes to see us. We're going to continue to produce the very best professionals that we can for the entire state. We're going to continue to do research. We're going to continue to be the best citizens that we can be for the state, for our community. And as you struggle with the many issues that you have to struggle with, I'm not here to tell all you what to do; that's not my purpose. My purpose in being here is to let you know some of the difficulties that we face, what we are trying to do, and ask that you consider those issues as you make the decisions that you must make on the very important issues that you're dealing with. Thank you very much. And I'd be more than happy to answer any questions. [LR467]

SENATOR GAY: Thank you. Any questions? I've got one question on the disproportionate share of funding. [LR467]

DONALD FREY: Yes, sir. [LR467]

SENATOR GAY: Is that, then, cut--you said you were worried about it being cut and then not implementation of the healthcare act. So is that...when is that supposed to be cut, then, 2014 or...? [LR467]

DONALD FREY: My understanding is that it is a process that will begin and be completed by 2014. Yes. And, again, my concern is that there will be portions of the act that will be viewed as being somewhat favorable from a budgetary standpoint that will be implemented; other things such as increasing the number of insured--that will be the parts that won't be implemented. If everything goes according to plan, then, frankly, yes, there should be that increase in the number of insured that would compensate for the

loss of disproportionate share. The fact is I'm just concerned that that might not happen. And then the other factor, obviously, either way: Medicaid still is a critical factor for us in our work. [LR467]

SENATOR GAY: Yeah. And I know your representatives have talked to us about that. So it's something we should be aware of, too, because there's a lot of things going to happen. I'm with you. The anxiety of the whole thing is, you know, it's hard to plan. So, but anyway, I'm glad you brought that up. Are there any other questions? Oh, sorry. Senator Nordquist. Did you have one, Galen? [LR467]

SENATOR NORDQUIST: Dr. Frey... [LR467]

DONALD FREY: Yes, sir. [LR467]

SENATOR NORDQUIST: ...can you identify--does Creighton have any programs to incentivize students to go into primary care? And, I mean, just kind of outline what you have. [LR467]

DONALD FREY: Certainly. The more critical issues are in the admission process. We try to identify those students, in the admission process, who'd be most motivated to go into primary care, both in rural areas but also in other underserved areas as well, and try to target those people and try to foster those kinds of things. In terms of...and we have a number of electives that they're designed to underscore students' interest in those areas. In terms of a financial program at Creighton, we do not have that. What we do have--and I can speak to this from my number of years on the state Rural Health Advisory Commission--we do try to funnel those students with an interest in primary care to those programs that, in my opinion, are very effectively carried out by the Office of Rural Health and the Rural Health Advisory Commission that basically are either student loan programs or loan repayment programs that, in my opinion, have been very, very effective in bringing more students into not only rural areas but under the auspices

of that program, also urban underserved areas have also been designated as well. [LR467]

SENATOR NORDQUIST: Great. Thank you. [LR467]

DONALD FREY: Yes, sir. [LR467]

SENATOR GAY: Senator Cook. [LR467]

SENATOR COOK: Thank you. Dr. Frey, I have a question related to some testimony that was offered earlier by the hospital association. [LR467]

DONALD FREY: Yes, ma'am. [LR467]

SENATOR COOK: They offered--sorry, Bruce, I'm going to interpret--some numbers, some projections, saying, for example, people who would not be insured after they'd already been insured. And Senator Gay asked some questions about your DSH and how that's going away. Can you give me an idea of where Creighton's number is right now for what used to be called indigent patients but now there's probably a new word for it? [LR467]

DONALD FREY: Yeah, the buzzword now, I suppose, is called "uncompensated care"--care for which we receive no compensation. [LR467]

SENATOR COOK: Okay. Thank you. [LR467]

DONALD FREY: Basically, if you look at the charges that are entered, both in our clinics and in the hospital, it appears that we do about $30 million a year in uncompensated care. We provide the care, and we receive no compensation for that. I think, in all honesty, that's true for every hospital, even hospitals that may be in a--I'm trying to think

of a way to say this without sounding too pejorative--even some hospitals in pretty cushy areas. Okay. Even those hospitals will have some degree of uncompensated care. But in terms of a total number, I'm not aware that any hospital in the state provides more uncompensated care than the $30 million we do. [LR467]

SENATOR COOK: Thank you. [LR467]

DONALD FREY: Yes, ma'am. [LR467]

SENATOR GAY: Any other questions? Don't see any. Thank you for joining us today. [LR467]

DONALD FREY: Thank you very much. [LR467]

SENATOR GAY: Appreciate it. [LR467]

DONALD FREY: My pleasure. [LR467]

SENATOR GAY: Thank you. [LR467]

DONALD FREY: Thank you. [LR467]

SENATOR GAY: All right. Topher is jumping right up here. Perfect. Thanks for coming. [LR467]

TOPHER HANSEN: Yeah. Thanks for having me. [LR467]

SENATOR GAY: Hey, thank you for coming. We got you about 15 minutes. [LR467]

TOPHER HANSEN: (Exhibit 7) Good afternoon, ladies and gentlemen. I'm Topher

Hansen; I'm executive director of CenterPointe here in Lincoln and also a member of NABHO, which is Nebraska Association of Behavioral Health Organizations. I have a sheet here with my testimony on it. You'll have to forgive me, I addressed it to Health and Human Service Committee just sort of out of habit, and so forgive my audacity in reassigning your committees, and we'll just kind of ignore that piece and go from there. Again, I'm Topher Hansen, and I'm pleased to be here, because this allows us an opportunity to advise and inform about the impact of healthcare reform on behavioral health issues. One of the big challenges in our world--that we're evolving slowly, but we're getting there piece by piece--is to understand behavioral healthcare issues as something different than what we have known them to be in the past. It's sort of the one area of medicine, if you will, that we have had a lot of judgment about and misconception about over the years. And it's required us to take some special efforts to address issues like healthcare reform and parity in order to bring it up to par, or closer to par, with other healthcare issues. Indeed, mental health and substance issues are chronic issues; they're chronic-care issues. Addiction, as a disease, is a brain disease. Science knows that your brain chemistry changes, and it's not just a matter of will or a lack of will or other things like that. There is actually a chemistry in play in your brain compelling--it's a compulsion to cause people to do things. And that's why you see some of the most unbelievable kinds of behavior out of people--who are gambling; or headlines of Tiger Woods in the paper; people who are addicts to drugs, seemingly drugs that don't have a physical dependence but seem to drag people's lives down; just things that seem illogical and nonsensical but very compelling. And that is the chronicity of this. They know that some addictions have the chemistry that's going in the brain that is as powerful as our drive to eat food. So if we think about ourselves after two or three days of not eating food, where our priorities are going to be and where that pull is going to be, that's the power of addiction. Mental health issues--mental illness is similar, in that--I always explain it to the public when I speak, is it's just like juices being out of balance and that the psychiatrist is the chemist that comes in and listens to the information to discern where the chemistry is and then tries to adjust that chemistry. And what people will tell you is that once that chemistry is achieved, they have an

existence that they did not know before. And they're...I have personally witnessed situations where people were actively psychotic, out of control all the time in terms of not being able to make choices or not being able to sustain daily life in ways that provided food and housing and so on. And as little as one medication can help change that, to cause people to get clear thinking, get those juices in line, and begin to function on a daily basis as anybody else would. So for us to then begin to address chronic illness as--whether it be mental health, substance, diabetes, heart disease, other kinds of things that affect us over a lifetime--is critical in terms of the well-being of the individual and the cost to society. The ways that healthcare reform will help achieve some of the parity issues: one is that insurance policies cannot be denied based on pre-existing conditions. Many people acquire mental illness at the late-teen, early adulthood. But, believe me, they don't know they have it; it doesn't announce itself. And so people will live for years trying to compensate for some new weird thing that's happening to them before they actually come to terms with what the issue is. And by then you may have a pre-existing condition, where you could be denied insurance coverage. Mandatory renewals of policies: again, not allowing people that have a chronic condition to be denied. And eliminating all annual and lifetime limits. The 30-day treatment rule: we've all heard of doing 30 days in rehab. Well, 30 days did not come from a clinician; it came from an insurance company, and it's even less than that now. And, in fact, residential treatment payment is virtually nonexistent. So for us to have more of a clinical drive and a medical drive, to understanding what we need to do and how we need to serve people, what the realistic time frames are, makes much more sense. Other ways that this helps make insurance available to people that are currently uninsured would be the expansion of Medicaid to 133 percent of poverty and state-based purchasing pools, known as insurance exchanges. And the one requirement in that, in the law, that revolves around the exchanges is the "essential health benefits" language. And that stipulates that those essential health benefits must include mental health and substance use conditions and that the requirements...that helps to meet the requirements of the federal Mental Health Parity and Addiction Equity Act. Again, the chronic condition is best met early on, no matter what the chronic

condition is. If you can get to somebody who has heart disease very early, you can avoid the heart attack and avoid the long-term, very expensive care that that can bring. Same with diabetes. Same with mental health. Same with addiction issues. And so for us to put into place a care act that helps bring us more cost-efficient care to the population makes much more sense. This is huge for behavioral health, because it tends to be...we have a lot of judgment about it, as I said in the beginning. And people who have that condition come on at 17, 19, 23. Then, oftentimes, we can see them begin to use substances to compensate for what's going on in their system--not unusual at all. Better than 50 percent of people with mental health (sic) will often have substance issues, especially in the bipolar and anxiety-depression issues. And so for that to go further down the road, they often lose their job, lose their house, lose their family, and they become uninsured. To get a healthcare system that can get them back on track and participating again, again, saves us tons of time and money as a society. With that, I'll stop and take questions if you have any. [LR467]

SENATOR GAY: Very good. Thanks, Topher. Senator Hadley. [LR467]

SENATOR HADLEY: Senator Gay, thank you. Topher, thank you for being here. We've talked a lot in this committee about the healthcare professionals needed, especially when this gets going and more people require those services. Isn't it true, a statement that outstate Nebraska, rural Nebraska, really suffers from a lack of mental health professionals, facilities, and such as that right now? Will this exacerbate that shortage? [LR467]

