Health and Human Services Committee March 28, 2019

HOWARD: [RECORDER MALFUNCTION] Howard and I represent the 9th Legislative District in Omaha and I serve as Chair of this committee. I'll invite the members of the committee to introduce themselves.

CAVANAUGH: Machaela Cavanaugh, District 6, west-central Omaha, Douglas County.

HOWARD: Also assisting the committee is our legal counsel Jennifer Carter and our committee clerk Sherry Shaffer and our committee pages, Maddy and Erika. The department has requested a public hearing for the Community Service-- Services Block Grant and we're excited to hear more about it. Thank you, Director.

MATT WALLEN: Well, good afternoon, Chairperson Howard and members of the Health and Human Services Committee. My name is Matt Wallen, M-a-t-t W-a-l-l-e-n, and I serve as the director of the Division of Children and Family Services for the Nebraska Department of Health and Human Services. I am here today to provide an overview of the Community Service Block Grant program in Nebraska. The CSBG Act of 1998 states: In order to be eligible to receive a grant or allotment, the state shall hold at least one legislative hearing every three years in

conjunction with the development of the state plan. So today will serve as that one legislative hearing within three years for us. Nebraska submits a state plan every two years to the Office of Community Services in the United-- in the United States Department of Health Human Services, establishing the state and Community Action agencies' intent for funding during the specified period. The fiscal year-- federal fiscal year 2019 and 2020 state plan was approved by the federal Office of Community Services to be implemented as of October 2018. A public hearing was held on August 20, 2018, prior to that submission as required by the CSBG Act. So on page-- on slide two, Community Action Program, or CAP, originated under former President Lyndon B. Johnson's administration. Through CAP, public agencies and private nonprofits called Community Action agencies reform to promote self-sufficiency and respond to immediate social and economic needs within their communities. In 1981, CAP and several other funding streams were consolidated into the Community Services Block Grant and reauthorized in 1998. The national CSBG network includes federal partners, state, territory, tribal grantees, CSBG-eligible entities, state Community Action associations, and national partner associations. CSBG is administered federally by the Office of Community Services within the Administration for Children and

Families within the U.S. Department of Health and Human Services. CSBG funding is distributed to CSBG-eligible entities, which are most commonly Community Action agencies. Membership associations such as state Community Action associations and national membership associations assist in supporting the CSBG network as well. As per Nebraska's state regulations at 481 NAC 1-002. The purpose of CSBG is to provide assistance to states and local communities working through a network of Community Action agencies and other neighborhood-based organizations for the reduction of poverty, the revitalization of low-income communities, and the empowerment of low-income families and individuals in rural and urban areas to become fully self-sufficient. And on page 4, slide number four, we can see we've provided a map that shows the geographical footprint for each of the nine Community Action agencies in Nebraska. Turning to the next page, we've provided the name and location for each of the nine Community Action agencies around Nebraska. So on slide six, we'll see CSBG funds are federal funds distributed to the states and earmarked by federal law for distribution to eligible entities which in Nebraska are Community Action agencies. A formula based on each state's poverty population determines each state's grant amount. Nebraska receives more than $4.9 million annually. Each state determines the formula used to distribute

the block grant to the network of designated eligible entities, taking care that all areas are adequately served. Nebraska recognizes nine Community Action agencies serving all 93 counties. Per-- per federal law, 90 percent of the funds go to the-- Nebraska's nine Community Action agencies. The state may use up to 5 percent of the funds for state administration of the grant and the remaining 5 percent of the funds are discretionary funds for purposes such as training and technical assistance for agencies. Community Action of Nebraska assists in providing training and technical assistance services to the Community Action agencies. On slide seven, see Nebraska's Community Action agencies conduct an in-depth community needs assessment at least once every three years. The community needs assessment provides a picture of the services and programs needed, which includes identifying strengths and opportunities in the community to address low-income issues, poverty, and helping individuals achieve self-sufficiency. The Community Action agencies must administer the CSBG through a tripartite board that participates in the development, planning, and evaluation of the programs. The board of each agency is comprised of one third low-income representatives, one third elected officials or their representatives, and one third private -sector representatives, all who live in the agency service area. The agencies are

accountable for their plans, results, and efforts to adapt to the needs of the people they serve. Community Action agencies implement a comprehensive, performance-based management system called Results Oriented Management and Accountability. Through this system the agencies establish an objective and measurable goals, described the organizational processes and capacity required to meet these goals, develop performance indicators to qualify the success of each intervention, and evaluate their results versus anticipated outcomes and improve their services and programs to better serve the families and communities in their respective service delivery areas. In order to maintain a strong culture of accountability, a network of nationally certified Roma trainers in Nebraska provides continuing education to community agents-- action agency staff and board members. The state is responsible for monitoring and providing oversight of the agencies to assure compliance with federal and state laws and regulations and to ensure organizational standards are met. CSBG funding provides for a range of services and activities to assist the needs of low-income individuals. Community Action agencies are required to provide the funded services and activities addressing these needs in Nebraska. Agencies focus on holistic approaches to alleviating poverty. Much of their efforts are focused around in-depth case

management for their clients. While each agency is diverse and offers a variety of services based on their communities, several programs are similar including Head Start, Early Head Start, adult education programs, job training and direct employment of low-income individuals, AmeriCorps, housing services, childcare, homeless shelter and other homeless assistance and migrant services. Emergency assistance is also a key program area for Community Action agencies. These services provide rental assistance, utility deposits, and payment of past-due-- bills due with a shut-off notice, food and transportation, alcohol and drug counseling, mental health services, and food pantries, food banks, and a commodity foods program. Agencies also collaborate with other state entities such as the Division of Public Health's WIC and maternal child health program and immunizations programs as well as Nebraska Energy Offices for low-income weatherization program. They work with local organizations to operate programs such as senior centers and others senior programs, including home-delivered meals and transportation and youth mentoring projects. On slide nine, you'll see agencies report outcomes and activities twice a year and send an annual report to the Office of Community Services with the Administration for Children and Families within the U.S. Department of Health and Human Services. In federal fiscal year

2017, Community Action agencies in Nebraska provided services to more than 84,000 low-income individuals, for more than 26,000 families facing a variety of barriers to self-sufficiency. More than 24,000 of these were children and more than 11,000 of these were senior citizens. The agencies continue to serve mostly families at or below 125 percent of the federal poverty level. I would like to take a moment to highlight a couple of the many success stories that show how CSBG funding is used to serve Nebraskans. Specifically, these are success stories involving Community Action agencies from the legislative districts of a few of the senators serving on this committee. Community Action Partnership of Mid-Nebraska identified affordable food as being one of the top basic needs respondents struggled with based upon the 2016 Community Action of Nebraska State and Regional Community Assessment Report. To assist in addressing this need, mobile produce pantries were implemented to go to different Buffalo County communities twice a month. From July 18, 2017, through November 16, 2017, there were nine mobile produce pantries that served a total of 938 households, computing to approximately 3,116 individuals. An average of 16 towns were represented at each mobile site. Based on food donations, food products from the food rescue program, and produce from the Food Bank of the Heartland, a total of 43,120 pounds of food was

distributed to community members in that time frame, and that time frame, again, was July 2017 through November 2017. Northeast Community-- Northeast Nebraska Community Action Partnership, NNCAP, identified a common barrier for homeless or near-homeless clients as not being familiar with the services available in their communities. On June 23, 2017, NNCAP participated in a one-day event in Norfolk, Nebraska, called Project Homeless Connect to provide direct services and resources to the population of homeless or near-homeless individuals. Project Homeless Connect Norfolk served 226 individuals during the one-day event. The Eastern Nebraska Community Action Partnership, ENCAP, distributed 33,920 food boxes throughout Douglas and Sarpy Counties through ENCAP's nutrition center and hunger relief efforts in federal fiscal year 2017. CSBG funds allow ENCAP to utilize this program to address the client's immediate need of food; however, it also allows ENCAP to work with families to wrap around additional services, address safety concerns, and increase their ability for self-sufficiency to address the root cause of the client's food insecurity. In that-- on page 10, I'll just note that-- you know, thank you for allowing me the opportunity to present information regarding Nebraska's submission to the CSBG state plan and to provide you a small sampling of what Community

Action does in our state. If you are not familiar with the Community Action agency in your district, I invite you to visit one of those agencies. Again, I want to thank Chairperson Howard and members of the Health and Human Services Committee for the opportunity to provide an informational briefing related to the CSBG grant. I want to thank all of our Community Action agencies and the thousands of volunteers that donate their-- their time throughout the year to help support the work of the Community Action agencies. And with that, I would certainly be happy to answer any questions that the committee members might have.

HOWARD: Thank you.

MATT WALLEN: Thank you.

HOWARD: Are there questions? Senator Cavanaugh.

CAVANAUGH: Thank you, Chairman Howard. Thank you, Deputy Director Wallen. And thank you for this informative update on the Community Services Block Grant, a lot of information that's new to me. I wanted to-- I saw on slide six, the 5 percent of funds are discretionary funds. Could you just give a little bit more information as to what that means?

MATT WALLEN: Sure. Sure. The-- what it-- what it means is it-- it gives us a little more flexibility with those discretionary

funds and what we do is we work with and-- and-- and provide most of those funds to the Community Action of Nebraska. And they really assist with coordinating the nine Community Action agencies. They do some additional training and coordination-type efforts.

CAVANAUGH: And is that the structure of how the funds are-- are used, does that come down from the federal government or is that something that we were able to do ourselves?

MATT WALLEN: Well, we have to-- per the federal government, 90 percent of the funds have to go to the-- to the nine agencies and then we have the 5 percent discretionary and the 5 percent administrative funds. But for the most part, to serve the purposes identified in Nebraska, to help communities alleviate poverty-- poverty and to achieve self-sufficiency, the Community Services Block Grant is-- is fairly flexible. And it's often utilized by these agencies to leverage state-- you know, state or other federal funds volunteer hours--

CAVANAUGH: Sure.

MATT WALLEN: --all sorts of different funding avenues.

CAVANAUGH: I have a couple other questions but-- so on slide nine, when you're talk-- taking us through the success stories--

MATT WALLEN: Yes.

CAVANAUGH: --the-- the Community Action Partnership of the-- of Mid-Nebraska, you talked about a food rescue program. I'm familiar-- in Omaha we have Saving Grace, which is a food rescue program. And I-- I'm not familiar-- are-- if-- is that the food rescue program or is there a statewide program?

MATT WALLEN: I mean each-- each of the Community Action agencies really partner with what is in their local communities.

CAVANAUGH: OK.

MATT WALLEN: So there's not one kind of overarching, if you will.

CAVANAUGH: And how-- I'm very interested in-- in just the food rescue concept and how we can be utilizing that to feed our food-insecure populations. So would it be possible-- could you help facilitate getting that information?

MATT WALLEN: Absolutely.

CAVANAUGH: Thank you. And then my final, I think, question is on the Eastern Nebraska Community Action Partnership you talked about the food boxes and as you're probably aware, yesterday we had a robust conversation on the floor of the Legislature about

SNAP benefits. And when we had the hearing here in this committee on SNAP benefits, we heard from food pantries about food boxes. So is this program supplementing when people are not qualifying for SNAP or could you speak to it just a little bit more what the food boxes do and who they serve?

MATT WALLEN: Sure. Sure. I mean the ENCAP and NNCAP and most of the other Community Action agencies, they work primarily with-- with low-income households. So I think the statistic is close to about 85 percent of the services they provide are to families or households at 125 percent of the federal poverty level. So-- so they're fairly low-income families. And these-- these organizations do a great job in-- in leveraging and maximizing, you know, all sorts of programs, from the homeless program, the NHAP pro-- program that we have, Nebraska Housing [SIC] Assistance Program, so it's really-- they help bring a lot of different efforts together within the communities to meet the needs of their communities. And it's really based on those community assessments that they do every three years to identify what are those specific needs in their communities.

CAVANAUGH: So for this specific program of the food boxes that the part-- the NNCAP is offering--

MATT WALLEN: Yeah.

CAVANAUGH: --are there requirements that are as rigorous as the SNAP process to-- to receive those food boxes?

MATT WALLEN: No. If there's--

CAVANAUGH: No.

MATT WALLEN: If there's a need and someone identify-- comes in and presents with a need, it's generally families, again, that are lower income or that are experiencing an immediate crisis, emergency assistance, those types of things.

CAVANAUGH: And they're administered like in-- in Omaha, they be administered through the food pantry, the Food Bank of the Heartland or together, those two-- those--

MATT WALLEN: Yep, that-- that partnership together. Yeah.

CAVANAUGH: OK. And just, again, to clarify, both SNAP benefits and this partnership are funded by federal dollars.

MATT WALLEN: The-- the CSB and the-- the grant that goes to these--

CAVANAUGH: Yes.

MATT WALLEN: --are federal dollars, that's correct.

CAVANAUGH: OK. Thank you very much.

MATT WALLEN: Sure.

HOWARD: All right. Any other questions? Seeing none, thank you for your briefing today.

MATT WALLEN: Thank you for the opportunity.

HOWARD: All right. Now we are actually going to have a gubernatorial appointment for Dr. Alysson Muotri to the Nebraska Stem Cell Research Advisory Committee. And so we'll wait for her to get on the phone and then we'll do introductions for the senators when she's on the phone. [RECORDER MALFUNCTION] My colleagues introduce themselves starting on my right with Senator Murman.

MURMAN: Hello. I'm Senator Dave Murman from Glenvil: Clay, Webster, Nuckolls, Franklin, Kearney, Phelps, and southwest Buffalo County.

ARCH: This is Senator John Arch and I am with District 14 and that is Papillion and La Vista in Sarpy County.

WILLIAMS: Matt Williams, Legislative District 36, Dawson, Custer, and the north portions of Buffalo County.

CAVANAUGH: Machaela Cavanaugh, District 6, west-central, Omaha, Douglas County.

HOWARD: So, Doctor, we were hoping you could tell us a little bit about your background and-- and maybe some of your experience. I know you've been on the Nebraska Stem Cell Research Advisory Committee before and this is a reappointment. So we were hoping you could tell us a little bit about yourself and a little bit about your experience on the advisory committee.

ALYSSON MUOTRI: All right. So I have my lab at San Diego for the past ten years and my background is on human genetics. My research has been focusing on the use of stem cells as a model for neurological disorders. So we've been focusing more on-- on autism spectrum disorders or diseases that affect the pediatric population. So we use the stem cells, try to understand exactly what's the neuropathology of the disease and-- and-- and-- use these models which bring potential new medicine, so it can speed up drug discovery. So as my-- my function on the committee, I've been serving for the past three years and it's been a very positive experience. I can see that over the years the quality of the proposals have increased dramatically. Most of the investigators are thinking in consideration of the feedback from

the committee ad as a consequence we-- we are getting more and more-- the high-quality applications. So in a way it's becoming very difficult to select the best ones because they are all of super high quality. So as I said, very positive experience. I'm glad this is a proposal to review the program. I mean wish more states would have stem cell initiatives like this one.

