HANSEN: Good afternoon and welcome to the Health and Human Services Committee interim hearing. My name is Senator Ben Hansen. I represent the 16th Legislative District in Washington, Burt, Cuming, and parts of Stanton County, and I serve as Chair of the Health and Human Services Committee. I would like to invite the members of the committee to introduce themselves, starting on my right with Senator Ballard.

BALLARD: Beau Ballard, District 21, northwest Lincoln and northern Lancaster County.

RIEPE: Merv Riepe, Legislative District 12, which is Omaha and Ralston.

HANSEN: And Senator Cavanaugh was going to try to call in here. So she's going to try-- to try to join us here shortly. And Senator Walz just indicated she's going to be just a little late for today's hearing so she'll be in here shortly, too. So also assisting the committee is our research analyst, Bryson Bartels, and our committee clerk, Christina Campbell. A few notes about our policy and procedures for today. First, please turn off or silence your cell phones. This afternoon, we'll be hearing five interim study resolutions. We'll be taking them in the order listed on the agenda outside the room. At the request of Senator Blood, LR233, LR232, and LR132 will be combined into one hearing. The hearing on each resolution will begin with the introducer's opening statement. At the request of the introducers, all five resolutions for today are limited to invited testifiers only. After the opening statement, we will hear from those individuals. I'll call them up in order. The introducer of the resolution will then be given the opportunity to make closing statements if they wish to do so. For those of you who have been invited to testify, you will find green testifier sheets on the table near the entrance of the hearing room. Please fill out one to-- please fill one of them out and hand it to Christina when you come to testify. This will help keep an accurate record of the hearing. I'm asking that you try to limit your testimony to five minutes each. The light system, which you'll see in front of you when you come to testify, will give you an indication of how long you've been speaking. At four minutes, the yellow light will come on. And at five minutes, the red light will come on, which we then ask you to wrap up your final thoughts. These are study resolutions for information gathering purposes only and not bills so there's no record of proponents or opponents. However, if you wish to submit written comments for the record, you may do so online via the Chamber Viewer

page for each resolution. Online comments must be submitted prior to noon on the workday before the hearing in order to be included in the official record. And obviously it's a little bit too late for today's resolutions, but I just want to point that out that the feature is still available on the Legislature's web page. So with that, we will welcome Senator Blood to introduce the three LRs for today.

BLOOD: Thank you, Chairman Hansen, and good afternoon to you and the members of the Health and Human Services Committee. My name is Senator Carol Blood and that is spelled C-a-r-o-l B as in boy-l-o-o-d as in Don and I represent District 3, which is the western half of Bellevue and eastern Papillion, Nebraska. I appreciate the opportunity to bring forward LR132, LR232, and LR233, all interim studies exploring Nebraska joining three new interstate compacts. LR233 relates to the Interstate Compact for Physician Associates [SIC]; LR132 is the Interstate Compact for Dentists and Dental Hygienists; and LR232 is the Interstate Compact for Social Workers. The Department of Defense has partnered with the Council of State Governments to fund and support the development of two of these three interstate compacts for occupational licensure, and this has been a driving force for this effort. It is my hope that by bringing everyone together during the interim, we can be better prepared when it is time to bring forward the legislation in January and this committee will be better informed on these topics. Occupational licensing interstate compacts allow professionals in licensed occupations to transcend state boundaries by creating uniform standards of practice. Interstate compacts are a legal contract between two or more states that allow the states to cooperatively address shared problems such as workforce shortages. It allows the states to maintain sovereignty over issues belonging to states and to respond to national priorities with one voice. These compacts support professionals in state-licensed occupations, including our military spouses. The goals of these compacts are as follows: to streamline licensing between states of the compact for all practitioners in that particular occupation; to support spouses of relocating active duty military personnel through provisions, recognizing unique requirements of military life; to create streamlined pathways for interstate practice; to increase public access to care or services; to enhance the state's ability to protect the public's health and safety while preserving state authority over professional licensing; to encourage the cooperation of compact member states in regulating multistate practice; to help maximize state membership in licensed professions; and it clearly enhances the exchange of licensure, investigative, and disciplinary information by

means of a compact commission database. Now, it's no secret that every state in the United States has a workforce shortage, and Nebraska is not the exception. Nebraska's healthcare industry is one that suffers the most from this shortage. This shortage means limited access to treatment, especially in our more rural areas and other underserved communities. These shortages aren't just from states being unprepared when all were warned about the baby boomers aging out of the workforce decades ago, but also the result of certain federal and state policies and payments and provider capacity to name only a few of the issues that have created the shortage. The burdens created within our healthcare industry also affects the mental and physical well-being of these professionals, creating the secondary issue of higher suicide rates, an increase in mental health issues, burnout, early retirement, and exhaustion, to name only a few of the concerns. As many of you are aware, one bright spot that emerged from many of these compacts was the emergence of telemedicine. Now, Nebraska has been a leader over the last seven years when it comes to interstate compacts, and it is beneficial to our state if we can continue the streak of unified bipartisan success. So let's discuss each industry a bit before the testifiers step up and refine the facts for their particular, particular industry for all of us. So the Council of State Governments, CSG, partnered with the Department of Defense, the DOD, the American Dental Association, ADA, and the American Dental Hygienist Association, ADHA, to support the mobility of licensed dentists and dental hygienists through the development of a new interstate compact. This compact will create reciprocity among participant states and reduce the barriers to licensed-- license portability. Accessibility to dental care in the more rural areas in Nebraska is part of Nebraska's healthcare crisis. In the dental office, the dentist and the hygienist work together to meet the oral needs of patients. But there are certainly limits as to the clients they can provide services to if they do not have the staff to accommodate those needs. Forty-three counties in Nebraska do not have a single dentist able to help low-income Nebraskans. Patients, mostly those relying on Medicaid in western Nebraska, are forced to journey to Lincoln to receive appropriate dental care. Studying the benefits of the dentist and dental hygienist compact will lead us to one of the avenues to mitigate Nebraska's workforce challenges in dentistry. We currently have 1,237 licensed dentists in Nebraska and 1,280 employed dental hygienists in our state. To put this in perspective, we have a population of 1.96 million. This compact can help to make these issues better. CSG partnered with the DOD and the Association of Social Work Boards, ASWB, with support from the National Association of Social

Workers, NASW, and the Clinical Social Work Association, CSWA, lots of acronyms, to support the mobility of licensed social workers through the development of a new interstate compact. This additional licensing pathway will facilitate multistate practice, multistate practice among member states and reduce the barriers to license portability. Social workers are people who are dedicated to helping others. They help vulnerable groups of people to overcome challenges and to meet their personal goals while providing important services to their community. There are many specialties with social work along with spec-- along with specific certifications. A certified social worker is trained to help people while being compassionate and understanding of their needs. Social workers are advocates for people in their community and help them to solve problems. They help both individuals and families work through challenging situations like poverty, addiction, and unemployment. They help to raise awareness for both-- they help raise awareness both for and with the people that they represent on a local, state, and national level. Social workers require prior knowledge in many areas, including human development, behavior, social, economic and cultural institutions, and an understanding of how all these things work together so they can help those whom they serve. Now, as this committee is well aware, there is a shortage of behavioral health workers throughout Nebraska. To receive appropriate care from licensed social workers, Nebraskans often must travel to more metropolitan areas to receive necessary care if they are lucky enough to procure an appointment. This is especially concerning for our at-risk children, adolescents, and transition-age youth with behavioral problems. This new compact is part of the solution as to how we start to address the shortage. In June of 2019, a joint initiative by the Council of State Governments, the Federation of State Medical Boards, the American Academy of Physician Associates, and the National Commission on Certification of Physician Assistants was created to develop an Interstate Compact for the Interstate Practice of Physicians Assistants. Funding support for this initiative actually came from the Department of Health and Human Services. The Physician, Physician Associates Licensure Compact will facilitate the ability of licensed PAs to practice in multiple states without having to obtain an individual state professional license in each state of practice. The compact will provide for greater in-person and telehealth access to care and will significantly enhance practitioner mobility, including in times of public health emergencies. The PA compact will also strengthen public protection by establishing a data system that facilitates information sharing and coordination on disciplinary action between participating states as do all the compacts. In the PA