TOPHER HANSEN: It will put more people in the system and put more people onto caseloads that currently exist of those professionals in the area. The question is our response to that and how we go about being creative in our response to healthcare, not just in behavioral health but across the board. And so what we have in Nebraska, we're actually fortunate in Nebraska to have a telehealth infrastructure that we don't really utilize as well as we might be able to. We also have physician offices throughout, that

we haven't integrated behavioral healthcare into those, but we know that those are places that people go. If we can start to be creative in the way that we use our existing resources and capitalize on the infrastructure that's there, we can begin to respond to that. Yes, indeed, there are few professionals out in Cherry County, for instance. And I can't tell you the number of people that we've talked to who travel great distances to find behavioral healthcare--but especially if it's co-occurring, which is what CenterPointe does, is focus on both mental health and substance, integrated. They essentially are coming to Lincoln or being referred to Lincoln, to us, to get that healthcare. If we had...if we utilize our telehealth services better, capitalize on the psychiatric services we do have available, and begin to reach out to communities, we could do a better job than we're currently doing. In theory what this does, though, is reach out to more people, yes. [LR467]

SENATOR HADLEY: I guess I just asked the question or made the point because I know, in a prior life in Kearney working with Richard Young and the psychiatrists, the problems we had recruiting psychiatrists. And also Richard Young, the mental health hospital, was just very, very expensive to maintain, and the reimbursement rates were so low and such as that. [LR467]

TOPHER HANSEN: Yes. [LR467]

SENATOR HADLEY: So it... [LR467]

TOPHER HANSEN: And the higher the paid professional--that is, the more licensure, more education, the more average salary, if you will, for those professionals--the harder it is to recruit to less-populated areas. And it's a giant problem. So you might be able to get a few over time who say: But this is where I love to live, therefore I will--and hallelujah for that. But then the other side is: are they competent in the area? Because it's a very specialized area to practice in, number one. And it still doesn't take away the, I think, our duty to use the resources that we have in a creative way to access people in

less-populated parts of Nebraska. They should be able to get the kind of healthcare they need, whether it be behavioral health or physical healthcare. And for us to utilize that telehealth system makes a lot of sense. The technology is there; we just have to begin to modify our system to allow that to happen. [LR467]

SENATOR HADLEY: Thank you. [LR467]

TOPHER HANSEN: Yup, thanks. [LR467]

SENATOR GAY: Any other questions? [LR467]

SENATOR NORDQUIST: Yeah. [LR467]

SENATOR GAY: Senator Nordquist. [LR467]

SENATOR NORDQUIST: Thank you, Mr. Hansen, for being here. Looking at, kind of, the change in mental health care from, I don't know, the mid-'50s or following Medicare and Medicaid in the '60s--the precipitous drop-off in state-run beds and the decentralization of mental healthcare treatment--obviously Medicare and Medicaid played a huge role in that. Now, with this change...and that change happened, you know--a big change--in the decade or two following the enactment of those policies. Do you see...is there...I guess looking into your crystal ball, what do you see in the next decade or so for the system, now that people are not going to be denied for coverage and are going to have guaranteed access to mental health treatment? What does that system look like a decade from now? [LR467]

TOPHER HANSEN: Good question. And like every good system, it depends on execution. And it depends on the people that are running the system and how confined they are to the pigeonholes and how out of the box they can get their thinking to use the infrastructure that's in place to get the job done. An example: CenterPointe started

co-occurring treatment in, officially, in 1989. I guarantee you it wasn't in the lexicon back then. People had no idea about it. We had a lot of things said about us because we were doing it. But the fact of the matter is what we did was just get outside the box and figure out a way to lace it together to make it work, because we knew that's what the consumers needed in order to get better sooner for longer. So if what we do is take the limitations that we have, which is dollars, and the infrastructure that we have, which is beginning to give more people access, and begin to think in ways that are long term, strategic, and focused on the consumer, we're more likely to develop a quality system. Especially if we incent quality in the management of that, we are more likely to get a system that really does well. It doesn't necessarily take a billion dollars to have a good product; it takes an adequate amount of money along with creative and resourceful thinking. And I think we have to combine those two. We get pretty focused on looking at our shoes instead of the horizon and get penny wise, pound foolish, and it really costs our system in the long run. And if we can use this system in ways that are creative and productive for the consumer, I think we can do well. How that'll go in Nebraska versus Connecticut I can't tell you. But I can tell you that we're two different places with different sets of...different thinking, and we need to focus here in Nebraska on what the challenges are, what the opportunities are, and then how we can meet our goals in all of this. I think it's very possible. We do have some challenges, but we only have 1.8 million people, and we have a good...there are many people who are envious of our telehealth infrastructure, for instance, that we have a system that's there in place, and many don't. And I think we need to start utilizing our system to access and get the care that folks need. [LR467]

SENATOR NORDQUIST: Sure. How do you see--I guess now that everyone will have some level of coverage--kind of readjusting our region system to fit that...is there going to be a need for that, do you think, with our behavioral health? [LR467]

TOPHER HANSEN: Readjusting the behavioral health regions? [LR467]

SENATOR NORDQUIST: Yeah. [LR467]

TOPHER HANSEN: I don't anticipate that right now. I mean, I don't forecast seeing a giant change that would cause us to have to realign. I think the region is our strength, frankly, and that it...you know, if you're of a persuasion that you like local control, then the region ought to be your best asset and your best friend. I believe in it wholeheartedly, because I think they have a real feel for what the needs of that particular area are and can manage dollars and care in ways that are very productive. And I think our regions have shown that time and time again across the state, on how they can take limited dollars and provide essential services with productive outcomes. From Region I across the state to Region VI, we've...over the almost two decades, coming up, that I've been involved in this business, I have seen regions really step to the plate and do great. I think that's one of our strengths in behavioral healthcare. [LR467]

SENATOR NORDQUIST: Thank you. [LR467]

SENATOR GAY: All right. We're going to... [LR467]

SENATOR HADLEY: I just want to make one comment. [LR467]

SENATOR GAY: Okay. [LR467]

SENATOR HADLEY: And I...you talk about telemedicine. [LR467]

TOPHER HANSEN: Um-hum. [LR467]

SENATOR HADLEY: Just our wonderful federal government has decided that Good Samaritan Hospital in Kearney has too many people in its area, so they're going to lose their grant for telemedicine, in the middle of outstate Nebraska. [LR467]

SENATOR GAY: Instead of promoting it, they're losing it? [LR467]

SENATOR HADLEY: I just thought people would like to know that. [LR467]

SENATOR GAY: Wow. That's unfortunate. [LR467]

TOPHER HANSEN: (Laugh) [LR467]

SENATOR HADLEY: It has nothing to do with the space they're covering. [LR467]

TOPHER HANSEN: No. [LR467]

SENATOR HADLEY: Somehow it...they have too many people in their geographic area they're covering, so. [LR467]

TOPHER HANSEN: So we need to send a bunch of U-Hauls out to...? [LR467]

SENATOR HADLEY: Well, I guess. I don't know. I just thought I'd... [LR467]

SENATOR GAY: (Laugh) Thank you, Topher, for coming and sharing that with us. Appreciate it. And if we need anything I'm sure we can count on you. [LR467]

TOPHER HANSEN: Yes. Thank you much. [LR467]

SENATOR GAY: All right. Nebraska Pharmacists Association, Joni Cover. [LR467]

JONI COVER: (Exhibit 8) Hi. How are you? Good afternoon, Senators, Senator Gay, members of the committee, the esteemed committee. I'm Joni Cover, J-o-n-i C-o-v-e-r. And I'm the executive vice president of the Nebraska Pharmacists Association, and I

want to thank you very much for allowing me to share some information with you about the pharmacists' perspective of healthcare reform and the Affordable Care Act. We have some of the same concerns that have been shared throughout the many, many days of testimony you've heard about the cost, about the impact, about the regulations, about how we're going to manage this. And you've been given an enormous amount of information about the entire healthcare reform legislation. We're one of those groups also that's "to be determined." We've got some grant projects and some language that is included in the reform acts that we think is actually very positive for pharmacy. But the devil is in the details, and we don't have those details yet. But I wanted to share with you some of the opportunities that we feel are presented in the healthcare reform act. We've also shared these opportunities with our members of Congress, so they're hearing the same message from us that you are. According to the article published in the Journal of the American Pharmacists Association, improper medication use costs our nation approximately $177 billion a year. Pharmacist-provided MTM services, where pharmacists coach patients to help them get the maximum benefit from their medications, can improve health outcomes and reduce overall healthcare costs. In the healthcare reform legislation, several bipartisan provisions--and I think that's important to underscore "bipartisan," because there wasn't much of this bill that was bipartisan--but some of the bipartisan provisions that were included to establish pilot programs focusing on disease state management, which includes medication therapy management. Pharmacists are uniquely positioned to advance the two central healthcare goals, which is improving quality and reducing costs. While most people's experience at the pharmacy consists of simply receiving their medications and occasionally asking questions, pharmacists are trained to do far more for patients, particularly regarding MTM and med rec. Medication reconciliation and MTM services--I've kind of given you a little bit of a definition of what both of those entail. MTM services include formulating a medication treatment plan; monitoring and evaluating the patient's response to therapy; performing a comprehensive med review to identify, resolve, and prevent medication-related problems; and then coordinating and integrating MTM services within the broader healthcare management services being