HOWARD: Wow, that's wonderful. And I noticed as well you've done some work on the Zika virus as well. Do you want to tell us about that?

ALYSSON MUOTRI: Oh, yes, yes. That's a very fitting experiment. Using stem cells [INAUDIBLE] we create what we call a "minibrain" in a dish or early stages of the neurodevelopment and this [INAUDIBLE] what happens in humans [INAUDIBLE] But it's outside the body so we-- we are in controlled conditions of the lab environment. So when the Zika virus outbreak happened in 2016, Brazil I got to know beforehand. I'm from Brazil, so my-- my colleagues were communicating to me that this virus was causing like birth defects, especially microcephaly. But there was no causation. It was only a correlation between the virus and the condition. So we were able to get a little bit of an [INAUDIBLE] of this virus from an infected state and I tested in-- in our minibrain and as a consequence we noticed that the

virus could not only [INAUDIBLE] the cells but cause a dramatic malformation during brain development. So that was a study that was published in a very high-profile journal and as a consequence, we started screening drugs that could prevent the virus replication. So in 2017, we found a drug that was already approved for [INAUDIBLE] and could be repurposed for the Zika virus. So in case of a new outbreak in America or in other places of the world, we already have a drug that might be useful to protect pregnant females.

HOWARD: Wow. That is incredible. Let me see if there are any questions from the committee. Senator Arch.

ARCH: This is Senator Arch. I happen to have some background in research. I see that you have multiple R01s, very well funded, very well published. I'm curious as to your connection to the state of Nebraska and how you became engaged in this particular committee.

ALYSSON MUOTRI: I was invited by a former member to join the committee and I think who appointed me was Larry Goldstein [PHONETIC] [INAUDIBLE] who suggested that I should join as a way to start establishing my connections in the U.S. and it was good advice. And so I'm glad that I took the opportunity. But it was by an invitation.

ARCH: Well, we're-- we're glad you took the opportunity as well. I'm sure your expertise is well appreciated on that committee.

ALYSSON MUOTRI: Thank you. Thank you, Senator.

HOWARD: Any other questions? Senator Murman.

MURMAN: Yes. I'm Senator Dave Murman. I just happened to notice one of your research-- ongoing research projects is-- involves Rett syndrome. So thank you.

ALYSSON MUOTRI: Yeah. Yeah. So I've been involved with Rett syndrome for ten years and I'm helping both the international society as well as the Rett Syndrome Research Trust. So it's been an interesting opportunity to know the discovery of the gene, everything about the biology of how to keep my [INAUDIBLE] you don't know everything. But now [INAUDIBLE] for a new drug that's coming up in in clinical trial in gene therapy. So it's a good momentum. It took years but we are finally getting there.

MURMAN: Well, thank you very much. I just happen to have a daughter that's a 31-year-old that has that disorder, so thank you.

ALYSSON MUOTRI: Oh, OK.

HOWARD: All right. Seeing no further questions, Doctor, we are so grateful that you're willing to serve on this committee and we do appreciate your time today.

ALYSSON MUOTRI: All right. Thank you so much.

HOWARD: Thank you.

ALYSSON MUOTRI: And, yeah, willing to continue to work with you guys. Thank you so much.

HOWARD: Well, and send us some of that California sunshine next time you call, OK?

ALYSSON MUOTRI: All right. OK. Bye.

HOWARD: Thank you. All right. We've got a few minutes before we start. Welcome to the Health and Human Services Committee. My name is Senator Sara Howard and I represent the 9th Legislative District in Omaha and I serve as Chair of this committee. I'd like to invite the members of the committee to introduce themselves starting on my right with Senator Murman.

MURMAN: I'm Senator Dave Murman from Glenvil: Clay, Webster, Nuckolls, Kearney, Phelps and southwestern Buffalo County.

WALZ: Good afternoon. I'm Senator Lynne Walz and I represent Legislative District 15 which is Dodge County.

ARCH: Senator John Arch, District 14, Sarpy County, Papillion and La Vista.

WILLIAMS: Matt Williams from Gothenburg, Legislative District 36 which is Dawson, Custer, and the north portion of Buffalo Counties.

CAVANAUGH: Machaela Cavanaugh, District 6, west-central Omaha, Douglas County.

HOWARD: Also assisting the committee is our legal counsel Jennifer Carter and our committee clerk Sherry Schaffer and our committee pages, Maddy and Erika. A few notes about our policies and procedures. Please turn off or silence your cell phones. This afternoon we'll be hearing three bills and we'll be taking them in the order listed on the agenda outside of the room. On each of the door-- of the tables near the doors to the hearing room, you will find green testifier sheets. If you're planning to testify today, please fill one out and hand it to Sherry when you come up to testify. This will help us keep an accurate record of the hearing. If you are not testifying at the microphone but want to go on record as having a position on a

bill being heard today, there are white sign-in sheets at each entrance where you may leave your name and other pertinent information. Also I would note, if you are not testifying but have written testimony to submit, the Legislature's policy is that all letters for the record must be received by the committee by 5:00 p.m. the day prior to the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. We would ask that if you do have any handouts, that you please bring ten copies and give them to the page when you come up to testify. We do use a light system in this committee. Each testifier will have five minutes to testify. When you begin, the light will be green. When the light turns yellow, that means you have one minute. And when the light turns red, it's time to end your testimony and we will ask you to wrap up your final thoughts. When you come to testify, please begin by stating your name clearly into the microphone, then please spell both your first and last name. The hearing on each bill will begin with the introducer's opening statement. After the opening statement we will hear from supporters of the bill, then from those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given the opportunity to make closing statements if they wish to do so. We do have a very strict no-prop policy in this committee.

And with that, we'll begin today's hearing with my bill, Senator, LB489, and I will pass it off to my very capable Vice Chair Senator Arch.

ARCH: Welcome, Senator Howard. And you may proceed with the introduction of LB489.

HOWARD: Good afternoon, Senator Arch and members of the Health and Human Services Committee. My name is Senator Sara Howard, H-o-w-a-r-d, and I represent District 9 in midtown Omaha. Today I'm presenting LB489, a bill that requires registration for Nebraska's Prescription Drug Monitoring Program. I'm bringing you an amendment that's being passed out that will replace the bill and has a few changes, and my testimony will speak to the amendment instead of the green copy. Under AM929, beginning October 1 of 2020, each credential holder under the Uniform Credentialing Act who has prescribing privileges shall be required to register for the PDMP. There are a few exceptions and those include veterinarians, a credential holder who is in the military who does not practice in Nebraska, or retired credential holders that still hold a license but do not treat patients, credential holders who are research based and do not treat patients, college or university faculty members who do not treat patients, and other credential holders who do not treat

patients. Thirty-three states currently have mandatory registration for both providers-- prescribers and dispenser-- providers and dispensers. Nineteen states currently have a mandated check. So that means before you prescribe or dispense, you absolutely have to check the Prescription Drug Monitoring Program. Mandatory enrollment in most states is the first step to a mandatory check. However, the reason why I scheduled this for the last day is because I'm not asking the committee to move it because on the federal level they're considering legislation that mandates a check and ties it to federal funding for your Prescription Drug Monitoring Program. So H.R.6 is being considered and in-- in the House right now and it's proposing a mandatory check as early as October 2021, but then it would also provide funding in perpetuity for our Prescription Drug Monitoring Program which would enable-- continue to enable us to provide this service at no cost to prescribers and dispensers. So with that, I'm happy to try to answer any questions you may have.

ARCH: Questions for Senator Howard? I have a couple.

HOWARD: Oh, yes.

ARCH: Do you have any idea right now of the people that you are-- the-- the professions that you identified here, how many now are-- are signed up?

HOWARD: Dr. Bland from NeHII is coming--

ARCH: OK.

HOWARD: --and she should have that information.

ARCH: OK. And does this include residents as well?

HOWARD: Oh, you know, I don't know. That's a good question.

ARCH: In-- in training, can they-- you know, they-- they can write.

HOWARD: They can write scripts, you're right.

ARCH: So I didn't know if it's all residents as well but--

HOWARD: And I would guess when the mandatory check comes down from the feds it's anybody who can write a script--

ARCH: Yeah.

HOWARD: --is going to have to check it, and so we would want to mirror that language. But really this is a placeholder for when we know what they-- they are doing.

ARCH: OK.

HOWARD: But that's a great question.

ARCH: OK. Any other questions? Seeing none, thank you.

HOWARD: Thank you.

ARCH: At this time we'll ask anyone who would like to speak as a proponent, first proponent, please come up and-- welcome.

KEVIN BORCHER: Welcome. Thank you, Vice Chairman Arch and members of the Health and Human Services Committee. My name is Kevin Borcher, K-e-v-i-n B-o-r-c-h-e-r. I'm testifying in support of the amendment to LB489 today. Although I am a member of the Nebraska Board of Health, I'm here testifying today has a the Prescription Drug Monitoring Program director at the Nebraska Health Information Initiative, or NeHII. The value of the PDMPs across the country has been recognized on both federal and state levels. Several federal agencies recommend and support the use of the PDMP. Through the Quality Payment Program Merit-based Incentive Payment System, which is hard to say, or MIPS program, a measure for performance requires that prescribers check the PDMP for Medicare recipients beginning January 2020. In the SUPPORT for Patients and Communities Act, signed into law by President Trump October 2018, prescribers will be required to

check the PDMP for Medicaid beneficiaries beginning in 2021. Registration is a first step in ensuring provider success in this process. Pharmacists understand the benefits of reviewing-- reviewing not only their patients' opioid and other controlled substance prescriptions, but in Nebraska having the access to view all dispensed prescriptions for a more thorough picture of the patient's medication history. This is important for the medication reconciliation systems that clinicians use and contributes to safe clinical care every day through avoidance of medication errors. In addition, a comprehensive medication history improves outcomes by preventing medication errors that lead to or extend hospitalizations. The attached map shows that as of January this year, there were 43 states which require in some form or fashion prescribers or pharmacists to register with the state PDMP. In Nebraska, 7,762, or 48.1 percent, of allowed prescribers and pharmacists have voluntarily registered to use the PDMP. While these providers are seeing the value of the PDMP, there are others that, as one physician recently told me, they don't know what they're missing. By offering clinicians access to this valuable tool, we are enabling all providers access, which will soon be a required process for full reimbursement through CMS. The amendment to LB489 helps to align the Nebraska PDMP with the federal policy and regulations by

supporting the access to check the PDMP. I thank you for allowing me to speak with you today. I'm honored and fortunate to be Nebraska's Prescription Drug Monitoring Program director in keeping with Nebraska's successful implementation of the PDMP noticed across the country. With your help, we can continue to build on the strong foundation the Nebraska Legislature has created for the PDMP. With that, I'd be willing to answer any questions you may have.

ARCH: Any questions? Senator Cavanaugh.

CAVANAUGH: Thank you, Vice Chairman Arch. And thank you, Doctor--

CAVANAUGH: Dr. Borcher.

CAVANAUGH: --Borcher, for being here today. So currently you said 48.1 percent of all prescribers have voluntarily registered. Do they have to register in order to use the system?

KEVIN BORCHER: Yes, they would have to register and complete a training video.

CAVANAUGH: So we know for-- we know for certain that 49.9 percent are not.

KEVIN BORCHER: As of this-- these numbers we're at the--

CAVANAUGH: Or 51, I'm sorry-- my math was bad-- 51.9 percent.

KEVIN BORCHER: As of February 28, there were 48.1 percent of those allowed.

CAVANAUGH: OK. And have-- I appreciate that they don't know what they're missing. Have you heard from them why they're not registering?

KEVIN BORCHER: You know, we just hear anecdotal reports. There are some people that, believe it or not, have not heard much about the PDMP. There are others that haven't seen the value in their practice and there are a lot of others that are being, I would say, educated and encouraged by their organizations to sign up that may not feel they have the time to do that within their practice.

CAVANAUGH: It just-- we've talked a lot about NeHII here and I shared with my committee members that actually my own provider used NeHII recently and it's helpful to make sure that you're getting comprehensive care, that-- your records from other doctors. And so I just was curious to hear a little bit more as far as prescription drug monitoring, so thank you.

KEVIN BORCHER: Thank you.

ARCH: Other questions? I have a couple.

KEVIN BORCHER: Yes, sir.

ARCH: So there are thousands of those that would be credentialed in the-- in the state of Nebraska. Some of those don't practice in the state of Nebraska. They-- they could be a radiologist reading film from Australia. Although probably capable of writing a prescription, I mean certainly the license would allow something like that, do you-- do you see any shaping of the numbers of people? This-- this is like anybody credentialed. Would you-- would you see that for all physicians and other professionals that even may-- may-- may have a license in the state? Would they be required to register?

KEVIN BORCHER: My understanding with the amendment that was brought forth today is that there are some exceptions to that. There are some waivers where if they're not having a treating relationship with a patient, then they-- they would not have to do that.

ARCH: Right, or even-- they're even writing a script in the state of Nebraska. That-- that's a possibility as well. They may have the ability to do that but-- but honestly it would not happen. It would just-- one of those things might be it just

becomes one more thing in order to maintain your priv-- your credentialing here in the state. But anyway, you-- you could take a look at that. The-- the other question that I had was on line 9 of the amendment. "The department shall establish a system of registration," that system really is already established. Is that right? It is-- it is the system that is in existence now. There would just be more people that would-- that would-- that would go through that system.

KEVIN BORCHER: That's correct. The system is in place and it would just evolve into a better, more efficient system.

ARCH: OK. All right. Thank you. Seeing no other questions, thank you very much.

KEVIN BORCHER: Thank you very much.

ARCH: Thank you for your testimony. Other proponents? Welcome.

ANN POLICH: Good afternoon, Vice Chair Arch and members of the Health and Human Services Committee. My name is Dr. Ann Polich, A-n-n P-o-l-i-c-h, vice president for quality, patient safety, and population health at the Methodist Healthcare [SIC] System. I'm testifying today in support of the amendment to LB489 on behalf of both Methodist as well as the Nebraska Medical Association. By amending this legislation, credentialing holders

who will prescribe and dispense narcotics to patients in Nebraska will be required to register for the PDMP, as you know. Federal legislation, as we have talked about, the substance use disorder prevention that promotes opioid recovery and treatment, the SUPPORT Act for Patients and Communities, will require mandatory-- mandatory PDMP checks prior to prescribing a controlled substance as of 2021. Providers will need to develop appropriate practices and procedures to ensure this compliance, and that's within my confines of my job to fulfill that. Currently some of our commercial insurance carriers are requiring PDMP checks prior to narcotic prescribing and we expect that to expand as well. As PDMP registration is the first step to comply with these mandates, this amendment will support our present efforts. The lessons learned from the opioid crisis include the understanding that safe narcotic prescribing includes a thorough review of all patient medications, and we do appreciate this report that is now available through the PDMP. Aligning federal, state, and payer requirements as much as possible around the PDMP review prior to prescribing a controlled substance will further support optimal compliance and enhance patient safety. In closing, I would like to thank the committee members for allowing me to testify today on behalf of

the NMA in support of the amendment to LB489. I'm happy to entertain any questions you may have.