compact licensure mobility, it is-- facilitates a privilege to practice model, which allows individual licenses to seek a compact privilege in any compact member state they choose. The licensee's application for a privilege to practice in a specific state is expedited by utilizing the compact data system to ensure the individual is eligible for that privilege by meeting the requirements in the compacts. PAs are versatile and collaborative. They practice in every state, in every medical setting and specialty, improving healthcare access and quality. They provide a flex-- they provide flexibility amongst health professions because of the versatility and adaptability, and they are also trusted, well-educated healthcare providers. Now, I became involved with interstate compacts because of their benefit to our military spouses and their families. Military spouses tend to be underemployed and unemployed for a variety of reasons. When you consider the national unemployment rate is 3.5 percent and unemployment rate for military spouses is 20 to 25 percent, it's clear they suffer a rate that is 5 to 6 times greater than the national average. But why is that, especially when there's clearly a workforce shortage and jobs available? Well, you should know that 60 percent of military spouses report that they are looking for full-time or part-time employment because they do need two incomes for financial stability. But they have hurdles that are common with other members of the workforce and others that speak directly to being in a military family. Military spouses also experience substantial income loss after a military transfer for a variety of reasons, such as job availability at a new location, licensing requirements for their occupation, and the cost of living in a new state. But for today's purpose, we're clearly focusing on the licensure issue. According to a study by the U.S. Chamber of Commerce Foundation, military spouses earn an average of $12,374 less per year than their civilian counterparts. Some of the reasons for the income loss are frequent moves, licensing barriers, childcare costs, and a long list of other reasons. There have been alternatives proposed to interstate compacts, including universal licensure. Now I want to discuss why the interstate compacts are the best options for Nebraska and what the other proposals lack in proper regulatory structure and oversight of industries. So in recent years, states have worked to reduce barriers to interstate mobility for licensed professionals through these interstate licensure compacts or statutorily enacted agreements among states allowing licensees to practice across state lines and universal license recognition laws in which a single state determines its unique process to grant a license by endorsement to a license holder from another state or territory. Now, these policies help to solve similar

problems, but there are several major differences. Notably, compacts are tailored to a particular profession, and they allow licensees to engage in interstate practice in all compact member states; whereas, universal recognition laws attempt to account for most or all professions a state regulates, but only with regard to practice within that state's borders. Universal recognition sounds like a great idea, but is proving to be problematic in other areas, especially for our military families. Universal license recognition, the laws do not provide for true reciprocity, instantaneous recognition of another state's license, and may still require an application process and allow for some discretion by the licensing board in license decisions, even though they have the intended effect of lowering the threshold for license portability in a state and reducing time to licensure. These types of policy do not attempt to streamline licensure on, excuse me, do attempt to streamline licensure on a wider scale, often lowering the thresholds for licensure across a variety of professions and reducing time to licensure. But to mitigate conflicts of difference of standards across states, ULR grants licenses for substantially equivalent or substantially similar experience. That's how they're usually written. While on the surface this appears easier to implement and casts a wider net to fill in job vacancies, universal licensure weakens licensing requirements. Diluting requirements and licensure can end up harming employers and consumers, especially in the industries we're discussing today. A recent study done by the Alliance for Responsible Professional Licensing found that 85 percent of businesses would have less confidence if licensing in their industries were downgraded. If we become too hasty in addressing workforce challenges through programs like universal licensing, we eliminate or weaken crucial safeguards in high impact industries such as healthcare. What could result is a decline of quality and increased liability for those businesses. A good example of this in Nebraska would be our massage therapy industry. Our state requires hundreds of hours more in training than many other states, and the industry is adamant that they want to keep the bar high because their consumers demand it to be so. And so it's likely that a massage therapy compact, based on the conversations we've had this year, will never pass in Nebraska because of those issues. Feedback returned on ULR policies found some applicants felt applying for out-of-state licenses became more confusing and difficult to manage for boards. States with a residency requirement were made more difficult with the ULR licensing process, while interstate compacts address that very hurdle. ULR attempting to address licensure differences across states has also seen some negative results. The substantially similar criteria has run

into problems as definitions of occupations differ from state to state. That language doesn't always solve disagreements between states' boards and licensing bodies, as sometimes applicants from out of state receive licenses despite having significantly lower requirements than in-state licensed practitioners. Also, with increased traffic of out-of-state applicants, some state boards' systems were overwhelmed and not outfitted to handle an increased influx of applicants. Interstate compacts address these problems, as states within the compact collaborate to resolve differences in license and share databases of applicants. Interstate compacts would protect employers and consumers in Nebraska while addressing workforce issues in a responsible manner without diluting the qualification process. Licensure compacts and universal recognition statutes can coexist without conflict or redundancy, as long as provisions to exclude interstate compacts are inserted into the universal recognition bills. Enhancing the ability of practitioners to engage in interstate practice requires more than a one-size-fits-all approach. States should account for industry-tailored reciprocity mechanisms such as interstate compacts when crafting these new universal recognition laws and understand that neither reciprocity nor ULRs are the end-all solution for this problem. With that, I'll step aside and have the testifiers come forward to talk more about the benefits of these compacts that they have to their particular industries, and also hopefully paint a more comprehensive picture of why we need to continue on this path here in Nebraska. Sorry for the long introduction, but there were three of them.

HANSEN: You got all three of them in there so that's good.

BLOOD: I did and I talked as fast as I could.

HANSEN: All right. Thank you, Senator Blood. Are there any questions from the committee to make sure? Yes, Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here, Senator Blood. To your credit, you have been the champion for these particular movements, if you will--

BLOOD: I have.

RIEPE: --if I may call them that, on the compacts. And you've done a, as usual, a very thorough job. You've always been known to do your homework. I've worked with you on committees. I'm proud to say that. I also would note that because of these handouts, I think it's fair to

assume that you have the support, if you will, from these different groups.

BLOOD: Absolutely, especially--

RIEPE: Now the other selfish question that I would ask from the state of Nebraska is on the net effect of compacts, will that increase our worker supply or decrease it? Will there be more moving away from Nebraska than moving to Nebraska?

BLOOD: That's a fair question. I've been asked that on other compacts, and I can tell you that data does not show that people move out, they move in. For our military spouses especially, right, we want to make sure that they can hit the ground running because we have this highly educated workforce that ends up having to jump through hurdles to get things done and are losing out on income and, and are not able to get to work as fast as we possibly can get them to work. So I can only go with the data. You know me, I always say data, facts, and science, right? And the data for the other states that participate in compacts, nobody is experiencing that. What we are seeing are people that live in more rural areas, that live close to borders, that can't find jobs locally do have the ability to cross that state line into a neighboring compact state such as Kansas, Iowa, Colorado, and have the ability to generate a better income as a result of the compacts. So that's the only thing that I've been able to document are people that are living on borders. They're not moving. They're staying in their, their little towns and their little communities or their farms, but they are having to cross that border to work because it's a closer drive. So and I think that's positive because they stay in Nebraska and spend their dollars here and raise their families here so. But that is a common question, but data shows that that is not a fact.

RIEPE: Well, we do live in a free society where they are not indentured servants so--

BLOOD: It's true.

RIEPE: --our job is to try and make it appealing enough that they prefer to be in our communities and to not leave our communities for any and all reasons but.

BLOOD: And it's our job to pass the laws that make it as easy as we can to remove these hurdles. And this is just one of the tools that we

put into our toolbox, as we've done, I think, seven times in the last seven years.

RIEPE: I know there are some other professional groups that are looking forward in the future for compacts, and so--

BLOOD: There are.

RIEPE: --maybe you'll have to take a break and come back and run again and then [INAUDIBLE].

BLOOD: Gee, that sounds like so much fun I'll have to consider that.

RIEPE: For another eight years and away you go. OK. Thank you, Mr. Chairman, appreciate it.

HANSEN: Any other questions from the committee? Senator Ballard.

BALLARD: Thank you, Mr. Chairman. Thank you. Thank you, Senator Blood, for being here and for your advocacy of this issue. How long has the DOD been-- how long has this been an initiative of theirs?

BLOOD: So, to my knowledge, at least seven years, because I, to be really frank, one of the very first meetings I ever went to as a freshman senator, I ended up, it was very happenstance, sitting next to a CSG rep, somebody who is working with CSG, who is from the DOD, and we were part of his territory and he asked if I had heard of interstate compacts, which I had not. And he had said that he had brought them forward to the previous senator for my district-- senator from my district who was uninterested in taking-- we could have been further ahead than we are already in taking these on and would I like to learn more about them. So I know-- so that would be at least eight years, I guess.

BALLARD: Eight years.

BLOOD: And we have people from CSG that can maybe answer that better than I. But I know that every new compact that has been created, we have usually picked them up within 30 days of we're in session. So we are far ahead. But I know at least seven to eight years. And it's and I can get you information on the contract but it's-- they have paid CSG and CSG has put together a roundtable of experts. So they bring people in from the profession, they bring in legal minds because, of course, we want to make sure that legally these are correct. They bring in policymakers from all over the country. I've been-- I was

just in D.C. last week talking about the dental compact. So they've got it down to a science. It's like a little compact factory.

BALLARD: Yeah.