provided to the patient. Medication reconciliation is something that's been sort of a hot topic in pharmacy and in healthcare in the last few years. Basically what it does: Medication reconciliation is the management of the medication from transition of care--so from the hospital back to home, from the hospital to the nursing home. A lot of times the medications that patients are on in the hospital will be different than what they were on at home, when they get dismissed. Maybe the formulary in the hospital was different than what their insurance formulary is outside the hospital. Medication reconciliation is providing that expertise, sitting down with the patient and making sure that the flow from the hospital to wherever it is the patient is headed--home or next level of care--that that all meshes and it's in the best interest of the patient. And I know that there's hospitals in the state and community pharmacists in our state that are putting in these type of med rec programs, so that their transition of care with their medications is going much more smoothly. The goal, really, of MTM is to keep patients with chronic illnesses out of the hospitals and to keep the elderly out of the nursing homes and to keep employees productive and resulting in the reduction of cost of the system while greatly expanding access to care and improving the quality for the life of the patient. Pharmacy is often referred to as the most accessible healthcare provider, because you don't have to have an appointment to come see us; you can walk into a pharmacy. And in some of our communities in the state, we're lucky to have 24-hour pharmacies, but in many of our rural areas we don't have that access. But you can still go to a pharmacy without having an appointment. Opening up the system by removing impediments to MTM by pharmacists accomplishes both goals at the same time. And I've included in your packet some information about different state Medicaid programs that have implemented MTM programs. There's a nationally known Asheville Project, which I just put a little, tiny blurb in there for you, and the Diabetes Ten City Challenge. I have a lot more information if you'd like that at some time; I just didn't want to kill any more trees than I already did. So those are some programs that are already proven, they're already working. And those are the kinds of things that we're hoping to model in the Affordable Care Act and healthcare reform, in the pilot programs that are outlined in the act. There's really four basic types of programs that have been included in the healthcare

reform act. One is the establishment of the medication therapy management delivery programs, and it's really just providing more opportunities to have MTM services in all pharmacy programs. In addition: Improving current MTM programs. When Medicare Part D passed--Medicare Modernization Act--in 2003, there was a provision in that federal legislation to highlight and encourage medication therapy management. And the problem with that was that there wasn't a set of standards for MTM--that every plan could have their own, you know, how many drugs the patient had to be on, age, cost, whatever. And so the language in the healthcare reform act really put some standardization into those MTM programs. We've seen some very successful programs being implemented through the Medicare Part D program, and so we're hopeful that because of those successes...and we've got folks working on this on a national level, trying to take the information that we've learned since Part D passed and share that with the rest of the programs in the Affordable Care Act to, I guess, mirror or tweak or whatever to make them all robust, all good, and all across the plans that medication therapy management can be offered. In addition, there are some pilot projects to talk about integrated care models, which is like our medical home model. And so I've had a conversation briefly with Senator Gloor to talk about how we can in Nebraska get pharmacists included in that medical home pilot project. And then the transitional care models, which, really, helps establish some community-based services for medication therapy management and med rec as well. So each of these provisions highlights the importance of including pharmacists in the healthcare team and the valuable medication expertise pharmacists provide to patients in various points-of-care settings. And we know, because of the studies we've done, the pilot programs that we've had, and the MTM successes, that when patients utilize their medications properly, managed by pharmacists working very collaboratively with physicians, health outcomes are improved. And we know that paying pharmacists for their expertise in medication management also saves money. Currently there are several state Medicaid programs, which I had discussed earlier, that have initiated pharmacist disease management programs, paying pharmacists for their MTM services. And that has ultimately saved money for Medicaid programs. Convincing Medicaid programs to spend money on the

front end to save money on the back end, though, is a bit of a challenge. (Laugh) I'm not going to try to do that today. But I will tell you that those programs have been successful in other states. I wanted to--sort of a little bit off topic, but--talk about this, because it's something that's going to impact all areas of healthcare, and that's health information technology and how much of a, I guess, good thing or a bad thing it is, depending on which chair you sit in. We've talked a lot about e-prescribing from the pharmacy perspective. And it's being touted as the savior to fix all medication errors. And what we found out is that when it works, it's great, and there are some definite benefits and advantages to having e-prescribing. Unfortunately it doesn't work that great all the time. So one of the things that we've begged for is, there's a--in the federal law there's an incentive for physicians to adopt e-prescribing, but there's no corresponding incentive for pharmacists to accept the e-prescription. And what we see, instead of us getting incentivized to engage in e-prescribing--because, really, most of the time it's just a switch of something in our computer systems--it's costing pharmacy to accept each one of those e-prescriptions. And then every time it's wrong, you know, we don't get the money given back to us; it still costs us money. So we're trying to figure out and have a conversation, to dialogue, about how, maybe, pharmacy can be incentivized on the e-prescription side too. It's irritating to the pharmacies, and it's irritating to the physicians when it doesn't work smoothly. And in some instances, when it's gone great, work flow is great, outcomes are great. But when the physician has to send it in to us and it's incorrect, whether it got sent to us incorrectly or there was some mess-up in the transaction, it's a frustration on both sides. So we understand our counterparts' in the physician offices frustration, and we share that frustration as well. But one of the things that we do think is important is, if we're going to be allowed to perform the medication therapy management and disease management programs, that we need to be able to access the electronic medical record. So our systems need to be able to talk to the physicians' systems or the hospitals' systems so that we can coordinate the care better. And we are working on that stage as well, but I thought it was fair to share that with you, because we're hearing so much about electronic medical records and HIT and those sorts of things. So, you know, we've been talking about electronic prescribing for a long

time, and that's just one piece of the puzzle. So finally what I'd like to share is just that pharmacists, we feel, in Nebraska are perfectly situated, as the most accessible healthcare provider, to improve the health of their patient, with the implementation of MTM and disease management programs saving money and improving health outcomes, which meets the goal of the healthcare reform. And I'd like to thank you for having the opportunity to talk to you. [LR467]

SENATOR GAY: Thanks, Joni. It was very good information. Are there any questions? I don't see any right now. I got one, I guess--when you talk about the IT. On these other medical...on the MTMs and all that, you'd almost need that IT working, wouldn't you, to make that? [LR467]

JONI COVER: Yeah, what happens now with the programs when we need to have access to medical records is we have to rely on the physicians' offices or the hospitals to share that information with us. So it's making copies, faxing things over. That's an inefficient use of the physicians and their staff time, and it's inefficient use of pharmacy time. So that's kind of what happens right now. [LR467]

SENATOR GAY: Okay. But then you had talked about some of your members, though, that might be starting to do this. So, I mean, when I think of a pharmacy, like I'd go to Target or something like that is kind of where we go, but...so you go in. Why aren't they, just, on their own, without government, saying: Hey, you know what, we got an extra service we can provide--and put it...are they going to do that, where they put it out there and say: Here's a service. And I'm talking maybe...well, a small town could too. [LR467]

JONI COVER: Right. [LR467]

SENATOR GAY: Let me help you; you shouldn't be taking six medications, when four will maybe do you; let's talk. [LR467]

JONI COVER: Many of our... [LR467]

SENATOR GAY: Why wouldn't the...and that's still a private-sector business pharmacy. [LR467]

JONI COVER: Right. Right. [LR467]

SENATOR GAY: Why wouldn't they just go ahead and do this now, or...? [LR467]

JONI COVER: Many of them do. [LR467]

SENATOR GAY: They are now? [LR467]

JONI COVER: Many of them do. But I will... [LR467]

SENATOR GAY: Because I don't see it advertised, and maybe I'm just missing it. [LR467]

JONI COVER: The model of...you know, remember, we're healthcare, and we're also business. So keeping the doors open in pharmacy requires...we don't get paid for the services. We don't get paid to sit down with you, Senator Tim Gay, and talk to you about the four medications that you're taking and how they interact. What we do get paid to do is to put the medications in the bottle and get them to you safely. That payment model has to change. And that's part of what we're hoping with these programs, is that people will understand there's more to the value of the drug and it's more effective and better for you if you have some management of that medication versus just, here's your pill, and, you know, do you have any questions? [LR467]

SENATOR GAY: Yeah. But I... [LR467]

JONI COVER: So we do have... [LR467]

SENATOR GAY: ...you know, don't be a pill pusher, but you can be a value-added, which is... [LR467]

JONI COVER: Right. Right. And we do have pharmacists all across... [LR467]

SENATOR GAY: Up here. [LR467]

JONI COVER: ...the state that are doing this. [LR467]

SENATOR GAY: Right. Oh, (inaudible). [LR467]

JONI COVER: It's just we're not getting paid for it. [LR467]

SENATOR GAY: So they can't find another way that they could charge their customer, and get the government out of it,.. [LR467]

JONI COVER: Well, unfortunately... [LR467]

SENATOR GAY: ...and say: I'll pay; by the way, I'll enroll in your program for $20 a year and... [LR467]

JONI COVER: (Laugh) yeah. Unfortunately, what happens is that because of the way third-party contracts are set up for pharmacies, pharmacies are most often prohibited to charge any... [LR467]

SENATOR GAY: Oh. Okay. [LR467]

JONI COVER: ...excessive fees. [LR467]

SENATOR GAY: That's where it was going. [LR467]

JONI COVER: So you agree to dispense the drug, and your cost of dispensing, which includes, you know, all of your overhead and the bottle and... [LR467]

SENATOR GAY: Okay, you just... [LR467]

JONI COVER: ...the counseling, is all in the fee. [LR467]

SENATOR GAY: That gets it for me. [LR467]

JONI COVER: So then to be able to say, oh, and by the way, we want to charge you whatever the fee is for this extra service, we're prohibited, in most instances, from doing that. [LR467]

SENATOR GAY: All right. [LR467]

JONI COVER: And I've had some conversations with some of our insurers in Nebraska about looking into those kinds of things, because we can't grow and provide these opportunities if we're prohibited on the payment side from doing such. [LR467]

SENATOR GAY: Yeah. [LR467]

JONI COVER: So that's a conversation that is taking place outside of this government program and how we're going to be allowed to do it without violating our contractual agreement with our third parties. [LR467]

SENATOR GAY: Well, good luck. I mean, that sounds like a great program, really... [LR467]

JONI COVER: Yeah. [LR467]

SENATOR GAY: ...if you can get it going. All right, thank you very much. [LR467]

JONI COVER: Thank you. [LR467]

SENATOR GAY: Appreciate it. Melissa Florell, Center for Rural Affairs. Melissa, you're going to talk about Exchanges and rural health considerations, I see? [LR467]