ARCH: Thank you. Any questions? Seeing none, thank you very much.

ANN POLICH: Thank you.

ARCH: Thanks for coming and for your testimony. Next proponent. Welcome.

JONI COVER: Good afternoon. Senator Arch and members of the committee, my name is Joni Cover; it's J-o-n-i C-o-v-e-r. I'm the CEO of the Nebraska Pharmacists Association and I'm here in support of LB489, and particularly with the AM929. Many of the pharmacists across Nebraska are really-- are-- are already using the PDMP and particularly in the chain area where it is mandatory to use it before they dispense a controlled substance. In fact, we're the highest utilizers of the PDMP in all healthcare professionals in Nebraska. There are-- but there are over 5,200 pharmacists that are licensed in the state, many of whom don't live here or practice here. And so with the amendment it makes sense that we would have some exceptions and some carve outs of those folks who-- who, if they don't have active patient care, wouldn't be mandated to register. So every-- those who

came before me gave you all the good statistics and stuff. So with that, I'll close and just say we support the bill and the amendment. So thank you very much and thank you to Senator Howard and the department and NeHII for working on the amendment.

ARCH: Any questions for Ms. Cover? Seeing none, thank you.

JONI COVER: Thank you very much.

ARCH: Any other proponents for this bill? We did receive a letter from Kayla Allmendinger, the National Association of Social Workers, the Nebraska Chapter, as a proponent. Are there any opponents to this bill? Anybody want to testify in a neutral capacity? Seeing none, Senator Howard is waving-- that means she's waiving close-- so we will end the committee-- the committee hearing for LB489 at this time.

HOWARD: All right. This will open the hearing for LB645, Senator McDonnell's bill to change provisions of the Medical Assistance Act. Welcome, Senator McDonnell.

McDONNELL: Thank you, Chairperson Howard and members of the committee. My name is Mike McDonnell, M-i-k-e M-c-D-o-n-n-e-l-l. I represent Legislative District 5, south Omaha. I appear before you today to introduce LB645, including AM963 which addresses

some technical language in the bill. I provided a copy of my testimony and handouts for your reference. In 2017, I introduced LB578 with the simple goal of providing additional funding to first responders in our state. The bill was adopted on Final Reading with a vote of 41 to 0 and subsequently signed into law by Gov--by our Governor on May 22, 2017. Most of our fire and rescue departments across the state are financially strapped and in critical-- critically in need of additional funding to help protect our Nebraska communities, in part because the cost of providing emergency response services is exceeding the level of the reimbursement that providers are receiving. LB578 called for the implementation of what is referred to as the ground emergency medical transportation, or GEMT, program that allows for supplemental payment structure for emergency transports through-- through the state Medicaid programs. When a 911 call comes in, our state's first responders are not able to decide if they want to respond based on the patient's ability to pay or what insurance they may have, and rightfully so. The first responders just go and help. This means that there are many times when there is no reimbursement for the services provided. Even when the emergency care and transfers are for patients with Medicare and Medicaid coverage, the reimbursement rate falls well below the actual cost of providing the services, created an

additional gap in funding. The ground emergency medical transportation program required by LB578, which is-- it was passed in 2017, was a means to address this gap in recognition of underpayment by the federal and state payers. Essentially LB645 is a technical cleanup of LB578 that directs the Department of Health and Human Services to apply again for a State Plan amendment to the Centers for Medicare and Medicaid Services the CMS will approve that aligns with approved programs in many other states. In 2017, to comply with LB578, DHHS submitted a State Plan amendment to the Centers for Medicare and Medicaid Services that it knew was not likely to be approved. This may have been done to meet the letter of the law basically as set forth in LB578, but it did not meet the overarching intent of LB578 as approved by the full Legislature. The Centers for Medicare and Medicaid Services gave DHHS the opportunity to modify the 2017 State Plan amendment and its-- and its proposed methodology to align with programs approved in other states. DHHS declined to accept the recommendations from CMS which would have met the Legislature's intent of LB578, and this is where we are today. This bill, LB645, along with AM963 directs the Department of Health and Human Services to resubmit a State Plan amendment that uses the methodology for ground medical emergency transport that the Centers for Medicare and Medicaid Services

has approved in other states. The amendment aligns the language of the bill with these methodologies and removes some outdated references. The language is generally more encompassing to prevent another failed submission of a State Plan amendment from DHHS by referring to a supplemental payment program instead of a specific type of methodology. It firms up the language in the bill to ensure that DHHS costs are reimbursed through agreements with the participating providers. Lastly, it gives DHHS a more reasonable amount of time to submit the State Plan, moving the deadline from July to December of 2019. For background for the new senators who did not serve on this committee in 2017, and as a reminder for those who did and recognize the importance of this program, I will try to explain the fundamentals of how the ground medical transportation works. The local fire and rescue departments will complete cost reports that ver-- verify expenses specific to their local agency. The enhanced reimbursement made through the federal funds is based on the cost reports and flows back through the DHHS to the respective agencies. The state will be kept whole in any cost as it-- it has in administering the program. As you will notice in the May 4, 2017, fiscal note for LB578, the bill required that there be no impact to the State General Fund, again, and LB578 was adopted on Final Reading with no opposition and signed into law

by our Governor, yet here we are almost two years later with legislative-- LB645 to enforce previously enacted legislation with an accompanying fiscal note that suggests a General Fund impact of $3.6 million and $3.5 million in years of 2019-20 and '20-21, respectively. There are a few key points that I want to emphasize which also address questions we received. Can the state do this without legislation? The state could submit a State Plan amendment using the methodology that the Centers for Medicare and Medicaid Services will approve without this cleanup bill. However, representatives from the Nebraska fire agencies met three times with DHHS representatives since November of 2018, but DHHS-- DHHS staff were resistant to any solutions presented during these meetings. Have other states had positive experiences with this? Yes. Thirteen states have implemented this program. Stakeholders in some of the-- those states provided neutral letters for LB578 in 2017. Eight other states are currently pursuing similar programs. Does this come from an Affordable Care Act? No. This program comes from the Social Security Act with similar EMS transport provisions that can be traced back 20 years within the state of Minnesota. Will this program require Medicaid to get a new claims payment system? No. Even though the bill calls for the claims to be paid as a fee for service outside of the managed care payment structure, the

bottom line is that there will always be some claims that will be outside of the managed care that DHHS will need to weigh the process and are currently still processing. One of the-- one of your committee's priority bills this session, LB468, also requires that some Medicaid populations not be included in managed care either. And these ground medical-- these ground emergency medical transportation claims would fall in line with those other claims outside of the managed care system. Otherwise, the bulk of this work for this program is done through processing cost reports which would-- which could be done in spreadsheets. Moreover, LB578 previously provided DHHS with our FTE to expressly help with this program. In closing, I want to reiterate that I'm trying to help our first responders with funding and in navigating DHHS to the solution that meets the legislative intent of both LB578 and LB645. I recognize the fiscal restraints of-- our state faces, especially as local entities try to recover from the devastation we have seen across our state this spring. Once this program is up and running, it will help our local departments fill a funding gap without dipping into the State's General Fund, just as it is doing in the-- those 13 other states with ground emergency medical transportation programs, and the list is growing. This is very important for our state, as you will hear from testifiers

following me, two of which include Micheal Despain, fire chief of-- of Lincoln Fire and Rescue; Steven Curtis, financial director of the city of Omaha. We are willing to help however we can with this committee to advance LB645 and find some means to pass it this session. I got to apologize to Senator Howard. In January, I went to her and I said, can you please schedule this bill for your last possible day of hearings, because I was overly confident that I would not be sitting here today, because I thought for sure the Department of Health and Human Services would work with all of these first responders that are sitting behind me-- and I only mentioned two of them because I didn't know how many were going to show up today-- because back-- they did-- they did their work back in 2017 when they testified on LB578. We already did this. We've already went through this process and we know that the-- the-- the ground was plowed by 13 other states. And now here we are two years later. We still have the first responders coming down here to testify for a bill that's supposed to be a cleanup bill now, based on just trying to help people. That's all they want to do. They want to respond and help people. They want to offset the cost as much as possible so the next time someone calls 911, they're there to respond. I really don't even know what to say today. I am so disappointed in the Department of Health and Human Services.

These people are the subject matter experts. They're going to be here to testify. They're going to be here to tell you how hard these people are working out there that dedicated their life to help other people, and they just want to try to offset the cost. And we know it's possible. If people would just sit in the same room and be reasonable, I know we can get this done and that's why I apologized to this committee, because I really felt in January that I would be telling Senator Howard, please IPP this bill because they came to a solution, they worked it out, they came in the room like adults and they found a solution. I-- I apologize that did not happen. I'll be here to answer your questions. I'm also going to close today.

HOWARD: I'm sorry. Are there questions?

WILLIAMS: Go ahead.

CAVANAUGH: You go first.

HOWARD: Senator Williams.

WILLIAMS: Thank you, Senator Howard, and thank you, Senator McDonnell, for being back again this year. Can you help me at least understand what is a marked change in the fiscal note from before when we were here-- and I was on the committee at that time, too-- and-- and now what we're seeing?

McDONNELL: And as you are all aware of, we get the fiscal notes within 24 hours of the bill and I really don't understand it. If you look at the state of California with 40 million people-- in the state of Nebraska, we have 1.9 million people-- they have one-and-a-half people assigned to do this work and they've been doing it for a number of years. Chief Despain, who was actually a fire chief in California, will talk a little bit about that. But I can't understand the fiscal note. I don't understand-- I don't know if this is going to be death by fiscal note, is that-- was that the intent of this, because, Senator Williams, I don't know. When I looked at it, my jaw dropped. I don't know if it's a-- it's an opportunity to say, well, we have to make some changes in the Department of Health and Human Services with some of our systems and-- and technology and we're going to use this bill as that -- as that vehicle. I don't even think that's-- that fiscal note is sincere. So can't-- I can't elaborate on that fiscal note.

WILLIAMS: Thank you.

HOWARD: Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman Howard. And thank you, Senator McDonnell, for being here today. The fiscal note that you have here of the $15,000 from 2017-18, so was that number used?

McDONNELL: No. Actually, if you look at the-- the bill, LB578, and you go to page 2 and you go to line-- of the bill, I think it's line 17. It says there will be no-- and it's still in the current bill in our-- in our current LB645. Turn to page 2, it's line 17: No General Funds will be used in carrying out the Ground Medical-- Emergency Medical Transportation Act. We could not have made it more clear and that's still in this-- this bill. So the idea of any cost that would-- the state would occur [SIC] we were going to make sure that those costs were offset through the reimbursement process so the state would be made whole. That's still the goal. That was-- that was the intent and that's what we passed with LB578 and that's still what we're doing with LB645.

CAVANAUGH: I have an additional--

HOWARD: Sure.

CAVANAUGH: --questions. So the previous bill was enacted, signed into law May 22, 2017. Did it-- was it not specific enough to say that they had to do this? Is that the problem?

McDONNELL: We believe there was-- there was problems that the Department of Health and Human Services saw, but there was

solutions that were given to them based on 13 other states that had enacted similar language that we have here.

CAVANAUGH: But generally when we pass a law, I mean, it's not a suggestion.

McDONNELL: No, I-- I don't believe the Department of Health and Human Services have become the fourth branch of government. I don't believe they've become the fourth branch of government, but actually, yeah, we're not supposed to be making suggestions to Department Health and Human Services. We're-- we're directing them by a law to get this done. Now if-- if there was ways for them to do that that they felt were more appropriate that would-- would-- would help, then that's-- that's something else. But the idea of actually just to say, no, we can't do this and we don't believe what the other 13 states that have done this, we don't want to do it the way they have, I don't-- I just don't understand that.

CAVANAUGH: So they just never attempted to draw down those funds for reimbursement?

McDONNELL: This bill has never been enacted.

CAVANAUGH: OK. I have additional questions.

McDONNELL: I should say that it was a bill and now it's a law.

CAVANAUGH: Yeah. Yeah.

HOWARD: Are there other questions? All right.

CAVANAUGH: OK.

HOWARD: Senator Cavanaugh. All right.

CAVANAUGH: OK, so I'm trying to like get my head around this because it seems counterintuitive that they wouldn't carry out a law. And then I'm looking at the fiscal note and one of the notes is-- and I'm sorry, I was reading the previous one earlier, not the new one. The-- so the pass through, the cost is because of a new system that they currently have to pay fee for services for the long-term care services and other services, so they do have an infrastructure for paying within the department. So I guess-- and maybe this is a question for them if they are testifying today-- is this to put the burden of the cost of-- of implementing a new system for these other entities on this bill? I mean you said death by fiscal note, but maybe they need these funds and they look at this as a vehicle for that?

McDONNELL: Yeah, when they come in to testify against my bill today, I'd ask them that question.

CAVANAUGH: I will. Thank you.

McDONNELL: Yeah. Thank you.

HOWARD: Senator Arch.

ARCH: Is the ground emergency medical transport program, I'd call it that, the GEMT, is that a fee for service? In other words, when a-- when an expense is incurred, it's billed and then the dollars flow?

McDONNELL: Yes.

ARCH: Is that how it works? OK, thank you.

HOWARD: Other questions? Senator McDonnell, I want to be clear. I remember working on this bill with you in '17 because I was confused by it and then we made the language work. So the department did submit a State Plan amendment, but they submitted it with a cost structure that they knew wasn't allowable?

McDONNELL: Yes. I-- I believe-- I can't answer that any more directly but yes.

HOWARD: OK. Any other questions? Seeing none, you'll be staying to close?

McDONNELL: Yes.

HOWARD: Wonderful. Thank you. All right. I'd like to invite our first proponent testifier for LB645. Good afternoon.