BLOOD: But the reason they got involved with this is because they wanted to find something that could be unified throughout the United States that was consistent so these military spouses didn't have this constant hurdle of trying to figure out which state does what and what hurdles they have to walk through. And they were finding things like reciprocity and universal licensure was not helping their military spouses for the reasons that I mentioned. And they saw this as a solution. And it's been a very good solution. I have-- I have had several other things happen that were similar to the compacts that we didn't have to push through as policy, that we were able to just do, like for the military spouse attorneys, through working with our departments here in Nebraska. But we find that it's much easier to do the compacts because then we know it's in writing and that it's similar in all states that join the compact. We were going to originally bring and, in fact, I think he was actually the liaison for that, we were originally going to bring it forward as a compact and they're like, hey, we think we can do this without a compact and we did. But that's not true of the medical professions.

BALLARD: And [INAUDIBLE] you answered with Senator Riepe's question or the-- does DOD track metrics on this?

BLOOD: Oh, they do, yeah.

BALLARD: OK.

BLOOD: Yeah, absolutely. I think Michelle [PHONETIC], who would have been here and couldn't from the DOD, who represents this specific area, wrote a letter of support in, in the system. She's somebody you can definitely meet with or I can have other people contact your office and share those metrics with you.

BALLARD: OK.

BLOOD: But they would not have invested further money had it not worked from the very beginning.

BALLARD: OK. Thank you. Thank you.

HANSEN: Any other questions from the committee? All right. Seeing none, are you planning to stay to close?

BLOOD: I am.

HANSEN: All right, good deal.

BLOOD: Thank you.

HANSEN: So with that, we will take our first invited testimony. And on the list that I got here, I have Susan Reay with UNO would like to testify first. She put you up first so you must be like, you know, the best there is.

SUSAN REAY: The pressure is on now. Hello. Hi. My name is Dr. Susan Reay, spelled S-u-s-a-n, last name R-e-a-y. I-- my doctorate is in education. I'm a licensed clinical social worker. I am the director at The Grace Abbott School Social Work at the University of Nebraska at Omaha. However, I'm not here representing the University of Nebraska's position. I'm representing myself as a social worker. I was on the Board of Mental Health Practice in Nebraska for about 13 years and termed off-- term limited off in 2021. My area of research is regulatory science, and I do a significant amount of research in the area of licensing, particularly with social work. I am also a practitioner of social work. I have some prepared testimony that I provided, but I believe that-- and I could say a whole lot about how this is a really great thing, but I think it's best articulated by telling you a short, very brief example of why this is important. In my practice about two years ago, I had a college student was seeing me. I was her social worker. She had a very significant eating disorder. She was in college in Nebraska, but lived in another state. She decided to take the semester off from school and go home to be with her family and to be taken care of. I was not licensed in the other state and I felt that it was important that her care continue, particularly during this very significant time in her life. However, I went through the process of trying to get licensed in this other state and made many, many phone calls. I went through lots of hoops, found out I needed to do fingerprinting, background checks. I needed to have my college transcripts for my master's degree, which was in 1998, officially sent from the university, and that I would need to fill out a whole lot of paperwork and pay some fees. That took me probably five, six hours total to figure even out what I needed to do. And then the process of doing all of that, submitting it, and then waiting for the other state's turnaround time to be about, they said six to eight

weeks for that paperwork to be processed. I figured it was not going to be-- it's not going to happen. This student is going home this week, and by the time all this gets done, she will be back already. I turned my focus to finding her a social worker in the state where she lived. Went through the process of figuring that out, talked to the other social worker. Did all of that. And in the end, the student and her family decided by the time all the insurance reimbursement got worked out, they got on the other person's waiting list, it would also be about the amount of-- same amount of time for her to seek treatment there. She would already back-- be back at school in Nebraska. So she did not get treatment while she was home with her family for that semester, which caused significant stress for her and her family. They were up in the middle of the night checking every hour to make sure that she wasn't exercising, that the daughter did not get any mental healthcare. I was not able to provide care to her. To Senator Blood's point about the stress of the practitioner, the social worker in these situations, there's really not any amount of self-care that you can do as a social worker to prevent yourself from not worrying about people. And in this particular situation, it was something that did keep me up at night. She ended up coming back to school in Nebraska the following semester and she was rested and she felt loved. But the pathology of her disorder was so significant, it was worse than when she was there before. And so it basically set her back a very long time in her treatment and undue suffering for everyone involved. I believe that this process and this study, interim study, is so critical to what we do. We need to figure out a better way to do this. And I really very much appreciate your time on this and to Senator Blood and everyone else's attention here, because this sort of legislation helps us to feel seen in our practice and helps us to feel valued in what we do. So thank you very much.

HANSEN: Thank you for your testimony. Real quick, I just want to make sure, see if there's any questions from the committee. Are there any questions from the committee? Yes, Senator Riepe.

RIEPE: Thank you, Chairman. [INAUDIBLE] You know that she had, had set her back. Did she have irreversible damage?

SUSAN REAY: She ended up-- it's hard to say. She ended up-- she's doing really well. I don't know if she-- if the, the process would have been shorter for her or the pathology would not have been long-- as longstanding. But it's a-- it's a good question. I still have contact with her. She's doing really, really well and gave me permission to share her story with you all today. However, I believe

it would have not taken as long for her to recover as it would have if, if her treatment would have continued.

RIEPE: OK. Thank you very much. Thank you, Mr. Chairman.

HANSEN: Thank you for coming to testify, appreciate it. All right. We will take our next invited testimony. And I have here Mary Bahney with the National Association of Social Workers. Welcome.

MARY BAHNEY: OK. I'm going to read mine. Senator Hansen and members of the Health and Human Services Committee, my name is Mary Bahney, M-a-r-y B-a-h-n-e-y. I'm a licensed clinical social worker in Nebraska, and I'm a member of the Nebraska Chapter of the National Association of Social Workers. We say NASW-NE. Currently I'm chair of our chapter's, NASW-NE's, advocacy committee. Our association is the state's largest organization of professional social workers and we are chapter of the largest national organization of professional social workers. In Nebraska, social workers who are licensed as mental health providers or practitioners or independent mental health providers or practitioners can provide mental health therapy services. I'm here to express support of our association for LR232, the proposed Interstate Social Work Compact. The National Association of Social Workers at our national level states that the compact eliminates barriers to practice and increases access to care, especially in areas that are underserved and geographically isolated, as we have in Nebraska. Currently, social workers must obtain a separate license in each state in which they wish to practice as Susan just explained in her example. This can be overly burdensome in time and money, as she said, for professional social workers. The implementation of this interstate compact will improve access to tele-mental health, improve continen-- continuity of care when clients travel or relocate, and it will ensure the safety of the public by allowing only licensed social workers to take part in this effort. The Nebraska Chapter of the National Association of Social Workers strongly supports the implementation of the Interstate Social Work Compact. And thank you for consideration of this matter.

HANSEN: Thank you for coming to testify. Are there any questions from the committee? You're off the hook.

MARY BAHNEY: Hey, that sounds good.

HANSEN: All right. Thank you.

MARY BAHNEY: You didn't ask me.

RIEPE: I know.

HANSEN: All right. We'll take our next invited testifier. I have here Sarah Maresh from Nebraska Appleseed.

SARAH MARESH: Hello.

HANSEN: Welcome.

SARAH MARESH: Chairperson Hansen and members of the Health and Human Services Committee, my name is Sarah Maresh, S-a-r-a-h M-a-r-e-s-h, and I'm the healthcare access program director at Nebraska Appleseed, testifying on LR132 on behalf of Nebraska Appleseed. We're a nonprofit legal advocacy organization that fights for justice and opportunity for all Nebraskans. And one of our core priorities is ensuring that all Nebraskans have equitable access to quality, affordable healthcare. Even though oral health is a critical part of overall health, many Nebraskans don't get the care that they need. And this is particularly true for people enrolled in the Nebraska Medicaid program. Even though some dental coverage is included for adults, a majority of adults with Medicaid aren't utilizing any dental services. Among adults with Nebraska Medicaid coverage, only 42.6 percent in 2018 and 41.9 percent in 2019 had an annual dental visit. Increasing access to dental care in Nebraska's Medicaid program presents a wide variety of benefits from improving individual health to addressing racial disparities and to even supporting the economy. Nebraska Appleseed's recent policy brief covering these issues and more is available at the link in the testimony, but also is being handed out to you as well in a packet. We regularly hear at Appleseed from community members that even when they have coverage through Medicaid they struggle to find dental providers that accept Medicaid and accept new patients. A potential interstate compact for dental professionals could be one opportunity to increase the dental workforce in Nebraska, not only for individuals with Medicaid, but for Nebraskans regardless of coverage. This new interstate compact that would support the mobility of licensed dentists and dentists across the state is promoted by many organizations, many of which has already been shared. And states that joined the compact would have reciprocity for dental professionals to move more easily from one state to another, you know, supporting our workforce initiatives and also making sure that other folks in our state are able to access the dental care they need. Other healthcare professionals already have similar interstate compacts, including physicians, nurses, physical therapists, among others. This compact may be one way to address the dental workforce to better serve

Nebraskans regardless of the healthcare coverage. And Nebraska Appleseed supports efforts to improve dental workforce and access to dental services. I'm happy to answer any questions.