MELISSA FLORELL: (Exhibit 9) It's a big chair for not a very tall person. Good afternoon. Thank you for the opportunity to speak today. Like you introduced me, my name is Melissa Florell. I'm a lifelong rural Nebraskan. I grew up on a farm in northeast Nebraska, and now my family and I farm near Kearney. And my perspective on health reform implementation is both personal and professional. I practice as a registered nurse, and through talking to my friends, family, patients I care for, I've realized that the healthcare system is truly inaccessible to many people, especially those living in rural America. The high cost of healthcare inhibits economic growth and reinvestment in small businesses including family farms. And farm families are more likely to be uninsured or underinsured than nonfarm families, and a staggering number carry medical debt. The cost of health insurance continues to rise while benefits decrease, causing hardships for many families including my own. And it was a personal choice in my case. I chose to work part time as a nurse in order to complete an advanced nursing degree and to be more available and active in our farming operation. Therefore I'm not eligible for health benefits through my employer, and we go to the private market to purchase that insurance. And we're a healthy family of five with a $3,000 deductible and a premium that's risen in the past three years 49 percent to over $750 a month. And when we reapplied to our insurance company a year ago, my healthy sons, 13 and 9, were excluded. They have no chronic health conditions. They're healthy boys with a propensity--you know, they're active in athletics, so they've had a couple of sports

injuries that were minor, but they were excluded from our plan, preventing us from reapplying. Now that won't happen anymore, thanks to the provisions that went into effect on the 23rd, so that's a good thing. And the reason that I came here today is that my story is a positive one. I have it so much better than so many people that I take care of that have higher healthcare costs than we do. A 2007 survey conducted by The Access Project found that families purchasing health insurance on the private market spend $4,359 more annually than those who receive coverage through their employers. Those individual insurance plans only cover an average of 63 percent of medical costs compared to group insurance that typically averages about 75 percent of the cost. And as agriculture continues to be an integral part of the rural economy and for this economy to remain strong, health insurance has to be accessible. These are personal stories. They're not isolated incidents; they're examples of why the current insurance market doesn't provide adequate options for rural residents, especially those who are self-employed. So many people that I know and care for wait too long to access care because they feel they can't afford it or they fear becoming uninsurable. And the Patient Protection and Affordable Care Act supports some initial steps to improve the access and availability of healthcare in rural Nebraska. In addition to the challenge of obtaining adequate and affordable health insurance, residents, as you've heard before, face a critical shortage of primary care providers. Primary care providers offer the routine primary care, health promotion, disease prevention, and treat chronic conditions--fundamental needs of the rural population who consistently have higher incidence of chronic illness, such as asthma, arthritis, heart disease, and untreated mental disorders, than urban residents. And the shortage of providers does lead to diminished health status and quality of life for rural residents. In order to build strong rural communities, you have to invest in all areas of that rural work force. And Title V of the Patient Protection and Affordable Care Act contains provisions with the potential to positively impact the rural healthcare work force. Rural physician training grants and interdisciplinary community-based linkages programs are both intended to recruit prospective primary care providers from rural areas, support them financially and academically in their preparation. Both of these programs contain funding that support

area health education centers. AHECs work to adapt national initiatives to address local and regional healthcare issues. They use community-based training to recruit, train, and retain healthcare providers in rural areas. The healthcare reform law also contains provisions supporting the recruitment and retention of registered nurses and advanced practice nurses. Registered nurses make up the largest sector of the healthcare work force and are facing severe and increasing shortages. The law authorizes $338 million for fiscal year 2010 for existing and revised Title VIII nursing work force development programs, including advanced-education grants; nursing work force diversity grants; and nurse education, quality, and retention programs. It also supports faculty nurse education. Nebraska's effective implementation of national healthcare reform can help to ensure vibrant, healthy rural communities with the new state-level Health Insurance Exchange that will be created under the Affordable Care Act and can serve as a major insurance marketplace when it begins in 2014. The Exchange will provide many currently un- and underinsured Nebraskans with a simple way to obtain quality, affordable coverage. This is especially true for rural Nebraskans, who are less likely to have access to health insurance than those in non-rural areas. As Nebraska policymakers structure the Health Insurance Exchange, I ask that you consider the unique circumstances of rural residents. Rural places and residents are more isolated, particularly true of low-income rural residents, who need affordable health insurance the most. The Exchange has to be able to reach these populations--and they won't be able to do it without dedicated outreach and education--who are especially concerned about what seems to be the conventional wisdom that the Exchange has to be Web-based to be most effective and efficient. And that is true for the largest number of Americans, but it's not necessarily true for many rural people in our state. Generally, rural people have, especially low-income residents have less access to high-speed telecommunication technology. A Web-based Exchange would leave out a significant portion of the rural population and provide less than optimum service for a larger share. If that's the case, healthcare reform would accomplish little to address the health insurance disparities currently endured by many rural Americans. Small businesses and self-employed individuals make up a substantial percentage of Nebraska's rural population, and

historically these people have the highest likelihood of being uninsured, due to the high cost resulting from very small risk pools. The Exchange must be structured to ensure that rural businesses and farm families can pool their employees with other individuals to spread the risk, and lower insurance costs. It would be most optimum to create one insurance pool with both small businesses and individual consumers. Regulations should create incentives for states to create one large insurance pool that would capture these individuals. The opportunity for broader pools would address many of the issues that lead to high rates of un- and underinsurance in rural areas. [LR467]

SENATOR GAY: All right. Thank you. [LR467]

MELISSA FLORELL: I'd be happy to answer any questions. [LR467]

SENATOR GAY: Any questions? No, I don't see any. Good points, actually. I think the Exchange is an opportunity. Who knows where it's going to be. I asked earlier, I don't know if you were here, about are other...is there multi states talking yet? [LR467]

MELISSA FLORELL: Um-hum. And I... [LR467]

SENATOR GAY: And only 18 states have started doing this. But... [LR467]

MELISSA FLORELL: Um-hum. [LR467]

SENATOR GAY: ...the opportunity, you know, you talk about rural, but I think small businesses as well. [LR467]

MELISSA FLORELL: Um-hum. [LR467]

SENATOR GAY: I don't know what it's going to end up all looking like. But very good points. I appreciate it. [LR467]

MELISSA FLORELL: Yeah. The larger you can make those groups... [LR467]

SENATOR GAY: Yeah. [LR467]

MELISSA FLORELL: ...the more effective it's going to be for--and the more opportunities it's going to open up for individuals who are, you know, farm families. [LR467]

SENATOR GAY: Especially interstate... [LR467]

MELISSA FLORELL: Um-hum. [LR467]

SENATOR GAY: ...competition or comparisons... [LR467]

MELISSA FLORELL: Absolutely. [LR467]

SENATOR GAY: ...would be good. Thank you very much. [LR467]

MELISSA FLORELL: Um-hum. [LR467]

SENATOR GAY: Appreciate it. All right. Kay is here, I see. How are you? Friends of Public Health. Kay, you're going to talk about funding opportunities in public health? It's what I have here. Is that correct? [LR467]

KAY OESTMANN: (Exhibit 10) I am. [LR467]

SENATOR GAY: All right. [LR467]

KAY OESTMANN: My name is Kay Oestmann, K-a-y O-e-s-t-m-a-n-n. I wear several

hats today. I'm speaking as the president of the Public Health Association of Nebraska. I'm also a health director in the Southeast District Health Department, which is everything south of Lincoln and east. Senators, I'm here today to talk about public health's role in the Affordable Care Act, public health act. The act provides for expanded and sustained national investment in prevention and public health programs authorized by the Public Health Service Act for Prevention, Wellness, and Public Health Activities including prevention, research, and health screenings. Competitive grants will be available for state and local governmental agencies as well as community-based organizations. The purpose of the funding will be to reduce chronic disease rates, address health disparities, and develop a stronger evidence base for effective prevention programming. Currently local health departments address prevention activities. This additional funding will provide for implementation of proven prevention activities at the local level--things like diabetes, obesity, WorkWell, and those kinds of things that we haven't previously--we've done as well as we can, but we haven't had the funding to do. The appropriations I have listed for you at the bottom of page--of the first page. These are all things that we're pretty excited about, because they're things that we're currently doing but doing on a level that we need more funding for. The public health work force is a real concern for us, and it should be improved with the new School of Public Health, but, you know, currently we really need to improve--like all healthcare in the state of Nebraska needs to improve--the work force. Community transformation grants: This is one that Omaha has currently just received funding for that Michelle Obama came to the state and announced. It reduces chronic disease rates, addresses health disparities, and develops a stronger evidence base of effective prevention programming. Twenty percent of these grants are targeted to rural and frontier areas. Healthy living and living well community-based public health interventions that include improvement in nutrition, increase physical activity, and reduce tobacco use and substance abuse and improve mental health and promote lifestyles, and this is done in the workplace usually. Major opportunities are to build a system of care that focuses on prevention and primary care, to develop and expand the field of public health systems and services research. Current health statistics tell us that one in four

Americans has heart disease, one in three has high blood pressure, 24 million Americans have type 2 diabetes, and another 54 million are pre-diabetic and at high risk for developing type 2 diabetes; an estimated 2 million adolescents have pre-diabetes. The financial burden of specific diseases that can be impacted by physical activity, nutrition, and smoking: Diabetes or high blood pressure, the combination of the two diseases--the costs in the United States are 9.4 percent for that. The high blood pressure, diabetes in people who have heart disease or stroke and/or kidney disease--16 percent of our funding goes to that. Heart disease or stroke and kidney disease who do not have diabetes or high blood pressure--6.2 percent of our costs for medical care goes to that. Cancer--3.1 percent. Arthritis--1.1 percent. And COPD--2.0 percent. The impact of funding on prevention activities: Intervention cost on investment, $10 per person in Nebraska--it would cost us $17,470,000; one to two years' savings would be $35,500,000; and in five years, $18,100,000. I've given you a chart of the impact of prevention dollars. A very wise senator once told me that most of the senators in the house can read and that they like to look at these things themselves and they like testimony to be brief. So I'll let you read that. In conclusion, I'd just like to say that as far as public health is concerned, that health reform is a journey not a destination, that we do things--that we believe in public health that prevention is the primary cornerstone for all the nation's health, and that, you know, the money that we can save through prevention activities may not be noticeable right away, but I have the statistics there to show you that in the long run, why, we can do some really great things if we have this funding. So I would entertain any questions. [LR467]