MICHEAL DESPAIN: Good afternoon, Senator Howard. Members of the committee, for the record, my name is Micheal Despain, M-i-c-h-e-a-l D-e-s-p-a-i-n. I'm the fire chief for the city of Lincoln and today I'm speaking in support of LB645 on behalf of both the city of Lincoln and a wide array of fire agencies throughout the state that you can see behind me now. I have over 34 years of experience in fire and EMS service, including some experience with the impacts of GEMT-type programs in other states. In 2017, this committee advanced, the legislate-- Legislature subsequently passed LB578, recognizing the crucial-- crucial need for a ground emergency medical transport program in our state. The Nebraska Department of Health and Human Services Division of Medicaid and Long-Term Care responded by submitting a State Plan amendment that-- that-- and essentially a method of implementing the GEMT program to Centers for Medicaid and Medicare Services that DHHS knew CMS would not approve. CMS gave HHS the opportunity to revise the methodology to align with GEMT programs CMS has approved in other states and HHS declined that offer. I have returned today to support LB645 as a means to compel HHS to complete the process of implementing GEMT program in a timely manner to follow through with the intent of-- the

legislative intent of LB578. For review and for new committee members, I'll try and provide some insight into the crisis growing within the emergency medical field and how ultimately LB645 would provide some relief to the first responders statewide. There is a widening gap between the cost of providing services and the federal reimbursement rates for services provided. As an example, the average cost of running an ambulance call in the city of Lincoln is approximately $500. However, Medicaid and Medicare will only pay about $170 for this service. Notably, this reimbursement rate as a percentage of actual cost has dropped every year for at least the last decade. This drastic underpayment means that we must charge other non-Medicaid and Medicare patients who receive the same service in excess of $1,000 to make up the budget deficit the underpayment creates. This is a statewide and national-- nationwide concern. Accordingly, CMS has approved GEMT programs in over 13 states to provide some relief for providers and at least 8 other states are currently pursuing the programs, the GEMT programs. The Medicaid programs in nearly all the states have managed care components and yet still realize the advantages of a GEMT program as a complement to the managed care delivery model. These 21 states, the medical industry, and also CMS have come to recognize the value of initial EMS treatment and transport has

on definitive care. "Definitive care" is a term used to describe medical care that makes a difference in terms of patient outcomes, where the focus of managed care also lies. Outcomes might be measured in a percentage of patients that survive a medical emergency, the level of care provided at the hospital, the length of stay at a-- a hospital stay, how much treatment was meted after discharge, etcetera. Proper EMS deployment improves a patient's chance of surviving a sudden medical emergency, decreases the amount of medical intervention needed at the hospital, and lessens the need and thus lowers the cost of subsequent care. Improper EMS deployment, typically due to funding shortages, means a lower chance of surviving a sudden medical emergency and more intense and expensive intervention through the hospitals and downstream care. The last time I was before this committee, I provided an example cost comparison from a 2015 National Academy of Sciences report that showed the cost of treatment for a patient who suffers an out-of-hospital cardiac arrest and survives with good neurological function was approximately $40,000 in 2009 dollars. The cost of a similar patient with poor neurological function, the risk for which is mitigated by rapid and effective EMS response, who requires long-term skilled nursing care-- nursing care will have care cost over $102,000 a year, an amount that will no doubt continue

to increase year over year for the remainder of the patient's life. This example is one of the fundamental reasons for cooperation from the federal and state government on programs such as GEMT and the-- and community paramedicine. Better reimbursement for first responders to improve outcomes significantly saves future Medicare/Medicaid dollars. In summary, for the city of Lincoln and territory around it that Lincoln Fire and Rescue serves, the passage of LB645 will mean the difference between service levels determining-- deteriorating and maintaining current service levels by requiring HHS to complete the implementation of the GEMT program the Legislature already supported and authorized.

HOWARD: Thank you. Are there questions? Senator Arch.

ARCH: In your-- in your test-- thank you, by the way, for coming today. In your testimony, you indicate that Medicare/Medicaid pays around $170. Have you given an estimate as to what additional funds would be available through this program, approximately?

MICHEAL DESPAIN: So it depends on the agency, their cost reporting, but for Lincoln, for example, we suspect that that gap between the $500 and the $170 would be closed by about 50 percent.

ARCH: OK.

MICHEAL DESPAIN: So it doesn't get us all the way there.

ARCH: No.

MICHEAL DESPAIN: They're not paying full cost but it's a-- what we would describe as a more fair share and would take the pressure off, you know, the taxpayer, the insured person that gets the higher bill.

ARCH: So-- so as a result of cost shifting, the need to cost shift would-- would-- would decrease--

MICHEAL DESPAIN: Right.

ARCH: --if-- if you had those.

MICHEAL DESPAIN: And cost shifting can only go so far. I mean you can only charge so much to--

ARCH: I-- I fully understand. Yes.

MICHEAL DESPAIN: --the taxpayer.

ARCH: Right. Thank you.

HOWARD: Are there other questions? Senator Cavanaugh.

CAVANAUGH: Thank you Chairwoman. Thank you for being here today, for your testimony. Do you have an idea-- and I apologize if I've missed it in your materials-- of how much money the city of Lincoln has lost as-- as a result of not enacting this?

MICHEAL DESPAIN: It would take me a while to calculate that but I can tell you for sure it's-- we only-- we only recoup about 50 percent of our cost as is, and that's all payer profiles. And so we run about a $10-14 million operation that recoups about $6 million a year. The biggest violator of that ability to pay is the federal government.

CAVANAUGH: OK. Thank you.

HOWARD: Any other questions? Seeing none, thank you for your testimony today.

MICHEAL DESPAIN: OK. Thank you very much.

HOWARD: Our next proponent testifier. Good afternoon.

STEPHEN CURTISS: Good afternoon, Senator-- Senator Howard and the members of the Health and Human Services Committee. My name is Stephen Curtiss, spelled C-u-r-t-i-s-s. I'm the finance director for the city of Omaha. From 2000 to 2004, I was the director of HHS for Governor Johanns and I was responsible for

the Medicaid program. I spent the next nine years-- nine years after that as a consultant for Medicaid at both state and CMS at the federal level. I'm here today to support LB645 and I'd like to Senator McDonnell for introducing it. As an aside, I know the question came up, well, what's the impact been to the city of Lincoln? In this case, the city of Omaha, I know we had a $4 million-- we assumed that this would have been implemented as it was laid out and we had a $4 million, almost a $3.5-4 million shortfall in our revenue. As you know, our roads are not in great shape up there, and a lot of other things, and that money would have come in handy because we went ahead and funded everything on fire, including a new EMS station, and that was at the expense of other things in the budget. LB645 would provide for enhanced Medicaid funding for cities and rural provide-- and rural providers who provide ground medical emergency transport. And as you've heard before, this bill is a-- a small technical fix to LB578 which was passed unanimously by the Legislature and signed into law in 2017, as you've already heard. LB645 direct DHHS to request what I would estimate to be about $10 million of federal funding to be paid to governmental EMS first responders. This bill requires no state funding or appropriations bill and this bill is not a Medicaid expansion, as you've heard, because it does not add any new Medicaid recipients and it adds no new

services. These are all included in the current plan. The bill requires DHHS to submit a Medicaid State Plan amendment to secure the additional funding for federal funding only. This funding would cover some of the differences, as you've heard, between what get paid and what is the actual cost. DHHS has expressed their desire not to implement the fix because they would rather not move ambulance runs back to fee for service from managed care where they currently are. They claim that is not the direction they want to go and in their fiscal note, as we all talked about it, shows they intend to move all services to managed care, including long-term care, despite how much wisdom may be in that. And as it's been said, there is currently a system. Oddly enough, though, the way that this bill is written, they can recoup their costs. So if this produced $10 million and they can prove their costs were $20 million, this $10 million would go a long way for a new system. I would suggest that's probably not-- not the right direction to go but oddly enough, this would provide $10 million in funding if they really went to that level. The bill would likely include a dozen or a few dozen providers and a de minimis number of claims in the grand scheme of-- of Medicaid. And I understand the need for a long-term claims processing solution, but moving everything to managed care at the expense of all else doesn't seem like the

right solution. So we could debate the wisdom of doing that, but this bill does allow them to recoup their costs, their reasonable costs. I should put brackets around "reasonable cost." I'm not sure about their fiscal note either. That was pretty breathtaking, as my former boss would have said, Governor Johanns. LB645 helps to offset costs currently uncompensated by the Medicaid program. It's-- it's provided entirely by the federal government and provides some much-needed financial relief to cities and rural agencies that currently must rely on, as you've heard before, local taxpayers and private insurance providers to subsidize-- subsidize the federal government. And I'd be happy to answer any questions.

HOWARD: Thank you. Are there questions? Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman Howard, and thank you, Mr. Curtiss, for being here today and for serving the city of Omaha as well. And, yes, we could use that money for some road repair. So have you had any conversations with the Governor's Office or has the city of Omaha had any conversations with the Governor's Office as to-- obviously DHHS has expressed its desire to not implement this, but the Governor did sign this into law.

STEPHEN CURTISS: He did. And I can only speculate who all knew that this small technical glitch was in there, and the glitch

was it required this transfer mechanism would be --mech-- mechanism to be an intergovernmental transfer, which became kind of a no-no in fed speak, so we laid out a different plan to do it and the response we got was, well, no, we're just going to file it like the bill told us to, and that's what they did.

CAVANAUGH: OK. Thank you.

HOWARD: Further questions? Seeing none, thank you for your testimony today.

STEPHEN CURTISS: Thank you.

HOWARD: Our next proponent testifier for LB645.

JERRY STILMOCK: Madam Chair, members of the committee, my name is Jerry Stilmock, J-e-r-r-y, Stilmock, S-t-i-l-m-o-c-k, testifying on behalf of the-- my clients ,the Nebraska State Volunteer Firefighters Association and the Nebraska Fire Chiefs Association in support of the measure. We were here in 2017. We were very excited, though in the rural setting not all communities are going to be able to participate in this reimbursement plan. But we believe many will be able to, so we're equally disappointed that it did not happen at this point. I don't know that I can add to what Chief Despain has said, nor what Mr. Curtiss has said, other than we have members, over

7,000 men and ladies that are out as volunteers morning, noon, night. You know the calamities that we've read about. Some have endured. But I guarantee you, the volunteer first responders have been out there morning, noon, and night, along with the-- the paid colleagues. You know, I read an article once and it-- it did go to the volunteer service and I've often had an opportunity to speak about it and oftentimes write about it without being overly dramatic. But truly, for the communities of 300 people or 5,000 people or 10,000 people that rely on the men and lady volunteers throughout the state and our travelers relying upon it, I ponder upon the question of what happens if nobody answered the call. That's really perhaps a little dramatic for a setting this afternoon on the last day of hearings, but yet it rings home of we take for granted, right? Law enforcement's going to be there, our educational system is going to be there, we're going to move to a community, might have to bus a little bit, but what do we look at for EMS? And the-- the-- the troubling part is, as Senator McDonnell shared at the beginning his-- you know, the disappointment of being back, I don't know all the ramifications of those that came before me in testifying this afternoon, but I can tell you that the volunteers are very supportive of LB645 and-- and thankful

that Senator McDonnell is back up swinging again. Thank you, Senators.

HOWARD: Thank you. Are there questions? Senator Arch.

ARCH: You made a statement that not all would be able to take advantage of this program. Is that because not all are billing?

JERRY STILMOCK: Well, no, I think it's more of the-- the steps it would have to take, Senator Arch. Though some, as we learned last week, some are not billing, I think it's more of the components and how the strategy of that volunteer department, how much they're willing to put into the legwork that would have to happen.

ARCH: Which is--

JERRY STILMOCK: City of Lincoln--

ARCH: --the cost report, right?

JERRY STILMOCK: Yes, sir.

ARCH: I mean that's the--

JERRY STILMOCK: That, and there's the-- there's a participation up-front that as I understood it, sir, from 2017, that there would be a-- a financial outlay by the community. I'll pick on

my hometown, the city-- city of Syracuse. Syracuse would have to have a finan-- financial outlay at the beginning of the process, kind of a-- I-- I won't use the term, but there would have be a financial outlay at the beginning and then as the program went on, that money would be recouped by the participating community. So it's going to be a, you know, local-- it's going to be-- the people at home are going to have to decide whether they want to participate or not. It's not because of whether they're-- they would be-- they wouldn't be able to do it if they weren't billing, yes, sir, to answer your straightforward question, and I gave you too long of a long-winded answer.

ARCH: All right. Thank you. Yes.

JERRY STILMOCK: Yes, sir.

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

JERRY STILMOCK: Thank you, Senators.

HOWARD: Our next proponent testifier for LB645. Good afternoon.

DARREN GARREAN: Good afternoon, Senator Howard, members of the committee. My name is Darren Garrean, D-a-r-r-e-n, last name Garrean, G-a-r-r-e-a-n. I am president of the Nebraska

Professional Fire Fighters Association, representing the paid union firefighters and paramedics from Scottsbluff to South Sioux City to Beatrice and-- and in between. We rise in support of LB645 and it-- it is unfortunate that we have to come back and discuss this issue. I-- I represent the people that put their hands on the patients, so it is my duty to help protect those people, to make sure that they have the tools and the resources and the things they could do to do their job. You-- you've heard a lot of testimony on, you know, costs and-- and kind of how we ended up here. But the reason why I'm here is because of that-- that bottom line of we want to protect those people that are doing the job. When somebody dials 911, they just have that expectation that somebody is going to be there, whether it's a heart attack, car crash, all those other things. Just a simple matter of, hey, we-- we need to provide gloves to make sure that our members don't get infected from blood-borne pathogens, there's a cost to that. I think you heard Chief Despain talk about the $500 cost to put an ambulance out for a call. It's the ongoing training. It is-- it is making sure that what we do is provide a good service to the citizens of Nebraska, in addition to those people, you know, driving through the state, whether they're tourists or-- or just traveling through to some-- some other destination. So-- so just in a-- in

a broad scope of-- of what this is, is an attempt to bring back some money through reimbursements to Nebraska. You have other states that are doing this. This isn't plowing new ground, as-- as you've heard. There are other states that are-- that are taking this and doing it and-- and there's no reason why we can't do that here. Everybody-- everybody in here knows that there is-- there is a burden on the taxpayers. There is an opportunity here, I think, to look at that as a potential of maybe lightening some of that tax burden, whether it's the local municipality, the-- the local fire, rural board. Whatever it is, there is something here that we can look at that maybe would-- would lighten that up. In addition to-- I think you heard testimony-- testimony that I-- I believe the Department Health and Human Services is going to oppose this, and I don't know why and I'm sure they're going to tell you why, but the opportunity to bring money into-- into that system, whether it's just specifically for EMS or whatever they do with that, is an opportunity to bring money back to-- to lighten their load, too. I ask that maybe you ask-- ask those specific questions of why they would be opposed to-- to helping them in addition to all those first responders. I'd be willing to answer any questions if there are any.

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

DARREN GARREAN: Thank you. Thank you, Senator Walz, for your support of the first responders in the Fremont area. I know everybody's got devastation going on right now, but thank you.

HOWARD: Our next proponent testifier for LB645. Seeing none, we do have a letter, Lynn Rex from the League of Nebraska Municipalities, in support. Is there anyone wishing to testify in opposition to LB645? Good afternoon.