HANSEN: All right. Thank you for coming to testify. Are there any questions from the committee? Yes, Senator Riepe.

RIEPE: [INAUDIBLE] question, Mr. Chairman, thank you. Thank you for being here. The one question I'm looking at-- I'm looking at your letter and you were talking about the compact in this particular LR132. And yet this handout talks about improving or expanding Nebraska Medicaid. I mean, is one dependent upon the other one or is this just a copy that you had and you want to share this one as well?

SARAH MARESH: Yeah, that's a good question. So the issue brief that we handed out actually deals with a variety of suggestions to improve oral healthcare under Nebraska Medicaid program. And one of the suggestions because of the workforce shortage issues is to, you know, take up initiatives such as compacts to increase the number of dental providers that we have who accept Medicaid. So we, we at Appleseed have an interest in oral healthcare in general. And so this suggestion to include the interstate compact and have that adopted in Nebraska is just one of the suggestions in our policy brief as well, among with others.

RIEPE: My interpretation is that is, correct me if I'm wrong, is that if you increase the number through the compact, you help everyone.

SARAH MARESH: Yep, exactly, regardless of coverage. Yeah.

RIEPE: OK. Thank you, Mr. Chairman.

HANSEN: Any other questions? Senator Day.

DAY: Thank you, Chairman Hansen, and thank you for being here today. So kind of piggybacking off of Senator Riepe's question, we know, obviously on this committee that healthcare access, particularly in rural areas, is not great in Nebraska. Do we have any idea what that looks like, especially related to Medicaid dental access in rural areas?

SARAH MARESH: Yeah, there, there might be. I don't have the exact information in front of me, Senator Day. But there, there definitely are shortages and challenges and there may be people, providers in the dental space behind me that can better speak to some of the

deficiencies in that. But we do know and hear stories of people having to travel long distances. And we've also heard stories of folks, you know, trying to get higher level of care and not being able to access it and having to drive from, you know, further out west to Lincoln or Omaha to get kids, kids care even for their own children.

DAY: Excellent. Thank you.

HANSEN: Seeing no other questions, thank you for coming.

SARAH MARESH: Thank you.

HANSEN: And I, I messed up. I skipped over one person who is in line for the testifiers. So with that, we'll take the next testifier, Joey Enright. with the dental hygienists.

JOEY ENRIGHT: Yes.

HANSEN: Sorry about that. Welcome.

JOEY ENRIGHT: Thank you. So my name is Joey Enright. It's J-o-e-y E-n-r-i-g-h-t. I am a hygienist in Nebraska, and I'm testifying today on behalf of Nebraska Dental Hygienists Association. First, I would like to just express sincere gratitude for the committee, for Senator Blood, for your attention and consideration to the dental and dental hygienist compact. As Senator Blood had said, this compact is an initiative of the Department of Defense, the Council of State Governments, the American Dental Association, as well as the American Dental Hygienists Association. So Nebraska Dental Hygiene Association believes that dentists and dental hygienist compact will improve access to care for Nebraskans at a time when workforce shortages are definitely creating some gaps. According to the Health Policy Institute's research over the last few years, there is a mobility trend among practicing dentists with less than ten years of experience. Between 2019 and 2022, 14 percent of this demographic moved to another state. As it stands, our state does not accept clinical exam scores from the testing agency that offers the most portability, which may increase the odds that licensure candidates will not stay in the area upon graduation from dental school. Entering into the compact is an opportunity for Nebraska to offer the portability that these upcoming professionals seek, while increasing odds that they remain in the state to practice dentistry. According to the Department of Defense, military families move every three years on average, and 36 percent of military spouses require a professional

occupational license for employment. The compact helps military spouses relocate and begin work without delay by reducing the amount of time and effort needed to gain authorization to practice in a new state, even as compared to expedited licensure laws for military spouses. As a member of the compact, Nebraska, the home of Offutt Air Force Base, may become a more attractive option to call home for a military family with a dentist or dental hygienist. The Dentist and Dental Hygienist Compact would utilize a compact privilege model of interstate practice, much like the eight professional licensure compacts our state currently participates in. To utilize the compact, a dentist or dental hygienist must have a license in good standing in, in a state that is a member of the compact. This preserves the regulatory authority of each compact participating state and allows a participating state to continue to determine the requirements for licensure in that state. This maintains the state's unique scope of practice for all members of a profession practicing in that state, whether through a state, state-issued license or a compact privilege. Cost for participating in the compact are projected to be nominal by the Council of State Governments, but would incur due to additional software required to connect the compact's interstate licensure data system, as well as costs associated with attendance of our state's chosen commissioner to the annual Dentist and Dental Hygienist Compact Commission meeting once the compact is enacted in seven states. Thank you for your time and consideration and I'm willing to answer any questions.

HANSEN: Thank you. Are there any questions from the committee? Senator Ballard.

BALLARD: Thank you, Mr. Chairman. Thank you for being here. I appreciate it. You mentioned 14 percent of, of dental hygienists moving out of state. On the flip side, do you see a downtick in individuals going into dental education for dental hygienists?

JOEY ENRIGHT: Demand is still high. So programs-- I've been tracking this, you know, really since the pandemic, but I've been trying to pay close attention to those trends. It seems that there is still a lot of interest to go into dental hygiene and dentistry. So I'm not really fully sure of what is creating that kind of hypermobility trend that we're seeing in professionals. But I know for myself, I am getting a lot of people reaching out just to, to move back to Nebraska from other states. So hygienists, I do some hiring for my, my business. And, and so they are interested in coming to Nebraska. So it's just a matter of, you know, they have to figure out all the things that they

have to do, what boards do they take. That's going to be a big-- a big obstacle for some people. You know, nobody wants to have to retake boards. It's just it's costly. It's, it's just a lot of work. So that, that's an obstacle that we have in our state. And so I think this could be a good solution to some of those issues.

BALLARD: We are seeing a downtick in high school students--

JOEY ENRIGHT: They're interested.

BALLARD: --wanting to go into--

JOEY ENRIGHT: They want to go.

BALLARD: OK.

JOEY ENRIGHT: It's there's, there's some issues with just class sizes and accreditation and kind of the ratio of profession-- professors to students. And, you know, the programs are small so the output of the professionals is, is not as great as it could be, in my opinion, but--

BALLARD: Thank you.

JOEY ENRIGHT: -- that's a whole other issue.

BALLARD: Thank you.

JOEY ENRIGHT: Anything else?

HANSEN: I might have a couple of questions.

JOEY ENRIGHT: OK.

HANSEN: So does this, just to make sure I get this right, you know, I think I have an understanding of it. So somebody who has a good standing in licensure in another state, who may have less hours for licensure or continuing education hours, can now practice in the state of Nebraska?

JOEY ENRIGHT: So to my understanding, the licensee, they would have to know the rules and regulations of our state and follow them and practice according to that. So they would need to abide by those continuing education regulations that we have.

HANSEN: OK.

JOEY ENRIGHT: So and that's really no different than how you practice anywhere. I mean, as a licensee, you're responsible to know your scope of practice and what you can and cannot do, you know, as a licensed professional.

HANSEN: OK, just curious.

JOEY ENRIGHT: Yeah.

HANSEN: Seeing no other questions, thank you very much.

JOEY ENRIGHT: Thank you.

HANSEN: Appreciate it. All right. Next on the list is Isabel. OK, I got to pronounce this right, make sure I get it right, Illaison [PHONETICALLY]. OK. I just butchered it, didn't I?

ISABEL ELIASSEN: No worries.

HANSEN: OK, from the Council of State Governments.

ISABEL ELIASSEN: OK.

HANSEN: Welcome.