SENATOR GAY: Any questions? Just a comment. We were doing our budget, and Dr. Schaefer was speaking in this public meeting--no big deal--but I asked her about the public health, and she spoke very highly of working together with your agencies and the public health people throughout the state. What I had talked about a little bit--and you'd mentioned some of these grants--down the road there are opportunities. And we talked about this earlier this morning. There's, however you look at this healthcare reform, if those opportunities are there, are you getting together as organizations and seeking

those opportunities to get some funding? Because...and I don't know what's going to happen with the budget, but--and some of that budgeting--a lot of your budgets are from general funds. But are you seeking federal grants or opportunities, and where would the Legislature need to help you to achieve those? [LR467]

KAY OESTMANN: We still need to defend on our LB692 funding that's for the infrastructure; it's for the daily things that we do. The thing that's sad is that we've all done assessments; we know what the needs are in our communities. We are always looking for funding; we're always looking for ways to do it. The health directors have just positioned themselves so that they will be able to apply for grant funding as a group. So some of this funding that comes down--the feds are talking about, you know, giving it out to organizations like Robert Wood Johnson and those kind of things, who in turn would turn around and give it to us. What a waste, you know. They're going to take their administrative top off of that, and it could be used for the activities that we can do to improve people's lives. Every district health department has the same premise primarily, but through assessment we see what the needs are in our communities. And the things that are going on in Omaha aren't the same things that are going on in Falls City or Pawnee City. So, you know, we primarily--we all have to do smoking cessation; we all need to work on obesity; we all need to work on chronic disease that's plaguing the persons' lives. And in my area--I hear everything that the previous testifiers said, you know--I've got people with $5,000 deductible insurance, and they don't do any prevention activities because it's not included, or else they've got a healthcare savings account. And they, you know, they don't have the money to go in for mammograms, for, you know, just an EKG if they're having chest pain, you know. They don't have that money. So it's very important that we get some of these prevention dollars into our communities and start making people so that--helping them to live healthier lives rather than paying for them after they have the chronic disease. [LR467]

SENATOR GAY: But you'd talked about--so you as agencies can go out and search for some of the money in this reform bill. [LR467]

KAY OESTMANN: Some of the federal dollars... [LR467]

SENATOR GAY: Does the Legislature need to assist you in that? Or can you go out...there's probably some that say...when I read a federal bill, it says if you do this, you will receive this. [LR467]

KAY OESTMANN: Right. [LR467]

SENATOR GAY: Now, in some way that's like, well, if I spend a little more, I'll get a little more. Well, it's tough to spend. You said you're now working together as a group, that you could go out and seek federal grants and monies in the new Patient Protection Act? Is there...can you go out and chase this $250 million? [LR467]

KAY OESTMANN: Some of the funding, Senator Gay, will come down as pass-through only to state governments. [LR467]

SENATOR GAY: Okay. [LR467]

KAY OESTMANN: Some of it we aren't able to apply for. Health and Human Services just got a $1.2 million grant that was only available to states and, like, New York City and Chicago and, you know, the very large health departments; they were the only ones that could apply. We were very fortunate to be, you know...and the health departments will reap that; public health in Nebraska will reap the benefits of that. But, you know, some of these it's impossible for us to apply for, because... [LR467]

SENATOR GAY: Okay. That's... [LR467]

KAY OESTMANN: ...they have to go through the state government. [LR467]

SENATOR GAY: Well, I guess, on that--working together--because I know public health is mostly federally funded. [LR467]

KAY OESTMANN: Right. [LR467]

SENATOR GAY: And we get a lot of bang for our buck on that... [LR467]

KAY OESTMANN: Thank you. (Laugh) [LR467]

SENATOR GAY: ...the way it's set up. But I was just kind of seeing where your views were... [LR467]

KAY OESTMANN: Yeah. [LR467]

SENATOR GAY: ...and what your... [LR467]

KAY OESTMANN: Well, you know, with the economy, we have the same concerns everybody does. [LR467]

SENATOR GAY: Yeah. You had a question? [LR467]

SENATOR CAMPBELL: I just want to follow up on yours. [LR467]

KAY OESTMANN: Senator Campbell. [LR467]

SENATOR GAY: Yeah, go ahead, Senator Campbell. [LR467]

SENATOR CAMPBELL: Thank you, Senator Gay. I just want to follow up on Senator Gay's question, just to clarify, because we were talking about this the other day. How many district health centers are there in the state? []

KAY OESTMANN: LB692 departments? []

SENATOR CAMPBELL: Yes. [LR467]

KAY OESTMANN: Or health departments all together? [LR467]

SENATOR CAMPBELL: Hmm, both. [LR467]

KAY OESTMANN: Okay. There's 22 health departments; 21 are...wrong. Twenty are LB692. Nineteen...19 now. I'm sorry. We had another split. [LR467]

SENATOR GAY: But they're all multi-county, right? [LR467]

KAY OESTMANN: They're multi-county. The definition is that they had to be a minimum of 30,000 with three contiguous counties, 50,000 to stand alone. They were able to choose which counties they wanted to play with. So it's, you know...but, yeah, multi-counties. The Panhandle has ten counties; I have five. [LR467]

SENATOR CAMPBELL: But the counties--there's no requirement of the counties to put in any funding to you? [LR467]

KAY OESTMANN: Originally, no. If they had supported the health department before, they had to support the same amount. [LR467]

SENATOR CAMPBELL: A maintenance number. [LR467]

KAY OESTMANN: So Omaha, Lincoln, Grand Island are supporting their health departments. [LR467]

SENATOR GAY: Oh. So if you were already doing it, yeah, you couldn't pull the support away and turn it over to the state. [LR467]

KAY OESTMANN: Right. [LR467]

SENATOR GAY: But many counties right now... [LR467]

KAY OESTMANN: Right. [LR467]

SENATOR GAY: ...are not receiving aid from the counties, I don't think. But... [LR467]

KAY OESTMANN: Right. [LR467]

SENATOR CAMPBELL: Other than the three, none of them are. Are we correct in that, Kay? [LR467]

KAY OESTMANN: There might be some that are getting, you know, some support for things that they do for them... [LR467]

SENATOR CAMPBELL: Oh, okay. [LR467]

KAY OESTMANN: ...you know, that kind of thing--jail nursing, you know... [LR467]

SENATOR GAY: Oh. [LR467]

SENATOR CAMPBELL: Okay. [LR467]

KAY OESTMANN: ...that kind of stuff. So, but... [LR467]

SENATOR GAY: Like through interlocals? [LR467]

KAY OESTMANN: Yeah. [LR467]

SENATOR GAY: All right. [LR467]

KAY OESTMANN: Yeah, interlocal agreements. [LR467]

SENATOR CAMPBELL: Okay. [LR467]

SENATOR GAY: All right, thank you. [LR467]

SENATOR CAMPBELL: Thank you. [LR467]

SENATOR GAY: Any other questions? [LR467]

KAY OESTMANN: You're welcome. [LR467]

SENATOR GAY: I don't see any. Thanks, Kay. [LR467]

SENATOR COOK: Senator. [LR467]

SENATOR GAY: Oh, I'm sorry. Senator Cook. [LR467]

SENATOR COOK: I just have a--thank you--a quick question about what might define, from what you understand from the bill, the public health work force--$8 million for public health work force. Would that be agency directors or... [LR467]

KAY OESTMANN: It's to educate. It's to bring forth...you know, I mentioned the new School of Public Health. It may be things like leadership training--like Great Plains training assists with that. It may be, you know, just, there's several--University of

Nebraska at Kearney is doing an M.P.H. in public health now as part of their curriculum; I noticed Bellevue University has some public health things. But it's just bringing up the work force, you know, and getting them into the--to stay in the state mainly, you know, is what I would hope to see this go to in our state. [LR467]

SENATOR GAY: Would AHECs qualify for that? [LR467]

KAY OESTMANN: They do...their education primarily is with the school kids, to bring them up to all kinds of health education. It, you know--they have a small component that works toward public health. But they work with RHOP and those kinds of things--AHEC does. [LR467]

SENATOR GAY: So it's not...yeah, okay. [LR467]

KAY OESTMANN: Yeah. [LR467]

SENATOR GAY: All right. I don't see any other questions. Thank you. [LR467]

KAY OESTMANN: Thank you. [LR467]

SENATOR GAY: Appreciate it. Dr. Bob Rauner with family physicians. Here to talk about work force needs, Doctor? Just on family physician part of it? Or are you going to go...? [LR467]

BOB RAUNER: (Exhibits 11 and 11A) Mostly. Brief comments on the others, but. [LR467]

SENATOR GAY: Whatever. Don't...okay. [LR467]

BOB RAUNER: Okay. Go ahead and start? [LR467]

SENATOR GAY: Yup, go ahead. [LR467]