THOMAS "ROCKY" THOMPSON: Good afternoon, Madam Chair and members of Health and Human Services Committee. I'm glad to be here for your last day. My name is Thomas "Rocky" Thompson, T-h-o-m-a-s R-o-c-k-y T-h-o-m-p-s-o-n. I serve as the deputy director of policy communications for the Division of Medicaid and Long-Term care within the Department of Health and Human Services. I'm here to testify in opposition to LB645. And I-- just to be clear, I have not seen the most recent amendment. There was an amendment that was shared, but I don't think it's the number that Senator McDonnell referred to earlier. LB645 would mandate that Medicaid-- ground emergency medical transportation, or GEMT, services would be paid on a fee-for-service basis and would prohibit these services from being covered under any

managed care program, including Heritage Health. MLTC assumes the intention of this bill is increased payments to eligible providers by means of a supplemental federal pass-through payment. These are arrangements which have been prohibited in the managed care delivery model since 2016 and have been under scrutiny by the federal government for fee-for-service arrangements. GEMT is currently provided through managed care and has been even prior to the implementation of Heritage Health. Carving GEMT services out of managed care would require us to contract out for a new claims broker system, which would cost $22.6 million in up-front costs and $2.5 million in annual maintenance and operations cost. Our current fee-for-service payment system is outdated and we're trying to move-- and trying to move new claims into it is unworkable. The administration of this program would also lead to a significant number of complicated agreements and ongoing arrangements with public ambulance providers across the state, each with different governing authorities to be administered by Nebraska Medicaid. While this bill allows for the department to collect a 5 percent ad-- administrative fee from the nonfederal share of supplemental payment, this is not sufficient to cover the cost to implement or operate the program on an annual basis, which created a General Fund fiscal note, and I think that has been

shared with you. This is in direct conflict with the language in the statute which prohibits the use of General Funds to carry out the supplemental GEMT program, so I don't know where the extra funds would come from. Finally, the State Plan, the 1915(b) waiver, and the contract with the managed care companies would all have to be changed to accommodate the supplemental payment program. The apparent aim of LB645 would require costly reversals that would have to be subsidized by state General Funds. It would also reverse the Medicaid program's progress away from an outdated delivery model. For these reasons, we oppose LB645. I will note, as has been said, we have been actively engaged with both the city of Lincoln and city of Omaha on this issue. The department is more than willing to continue discussions to achieve the goals of this program within the constructs of the managed care program. This has been communicated in several meetings over the last year with both the cities of Lincoln and the cities of Omaha, including earlier this week. We have had several meetings with them and their consultant promising solutions to the managed care delivery model, but those were never given. Additionally, regarding Senator McDonnell's previous bill on this issue, the department was deeply engaged with the city of Lincoln, its consultant, and Senator McDonnell's office during the process leading to that

bill's passage. The city of Omaha was not involved at that point. We made it clear, as did the Legislative Fiscal Office, that the federal government would disapprove of the GEMT supplemental payment program as it was written. I believe also the legal counsel with HHS Committee at that time contacted CMS about this. However, we still submitted a State Plan amendment for the program as directed by the bill, which was disapproved in March of 2018 by the federal government. Thank you for this opportunity testify. I'm happy to answer any questions you might have.

HOWARD: Thank you. Was Director Van Patton not able to join us today?

THOMAS "ROCKY" THOMPSON: Director Van Patton is preparing for the Medicaid expansion on April 1.

HOWARD: Thank you. Are there questions? Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman Howard. Thank you, Deputy Director Thompson, for being here today. So you submitted a plan and you knew that the cost structure wasn't allowable.

THOMAS "ROCKY" THOMPSON: I'll clarify, Senator. It's not the cost structure. It's because it was in the managed care delivery model, an IGT in the managed care delivery model, which we made

clear to both Senator McDonnell and to cities of Lincoln at that time. Prior to passage we said we would still attempt to do it and we submitted a State Plan amendment as it was written, as it dictated in the bill.

CAVANAUGH: So when you received notification that-- from the federal government that that was not going to be workable and they offered you the opportunity to submit an amended application, you declined.

THOMAS "ROCKY" THOMPSON: Senator, the amended-- the change would have us carve it out of managed care, which we're not willing to do.

CAVANAUGH: You're not willing to do?

THOMAS "ROCKY" THOMPSON: Correct, for the reasons discussed, the cost, and also because that's not delivery model that we are working on. We have had--

CAVANAUGH: So the current fee-for-service payment system is outdated and not workable.

THOMAS "ROCKY" THOMPSON: It's 40 years old--

CAVANAUGH: OK.

THOMAS "ROCKY" THOMPSON: --over 40 years old.

CAVANAUGH: But you are currently using that system for other fee for service?

THOMAS "ROCKY" THOMPSON: Yes, Senator, mainly for long-term care services.

CAVANAUGH: So-- so it's-- it works.

THOMAS "ROCKY" THOMPSON: It works but the individuals who support that system are dying off because it is an outdated system.

CAVANAUGH: So it-- but it-- it works. It currently is operational and could be used for this.

THOMAS "ROCKY" THOMPSON: It could be used for this, Senator, but the support of this system, it's-- it's not there anymore. And also the Federal Government has indicated that it might not be willing to have enhanced funding for that system in the future.

CAVANAUGH: And the $22.6 million in up-front costs, did the department explore whether or not the federal government would reimburse-- reimburse any of that?

THOMAS "ROCKY" THOMPSON: Senator, that cost comes from an estimate that was given as part of a procurement for the claims broker system--

CAVANAUGH: Sure.

THOMAS "ROCKY" THOMPSON: --so that was a cost that was give--

CAVANAUGH: But would the federal government reimburse any of that?

THOMAS "ROCKY" THOMPSON: Yes, Senator. It would be at least 50/50; if the system is certified, it'll be 90/10.

CAVANAUGH: So we could potentially get an updated system for 90 percent of it paid by the federal government.

THOMAS "ROCKY" THOMPSON: If it is certified, yes, Senator.

CAVANAUGH: OK. And has that avenue been pursued by the department?

THOMAS "ROCKY" THOMPSON: Senator, when the Heritage Health procurement came out, part of the scope of work was a claims broker system. And so we were looking down that avenue and UnitedHealthcare won that-- that part of the procurement. But there was a cost that was associated with it which is a cost

that I gave to you. And at that point, it was determined that we need to move away from fee-for-service payments entirely and move towards 100 percent managed care.

CAVANAUGH: So I appreciate that you're representing the department today and Director Van Patton is not available, but it would be very helpful to know if part of the plan that is being submitted on April 1 to the federal government for Medicaid expansion would include this system, because that is part of the 90/10 match. Do you know if there is an intention to seek funds for this at this point in time considering not the bill that's in front of us today but considering the law that is in statute currently?

THOMAS "ROCKY" THOMPSON: Senator, the-- the managed-- the-- the Nebraska Medicaid expansion program director has indicated in the past I think to this committee and to the Appropriations Committee that it will be delivered through the Heritage Health program.

CAVANAUGH: OK. I guess I don't under-- so is that a yes or a no to my question?

THOMAS "ROCKY" THOMPSON: The-- so you're talking about the system or talking about the Medicaid expansion?

CAVANAUGH: Is there a request for-- in our expansion for-- to receive drawdown federal funds to cover an updating of our maintenance system?

THOMAS "ROCKY" THOMPSON: Senator--

CAVANAUGH: Maybe that's not the appropriate avenue. I don't-- I'm not an expert in this.

THOMAS "ROCKY" THOMPSON: And nobody's an expert.

CAVANAUGH: Well, that's true. But is that an avenue that's being explored by the department?

THOMAS "ROCKY" THOMPSON: Senator, because the managed-- the expansion program will be delivered through managed care, there's not a need to procure a new claims broker system, so that is not part of that.

CAVANAUGH: But there-- well, no, there is a need to because our current law says that you are to be pursuing these funds, and to pursue these funds you need this system, and in order to get this system you need the-- the funds for the system, and so there is a need for it. Clearly, in state statute, on May 22, 2017, the Governor agreed with the legislative body that there is a need for this and that the Department of Health and Human

Services should pursue that. So we're-- we're-- we as a body apparently were not strongly wording this enough to the department, which is why Senator McDonnell has come back today in front of us. And I just-- so you're saying, no, you're not pursuing the funds, but the application isn't done because-- it's not as far as I know. Is the application still being worked on?

THOMAS "ROCKY" THOMPSON: It's being-- the State Plan amendments for Medicaid expansion are still being worked on and they'll be submitted April 1.

CAVANAUGH: So we still have an opportunity. The clock has not run out. We can still today add in a request for these funds and Senator McDonnell can withdraw his bill and we can move forward with the old-- the previous bill and we can fund this program.

THOMAS "ROCKY" THOMPSON: Just to clarify a couple of your points, Senator, first of all, Senator McDonnell's previous bill we did that; we submitted that State Plan amendment to do the supplemental payments through managed care. We-- and it said if it was disapproved--

CAVANAUGH: Right.

THOMAS "ROCKY" THOMPSON: --then the rest the program would not be implemented.

CAVANAUGH: But if you were to create the system, get the funds for the system, this fee-for-service system, if you were to put that request in to the federal government in the Medicaid expansion package that we're putting together, then the current legislation would be moot because you would have the system in place, you could make the application to the federal government, and you could draw down those funds for our emergency responders.

THOMAS "ROCKY" THOMPSON: That's not entirely accurate, Senator. There-- there is a different process for seeking funds for IT projects which I-- I don't want to get into right now. It's different than the State Plan pro-- process. Additionally, this bill says no state General Funds shall be used, so where are we going to get those funds for that claims broker system?

CAVANAUGH: From the federal government.

THOMAS "ROCKY" THOMPSON: But, Senator, it's not-- not 100 percent federal funds and the 90/10 funding for IT project is only after a system is certified by the federal government.

CAVANAUGH: OK. I-- I have-- I have more questions but I want to be respectful to the committee.

HOWARD: Sure.

THOMAS "ROCKY" THOMPSON: And if you want to meet later on, we can discuss this further. I'm more than willing to.

CAVANAUGH: Probably.

THOMAS "ROCKY" THOMPSON: OK.

HOWARD: Senator Williams.

WILLIAMS: Thank you, Chairperson Howard, and thank you, Mr. Thompson, for being here again. We have a pretty significant need here all across the state with-- with the first responders here. This committee has also heard testimony for a lengthy period of time now on-- on managed care, the moving towards that being there now, and also the payment system that we've got. Walk me through how we can mesh that all together and find a solution for this that will take us into the managed care system but through the managed care ability be able to increase the reimbursements for the responders.

THOMAS "ROCKY" THOMPSON: Thank you for that question, Senator. I'm-- I'm glad you asked it. And we've been trying--

WILLIAMS: What's the solution? So let's--

THOMAS "ROCKY" THOMPSON: We-- we've been trying to figure out a solution for two years in managed care. And again, as I said, we have met with city of Lincoln's consultant and asked for different recommendations. There was one recommendation that was given, a Rogers amendment which we were promised additional information on but we never received that additional information. But late, I think, last month there was some information that was done by CMS regarding a Medicare payment model which will create quality metrics for emergency transport-- emergency medical services, emergency transportation. And there are other arrangements like this currently implemented by the state. There's a supplemental payment. It's not-- it's not a supplemental payment anymore because of managed care, but there are avenues to do directed payments through managed care but there have to be quality metrics that are attached to it. This is a process we went through with the College of Dentistry back in late 2007-- or, yeah, late 2017 when we went to the MCNA managed care program. So at first we were unable to pay those direct payments. There was a supplemental payment arrangement prior to the implementation of MCNA and this-- and the federal government said we cannot do it due to the managed care reg that came out that removed the ability to supplemental payment

arrangements. So we were seeking avenues to do that. And in-- I'll get the actual date for you-- in November of 2017, CMS released an avenue to do some directed payments but they had to be tied to quality metrics. So that's through a process of 438.6(c) Preprint, and I can provide this information to the committee if they would like. So this is a process that we went through with the Dental College to maintain their additional payments. It took about nine to ten months to get this approved by CMS, and this is an annual process we have to go through to maintain those. It-- it's really enhanced fee schedule that they-- those providers have. And they-- we're going through the same process right now with-- there is a-- there's these-- the UNMC physicians also have a supplemental payment, so we're going through this process also before those supplemental payment arrangements are phased out according to federal law that was-- came out in 2016. So there is an avenue for it and this is something we presented to the-- Senator McDonnell and the cities of Lincoln, the cities of Omaha, actually earlier this week, because we did not have the information about these quality metrics that CMS was already coming out with, with ground emergency medical transportation, but at that point they figured that it'd be best to go forward with this bill. I hope that made some sense to you.

WILLIAMS: So if-- if-- if we-- if we were to get on that horse versus this horse, what would your estimation be of the time frame that would be required and the possibility of being successful?

THOMAS "ROCKY" THOMPSON: Senator, I think that we need those quality metrics from CMS but CMS is very involved with this. There was a former Medicaid director for Nebraska that was on that call that we had with CMS last week discussing this. I think we'll get those quality metrics soon. And I think through the process it'll probably be a little bit easier than we went through with the supplemental payment arrangement that we had with the College of Dentistry, so maybe the lesson--

WILLIAMS: When-- when-- and when you say soon, Mr. Thompson, are-- are-- is soon weeks or months.

THOMAS "ROCKY" THOMPSON: It would be months. It-- it's-- it would be a-- it would probably be sooner than procuring a new claims brokerage system to have supplemental payments paid in fee for service and to-- the authorities to carve those out of the managed care contracts. So I would say November, December we could get something going.

WILLIAMS: Thank you.

THOMAS "ROCKY" THOMPSON: Thank you, Senator.

HOWARD: Senator Arch.

ARCH: Thank you. Thank you for being-- helping us understand a complicated issue here. It reminds me of discussions that we've had within healthcare for-- well, really, since the Affordable Care Act, where the move to value, the move to quality, the move to outcomes versus the fee for service, and we got-- in healthcare we-- we have made progress but got a little high centered, and I think the general consensus is 100 percent outcomes, 100 percent value, 100 is still a ways off, fee for service still has a piece of everyone's life. And-- and I guess what I-- you know, as I listen to this discussion, that-- that nut seems to be the-- DHHS's determination that we are going there and we're not going to keep investing in the fee-for-service side of-- of the equation. Is that-- is that an accurate statement?

THOMAS "ROCKY" THOMPSON: I think, Senator, there's a business reality that we cannot maintain our current MMIS.

ARCH: Right. And that's-- and that's the problem, right? I mean, if we had a 5-year-old fee-for-service system versus a 40-year-old fee-for-service system, we may have a-- we may have a

different discussion. Your-- your current-- your current IT support, I mean, it's an old system and we-- we recognize that. Have you-- have you explored any other options besides procurement of and complete replacing of-- of this, knowing that, you know, I don't know-- you can't predict the number of years-- 15 years from now maybe we'll be 100 percent. I don't-- I don't know but-- but where-- where there is a contracted-- there's a contracted service, it's always surprising to me that-- that it seems like we have to-- I mean now within-- within electronic medical records you're in the cloud, you-- you don't have your servers in your room anymore, you're not --you're not maintaining that in some-- in some closet down the hall. You're-- somebody is doing that in New Jersey, you know. So have you-- has the-- has the state explored the possibility of an outside contract versus an entire procurement of a new fee-for-service processing system?