ISABEL ELIASSEN: Thank you. Chair Hansen, I'm here today to talk about both the PA compact and the dentistry and dental hygiene compact. So I'm going to go through both of these at this time. All right. Chair Hansen, members of the committee, my name is Isabel Eliassen, I-s-a-b-e-l E-l-i-a-s-s-e-n, and I'm with the Council of State Governments. I'd like to express my appreciation for your interest in the dentist and dental hygienist compact. My testimony is meant to provide background educational information on the compact. There are approximately 425,000 licensed dentists and dental hygienists in the United States. Despite the high demand for oral health services, licensees are currently limited to providing services within state borders. The Dentist and Dental Hygienist Compact seeks to provide licensees with opportunities for multistate practice, support relocating practitioners, and foster workforce development by reducing unnecessary licensure burdens. The Dentist and Dental Hygienist Compact is an interstate occupational licensure compact. The compact was created through a cooperative agreement between the Department of Defense and the Council of State Governments. For the past 18 months, CSG has been developing the compact language with stakeholders in these professions, including the American Dental Association, American

Dental Hygiene Association, state regulatory boards, the education community, and others. The compact will enable dentists and dental hygienists to get a compact privilege to practice in other states that join the compact rather than needing an individual license in every state in which they wish to practice. The Dentist and Dental Hygienist Compact is similar in form and function to the nine occupational licensing compacts Nebraska is already a member of. Practitioners must pass a background check and meet other eligibility requirements related to education and examination. The Dentist and Dental Hygienist Compact also benefits military families. When a military family gets assigned to a new duty station in a contact member state, the service member or their spouse can continue to work with the current compact privilege. If the family gets assigned to a new duty station that is not in a compact member state, the service member or their spouse do not lose access to the compact, but would need to get a single state license in their new state if they wish to continue working in that state. From a regulatory perspective, the compact preserves the authority of each member state to protect public health and safety. The licensee practicing in Nebraska under contract privilege must abide by the laws and rules and regulations that govern the practice of dentistry and dental hygiene in Nebraska. Nebraska will be able to charge a fee for compact privilege. Like all other occupational licensing compacts, the Dentist and Dental Hygienist Compact will be governed by a commission made up of compact member states. Nebraska's delegate will be a representative from the Nebraska Board of Dentistry. Overall, the Dentist and Dental Hygienist Compact will increase license portability for dental professionals in Nebraska, support military families, and improve access to oral health services for Nebraska residents. Additionally, by sharing investigative and disciplinary information among participating states, the Dentist and Dental Hygienist Compact will allow participating states to better protect the public. Increasing access to healthcare is a key issue facing states, and the compact can help alleviate that problem. I would be happy to take questions on the dentist compact or I can just go ahead into the PA testimony as well.

HANSEN: Let's start with the dentist one first just to make sure.

ISABEL ELIASSEN: Great.

HANSEN: Are there any questions about the dentist compact? Are there any states so far that have filed or enacted the compact yet?

ISABEL ELIASSEN: Yes, there are. Unfortunately, I don't know off the top of my head which states. I want to say I think there are two or three that have already joined, a couple of others that have considered. We can definitely get you that information after, after, after this is over. We have it up on the compact website. But unfortunately, I just don't know off the top of my head which states that would be. Probably Utah is one of them because they love compacts.

HANSEN: Yeah, I think they have the PA one, too, don't they? OK. OK. Seeing no other questions for that one, you can move on to the next one.

ISABEL ELIASSEN: All right. Chair Hansen and members of the committee, my name is Isabel Eliassen. I'll spell that more time just in case, I-s-a-b-e-l E-l-i-a-s-s-e-n, and I'm again appearing on behalf of the Council of State Governments. Thank you for the opportunity to provide input on LR233 and the Physician Assistant Licensure Compact. The Council of State Governments is a nonpartisan membership organization that serves three branches of state government. We also provide technical assistance for states on interstate compacts, including the PA compact. The PA compact is an interstate license compact or contract among states which allows physicians, PAs licensed in a compact member state to practice in other compact states without the need for multiple licenses. Like other interstate licensure compacts, the PA compact is designed to improve access to services, enhance mobility for practitioners, support relocating military spouses, improve continuity of care, and ensure cooperation among compact member states. The PA compact reflects how states currently license PAs. For example, to participate in the compact, PAs must hold an unrestricted license, have no felony or misdemeanor convictions, and graduated from an accredited PA program and hold current National Commission on Certification of Physician's Assistant Certification. PAs who meet the uniform requirements are then able to quickly obtain a compact privilege, which is equivalent to a PA license in another state. The PA compact has no impact on a state's laws and regulations for PA practice and leave state specific licensure requirements in place. For example, any collaboration or supervision or controlled substance prescription authority requirements that Nebraska necessitates for practice would have to be met by a PA before they're able to exercise a privilege to practice. The compact creates a shared interstate licensure data system, allowing for a near instant verification of licensure status. Through the data system, the privilege to practice or the authorization to practice in another

compact member state can be obtained in a matter of minutes. The data system will also enhance public protection by ensuring that member states share investigative and disciplinary information with one another. We don't anticipate substantial additional costs for participating in this compact. Like with the Dentist and Dental Hygienist Compact, there may be a cost to connect your state's data system to the compact data system and also the cost of the attendance of your state's commissioner at the Compact Commission annual meeting. The PA Compact is newly available for states in 2023 and is one of 15 interstate compacts available for states. Thank you for the opportunity to deliver this informational testimony, and CSG is available to assist with any questions regarding the PA Compact or other compacts.

HANSEN: Any questions on the PA? OK. Seeing none, that's all.

ISABEL ELIASSEN: Oh, yeah.

HANSEN: OK. Just making sure. OK.

ISABEL ELIASSEN: Thank you. Thank you very much for your time.

HANSEN: All right. Thank you. All right. And next on the list we've got Kaitlyn Bilson [PHONETIC] with the Council of State Governments. Welcome.

KAITLYN BISON: Thank you. So Chair Hansen and members of the committee, I would like to express my appreciation for your consideration of the Social Work Licensure Compact. My name is Kaitlyn Bison. That's K-a-i-t-l-y-n B-i-s-o-n, also with the Council of State Governments. And I'm just going to provide some background educational information on the compact. So CSG, through its National Center for Interstate Compact, we facilitated the development process for all 15 of the active occupational licensing compacts, including the 9 that Nebraska is a member of. This includes ASLP counseling, EMS medicine, nursing, psychology, physical therapy, occupational therapy, and teaching. Nebraska is also a member of 38 other interstate compacts unrelated to professional licensing. There are approximately 500,000 licensed social workers in the U.S. and despite the high demand for social work services, licenses are currently limited to providing the services within their state borders. And the compact seeks to provide licensees with opportunities for multistate practice, support relocating practitioners, and foster workforce development. Like the other two compacts Isabel just mentioned, the compact was created

through a cooperative agreement with the Department of Defense and the Council of State Governments, and we've been working on this for the past 18 months, developing the compact language with stakeholders within the profession from the Association of Social Work Boards, National Association of Social Workers, Clinical Social Work Association, social work regulatory boards, the Social Work, Education Community and others. And this compact language was finalized in February 2023. The compact will enable social workers to obtain a multistate license issued by their home state to practice in other states that join the compact rather than get an individual license in every state in which they want to practice. Unlike the other two compacts that were just mentioned, they are a compact privilege model. The Social Work Compact is a multistate model, so like the compact for a driver's license, each compact member state agrees to mutually recognize the practitioner licenses issued by every other member state. It's similar in form and function to the other nine occupational licensing compacts that Nebraska is already a member of. You know, a social worker must hold an active, unencumbered license in their home state to be eligible for a multistate license. Licensees must also pass a background check and meet other eligibility requirements related to education and examinations. From a regulatory perspective, the compact preserves the authority of each compact member state to protect health and safety through the existing state regulatory structure. A licensee practicing under a multistate license must abide by the laws and regulations and rules that govern the practice of social work in the state in which they were located. And the Nebraska Department of Health and Human Services has jurisdiction over anyone practicing in Nebraska under a multistate license. The Social Work Licensure Compact also benefits military families as Isabel mentioned. And like all other occupational license compacts, the Social Work Licensure Compact will be governed by a commission made up of member states. The delegate will be a representative from the social work section of the Nebraska Department of Health and Human Services. The compact will come into effect once it's enacted by seven states. The compact is pretty new, so there is currently only one member state, Missouri. However, there are many states that are interested in introducing the bill in 2024. And in Nebraska, if it were enacted, Nebraska would have a seat at the table when the Compact Commission has its first meeting to establish the compact's rules and bylaws. Overall, the Social Work Compact will increase license portability for social work professionals in Nebraska, support military families, and improve access to social work services for Nebraska residents while maintaining the current system of state

licensure. Additionally, by ensuring the sharing of investigative and disciplinary information among the participating states, it will allow participating state regulatory entities to better protect the public. And I understand that increasing access to mental health providers is a key issue facing states, and we believe the compact will help with that. Thank you.

HANSEN: Thank you. Are there any questions from the committee? One question I think I hear about these compacts I've seen in some letters is do these compacts have the ability to supersede state law?

KAITLYN BISON: No. So this would just be an alternative pathway that a social worker can take. We don't touch scope of practice or anything to do with the individual state license.

HANSEN: OK. That's what I thought, just wanted to reiterate that point. All right. And seeing no questions from the committee, thank you very much, appreciate it.

KAITLYN BISON: Thank you.

HANSEN: All right. Next up we'll take Joyce Beck with the AARP.