BOB RAUNER: Okay. I'm Dr. Bob Rauner, spelled R-a-u-n-e-r, from here in Lincoln, Nebraska, although, like Dr. Frey earlier, I started out life as a rural family doctor but then ended up back in Lincoln because my wife is from here. So she won in the end. Mainly I'm going to talk about the family physician work force issues that are going to be coming up. I think one of the overlooked areas of the Patient Protection and Affordable Care Act is that it didn't do enough about discussing the long-term costs. It's going to cover more people, but the cost isn't significantly different. There's really three areas where you can get both better health and lower costs. The three areas are improvements in health information technology, the patient-centered medical home and more primary care, and efforts to decrease prevalence of obesity and increase physical activity. The information technology is already being addressed in Nebraska through the HITECH Act, NeHII, various (inaudible), so I won't talk at all about that. Dr. Tom Tape last month did a very good job of covering the evidence behind patient-centered medical home and primary care, so I won't repeat that other than to say that we definitely agree with most of what he said and, then, that the evidence is out there, so it can all be verified. The two things that I want to cover the most are the things that are going to be obstacles to advancing that in Nebraska right now. I included a couple of graphs. I'll start off with the graph here on the medical practice shortage area; this is the current shortage area. So you can see that most of our counties already are shortage areas; that's as we sit today. But what's important to know is also not today but what's going to happen five to ten years from now. And then if you flip to the next page, there's an age distribution of what the current family physician work force is. And you'll notice that there's a decidedly large peak in the early to mid-50s. That means ten years from now, when they retire, that shortage is going to get a lot worse, because you'll also notice there's not a corresponding peak coming after them. And the trend is actually getting worse, not better, for that. So I think Dr. Tape mentioned last month about Massachusetts and its issues. They expanded their healthcare system but then found

out there was no one to see them. And right now we're not so bad, but in ten years we will if we don't do anything to do this ahead of time. The areas where we can make the biggest progress--one is, of course, increasing the supply of family physicians. There's a couple things, though, that are obstacles to that. At the same time, we know that demand is going to keep going up, because we have an aging population. We have people who are getting more obese, more unfit, more diabetics. And then if you expand health insurance, which is--the ARRA is going to do, then that's even going to make it even tougher. So it's going to be really hard to find a physician either way. Some people have said mid-levels can account for some of that. But what that misses is the fact that, actually, the nursing shortage is even worse. If you take all these nurses and try to turn them into family physicians, you make the nursing shortage even that much worse. So it's kind of a robbing-Peter-to-pay-Paul issue. There's a couple issues that we can do to expand the work force. Mainly it's by starting at the front end, making sure that more of the people that go into medicine go into primary care. A big obstacle right now is student loans. The last graphic you have there--this is a--I work with the Office of Rural Health--this is the trend for student loans over the last few decades. And it was kind of keeping pace with inflation up until the last ten years; now it's gone way beyond that. I finished residency in '98; I had about $75,000 in student loans. That was workable. The rural work force repayment actually took care of a good chunk of that; the rest I made up with moonlighting in residency. We've had a lot of residents graduating the last few years with $200,000-$250,000. That gets to the point where they have to decide: Hmm, I'd rather become a cardiologist, because they make two or three times as much. And that's becoming an issue. And the repayment programs have not kept pace with this increase. You know, $20,000 up to $30,000 doesn't quite catch that when you owe $250,000. So that's an issue we're going to have to deal with, is either, one, paying off those loans at the back end or not charging them as much tuition on the front end. The other issue is admission of medical students into medical schools. And actually, Dr. Frey did a good job of covering that a little bit. And I actually echo that Creighton has done a better job. When I was in residency here at Lincoln, it was rare to ever get a Creighton resident. In the last five years, we've actually had more Creighton grads than

UNMC grads, because Creighton has made some efforts to do that. Unfortunately--I'll get in trouble for this--but I don't think UNMC has kept up the pace they had in the '90s. We've even had more Des Moines grads than UNMC grads here in Lincoln in the last five years. And so I think there needs to be a raising of that priority. UNMC has made great strides in their research dollars, but there's still west of Lincoln that they need to worry about. The last thing, though, that they need to work in is the back end, meaning the payment of how medicine works right now. The payment structure does not lend itself to primary care. The fee-for-service model means that the only way a family physician can keep up with office overhead is to simply see more patients. And that makes for what we call hamster-wheel medicine, and nobody likes that. The doctors don't like it; the patients don't like it. And that's where some of the drive for the patient-centered medical home comes from. But to do that, you have to change the payment structure so that it's not just fee-for-service. We've done some great work in Nebraska by starting a Medicaid pilot. But because of the way Medicaid contracting works, it can only happen in rural areas. It can't happen in Lincoln or Omaha, because that's Medicaid managed care, which means right now Coventry or UHC would have to cooperate. And at the present time we have not had that yet. There's only two--other than Nebraska Medicaid, the only other insurer we've been able to bring on board, at least to do some of this, is Blue Cross Blue Shield of Nebraska. They're launching a pilot this month with 80 to 100 family physicians. We've had several meetings trying to get the other insurers to participate, but they've not been interested. So one thing we can do is tell those: If you're going to be in Medicaid managed care, you have to participate with some of these multi-payer pilots in Omaha and Lincoln as well, because nothing can happen in Omaha and Lincoln successfully. To make it work in a physician, you have to have more than one payer participating; you're not going to change your entire business model for 10 percent of your business. You have to have it be a multi-payer project. And so if we want to make any efforts in this way in Omaha or Lincoln, we're going to have to find some way of getting either the Medicaid managed care or the other for-profit insurance companies to pay attention and start cooperating with the rest of us on this. And so that's an issue that--it's going to be politically dicey,

but in order to make it happen, you're going to have to change the payment structure. I didn't add--I have another article, but I didn't want to come up with too much paper. There's over 40 pilots, and more and more of them are multi-pilot (sic), all over the country right now. Six here even have results on savings per patient per year. And so a lot of them are successful at something we need to start moving toward in Nebraska. The last thing I'll touch on, because it's a little bit off topic, is that the third potential is, really, working on child health and obesity, working on fitness, things like that. There's a lot going on in the state right now from the community level. There's lots of models in other states, which we're also going...to make that really happen and do well, it's going to have to come from the top down in the state too. So that means the legislations (sic) and the Governor is going to have to start getting on board as well. So I'll just let you know that in a couple months you're going to hear a Nebraska Medical Association public health committee project that's going to come out. And we'll probably be inviting several of you to the next meeting in mid-November. So (inaudible). [LR467]

SENATOR GAY: Senator Campbell. [LR467]

SENATOR CAMPBELL: Dr. Rauner, do you know whether there's been any formal discussions with the Medicaid director on this whole area of the managed care contracts that they have in Lincoln and Omaha and this pilot with Blue Cross Blue Shield? Do you know? [LR467]

BOB RAUNER: Yeah, I've discussed it with her, and the answer was: That's up to them. You know, we contract with them; they're the ones who run it, and so...and then they did go along in having, of course, the rural side. So there will be two medium-size towns in the next few months that'll be picked, so that there will be a pilot outside of Lincoln and Omaha. But because Lincoln and Omaha right now--it's Coventry and UHC--unless they agree, it's just not going to happen. They do some things, like they'll pay some of the clinics per member per month, just because otherwise no one will take them. But they're not really a medical home model, where there's the rest of it. [LR467]

SENATOR CAMPBELL: So, to your knowledge, there's been no discussion between the two, between Blue Cross and the director. [LR467]

BOB RAUNER: Though there is... [LR467]

SENATOR CAMPBELL: Either on the pilots... [LR467]

BOB RAUNER: Well, Blue Cross is already working on this. [LR467]

SENATOR CAMPBELL: Right. No, I understand that. But I just thought maybe... [LR467]

BOB RAUNER: And there was the potential when they were still one of the medical managed-care providers. But when they didn't get selected, that went away, of course. [LR467]

SENATOR CAMPBELL: Got it. [LR467]

BOB RAUNER: So now we have to do it through Coventry and UHC in order to make it happen. [LR467]

SENATOR GAY: Any other questions? One quick one: When you showed that graph, it just goes--spikes up in the '90s, and then it says, 2000s... [LR467]

BOB RAUNER: Um-hum. [LR467]

SENATOR GAY: Well, it's 2010 now, so that's a... [LR467]

BOB RAUNER: Yeah. [LR467]

SENATOR GAY: 20-year time... [LR467]

BOB RAUNER: Yeah. So you'll see the average there is about $130,000; that's probably the average over the 2000s. Now we're hitting the $150,000-$200,000-$250,000 range. [LR467]

SENATOR GAY: So I guess, though, that's a heck of a spike when you go from the '70s to the '90s fairly flat. What happened in the '90s, then, to make it go through the roof? [LR467]

BOB RAUNER: One is just the cost of tuition. The tuition has gone up faster than inflation. So when... [LR467]

SENATOR GAY: Just college tuition in general? [LR467]

BOB RAUNER: Yeah. College and medical school tuition. You know, I think when I started at UNMC, it was $6,000 a year. I think it's up around $18,000 to $20,000 now. Creighton is around $40,000. The other thing we're having is that since the numbers being generated in-state have dropped down, all these people, say, who went to Des Moines had to pay out-of-state tuition in Des Moines. So half of our graduating class were Des Moines grads; they had to pay out-of-state tuition in Des Moines. So instead of $20,000 a year, they were borrowing $40,000 a year. And so part of...and what a lot of people don't realize right now is a fourth of our medical school grads are international grads, because our own system has not kept up pace. So a fourth of medical students in the United--or residency physicians are from outside of the country, because we don't train enough of our own. [LR467]

SENATOR GAY: Yeah. Senator Hadley. [LR467]

SENATOR HADLEY: Thank you. Your comment about foreign-born. I know that in shortage areas and such as that, is there...and being from Kearney, I know that it's worked a lot in the specialty areas, but family practice--do you get many foreign-born that are willing to go to underserved areas? [LR467]

BOB RAUNER: Temporarily, while their visa is being accepted. [LR467]

SENATOR HADLEY: Right. [LR467]

BOB RAUNER: So it's usually a two- to three-year, and then they end up moving on, typically. So I was in Sidney for five years. Kimball kind of kept having at these guys--would come in and then they'd leave, and they'd come in. To get someone to come and stay, they usually have to be from that area. And that's one of those things you use from a medical school admission thing, is to look--if someone grew up in Omaha and went to Duke University, are they going to go to Sidney, Nebraska? Probably not. If they grew up in Sidney and they went to the University of Nebraska at Kearney, are they likely to go back to rural areas? Much, much more likely, especially if their spouse is also from a rural area. [LR467]

SENATOR HADLEY: I know that the problem with the foreign-born is the three-year... [LR467]

BOB RAUNER: Um-hum. [LR467]

SENATOR HADLEY: ...and we've gone through numerous physicians in Kearney that spend... [LR467]

BOB RAUNER: Um-hum. [LR467]

SENATOR HADLEY: ...three years and one day and... [LR467]

BOB RAUNER: Um-hum. Yeah. And qualitywise, they're actually...there's a good study this year said that, actually, that qualitywise they... [LR467]

SENATOR HADLEY: Yeah. [LR467]

BOB RAUNER: ...provide good care. It's not... [LR467]