THOMAS "ROCKY" THOMPSON: I thank you for the question, Senator. Now the current MMIS is actually home grown. It-- we're one of the few states that actually have an MMIS that we actually own. Most states do contract out for that service.

ARCH: Most do now, most do contract out for the-- the service?

THOMAS "ROCKY" THOMPSON: Correct. Now there have been discussions about, you know, we possibly could have some remnants paid for by another state's MMIS. I think that's-- Hawaii has an arrangement like that. So there's different things that have been tossed around in the past and also continue to be tossed around because, you know, we do face a business [INAUDIBLE] we're going to have to sunset our current claims payment system.

ARCH: Right, and sunset the current claims, but this remnant of fee for service that still exists out there, you mentioned long-term care being the largest piece of that, but there's probably these little off programs that for some time are going to exist that still is going to require a fee-for-service processing.

THOMAS "ROCKY" THOMPSON: There-- there are those populations, those remnant populations and remnant services. Some of those populations are going to be carved in on June 30. I don't have that list in front of me right now for those populations. We also have-- our largest number of claims are nonemergency medical transportation, so those are the ones that take individuals to doctor's offices, for example, and we currently broker with Intelliride for those services. Those are being carved into Heritage Health in the middle of this year. So we

are working towards that plan and we are working on solutions. There-- there's other populations, a shared cost population that we are working on trying to figure out a solution for and-- trying to think of-- and then there's also the retro eligibility. Sometimes those are pay for fee for service because the plans, they only pay retro for three months prior to-- to-- and they're actually enrolled in the plan.

ARCH: Well, all of-- all of these decisions in business of course are just value equations, right? I mean when you're looking at millions of dollars here that could come into the state versus what cost, well, when you say we have to develop an-- we have to entirely develop a new-- a new system and own it and $20-some million dollars and the value suddenly flips and you say, well, it's not worth it, but if there are other alternatives such as sharing-- sharing that type of a system with another state, I mean, my guess is that the whole fee for service in all states is going to continue to shrink and there's probably going to be a number of states looking for a shared cost saving-type system that-- that could be-- could be multiple states but-- but supported together. I-- I don't know. I'm just-- I guess I would just encourage you that when-- when you're looking at something like this, that all those alternatives are explored and not simply, well, you know, I guess our only choice

is to spend $20 million dollars to do something that's bringing in five. Well, everybody goes, oh, we're not going to do that. There-- there's just-- there could be other alternatives that-- that arrive with something like this.

THOMAS "ROCKY" THOMPSON: And if you have any ideas, that-- that would be great. You know, this is something that's been in discussion since prior to the implementation of Heritage Health in 2017, so there have been alternatives that have been proposed. The city of Lincoln in one of our meetings proposed being a claim-- claims broker system and that was something that we didn't know if they would be certified by the federal government to do that.

ARCH: Well, OK. All right. Thank you.

HOWARD: Other questions? Senator Cavanaugh.

CAVANAUGH: Thank you. So you-- just a little clarification on what you were just discussing with Senator Arch. You do currently contract with a fee for service for some of this fee for services or that's not something you currently do?

THOMAS "ROCKY" THOMPSON: We currently pay some claims for fee for service.

CAVANAUGH: Right.

THOMAS "ROCKY" THOMPSON: The largest number of claims for-- are ground emergency-- ground nonemergency medical transportation.

CAVANAUGH: But you don't use an outside contract to do that.

THOMAS "ROCKY" THOMPSON: Our-- in the--

CAVANAUGH: It's all done through that 40-year-old system?

THOMAS "ROCKY" THOMPSON: That's correct.

CAVANAUGH: All of it is?

THOMAS "ROCKY" THOMPSON: That's correct.

CAVANAUGH: Did you explore the option of contracting with a system like other states do instead of purchasing or--

THOMAS "ROCKY" THOMPSON: That was part of the Heritage Health procurement and that was part of the claims broker scope of work that I discussed earlier, so yes.

CAVANAUGH: But they don't-- Heritage Health doesn't do fee for service as part of their--

THOMAS "ROCKY" THOMPSON: There-- there was a proposal in the RFP for Heritage Health, Senator. It was because each of the plans

have their own processing system for claims that we could utilize one of those systems to pay our remnant fee-for-service claims.

CAVANAUGH: And--

THOMAS "ROCKY" THOMPSON: So that was part of the scope of work. The highest scoring RFP would be awarded that scope of work.

CAVANAUGH: So was there a decision made to not include that in the scope of work?

THOMAS "ROCKY" THOMPSON: We actively discussed it for two years. And there-- there was the-- that-- that's the amount that-- the $20 million amount that I was talking about. That's how much it would cost the state to have that additional scope of work.

CAVANAUGH: OK, so we've had a lot of members of the department here over the last several weeks testifying on various bills and something that I have heard many people say, and I'm not sure if you have said this or if it was just your colleagues, but that it is the responsibility of the department to be good stewards of taxpayer dollars. I'm not trying to put words in your mouth, but would you agree with that statement?

THOMAS "ROCKY" THOMPSON: I don't believe, Senator, I said it this year, but I have said that in the past.

CAVANAUGH: OK.

THOMAS "ROCKY" THOMPSON: So I would agree.

CAVANAUGH: OK. So what I'm hearing from the people that came and testified in support and from the information that we have at hand is that we for the past two years have not sought the dollars, the reimbursement dollars that we could, for our local governments, our local communities. And we are as a state basically digging in the couch cushions for money right now. And this is several million dollars that we could have been giving to these communities to help offset these costs. And that would mean property tax relief. And we need to be talking about property tax relief in any way we can and giving local governments this opportunity to pay for some of their services, frees up their budgets. And it's our role as a state to help them to do that. So I'm concerned-- I'm extremely concerned that this bill went through the rigorous process of getting passed in the Legislature and signed by the Governor, but the department has not, in what I view, and obviously what Senator McDonnell views, as-- has not done everything that they can in good faith to enact this bill and I'm really concerned that we're not being

good stewards of the taxpayer dollars. My question in this is, is there an opportunity now to fix that?

THOMAS "ROCKY" THOMPSON: Thank you for that question, Senator. And first of all, I-- I think it's important to say this is not free money. I know this has been sold to certain groups as free money. This isn't--

CAVANAUGH: No, I don't-- I don't think it's been sold to anybody as free money. It's taxpayer money. It's taxpayer money that the people of Nebraska pay into the federal-- our federal income tax pay for this. No one is saying that this is free money, but this is money that is due to us. This is money that we are owed as citizens of the federal government and the people of Nebraska have expressed their desire to have the state of Nebraska seek out federal funds that are due to us and owed to us. So nobody is saying that this is free money. This is money that we have paid into the system and we are not drawing down but other states are drawing down. So we are paying into a system and other states are benefiting from us paying into the system. So let's be clear. Nobody saying this is free money.

THOMAS "ROCKY" THOMPSON: Thank you for that clarification because I was going to say that it is federal tax money also. So this is tax money but from our-- from our folks that we're

talking about. So this is-- we are willing to explore an avenue in managed care. What we're not willing to do is carve these services out of managed care as has been proposed in this bill. And the previous bill--

CAVANAUGH: But-- but you're-- what you're not willing to do is not enact a law, and that is-- that is very problematic for the state of Nebraska if a department decides that they don't have to do what the Legislature and the executive branch put into state statute. That is problematic.

THOMAS "ROCKY" THOMPSON: And again, Senator, we did-- we worked with Senator McDonnell and the city of Lincoln and their consultant during that process, that bill-making process, and with [INAUDIBLE]

CAVANAUGH: But you're not willing to do what you need to do to make the law happen.

THOMAS "ROCKY" THOMPSON: The law predicated having a State Plan amendment to put it into managed care through in IGT arrangement and that we've told Senator McDonnell, we told the city of Lincoln, and we told their consultant that would not be approved by CMS several times at several meetings I attended. And we have

continued to try to work with them on proposals to get this into the system like this for managed care.

CAVANAUGH: But the federal government doesn't like the system that you're using for this.

THOMAS "ROCKY" THOMPSON: The federal government does not like supplemental payment arrangements and that's why they prohibited them through the managed care mega reg back in 2016.

CAVANAUGH: So it doesn't matter what Senator McDonnell wants to agree to, it matters what the federal government will accept.

THOMAS "ROCKY" THOMPSON: And, Senator, as I explained to Senator Williams, there is an avenue that we can explore with the federal government that we have already implemented doing a similar arrangement with the UNMC College of Dentistry, that 436.6(c) Preprint process.

CAVANAUGH: And where-- you're waiting to hear back from them?

THOMAS "ROCKY" THOMPSON: We're waiting for quality metrics to be associated with the ground emergency medical transportation because that is a requirement of the Preprint process.

CAVANAUGH: OK.

THOMAS "ROCKY" THOMPSON: Thank you, Senator.

CAVANAUGH: Thank you.

HOWARD: Other questions? All right, I-- I wanted to ask you-- so we've got several services that are running through our MMIS and we've discussed them before in the committee, but can you remind me again what they are?

THOMAS "ROCKY" THOMPSON: The largest one, Chairwoman, is the nonemergency medical transportation which we are carving into Heritage Health in the middle of this year. There are additional populations. There's a share of cost individuals as people who spend down for Medicaid eligibility month by month, so their claims are processed fee for service. There is additionally some state wards, refugee that we're working on carving in at the middle of-- of this year, I believe. And then there's also the retro eligibility. So we currently pay to Heritage Health and their capitation rate, there is a portion of it dedicated to retro eligibility, but it's only three months. An individual can be-- can receive Medicaid services and have the services paid for by Medicaid up to three months prior to the date of application. Sometimes applications are not done within that three months for different reasons, verifications and such. So there are additional fee-for-service claims there.

HOWARD: And then all of our capitation payments for managed care are run through our MMIS. Is that correct?

THOMAS "ROCKY" THOMPSON: Currently, yes, Senator.

HOWARD: And then what's our time line for moving away from them? And I ask because I would presume that our capitation payments are our largest pass through on MMIS.

THOMAS "ROCKY" THOMPSON: I'm not sure about if it's the largest or not. I'd have to look at the most recent-- recent diagram that we had about the sunsetting of the MMIS. I think it was 2022 or 2023.

HOWARD: You-- so you're going to sunset the MMIS in 2022?

THOMAS "ROCKY" THOMPSON: I think that is the current time line. I would have to check, though, Senator, so we can get that information to you.

HOWARD: OK. And then I-- someone e-mailed me the CMS response on the State Plan amendment because I want to make sure that we're clear about what CMS said to you. And so in the letter to Matthew Van Patton on May 4, it says CMS communicated these concerns to the state and suggested Nebraska consider modifying its managed care contracts-- contracts to make state-directed

payments which could be used to direct-- to direct additional payments to GEMT providers. So from that assessment, it-- it's telling me that they told you to modify your MCO contracts. Did you do so?

THOMAS "ROCKY" THOMPSON: Senator, the law directed us to do a State Plan amendment, and that is what we did, as the law required. Then, following that, we had subsequent meetings with the city of Lincoln and the city of Omaha about ways to do this into managed care and they had felt those are avenues they don't want to pursue at this time.

HOWARD: So-- so Senator McDonnell told you that he didn't want them carved into managed care, he preferred the fee for service pass through, through the MMIS.

THOMAS "ROCKY" THOMPSON: It was not Senator McDonnell, Senator. There was a meeting actually we had earlier this week where a representative of city of Omaha said this was the safest way to do it and not to pursue a manner in-- with this Preprint.

HOWARD: Could you do it without any of us telling you to do it?

THOMAS "ROCKY" THOMPSON: Yes, Senator.

HOWARD: Would you do it without any of us telling you to do it?

THOMAS "ROCKY" THOMPSON: Yes, Madam Chair.

HOWARD: When?

THOMAS "ROCKY" THOMPSON: We're waiting for these quality metrics from CMS and we said that we would engage CMS about this actually earlier this week. So we're willing to take this I guess after next Monday when we have the Medicaid expansion rollout.

HOWARD: And remind me what the time line for the Medicaid expansion rollout is.

THOMAS "ROCKY" THOMPSON: It's-- well, we have a briefing with senators earlier and then we have a press conference. And I think there's a webinar later on today.

HOWARD: And then are we looking at a July 1 start or a January 1 start?

THOMAS "ROCKY" THOMPSON: I'd have to check most recent documentation about that.

HOWARD: And so when we overlay modifying our managed care contracts, we would overlay that with what we're doing on the expansion population as well?

THOMAS "ROCKY" THOMPSON: This would apply to the expansion population. The city of Lincoln has indicated that the Medicaid expansion will actually be a loss for their department. So they really would like to have some sort of directed payment system or additional payment because of the Medicaid expansion population.

HOWARD: So then would you anticipate modifying your contracts with the MCOs prior to Medicaid expansion going into effect?

THOMAS "ROCKY" THOMPSON: It depends, Madam Chair, about how soon CMS would approve the Preprint process.

HOWARD: OK. All right. Any other questions? Seeing none, thank you for your testimony today.

THOMAS "ROCKY" THOMPSON: Thank you, members. Thank you, Madam Chair.

HOWARD: Our next opponent testifier.

JAMES WATSON: Good afternoon, Senator Howard, members of the committee. My name is James Watson, that's J-a-m-e-s W-a-t-s-o-n, and I'm the executive director of the Nebraska Association of Medicaid Health Plans, testifying in opposition to LB645 because we believe carving out ground emergency transport services

through managed care will diminish care for Nebraska Medicaid recipients. Probably the best thing for me to do at this point is to tell you that I just have two points I want to make and they're not going to take a long time. First of all, I'd like to go back to the-- the vision of Heritage Health, which is to contain comprehensive services in an HMO package-- labeled managed care organization for the members. And that is something that I think needs to be considered as you start to evaluate fee for service versus keeping it in managed care. There is a lot to be said for offering a complete package of managed care services through the MCO so that members have one access point. So when you want to resolve an issue about it, there's one access point and that's the MCO that's responsible for the coverage. Secondly, carving out an important subset of services such as emergency transportation creates a disadvantage for the MCO without having a complete claim history because we use the information in claims to conduct the care management function on behalf of the members and to get them the services that they need in a timely way. And if we don't have a part of a package of services that's this big and this important and we don't have anything to do with it, it's going to compromise us. And that is something that I would ask you to consider as well. But that's-- all I have for you is just a sense of caution to, you know, look

carefully before you carve things out of something that we've been doing for a long time.