JOYCE BECK: Chair Hansen and members of the Health and Human Services Committee, my name is Joyce Beck, J-o-y-c-e B-e-c-k, and I am here today as a volunteer on behalf of AARP Nebraska to provide comments on LR233. According to the U.S. Census, more than one third of Nebraska's population in 2021 was 50 and over. When asked, AARP members made it clear that one of the highest priorities as they get older is to be able to age in place. In fact, 95-- 90 percent want to remain in their homes as long as possible. In 2020 UNMC report, 13 of the 93 counties have no active primary care physicians. The state has designated all counties except for Douglas and Lancaster County, as a shortage area for at least one type of primary care specialty. Fifty-eight of the 93 counties are designated shortage areas for family physicians. As a nursing home and a hospital CEO for 28 years in Nebraska and in Colorado, I saw firsthand the PA's essential role in the healthcare delivery system. It often makes sense for PAs to take care of less complicated patients who need constant care and ongoing monitoring and let physicians concentrate on those with the most intense needs and complications. Access barriers often delay patient care, especially in rural communities and other underserved areas. Delays in care also contribute to delays in diagnosis and delays in treatment, which result in poor patient outcomes. In Montrose, Colorado, for example,

we established that over 1,000 cardiac clinic appointments and follow-up appointments needed to be made in order to meet the needs of our patients. PA recruitment was paramount for that area. The PA address the clinic needs of many patients, freeing up the cardiologist for interventional-- for surgical interventions. While this example from my experience comes from Colorado, similar experiences can be found in Nebraska. Developing interstate compacts for healthcare professionals is essential to meet Nebraska's needs. In Thayer County Health Services in Hebron, Nebraska, where I was the CEO, interstate compacts were particularly important to the triage nurses providing services to patients in Nebraska as well as Kansas. This drives home the point that facilities on border towns will find the compact advantageous. Enactment of the Physician Assistants Licensure Compact will prove critical to enhancing and improving healthcare access in rural Nebraska and in-- throughout the state. PAs are clinically versatile, they are cost effective, they extend the services of the physician practices, and they improve the care delivery to underserved areas. They are an essential part of healthcare workforce. Consumers in our state need better access to high-quality primary and preventive care, and physician's assistants have the training and the skills necessary to provide that care, especially for older people who need to receive that care in their own communities. Enactment of the Physician Assistants License Compact is an additional step forward to ensuring Nebraskans receive the care they deserve. So thank you, Senator Blood, for introducing this critical study resolution. And thank you to the cCommittee for my opportunity to commute or to comment.

HANSEN: Thank you for your testimony. Are there questions from the committee? Seeing none, thank you very much.

JOYCE BECK: Thank you.

HANSEN: And lastly, we have Bethany Berg as a PA to come testify.

BETHANY BERG: Hello. Chairman Hansen and members of the Health and Human Services Committee, my name is Bethany Berg, spelled B-e-t-h-a-n-y B-e-r-g, and I'm appearing on behalf of the Nebraska Academy of PAs. I am a physician assistant working as the advanced practice provider lead at the University of Nebraska-Lincoln Student Health Center. Thank you for the opportunity to provide input on LR233 and the Physician Assistant Licensure Compact. For nearly 50 years, NAPA has represented the interests of the more than 1,300 PAs practicing in Nebraska, including advocacy for quality,

cost-effective, and accessible healthcare for Nebraskans throughout the state. It is our pleasure to provide this committee information on the PA Licensure Compact and its anticipated impacts to PAs, patients, and state administrators. NAPA did not request introduction of this interim study, nor has our board taken an official position on the compact. But our professional association wishes to be engaged as the Legislature continues this compact. While we can anticipate benefits to the compact, we also want to ensure that we address concerns that our members have already raised related to issues ranging from telehealth to Nebraska specific requirements like patient safety, fee payments. Like many states, Nebraska is competing to recruit and retain qualified healthcare providers to meet the needs of patients. The role that PAs play in meeting these healthcare needs in Nebraska and across the country is critically important. One quarter of PAs in Nebraska serve in rural areas and approximately 30 percent of work in primary--30 percent of these PAs work in primary care. So it is important that the state look for ways to fully leverage the PA workforce to meet the needs of Nebraskans. And the PA compact can be a useful tool in this effort. If enacted, we hope this compact will strengthen access to medical services provided by PAs via the mutual recognition of the PA's qualifying license by other compact participating states. Nebraska is no stranger to interstate licensure compacts, having enacted eight compacts for healthcare providers already. Like the other eight compacts that the state already participates in, the PA Compact is a constitutionally authorized, legally binding, and legislatively enacted compact among participating states. While NAPA is pleased to offer insights into the benefits of the PA Compact, we also recognize this is a nationwide effort. This year, seven states filed legislation to enter the PA compact, and the new compact is receiving support, expertise, and counsel from respected organizations such as the Federation of State Medical Boards, the National Commission on the Certification of Physician Assistants, the Council of State Governments, and the American Academy of PAs. Should Nebraska join the PA Compact, the compact would be administered from a compact commission and an interstate government agency comprised of delegates from compact member states. This would allow for the creation of a licensure data system to improve information sharing between compact member states, including disciplinary information. States joining the compact would agree to recognize a valid, unencumbered license issued by another compact member state via a compact privilege. Licensed PAs utilizing the compact can obtain a privilege in each compact member state where they want to practice. Importantly, PAs using a compact privilege to

practice in another state must adhere to laws and regulations of that state and are under the jurisdiction of the state's regulatory board in which they are practicing. The PA Compact also adopts the prevailing standard for PA licensure and affirms that the practice and delivery of medical services by the PA occurs where the patient is located at the time of the patient encounter, and therefore requires the PA to be under the jurisdiction of the state licensing board where the patient is located. So by preserving the sovereignty of states' rules and regulations, the compact safeguards Nebraska's ability to regulate the profession, charge licensing fees, and preserve the structure of the state-based licensing system. If enacted, we anticipate that the compact will provide several benefits to PAs, patients, and state regulators. First, the compact will facilitate license portability, making it easier for PAs to practice without lengthy licensing delays or administrative burdens. Rather than obtaining an individual license in each state they want to participate, a PA can utilize the PA Compact to apply for compact privileges through a streamlined process. This can make Nebraska more competitive in attracting high-quality practitioners. Licensure portability is essential-- essentially important for military families. The compact will more easily allow active-duty military personnel and their spouse to obtain a compact privilege in Nebraska if they are licensed in another compact state. For patients, this could mean expanded care access to highly qualified practitioners and will also help the state facilitate practitioner mobility during public health emergencies. But beyond benefits to the patients, the state could benefit from improved cross-state collaboration, enhanced public, public safety data through sharing, and strengthen healthcare labor market. Nebraska PAs stand ready to be a resource to you as you consider the PA Compact, and NAPA thanks you for the opportunity to provide input on this important discussion. I'm happy to answer any questions.

HANSEN: Thank you. Are there any questions from the committee? Senator Ballard.

BALLARD: Thank you, Mr. Chairman. Thank you for being here. How, how different are the license requirements from state to state? Or is this more just to cut red tape and kind of minimize delays?

BETHANY BERG: I don't know that I can speak to the definitive differences between states. We can get that information. But I think depending on the state, it can vary quite a bit.

BALLARD: Because if I remember right, you have undergraduate, PA school, and then boards. That's a national standard, correct?

BETHANY BERG: Correct.

BALLARD: OK. So [INAUDIBLE]. Thank you. I appreciate it.

HANSEN: I got a question. You mentioned something about the patient safety fee. What is that?

BETHANY BERG: I can get the details to be specific, but I know it's an additional fee that was recently added on to our license to help cover the Patient Safety Commission that is through the state of Nebraska, I believe. And I can get more detailed information.

HANSEN: I'd be curious about it. OK.

BETHANY BERG: We can follow up with the committee and share that.

HANSEN: Yeah, it'd be great, actually. Any other questions just to make sure? All right. Seeing none, thank you very much. All right. So that will conclude the invited testimony for LR132, LR232 and LR233. And we will invite Senator Blood back up here to close. And we did have some letters for the record while she's coming up here. LR132 had one proponent, one opponent and one neutral letter of the record. LR232 had one proponent, one neutral. And LR233 had two proponents and one neutral.

BLOOD: Can I ask who the opponent was?

HANSEN: Um, yes.

BLOOD: Because there's no actual bill.

HANSEN: It was someone reporting themselves and it was Melanie Stekelburg [PHONETIC].

BLOOD: OK, we're going to have to give that person a call.

HANSEN: Yep. She had a good question there.