SENATOR HADLEY: But they want to live in Chicago or... [LR467]

BOB RAUNER: Um-hum. Yeah. They don't want... [LR467]

SENATOR HADLEY: ...New York... [LR467]

BOB RAUNER: ...to live in Sidney... [LR467]

SENATOR HADLEY: ...Washington. [LR467]

BOB RAUNER: ...because there's not a good... [LR467]

SENATOR HADLEY: Sidney, Nebraska... [LR467]

BOB RAUNER: ...Indian community in Sidney, for example. [LR467]

SENATOR HADLEY: ...Kearney is not high on their list (inaudible). [LR467]

BOB RAUNER: So. [LR467]

SENATOR GAY: You know, in that situation, though, it's fine for the Legislature to discuss this work force development. The University of Nebraska Regents also run the

Med Center, so when you look at their admissions policies or whatever the case that may be... [LR467]

BOB RAUNER: Um-hum. [LR467]

SENATOR GAY: I just wonder if these same--I assume they do, but... [LR467]

BOB RAUNER: Um-hum. I think it's a matter of active debate. [LR467]

SENATOR GAY: ...it's for another day, but... [LR467]

BOB RAUNER: Yeah. There are some doctors that are at UNMC that are really pushing this, and they're doing a great job. [LR467]

SENATOR GAY: Oh. [LR467]

BOB RAUNER: Some of the Department of Family Medicine guys are doing... [LR467]

SENATOR GAY: Are they pushing it to the Regents, though, as well? Because... [LR467]

BOB RAUNER: It's--again, it's a competition between... [LR467]

SENATOR GAY: ...we fund the--they run the university, but... [LR467]

BOB RAUNER: Yeah. The money is in research; that's where the pressure is. [LR467]

SENATOR GAY: Well, I just kind of wonder, because we hear a lot--and I'm talking every other day--about work force shortages. [LR467]

BOB RAUNER: Um-hum. [LR467]

SENATOR GAY: And then it's the university Regents that run the universities. So at some point, if you ever get a chance, I think we should talk: Hey, what are you guys doing on...? [LR467]

BOB RAUNER: Yeah. [LR467]

SENATOR GAY: I don't know, but, I mean, we bump into them, you know, and you see them, and it's a good question. [LR467]

BOB RAUNER: Yeah. [LR467]

SENATOR CAMPBELL: We were talking up here, Dr. Rauner--and to follow up from Senator Gay's comment whether--as we looked at your chart also, what might have been cuts to the university in tuition increases. Because they probably play one to the other. I mean, you know... [LR467]

BOB RAUNER: Yeah. [LR467]

SENATOR CAMPBELL: ...it's just like everything else. [LR467]

BOB RAUNER: Yeah. [LR467]

SENATOR CAMPBELL: Everything has a cause and effect. [LR467]

BOB RAUNER: Um-hum. [LR467]

SENATOR CAMPBELL: And if they raise tuition... [LR467]

SENATOR HADLEY: I know in the...it wasn't me, but somebody in the '90s in the university system... [LR467]

BOB RAUNER: (Laugh) [LR467]

SENATOR HADLEY: ...we had a couple years of double-digit tuition increases in the... [LR467]

BOB RAUNER: Yeah. [LR467]

SENATOR HADLEY: ...kind of the mid-'90s, we were, like, 12 percent to 15 percent. [LR467]

BOB RAUNER: Yeah. And then that... [LR467]

SENATOR HADLEY: I was against it, but everybody else was... [LR467]

BOB RAUNER: When you look at medical education, that's an eight-year process. So that 12 percent cut in 2000 shows up in 2008 when they graduate. So there's--it's a very long delay. [LR467]

SENATOR HADLEY: Yeah. And, you know, you raise it two years, and, oh, 15 percent, and... [LR467]

SENATOR GAY: And then... [LR467]

SENATOR HADLEY: Then it compounds after that. [LR467]

SENATOR GAY: And then, they weren't double digits, but there's 8 percent and 9 percent pretty consistently. [LR467]

SENATOR HADLEY: Oh, yes. [LR467]

SENATOR GAY: I think 7 percent just for undergrads. [LR467]

SENATOR HADLEY: But I think, in fairness, the last few years it's been, you know, they've really worked hard to keep tuition increases down. But we did have, you know, we were low in the '90s, and that was... [LR467]

SENATOR GAY: All right. Well, thank you for that update. It's good information. And good luck on the other projects you're working on. All right. Korby Gilbertson is here from Nebraskans for Public Health Funding. [LR467]

KORBY GILBERTSON: (Exhibit 12) Good afternoon, Chairman Gay, members of the committee. For the record, my name is Korby Gilbertson--it's spelled K-o-r-b-y G-i-l-b-e-r-t-s-o-n--appearing today as a registered lobbyist on behalf of Nebraskans for Public Health Funding. And I want to spend some time today talking about what Senator Gay talked about earlier a little bit, about how public health funding is--really gives us a good bang for our buck. And I want to talk about an issue that's been in front of the Health Committee a few times now in the last five or six years. And that is the importance of Nebraska expanding our eligibility for Medicaid coverage of family planning services through state Medicaid family planning amendments. Before I go any further, I want to make it clear on the record that I'm not talking about funding for abortion. It would be a violation of both state and federal law to allow any of these funds to go directly or indirectly for abortion services. What I am talking about is basic preventive healthcare which can save the state millions of dollars annually and provide much-needed healthcare for thousands of Nebraskans. A majority of states have expanded the eligibility for Medicaid coverage, and I've given you a table--I think it's the second sheet in your little packet that says "State Medicaid Family Planning Eligibility Expansions." And it shows you the 27 different states and the different parameters of

each of those plans. Twenty-one states provide family planning benefits to individuals based just on income. And most states set the income, as you will see, at a ceiling at or near 200 percent of poverty. You'll see that most of them are either at 185 percent of poverty or 200 percent; there are only two states that are as low as 133 percent. Now I'm going to give you a little history. Back in 2005, the Nebraska Legislature established the state Medicaid Reform Task Force. Senator Don Pederson was the chair of the task force, and he was joined by Senator Kathy Campbell as well as representatives of the health insurance industry as well as Nebraska hospitals. One of the recommendations made by that task force was for the state to apply for a family planning waiver. And what I talked about today is doing a family planning amendment to our Medicaid plan. The feds have now come down and said that you don't necessarily have to now apply for a waiver. You can simply make amendments to your state Medicaid plan and still reap the benefits of this--of what they're willing to give, which is--I'll get into it in more detail--but it's a 90/10 match. So it actually saves the state a lot of money. But I'll get into that more in detail in a little bit. In 2009 Senator Danielle Nantkes introduced...I'm sorry, I wrote "Nantkes" in my testimony. (Laugh) Senator "Conrad," I should say. (Inaudible) she was "Nantkes" back then...but LB370, which would have required the state to apply for the waiver. That bill, unfortunately, died in the Health Committee at the end of last session. Why should we do this now? Obviously, there are many changes going on because of what's going on at the federal level. This is something that we can do to our Medicaid plan here in Nebraska that will work with the changes that are coming down because of the federal changes. There's been a poll conducted at the end of September. The results have not been released yet; they're just--they just actually received them last week. The poll was done by Anzalone Liszt Research and consisted of 800 likely voters in the state: 62 percent of those polled favored the expansion of family planning services, and 41 percent strongly supported the expansion. And there's also overwhelming support--or success stories in surrounding states and of the 27 who have done this. In a nearby state, Minnesota, since they've been providing these services to low-income and high-risk women, the number of abortions in the state has dropped significantly, and Minnesota currently has the fourth-lowest teen pregnancy rate in the

nation. Minnesota estimates that for every $1 they spend on family planning, they save $4 in general funds. A recent Iowa study shows that for every $1 they invest in their family planning program, they save more than $7; and that was savings that they recognized in the first year of the program. In 2008, Iowa covered between 50,000 and 60,000 women at 200 percent of the poverty level for $17.75 million, which with the 90/10 match was $1.75 million of state funds. Last year, when Iowa was making 10 percent across-the-board cuts, they actually expanded their coverage for family planning to 300 percent and doubled those covered and saw even more increased savings. So this is proof that this really does work. Current Medicaid eligibility limits for women in Nebraska are very different than what you see on these sheets. Right now, women with dependent children have to be at 58 percent of the federal poverty level; in Nebraska that's less than $11,000 a year. So we see that this is a significant difference between when you're looking at the states that provide this coverage and what Nebraska does right now. Women without dependent children cannot get coverage at all. There is some availability for some basic family planning services to be given to women of low income, but those are for women with incomes of less than $6,000 a year. A family planning state plan amendment would allow for a greater number of people to be served while saving the state real money. The federal match, as I said, is 90/10. If Nebraska would expand coverage to 185 percent of the federal poverty level, we would be able to serve more than 20,000 additional women. Based on figures from the fiscal note, which was the top sheet on the handout, they estimated that Nebraska would save over $3.5 million, at a minimum, in general funds each year that the plan was implemented. And that's if we applied for the waiver. But I think that's, as it says--if you read the entire fiscal note, those are very conservative numbers. So at a minimum they estimate that we will save that much a year. These savings are not just felt by our state but also by our citizens. And I think there is a very good example that was given during the testimony on LB370, which I wanted to share. There was a young woman who was age 22; she was working at a local convenience store, making $9 an hour. It was a full-time job. After taxes and minimal benefits, she brought home $1,350 a month. She pays $500 a month rent, $200 a month in utilities, $175 for a car, $60 a month for

property and casualty insurance, $60 for a cell phone, $100 for car fuel, $200 a month for food and household items. Any other very basic expenses, such as car repairs, money for clothes, haircuts, spending money, or healthcare, would have to come out of the remaining $55 a month. I know how much I pay for my health insurance, and I think it's very easy to see why we need to do something now to help protect these people and to provide healthcare--very basic, preventive healthcare--for people in Nebraska. And it's not just money that we have to spend to get money, it's money we are already spending. I listened this morning to the testimony, and I listened to Bruce Rieker talk about the number of people that wait way too long before they seek help and they end up at the hospitals. If we can give basic, preventive healthcare, give women screenings and tests, I think we can see a real improvement in our health in the state. I'd be happy to try to answer any questions. [LR467]