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

JAMES WATSON: Thanks.

HOWARD: Is there anyone else wishing to testify in opposition to LB645? Is there anyone wishing to testify in a neutral capacity? Senator McDonnell, you are welcome to close.

McDONNELL: Thank you. I know I'm standing between you and a four-day weekend that we all-- we all need. A couple of things on Mr. Thompson's testimony. I think he's having a little selective memory. And if you want to look at one of the handouts, we had a time line of how many times the city of Lincoln, the city of Omaha has met with people representing the Department of Health and Human Services. But yesterday at 10:00 a.m., we met in my office and there was people representing city of Omaha, city of Lincoln, Mr. Thompson and-- and others from the Department of Health Human Services. At that point I still had hope that we could possibly get to the point that we could have a compromise and put some kind of possible sunset language in. If what we were doing and what their goal and their long-

term goal as a department were different, then we could get something done but then sunset. At the point where Mr. Thompson told me that they were going to oppose it, I thought, hold on, we've been trying to work together, you're going to come in opposition to this bill, you're not coming in the neutral capacity to say that we're working together and that we've opened up to any kind of amendments that would actually put a sunset. Earlier Senator Cavanaugh asked Mr. Thompson a question about carve outs. His answer was we're not willing to do that. I think that's-- that's part of the problem here. We passed a law in 2017, and I'm not talking about all the work that went into that, that all of you know, the 12-14 hour days that we put down here because we took an oath to do that and we're here to serve the citizens of Nebraska. That's not the part that-- that's really bothering me about LB578 and all the people that took the time. the first responders, to come down and testify and support and talk to different senators. Sure, I was proud of that bill. I was proud of that bill when the-- when the Governor signed it and went into law not because of the work that went into it-- I was-- I was proud of my staff and the time they put in all these first responders-- but what it was going to do for the state of Nebraska because we were talking about money and some of these departments, some of the smaller departments are barely hanging

on. But when someone calls 911, they're going to respond and they're going to be there and they're going to do the best they possibly can to make a positive difference in that person's life that needs them at that time. Now we talk about money and definitely you're looking at the city of Omaha and-- and some of the issues they're having, especially with the streets and how that could offset and what was in their budget. But also we look at the City of Omaha all the way down to the smallest department, that one dollar that goes towards equipment, that next dollar that goes towards training, and that equipment, that training, what happens when someone calls 911 and with that training with that equipment, that makes a difference in their lives in a positive way? That's what we're talking about. So for two years there's been issue after issue with LB578. And again, you got a list of the number of times the city of Lincoln, the city of Omaha, others, have met and said let's try this, let's look at this, let's look at something to-- I'm asking for help. I really don't care how we get the ball across the finish line here. I don't care. I just want to make sure that we are getting that money back to the state of Nebraska, to those departments, to those first responders that they can use it in a way to train and buy equipment and make a difference in the citizens of Nebraska's lives. That's the goal here. So I'm-- I'm asking for

help. I'm asking-- I'm working-- I'm willing to work with anyone to get this done. Thank you for your time.

HOWARD: Thank you. Are there questions? Senator McDonnell, I want to go back to the letter from CMS because they basically recommended that you-- you require the department to have an enhanced payment within the managed care contracts. Is that something that you would consider? I've-- I've never seen it put in statute but--

McDONNELL: Yes, I definitely would. I'm-- I'm looking at any possible options.

HOWARD: And just following the of CMS's guidance and telling them that they absolutely have to include you with an enhanced payment.

McDONNELL: Yes.

HOWARD: OK. Any other questions? I apologize. Did Deputy Director Thompson tell you about that option?

McDONNELL: We had-- no, yesterday in the meeting, the 10:00 meeting in my office, we talked about the potential for today's hearing, what we could do, what we could work together. We had contract-- we concentrated on most of the meeting about a carve

out and possibly then looking at a sunset and then having them come in, in the neutral capacity.

HOWARD: OK. All right. Thank you so much. Thank you, Senator McDonnell. This will close the hearing for LB645 and the committee will take a ten-minute break and reconvene at 3:10.

BREAK

HOWARD: [RECORDER MALFUNCTION] and we will open the hearing for LB245, Senator Erdman's bill to eliminate an exception to the Medicaid preferred drug list. Welcome, Senator Erdman.

ERDMAN: Hey. Good afternoon, Senator Howard and committee. Thank you for allowing me to be here today. My name is Steve Erdman and I represent District 47, ten counties in the Panhandle. My name is spelled Steve, S-t-e-v-e, Erdman, E-r-d-m-a-n. I got good news, a couple good news pieces. One, this bill does not have a "may" in it anywhere. [LAUGHTER]

HOWARD: Thank you, Senator Erdman.

ERDMAN: Second, we're going to save you some money. OK? So those are the two good news. So we're going to change-- what we want to do is change provisions relating to prescription drug list. The department has asked me introduce this bill. This bill will

allow the Health and Human Services to add antipsychotic, antidepressant, and anticonvulsant drugs to the Medicaid preferred drug list, the PDL, which will allow the department to capture additional savings through supplemental rebates from drug manufacturers. Antipsychotic, antidepressants, and anticonvulsants are currently prohibited from being included in the PDL by statute. Adding these health drugs also help ensure compliance with the Mental Health Parity and Addiction Equality-- Equality Act, this law requiring health groups-- healthcare plans to offer mental health and other substance abuse benefits to pare the medical and surgical benefits offered. Noncompliance puts the DHHS at risk of penalties and sanctions. Adding these three therapeutic classes of medications to the PDL would provide additional consistency across the Heritage Health managed care plans for both Medicaid recipients and Medicaid. This means the same coverage, coverage limitations, and prior authorizations criteria across all three managed care plans and fee-for-service recipients. Drug spend for these three excluded therapeutic classes constitutes approximately one third of the total Medicaid drug spend for all prescriptions. Adding these therapeutic-- these therapeutic classes to the PDL would allow this department to improve the cost-effective treatment within the antipsychotic, antidepressant, and anticonvulsive

categories. So updating and maintaining the access will be more fiscally responsible with tax dollars. We're going to save some money. Brand versus generic drugs: Brand-name products are usually produced by the drug innovator. The drug manufacturer has exclusive rights to market the drug with their brand name for a certain number of years. After the exclusive rights period is up, the other drug manufacturers can market the same chemical entity under a generic name of the drug. Many of the commonly used mental health drugs were not available as brand-name products in 2008. Now many of the mental health drugs are available generically. The Office of Generic Drugs follows a rigorous review process and mental health drugs are available generically now. The Office of Generic Drugs follows a rigorous review plus makes sure that compared to the brand-name medications, the proposed generic medications do the following. They contain the same active ingredient, have the same strength, use the same dosage-- for instance, a tablet, capsule, or liquid-- and use the same route of administration, for instance, oral, topical, or injectable. Savings generated will be, the department estimates, $2.3 million annually added to the supplemental rebates. The supplemental rebate program: In order for Medicaid to cover any drug, the drug manufacturer must participate in the federal rebate program. The rebate system

allows Medicaid to pay the lowest price for drugs. A supplemental rebate is a rebate paid to the state in addition to the federal rebate. They are negotiated by the PDL. Vendors-- vendors multistate rebate paid purchasing pool is in exchange for a preferred position on the state's PDL list. The impact of Medicaid expansion: This legislation would allow for additional cost controls to-- on added-- on the added population for Medicaid expansion. All medications currently covered by Medicaid will continue to be covered and nonpreferred drugs will be available with prior authorization. So what this bill does, it allows the department to save the state about $2.3 million on the drugs that they are-- they are now prescribing. And so I would tell you that the technical part of this is going to be answered-- the questions will be answered by someone following me. But it was my intention to bring this today to make a savings for the state.

HOWARD: Thank you. Are there questions? Seeing none, thank you for your opening.

ERDMAN: Thank you.

HOWARD: Will you be staying to close?

ERDMAN: Yes, ma'am.

HOWARD: OK. Our first proponent testifier for LB245. Good afternoon.

CARISA SCHWEITZER MASEK: Good afternoon. Chairman Howard and members of the Health and Human Services Committee, my name is Carisa Schweitzer Masek, C-a-r-i-s-a S-c-h-w-e-i-t-z-e-r M-a-s-e-k. I'm the pharmacy director for the Division of Medicaid and Long-Term Care within the Department of Health and Human Services. I'm here to testify in support of LB245 which would add antipsychotic, antidepressant, and anticonvulsant drugs to the Medicaid preferred drug list, also known as the PDL. These three classes of drugs are used for mental health or seizure disorders and I would like to thank Senator Erdman for sponsoring this legislation. The PDL was created in 2008. Drugs included on the PDL are evaluated and recommended by a group of medical professionals who are members of the Nebraska Pharmaceutical and Therapeutics Committee. When the PDL was created, these three classes of drugs were expressly prohibited from being included. However, since that time, many of the most commonly prescribed mental health or seizure drugs are now available generically. Changes to the Medicaid program since 2008 at both the federal and the state levels now make it advantageous for the state to allow drugs in these classes to be added to the PDL. Indeed, adding these three classes of drugs to

the PDL would be beneficial to recipients, providers, and taxpayers. Regarding the recipients, the inclusion of these three classes of drugs on the PDL would eliminate inconsistent requirements to obtain prior authorization to receive these drugs. Not only would this reduce the burden on recipients, but Medicaid would continue to pay for name-brand drugs whenever medical providers determine that it is medically necessary. Regarding providers, each managed care health plan currently has its own list of preferred drugs for these classes. Many behavioral health providers have told us that it is difficult to keep track of which drugs are preferred by which plan. Adding these three classes of drugs to the PDL would mean that the same coverage criteria would exist across all three plans and the traditional fee-for-service patients. This would reduce the administrative burden on our state's behavioral health providers. Regarding taxpayers, the amount of money spent on these three classes of drugs is substantial. In fact, approximately one third of the total amount of money spent each year on prescription drugs is spent on just these three classes of drugs. Adding these two classes of drugs to the PDL would allow the department to obtain savings through additional supplemental rebates from drug man--drug manufacturers estimated to total $2.3 million. In conclusion, allowing antipsychotic,

antidepressant, and anticonvulsive drugs to be included on the Medicaid preferred drug list would lessen administrative burdens on providers, reduce burdens on recipients and not negatively affect their care, and protect the interests of taxpayers by maximizing rebates received from the pharmaceutical companies. For all these reasons, we support LB245 and again thank Senator Erdman for sponsoring this legislation. Thank you, and I ask that the committee support this legislation and move it to the floor for full debate.

HOWARD: Thank you. Senator Arch.

CARISA SCHWEITZER MASEK: Yes.

ARCH: Thank you, and-- and appreciate you being here to help-- help us understand. A previous bill that we heard here, I believe Senator Wishart brought it, had to do with the generic and name-brand issue and it was specific to psychotropic meds and-- and the impact on an individual. In that-- in that-- after that, after that testimony, I-- I went-- I went and contacted a child psychiatrist that I knew and just asked, so what's the process, right, how does this happen? And I-- I guess with MCOs involved, three, and as-- could you please help us understand what the process is when a psychiatrist says I don't want-- I

don't want generic, I want-- I want name brand. What-- what does that physician have to do to get that approved?

CARISA SCHWEITZER MASEK: Very good question. If the name brand is already on the preferred drug list, they don't have to do anything extra. They prescribe that medication, the patient takes it to the pharmacy, and the pharmacy fills it. If the name brand is on the nonpreferred side, the provider needs to fill out a prior authorization form which gives the medical reason or medical necessity why brand name-- why brand name is required or preferred for that patient. That type of medical necessity can include this patient has been stabilized on this medication for a long time, this patient has shown intolerance to the generic drug, or this patient, as a part of their medication regimen, we feel that it is best for the patient to stay on this medication. Today, because we have a different preferred drug list across all three plans, the provider needs to remember which drugs are preferred by which plan instead of being able to have one medication list to go to that would be the Nebraska-- the Nebraska Medicaid preferred drug list.

ARCH: You're saying-- but today we have three?

CARISA SCHWEITZER MASEK: Today for these three classes.

ARCH: Oh.

CARISA SCHWEITZER MASEK: Because they were excluded from the PDL for these three classes--

ARCH: I see.

CARISA SCHWEITZER MASEK: --we are not able to set a common, consistent requirement across all three MCOs.

ARCH: So-- so then it really boils down to what's on the formulary, right? I mean it really boils down to, well, are those name-- are those name-brand drugs on the list--

CARISA SCHWEITZER MASEK: Correct.

ARCH: --because if they are, it sounds like a relatively easy process. They-- the feedback I got was not simple, but it could have been that they were off-- they were just not on the list as well, and that's a possibility. But-- but if they are, so I guess we'd have to know, right? We'd have to know--

CARISA SCHWEITZER MASEK: Yeah.

ARCH: --how many of those name brands are on there. Is it routine that they would be on there? What-- who-- how would that be decided whether those are even on the formulary?

CARISA SCHWEITZER MASEK: Very good question, and it is a question that many individuals have no matter how long they've been in healthcare. I'm going to reference 2008 which is when these three classes of drugs were originally excluded. At that time, the majority of the antipsychotics and antidepressants were brand-name drugs and there was not a lot of literature on safety profiles, efficacy profiles, and there was a lot of lobbying done by the pharmaceutical companies to exclude these from the PDL. Since then, between 2014-2017, a majority of the most commonly prescribed anti-- antipsychotics, antidepressants are now generic drugs. So when a-- when a patient is newly diagnosed with a mental health disorder, most often when they go to the pharmacy, the first time they fill that prescription they are getting a generic drug. There is an opportunity for the provider to, on the prescription, if they have personal experience with a brand-name drug or prefer it, to write right on that prescription "dispensed as written," which allows the pharmacist then to go forward with that process.

ARCH: If-- if it's on the list.

CARISA SCHWEITZER MASEK: Yes, sir.

ARCH: Yeah. All right, thank you.

HOWARD: Other questions?

WALZ: I just have a quick question.

HOWARD: Oh, Senator Walz.

WALZ: Thank you. Thank you for coming today.

CARISA SCHWEITZER MASEK: Yeah.

WALZ: OK. I'm just trying to figure out this-- this need on the fiscal note. So the changes have already been made for us to allow drugs in these three classes to be added to the PDL.

CARISA SCHWEITZER MASEK: I apologize if I misspoke or-- or led to that conclusion. Currently these three classes of drugs-- anticonvulsants, antidepressants, and antipsychotics-- are excluded by LB830-- or the Statute 8-- by LB830 that was moving into statute by being included on the PDL, so because of that, Nebraska Medicaid is unable to create a common list through the Pharmacy and Therapeutics Committee. So each Heritage Health plan can decide whether they have a drug on the preferred list or the nonpreferred list. So currently these three classes of drugs are excluded from that process and we are asking that they be included into that process.