BLOOD: So I want to real briefly answer a couple of questions that were brought up that I think will be beneficial that I can go ahead and help you out with right now. You had asked about the metrics in reference to the Pentagon. They actually maintain a website that is meant for military families where they share that data. It's the

military OneSource website. It's a very convoluted website, but the data is on there. No offense to the-- to the Pentagon. And then you were asked about how many of these compacts-- how many states had joined these compacts. So I want you guys to be aware that actually these compacts are new. We had already gone through our ten-day process of dropping bills and the window of time shut for us. But that's how new they were. They came out-- a lot of these came out like January, February. So we weren't able to participate when they were first dropped. But on the social work one, there's only been one state that's passed it and six states that are pending. And again, that's within a nine-month period. The dentist compact, three states have passed it; five are pending. The PA Compact, two states have passed it, two are pending, and two have introduced it. So like most compacts, I anticipate in the next 6 to 12 months, you'll see 8 to 10 states. And the year after that, more states and more states. And then I just want to and they all touched down on this a little bit. We never change, especially for Senator Ballard, we never change the scope of practice ever. We remain sovereign when it comes to what's right and what's wrong. They can't come in and do whatever the heck they want. They have to abide by our rules. And the reason these compacts take so long to put together, they're not put together in a month. They're put together over years is because they bring in the national organizations. They bring in local people. They bring in a lot of attorneys, probably really well-paid attorneys, and they make sure that the bar is set at a level that is acceptable for most states. There are going to be compacts that we aren't going to want to participate in. And one of those would be the APRN Compact. That's one that I like to use for an example. If you read the body of that compact, you'll see where it says that it doesn't change scope of practice. And then two paragraphs later it says it changes scope of practice. So we're very aware of what these compacts are meant to say and we make sure that we don't change the language. In fact, Nebraska adds in additional language that pertains to protecting people legally that we get from the National Association of Trial, excuse me, Nebraska Association of Trial Attorneys. And I think we're the only state that does that. But the compacts allow us to do that because it doesn't change the text of the compacts. So we add in extra protections in our state, and I'm really proud of that. And then you heard the story about the social worker who talked about how she couldn't provide care because the patient was in another state. I go back to the psych pact and I think you were chair of the DHHS when we passed the psych pact. And I heard stories of patients who would go on vacation and have mental health issues and the Nebraska psychologist

couldn't counsel them on the phone because that was illegal, because they weren't licensed in Florida or California or wherever the other person was vacationing. With these interstate compacts, they don't have to get 20 different licenses. They had to get their home state license. And then they get the ability, the privilege is what they call it, to practice in those other states, which, if you think about it, is also financially beneficial sometimes because many of our psychiatrists can start secondary businesses by doing telemedicine in other states with these compacts. So again, people not leaving, but actually finding alternative sources for income. So with that, I'm going to close. So we all know that health is a vehicle. It's not a destination. What that means is that health is not a fixed point that you reach and then you hit the brakes. It's an ongoing journey and we know it requires continuous care and often a lot of effort. Now, if we want to help Nebraskans maintain good habits and take good care of themselves so they can live fulfilling lives, we must make sure that tools such as better access to healthcare is available so they can strive to be the healthiest versions of themselves, be they have broken bones, mental health issues, weight problems, long-term health concerns, whatever. Healthier Nebraskans mean that the residents of our state have better overall health, and to me, that is worth more than pretty much any law we will ever pass here in Nebraska. I made it fast.

HANSEN: I was going to say.

BLOOD: You need more time to write your note?

HANSEN: No, that was quick. All right. Any, just make sure, any questions? Yes, Senator Riepe.

RIEPE: Thank you, Mr. Chairman. Again, thank you, Senator Blood. I am a big fan of compacts. One of the questions that I had is I have a note here that says it requires seven states to create a compact.

BLOOD: It depends on the compact.

RIEPE: OK.

BLOOD: But most states it's 7 to 10.

RIEPE: And that led me over to the comment that you had made about the psychologist who was in another state. And it talked about what if-- what if it was a state that was outside the seven?

BLOOD: Well--

RIEPE: Then it gets very awkward [INAUDIBLE] Are there 7 in this compact and 10 in this one and 20 in that one? And how does a-- how do you know for sure who's in what?

BLOOD: Well, first of all there's--

RIEPE: Other than Google?

BLOOD: There's well, no, there's maps, literally maps for every compact that shows you what state has it pending, what state has it passed, which is how we get our information when we're sitting on the side there. We got to their compact websites. But also when you're in the industry, you know what states belong to your compact and not everybody-- here's the thing that we have to always point out. Boy, you're just losing everybody over here. You-- what you have to point out is that not everybody has to join the compact. It's optional. If I come to here to practice in Nebraska, isn't that I have to join the interstate compacts, compact, it's a choice. And if I come from a state where there is another compact, I have that benefit of using my home state license and then coming to practice in Nebraska. So it-- there doesn't seem to be, I mean, I can see you creating this confusion that maybe this is a problem, but we're not hearing that from anybody who participates.

RIEPE: OK.

BLOOD: Because in your industry, you know who belongs to the compact.

RIEPE: OK. I have one additional follow-up question--

HANSEN: Yes.

BLOOD: --if I may, is are we on the track for federal licensure?

BLOOD: Federal licensure? You mean universal licensure?

RIEPE: Yes.

BLOOD: It's my understanding that there is a senator in the body that is pushing that initiative. And that was one of the reasons--

RIEPE: At the federal level?

BLOOD: That's my understanding.

RIEPE: OK.

BLOOD: But that's one of the reasons I wanted to talk about it today in the interim study is that if we want to do things like that at the state or federal level, we just need to make sure that interstate compacts, be it state or federal level, bills are excluded from that.

RIEPE: OK.

BLOOD: Because we can have more than one tool in the toolbox and we can all get along and sing Kumbaya if we want, right?

RIEPE: OK. Thank you, Mr. Chairman.

HANSEN: Yes. I may have one question. I should have asked this of CSG when they were up here. So when we do all these compacts or other states have done all these compacts, is there data that shows that there is, like, the intention is being met?

BLOOD: Uh-huh.

HANSEN: Like, is there more safe-- is the safety, the quality of care, greater accessibility?

BLOOD: Yeah--

HANSEN: Like, that's the intentions of these compacts? Is that actually-- does that actually happen in the states that enact these compacts?

BLOOD: Yeah. To be really frank, if they weren't getting positive results, they wouldn't have done more compacts. The DOD didn't say, oh, I have this giant pot of money. Let's do as many as we can.

HANSEN: Sure.

BLOOD: They, they, they started doing them. They saw success and they track those metrics. And so it is the Military Families Office through the DOD that works on these compacts. You can talk to Daniel Logsdon at CSG or Matthew Shafer, who is the interstate compact guru now. There's a lot of resources you can get this data. But let's be frank. They, they wouldn't have done more than one if they hadn't achieved success with that first one.

HANSEN: Sure. You're asking me to trust government now here, you know that? [LAUGH]

BLOOD: No. I'm, I'm asking you to trust me. I'm asking you to trust the industries that have participated in it. Yeah, I don't trust government either and I'm a government official so.

HANSEN: And it makes sense. I'm just curious, like, to what extent it does. And--

BLOOD: Yeah.

HANSEN: --maybe some do better than others. I'm just kind of curious.

BLOOD: I mean, I didn't mean to minimize that, but, I mean, again, let's be frank. They're not going to put money, oh, maybe they would, but the industries wouldn't keep coming on board and wanting to do this unless it had been successful in previous industries.

HANSEN: Sure. That makes sense. All right. Seeing no other questions.

BLOOD: All right.

HANSEN: Thank you very much.

BLOOD: Thank you. I hope you have an enjoyable afternoon with the rest of your hearings.

HANSEN: All right. Thank you. All right. Well, that will close the LR132, LR232 and LR233 for today. And next up, we have-- let me get my notes here. All right. Next up, we have LR190, and we will welcome up Senator Fredrickson to open. Welcome to the HHS Committee.

FREDRICKSON: Welcome to the HHS Committee. Should I go?

HANSEN: You can begin whenever you're ready.

FREDRICKSON: All right. Good afternoon. Thank you, Chair Hansen and members of the Health and Human Services Committee. For the record, I am John Fredrickson, J-o-h-n F-r-e-d-r-i-c-k-s-o-n, and I represent District 20, which is in central-west Omaha. I'm happy to be here today to introduce LR190, which is the first of two interim studies I'm going to be introducing today. LR190 is a study examining how to better streamline communications on rules and regulations-- regulation changes proposed by the Department of Health and Human Services

relating specifically to Medicaid. So I have heard from numerous providers that processes in place by the Department do not always provide adequate transparency to allow stakeholders to compare rules and regulations with changes that have been proposed. So I was asked to bring this interim study to look at ways in which processes can be improved. I did reach out to Director Bagley and invited him or someone else from DHHS to come and testify today. Unfortunately, they have informed my office that they will not be testifying at this hearing. I do understand from other discussions I've had with other DHHS officials that they are taking steps to try to improve this process. They did provide some materials to my office late yesterday, but unfortunately, we did not have an opportunity to discuss these materials with them. It looks as though they are scheduling a number of meetings so I am encouraged by that. It is my hope that we can-- that we can connect stakeholders directly impacted with-- by these issues with DHHS officials sometime after this hearing and allow everyone an opportunity to discuss the process and make it a bit more transparent. I will let the testifiers we have lined up today talk to you a little bit more about their own experiences. But in preparation for that, I did want to pass out a few examples of hearing notices, hearing comment sheets, and summaries sent after the hearings. This may be helpful to you as the testifiers discuss the issues they are having. The first document in your packet is an example of draft changes as you will see marked in the upper left-hand corner of the document. The second document shows effective changes to the same regulations as you will see in the upper left. The third is a hearing summary sheet for the same regulations. I'm also going to read an excerpt from a letter provided by the Nebraska Medical Association for this hearing, which I believe sums up some of the issues we're seeing. Quote, One of the areas where the NMA sees opportunity for the state to improve communications and transparency is during the rule drafting period. Often, the public may not be aware a regulation is being proposed, amended, or repealed until the agency publishes the draft rule and notice of hearing, which is required 30 days before the hearing. While the public hearing is an opportunity for the public to comment on a proposed regulation, it often feels as though this comment period is too late to meaningfully influence the rulemaking. The Nebraska Secretary of State's webpage on regulation process acknowledges that, quote, It is difficult to significantly change a regulation once it has been set up for a hearing, unquote. Providing enhanced notice of opportunity for comment during the rule drafting period would promote transparency and meaningful public participation in the development of rules and regulations, end quote. Stakeholders