SENATOR GAY: Thank you. Any questions? Don't see any. [LR467]

KORBY GILBERTSON: Thank you. [LR467]

SENATOR GAY: All right, thanks. All right. Nebraska Medical Association. Dr. Filipi. [LR467]

DAVID FILIPI: Thank you. [LR467]

SENATOR GAY: How are you? [LR467]

DAVID FILIPI: (Exhibit 13) Good afternoon. I'm Dr. David Filipi. I'm a family physician and immediate past president of the Nebraska Medical Association. I've been chief medical officer of Methodist Physicians Clinic, an Omaha-based multi-specialty group of 160 doctors, and am now currently medical director for quality enhancement for Blue Cross Blue Shield of Nebraska. I speak today for the Nebraska Medical Association. I will share with you a white paper created several years ago on our ideas for healthcare

reform. I'll leave it with you; I won't go over it with you today. But they include two large concepts--number one: transparency; and number two: driving down the demand for healthcare services. First I will talk about transparency. As purchasers of healthcare, patients and employers currently have little solid evidence to make meaningful decisions. We currently go by such soft characteristics as reputation and past customer service. Even our literature says that many patients judge quality on how our waiting rooms appear than any other reason. Instead, we should look at quality differently. Systems of healthcare should compete on agreed-upon measures of clinical outcomes, when we can agree to measure together. What is the rate of surgical infections for a particular disease? And how does it vary by provider? Who has better results after a heart bypass surgery? We don't know that. We don't publicly disclose that. But we need to. We should also know what healthcare actually costs. Charges by both physicians and hospitals are terribly misleading, as most payers pay on a discount of those charges and not the billed rate. Ironically, the only patients that pay full price are those without insurance. Armed with the knowledge of clinical performance on quality and the actual cost of a service delivered, the marketplace will lower costs and increase value to all of us. Public expenditure on comparative outcomes research is another vital part of quality. Currently, drugs, devices, and diagnostic procedures are tested and approved only if they are proven effective in what they're supposed to be doing. This is required by the FDA so they can be placed on the market. However, these devices, these drugs, these procedures are not tested against competitive procedures in the clinical marketplace. The company that develops these tests, drugs, procedures does not want to risk failure in providing extensive research. So none is done. Physicians then must rely upon experience, anecdotes, and effective marketing by companies to make decisions on a new drug or technology. An independent agency, probably federal, to run head-to-head comparisons is needed to answer the question: Is a new, expensive drug really better than an older, cheaper one? And if better, how much better? If a new drug or technology is only a little bit better but costs great amounts of money, is it worth the cost? Is it worth the change? So much for transparency. Let's talk about driving down the demand for healthcare services. I see four strategies--number one: a healthier

Nebraska; number two: a decrease in the defensive cost of medicine; number three: reduction of waste due to service duplication; and fourth: ending futile end-of-life care. Somewhat controversial in all of those. First, a healthier Nebraska. Just like we've handled seat belts, motorcycle helmets, secondhand smoking, and driving when intoxicated, we must focus public policy and private efforts to combat obesity and increase exercise. Obesity and inactivity correlates well to the resource-consuming diseases of diabetes and heart disease. And it's not just about the money. It's about improving our quality of life to make more-productive citizens, to make happier citizens: those affected by these two diseases feel worse and are terribly less productive. To implement programs encouraging better diets and more exercise, we must adequately fund our community departments of public health. The most effective programs are local initiatives. They know where the problems are. Second, defensive medical tests and procedures to avoid malpractice claims is a terrible, wasteful expense. The Nebraska Medical Association urges true tort reform, such as through specialized, sophisticated, and separate malpractice courts or malpractice immunity if one practices under a recognized national medical standard for a given condition. Either improvement would remove the emotion of a tragic, unwanted outcome and significantly cut down the cost of defensive medicine. Third, the reduction of duplicative services. Let's face it, we have a terribly fragmented healthcare system. As physicians and hospitals become more electronic, we must link these systems together so that we know what has already been done in other practices or facilities. Fortunately, we have such a linkage in NeHII, or the Nebraska Health Information Initiative. If your facility is linked to NeHII, you can discover what has taken place in other facilities or offices with a simple connection. NeHII has already been successfully implemented in Omaha, Hastings, and North Platte. Not only does it decrease duplication, it improves diagnostic capabilities while reducing drug incompatibilities. Also helpful would be the promotion of primary care physicians and the successful development of the patient-centered medical home. I won't repeat the facts already shared by Dr. Rauner and Dr. Tape. Let's just say that Dr. Paul Grundy, the medical director of IBM, says that his employees internationally, in countries with strong primary care systems, cost 30 percent less than those with more sophisticated

specialty-driven systems. And lastly, let's facilitate the conversation with our patients about how they wish to end their own lives. We're not talking here about death squads; we're talking about honest conversation about the end of life. We're talking about how much expensive technology our patient wants us to give them when the inevitable becomes close. Let me give you an example. We now have a therapy for widespread prostate cancer. It will likely prolong life in end-stage disease by about six months. It does not do anything to cure cancer; it prolongs the life of a person suffering from cancer. Medicare fully pays the nearly $100,000 bill for this therapy, and the patient pays nearly nothing, with copays and with Part B insurance. Personally, would you pay over $500 a day out of pocket to live and suffer with widespread cancer for another 182 days? That's $500 a day. There you have it. I will give you the NMA white paper on healthcare reform. And you've heard my focus on improving healthcare through transparency and decreasing demand for healthcare services. Do you have any questions to ask me? [LR467]

SENATOR GAY: Thank you, Doctor. Any questions? I've got one on transparency. [LR467]

DAVID FILIPI: Yes. [LR467]

SENATOR GAY: With these health Exchanges--and no one knows where they're set up...but we had hearings on transparency, and it's just--it was all over. But with those health Exchanges, that's probably an opportunity for transparency at some point. Is the medical association going to be following that and putting--interjecting into those conversations? Because that's probably where you're going to get the transparency. [LR467]

DAVID FILIPI: Absolutely. I think there is several facets of the health Exchanges. I think primarily they're talking about--as I understand it, they're talking about the cost and the benefits, and you can compare side by side. I think the next phase of that would

probably be if you're in this sort of a plan, what sort of outcomes do you get with this particular type of plan? And the Nebraska Medical Association is engaged with the American Medical Association to define meaningful measures for each particular disease--what we should be measuring--and get some agreement. So when the time comes for us to have transparency, we've agreed on the methodologies to use. [LR467]

SENATOR GAY: The national and the state. [LR467]

DAVID FILIPI: Yes, both. [LR467]

SENATOR GAY: Yeah, okay. That's important. [LR467]

DAVID FILIPI: Because...and I think this is particularly important when you're talking about Exchanges between states and among states, that you have national standards that you rely upon, that Nebraska won't be different than Kansas, won't be different than Iowa; we will all agree on the same standards. [LR467]

SENATOR GAY: Well, and I think some of that leadership is going to come from outside government, quite honestly--I think probably from your others as well. [LR467]

DAVID FILIPI: Yes. [LR467]

SENATOR GAY: And that's an important part of our government, is outside influences. [LR467]

DAVID FILIPI: Where we're having meaningful conversation--former adversaries are having meaningful conversation--insurance companies are having meaningful conversation with physicians, provider groups, employer groups, that type of thing, we're agreeing we need to have reform; we need to have change. But we need to talk to each other as we have change and agree where we can. [LR467]

SENATOR GAY: Alright. All right. Anything else? Thank you for coming... [LR467]

DAVID FILIPI: Thank you. [LR467]

SENATOR GAY: ...and sharing that with us today. And you do have the paper--the white paper? [LR467]

DAVID FILIPI: Yes, I do. I will give that to the clerk... [LR467]

SENATOR GAY: All right, you can just give it to--give it to Lisa. [LR467]

DAVID FILIPI: ...and a copy of my testimony. [LR467]

SENATOR GAY: All right. On...thank you all for spending some time with us. And we do have a point here, too--is there anyone else who would like to public comment, come up and say anything about patient protection, healthcare reform? All right. I don't see anybody who wants to publicly...if anybody wants to send a comment or something, you can send it to my office. And we're coordinating the study, and it may be included in our final report. One thing Michelle wanted us to talk about a little bit is we have a meeting scheduled for the 11th, November 11. We're at the point I don't know if we have another meeting, but we're probably going to be talking to you and seeing what we're going to do. We've got to actually write something. We have a lot of good information here, quite honestly. And we could probably go all next year and not get this whole thing settled. But I think we've got a lot of information. If anyone would like to get together and discuss that, maybe informally, on what we should include, not write. And several of you have been here to all the hearings. And I want to make it as nonpolitical as I can--here's the facts; read it; sort it out for yourself; and go...whatever happens in the future. But we could do that probably informally. Would it be okay if we, maybe, picked a couple of dates or called around and had something where we did that and...? [LR467]

SENATOR CAMPBELL: I think we should meet one more time. [LR467]

SENATOR GAY: Or if you have anything to add, too, you could also check with Michelle. Is that okay? And so we probably wouldn't have the November 11 meeting. [LR467]

SENATOR _____: I think we should go into exec session if we're going to discuss more intricate details. [LR467]

SENATOR GAY: Yeah. And we could do that in exec session. No problem. What I'm saying is that probably would be an exec session. [LR467]

SENATOR COOK: Um-hum. [LR467]

SENATOR HADLEY: November 11? [LR467]

SENATOR GAY: Well, I don't know if it'll be...no, that's a public meeting. But we'll probably just do something. We'll check with your schedules and see, so. [LR467]

SENATOR CAMPBELL: I thought it had been originally set for the 10th. [LR467]

LISA JOHNS: It might be. I (inaudible). Maybe I... [LR467]

SENATOR GAY: November 10 or 11, either way. I think publicly we're done with this, so. Well, think that through and talk to Michelle. And thank you all for taking time out of your busy schedules to be with us today. Thank you. [LR467]