WALZ: OK. And-- and take me through the process again real quick how-- I guess I'm just trying to figure out why a pharmacist is need-- what's the pharmacist needed for? Twenty seven thousand and then $84,000 and what is a pharmacist going to do?

CARISA SCHWEITZER MASEK: Yes, good question. The responsibility of a pharmacist within the Nebraska Medicaid is to review literature, and not just cost containment but also safety and efficacy. With these three drug classes, due to the complexity of the patients and the side effect profile of a lot of these medications, there's a lot of literature that continues to come out. In addition, a lot of these medications, the use of off-label expands, and a lot of times that off label includes use in children or used for diagnoses that have not yet been proven as effective. What that pharmacist would be utilized is to focus on these three classes of drugs, continue to monitor the literature, work with the Pharmacy and Therapeutics Committee to identify opportunities for cost containment, but in addition to other needs for prior authorization. The-- from what I can find, the focus in 2008 was on brand versus generic and that is a step of util-- utilizing prior authorization. A very important use of prioritization is two other things. One of them is called step therapy and another is age limitation or dosage limitation. For some of these medications, the safety risk profile and the side

effect profile has been shown to be concerning enough that the FDA has actually said these should be second-line therapies, or literature and head-to-head clinical trials say these should be second-line therapies. In those instances, we would like to create that commonality across all three Heritage Health plans to make sure that we're keeping safety in mind and efficacy in mind for these patients. In addition, on the age limit, the medications have shown through national trends-- we have not looked at it in Nebraska but through national trends-- that they continue to be used in younger and younger patient populations. And there is some literature that shows up to the age of 17 there isn't a lot of efficacy, or up to the age of 10 there's not a lot of efficacy, and so a prior authorization could say if the child is less than ten years of age, based on the safety and efficacy profile, we would like the provider to provide additional information on either other therapies that have been tried or why this one that has a higher side effect profile would be the preference for this patient.

WALZ: Um-hum. So after fiscal year 2021, who would take over the responsibilities of that pharmacist? The resp-- the responsibilities that you were just explaining to me--

CARISA SCHWEITZER MASEK: Yeah.

WALZ: --who would take over that?

CARISA SCHWEITZER MASEK: I see in the fiscal note they included that-- just that year. I believe that would be an ongoing position to maintain these-- the utilization of these three drug classes.

WALZ: OK.

HOWARD: Other questions? Can you talk to me a little bit about the medical necessity and the time line for that?

CARISA SCHWEITZER MASEK: Yeah. If a-- when a provider or if a provider needs to request prior authorization based on medical-- medical necessity, it is required that they get a response within 24 hours and in that response sometimes there is a request for additional information and they are told directly what that additional information might be.

HOWARD: And during the process of-- of proving medical necessity and if they ask for additional information, is the patient still able to get the medications that they need?

CARISA SCHWEITZER MASEK: The pharmacist is allowed to dispense 72 hours of emergency medication in instances where it would be appropriate.

HOWARD: When there's additional documentation needed, can it ever go beyond 72 hours?

CARISA SCHWEITZER MASEK: Sometimes it may and most often it is due to the provider not being able or having the opportunity to get that information back to the pharmacy.

HOWARD: And then so if they can only dispense 72 hours, is there another 72 hours then or they--

CARISA SCHWEITZER MASEK: The physician can resubmit.

HOWARD: Can resubmit for the emergency dispensing.

CARISA SCHWEITZER MASEK: For the-- for the prescription again and then they can do another emergency.

HOWARD: And then since the-- the original statute went in place in 2008 and it was Senator Lathrop's.

CARISA SCHWEITZER MASEK: Yes.

HOWARD: Have you had the opportunity to speak with him about these modifications?

CARISA SCHWEITZER MASEK: I do believe we-- yes, we did have a hallway-- brief hallway conversation with Senator Lathrop and

were able to ask him about his personal-- his experience with the bill the first time.

HOWARD: And what was his feedback?

CARISA SCHWEITZER MASEK: His feedback was he recalls in 2008 that it was very important to exclude these three classes of drugs at that time based on information from the behavioral health providers and the pharmaceutical companies.

HOWARD: Thank you. Any other questions?. Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman. Thank you for being here today. I feel like I'm learning a lot about the pharmacy industry. So the 72 hours, if the-- I mean if this happens on a Friday and it's a holiday weekend and they need it, so are there, to Senator Howard question, are there fail-safes in place to make sure that a patient who needs emergency coverage will get that coverage while this is being sorted out on the administrative side?

CARISA SCHWEITZER MASEK: Yeah, good question. The 72 hours is that coverage for that patient and that is not specific to just Medicaid patients but-- or to these three classes but across all three classes of drugs. And so the challenge today is providers are being required to remember or to check which drug is on

which preferred Heritage Health plan for these very complex patients to remember or know if they need to submit that prior authorization and it creates a challenge.

CAVANAUGH: But they can submit a second 72-hour if needed.

CARISA SCHWEITZER MASEK: What they can do is submit a request for the prescription again and at that time it would continue the conversation with the Heritage Health plan.

CAVANAUGH: OK. Thank you.

HOWARD: Any other questions? Seeing none, thank you for your testimony today. Our next proponent testifier for LB245. Is there anyone wishing to testify in opposition to LB245? Good afternoon.

BETH ANN BROOKS: Good afternoon, Senator Howard and HHS Committee members. I am Beth Ann Brooks, B-e-t-h A-n-n B-r-o-o-k-s, a Nebraska licensed physician from Lincoln representing today the Nebraska Psychiatric Society, the Nebraska Medical Association, NABHO, which is the Nebraska Association of Behavioral Health Organizations, and the regional council of the American Academy of Child and Adolescent Psychiatry. I'm testifying in opposition to LB245. I'm a board-certified psychiatrist and child and adolescent psychiatrist who has

practiced for more than 40 years. I currently treat adolescents. Psychiatric patients frequently visit an emergency department when they are in crisis. Disruptions in medication continuity-- that could be delays in receiving or discontinuation of appropriate medications-- among our psychiatric patients are associated with high rates of symptom exacerbation or relapse, hospitalization, and other adverse consequences. Suicide rates are rising across the United States, and unfortunately also in Nebraska, and emergency departments are being forced to board patients with serious mental illness because appropriate treatment settings are not readily available. Healthcare professionals are committed to delivering the best treatment outcomes for their patients, which includes prescribing the best therapeutic option regarding medication. Psychiatry does not have diagnostic tests to inform us which specific antidepressant, antipsychotic, or anticonvulsant medication will be an exact match to treat an individual's unique psychiatric disorder. No two psychotropic medications are the same. They are among the most complex drugs in terms of understanding how they work and what disorders will benefit from them. We have to rely on our best clinical judgment to pair psychiatric symptoms with appropriate classes of medications, and then within those groups, to the anticipated benefits and side effects of specific

agents. If a first-degree family member has responded to a specific psychiatric drug, then that same medication often is best indicated for a patient with similar symptoms. It could be argued, and I think it has been argued, that Nebraska DHHS Medicaid and Long-Term Care could realize significant cost savings were it able to obtain rebates on the three medication classes at issue, but rebates can obscure the issue. As I understand it from one of the current MCOs, each of the three managed care-- MCOs has its own preferred drug list, as we've heard, and they receive the rebates for the currently exempted medications. Were those rebates to accrue to DHHS, then surely the MCOs would want to renegotiate higher contractual rates, resulting in increased costs to Medicaid. Healthcare prescribers are committed to saving patients and the healthcare delivery system prescription costs and they preferentially prescribe generic medications when appropriate, but cost considerations should not be the primary factor when selecting the best medication for an individual patient. When psychiatric practitioners are forced into a narrow formulary, less than optimal care can result in increased costs incurred from higher levels of care, including repeat hospitalizations. Judicious clinical decision making must be preserved in the treatment of neuropsychiatric disorders. As an illustration, a study found

that formulary restrictions within a Medicaid program appeared to lead to worse outcomes for patients with major depressive disorder, MDD, and increase the probability of an MDD-related hospitalization by nearly 17 percent with no significant reductions to pharmacy or total spending. Importantly, there was no evidence that these restrictions resulted in any net savings for Medicaid, and I've provided the literature source for that. Thank you for allowing me to testify about this bill which would not protect the best interest, well-being, or optimal treatment of some of Nebraska's most vulnerable citizens. I would be happy to entertain any questions you may have.

HOWARD: Thank you. Are there questions? Senator Arch.

ARCH: Do you happen to know if there are any psychiatrists on the P&T Committee that decides what goes on that formulary?

BETH ANN BROOKS: Now you're speaking of the--

ARCH: DHHS, the-- the ones that make the decision.

BETH ANN BROOKS: I-- I-- I believe they are required to have physician on that, but I do not know the person's name. There have been a number of-- of changes in physicians supporting Medicaid.

ARCH: OK. Thank you.

HOWARD: Other questions? Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman, and thank you, Dr. Brooks, for being here. The current system as it is, is that suitable to the needs of the patients?

BETH ANN BROOKS: From the viewpoint of the practitioner community, and I think you have also a support lever-- letter from nurses who are-- as APRNs, are able to prescribe. The preference of the psychiatric provider community is to continue to have those three classes of medication exempted. While the prior testimony was accurate that since the legislation was enacted in 2008 a number of medications have that were only available a generic-- or a specific brand name because of long patents have gone off patent, but in that amount of time we've had probably equally as many medications be developed and-- and have patents. So for example, if anyone here is familiar with antipsychotics, used to be antipsychotics when I was in training, now it's-- it's into a third generation but we call first generation, and all of those have been generic for a number of years, virtually all the second generation similarly, but there's a third generation. As a child/adolescent psychiatrist, even if you look at specific delivery systems,

whether it's by some osmotic process or sustained release or quick dissolving, many of the medications to treat attention deficit/hyperactivity disorder are-- are being developed. One just came out within the last month with FDA approval, so things move. And certainly in the very beginning, for whatever time line they're allowed, they have a lifetime where they can be brand name, and we have even seen extensions of those. So the ability to understand from a practitioner point of view as much as we can about side effects, presumed mechanism of action for-- so for example, we know that even though it's still rudimentary science, some of our antidepressants seem to work preferentially on the serotonin system or the norepinephrine system or a combination of the two. But to know if you're depressed versus someone else depressed, really what that is, we don't have a culture and sensitivity for it. So the ability to still write, dispense as written, and have those exempted, we believe in the-- perhaps the grayest area of prescribing practices, it gives us better opportunity to exercise clinical judgment, rather than having a-- a list. I don't think that the 72 hours always works quite as well as described, particularly when there is a weekend. And if the provider isn't able to get back, then it is left to pharmacist discretion and I might suggest that that might be too much discretion given to a pharmacist who could be

working a relief shift. So there are issues of brand versus generic. There are issues of when step therapy is required. And with LB554 there was testimony in terms of two family members who had their own family members of various ages who'd been compromised by managed care organizations in terms of what they require.

HOWARD: OK.

BETH ANN BROOKS: So it gives us some latitude at present.

HOWARD: Thank you. Other questions? Senator Williams.

WILLIAMS: Thank you, Senator Howard. And thank you, Doctor, and just-- just one quick question. When we're considering patient care-- leave the cost out-- patient care, am I hearing in your professional opinion this legislation would potentially decrease the quality of patient care?

BETH ANN BROOKS: Yes, that-- that is my professional opinion--

WILLIAMS: Thank you.

BETH ANN BROOKS: --and that of the organizations I'm representing.

HOWARD: All right. Any other questions?

BETH ANN BROOKS: Thank you.

HOWARD: Seeing none, thank you for your testimony today. Is there anyone else wishing to testify in opposition to LB245? Good afternoon.

BILL MUELLER: Senator Howard, members of the committee, my name is Bill Mueller, M-u-e-l-l-e-r. I appear here today on behalf of the Pharmaceutical Research Manufacturers of America in opposition to LB245. You are being provided a statement from PhRMA that-- that I will not read. I would certainly yield to Dr. Brooks and her medical judgment on this bill. PhRMA agrees with the doctor. I was frankly surprised to hear the-- the testimony of the proponents that we don't have a PDL, now we have three PDLs. I was here back in 2008 when this bill passed. The legislative intent was to have no limitation on these drugs, to not make them subject to the preferred drug list, because you were here when I-- and I was here when Senator Wishart's bill came up where she talked about a young man that had his medication changed and made a-- a horrible, horrible spiral back. That's why these bills are not to be on the PDL. They shouldn't be on one PDL. They shouldn't be on three different PDLs. If we need legislation to address the problem with physicians not knowing which MCO's PDL they are dealing with, we

should amend the statute to say that there-- these bill-- these drugs will not be prior authorized, these drugs will be able to be prescribed as the psychiatrists believe that they should be prescribed. We oppose this bill. To say that it makes it easier for providers, I don't believe is accurate. I'd be happy to answer any questions you may have.

HOWARD: All right, thank you. Are there questions? Seeing none, thank you for your testimony today.

BILL MUELLER: Thank you.

HOWARD: Our next opponent testifier for LB245. Seeing none, we do have one letter for the record from Linda Jensen at the Nebraska Nurses Association. Is there anyone wishing to testify in a neutral capacity? Seeing none, Senator Erdman, you are welcome to close.

ERDMAN: Thank you, Senator Howard I want to share this analogy. I think Senator Murman would agree. Whenever we work cattle all day long and we were running them through the chute and it was difficult, and when the last one went through, we would say that's the one we've been looking for. And so this is the last bill of the session. I appreciate that. Let me just follow up with these comments. I understand what the doctor was saying and

I'm very concerned about the way people are-- are treated and the results of the drugs they get. I think Senator Arch asked a very, very important question. His question was, what happens if a drop-- if a drug is a brand-name drug and the doctor wants to prescribe that, can they do that? And the answer was, yes, they can. And so I don't know that this is eliminating a doctor from making a choice of what drug they should prescribe, but that's what you heard. It's an opportunity for us I believe to make a contribution back to the state that helps us with Medicaid expansion and other things we have to cover. It does-- I don't believe it limits the doctors to do what they need to do. They can make the right recommendations based on the drugs that they prefer. And then they can treat their patients accordingly and if a patient has to have a-- a brand-name drug, so be it. But that's what happens. And you heard Mr. Mueller talk about I was here in 2008 when they did this before, and that's one of the things we find with term limits, that institutional historical knowledge is not here and no one served here when that happened. And so I'm asking you to consider this bill, move it forward, and let the department make a decision that's best for all of us financially, as well as taking care of the people who need to be taken care of. Thank you for your time. I appreciate being here. And it's a lot cooler than it was yesterday. Thank you.

HOWARD: Thank you. Are there questions? Seeing none, thank you, Senator Erdman.

ERDMAN: Thank you.

HOWARD: This will close the hearing for LB245 and we are done. All the hearings, we did it.