say that it would also be helpful for the agency to provide more narrative about proposed changes and rationale early in the process and to provide information on changes that may be adopted after public input. Since these regulation and rule changes impact so many lives, I think we can all agree that the-- they need to be handled in a way that allows the public to understand what is happening so they can weigh in and provide the best possible feedback to the department. I hope today's hearing will shed some light on this issue, and my hope is that DHHS will take the information we learn today into consideration as they strive to improve this process. With that, I'd be glad to take any questions you may have or ask those behind me to respond.

HANSEN: Thank you for that. Are there any questions from the committee? Yes, Senator Riepe.

RIEPE: Thank you, Chairman. Thank you, Senator, for being here. And I admire your motivation to take on the Medicaid delivery. That-- it's never an easy task to go against the bureaucracy, if you will. So I'll be interested to learn more and to follow accordingly. I have a great interest in Medicaid.

FREDRICKSON: Thank you, Senator Riepe.

RIEPE: I guess that wasn't a question, was it?

FREDRICKSON: I appreciate your comments.

HANSEN: All right. Any other questions from the committee? All right. Seeing none, you're staying to close for this I assume?

FREDRICKSON: Absolutely.

HANSEN: All right, good. OK. So with that, we do have three invited testifiers and we'll take the first one. Lori Scharff by-- from Boys Town. Welcome.

LORI SCHARFF: Hello. Good afternoon. Chairperson Hansen and members of the Health and Human Services Committee, my name is Lori Scharff, L-o-r-i S-c-h-a-r-f-f, and I am here today on behalf of the Nebraska Association of Behavioral Health Organizations. We represent over 50 community mental health and addiction provider organizations, regional behavioral health authorities, hospitals, and consumer organizations. We would like to thank Senator Fredrickson for introducing this resolution and the committee for getting it on the schedule. NABHO has

a long history of dealing with overly burdensome and prescriptive regulations that do not improve patient safety or quality of care. Often these regulations conflict with the Joint Commission, which is the major accrediting body in healthcare. The process to make or revise existing regulations has not been collaborative and transparent. Rather than spending time recounting the problems of the current system, let us suggest a road map to a new process. Section 1, HHS identifies the need for new regulations or revised regulations. HHS contacts the affected providers at the beginning of the change process. We have numerous professional and other healthcare associations that would like to provide early input. Using the associations to gain early insight into how a change will affect patients and/or providers is critical. In many circumstances, these associations can help assess whether the change will have the desired effect and what unintended negative consequences may occur. Many of our NABHO providers are more than willing to provide this input. Section 2, process needs to define exact language being changed from current regulations. We have proposed and have used a process in the past that demonstrates the exact language that is being changed. There's a-- an attached model example to what I handed out. We recommend that HHS considers using this model to help facilitate transparency and communication. In this model, the columns outline the current regulation, proposed language, and a request for clarification to include deletions, additions, and edits. This model also helps to define the reason and rationale behind the change. For instance, is it for clarification? Will it provide simplification? How will it affect safety and quality? Will it result in an unfunded mandate? Or is the department going to increase the relevant provider rate to offset any additional cost? Will it be less prescriptive? Often the newer change in regulation is overly prescriptive and impedes innovation, effectiveness, and can drive up costs. If the rules and regulations are being changed for federal reasons, where are the specific federal requirements? Where can these requirements be found? The current analysis of the regulatory changes only focuses on the cost impact on state government agencies. This is a fundamental failure of the current process. This analysis example may be expanded to include financial impact on families or patients, financial impact on providers. Will this change affect access? Will the change affect the type of providers providing this service? Are there other operational impacts? Are there unintended consequences? How will the change be monitored and/or enforced? Impact on provider accreditation; the time frame for reviewing the proposed regulations. We believe the hearings and comment periods are posted at least 30 days prior to the hearing.

But please understand that there are impacted stakeholders who are not always aware of those notices. Posting information as to how to sign up for those comment periods would ensure all impacted stakeholders understand what they need to do to stay informed. The opportunity to communicate is critical. For two-way communication on complex matters, we are requesting 30 days as a minimum for timely review. The need for HHS to consistently engage in active communication to provider and patients of new or changed regulations. Consistent active communication to include communicating the proposed change and why the change is necessary and critical for success. Some providers are distrustful of HHS because they fail to communicate the what and why. There may be a simple explan-- explanation on some changes, but the why is not shared. When the department simplifies or delegates regulations, they need to take credit for their efforts and we need to offer our thanks. Next steps. In summary, NABHO has had many years of experience with overly prescriptive regulations that have unintended consequences and have created unfunded mandates. We would suggest the following next steps. HHS leadership calls a meeting of the major stakeholders to discuss alter-- alternate processes. If there is agreement, then there should be a simple and short report back to this committee. If not, then we can work with members of this committee to create a revised process to fix the broken parts of the current processes. NABHO is very appreciative of the committee's time today, and we stand ready to help improve Nebraska's healthcare. Please let me know if you have any further questions. Thank you.

HANSEN: Thank you. Are there any questions from the committee? Yes, Senator Riepe.

RIEPE: Thank you, Chairman. My question will be is, and I think we had something I want to say. It was around the Scottsbluff area where they wanted some flexibility in terms of how to use their resources because they had a particular case or something and they were unable to do that. So my question is this. Will this make us more nimble in meeting individual and agency needs?

LORI SCHARFF: I think that's the intention, just to eliminate that confusion, the burden, the intimidation that sometimes can occur when you see regulations that maybe don't make sense, being able to collect information from association and stakeholders to better understand how, how these regulations can impact the work that we do.

RIEPE: OK. Thank you. Thank you, Mr. Chairman.

HANSEN: Any other questions? Yes, Senator Walz.

WALZ: Thank you. Thanks for coming. Can you talk a little bit more about the 30-day, the timeline or the time frame for reviewing the proposed regulations, the process? Because you mentioned 30 days and then you mentioned that you would like to see 30 days. So can you just kind of explain that?

LORI SCHARFF: Yes. Thank you for asking for clarification on that. It-- we've heard from some of our providers in our association that it's sometime-- it seems at times that whether it's that it's the providers not knowing, you know, maybe timely notification of those postings. And so we feel that we're behind in being able to have thorough conversations with the organizations that we support or that it's just being able to understand the access to when it has been maybe posted on the website or when those listservs come out. We just want to ensure that there's just clarity in is there enough time? If it's 30 days, if it's under 30 days, if there's a shorter time from that or a longer time from that, just really kind of clarity in that so that everybody has the ability to bring it back to their teams and have those really thorough conversations.

WALZ: Thank you.

HANSEN: Any other questions? All right. Seeing none, thank you much.

LORI SCHARFF: Thank you.

HANSEN: We'll take our next testifier, Angie Ling with the Nebraska Hospital Association.

ANGELA LING: Good afternoon, Chairperson Hansen and members of the Health and Human Services Committee. My name is Angela Ling, A-n-g-e-l-a L-i-n-g, and I am the senior director of hospital preparedness and regulatory improvement for the Nebraska Hospital Association. NHA thanks Senator Fredrickson for introducing the interim study, and we appreciate the opportunity to provide testimony for LR190 regarding streamlining communication on rules and regulation changes proposed by the Nebraska Department of Health and Human Services. Many of the rules and regulations apply to our hospital. And while we do our best to understand the changes, there are many ways we could improve communication understanding during a regulatory change. There have been various process iterations over the years communicating new rules and regulations. A few years ago, DHHS changed

regulations for just one chapter, reducing it from approximately 150 pages to 60 pages with no list of changes provided. We had to go through each page, line by line and determine what was changed, eliminated, or added. It was an extremely time consuming task. Most recently there was a review completed by DHHS and a red-line version of the document was published for review and comment. Much of the document had been moved to a different chapter but the changes were not word for word. Also, in this specific review, there were many paragraphs red lined, but the new verbiage was stated a few pages later. Those documents are incredibly difficult to review and understand what is new, old with edits, and/or completely eliminated. Title 175 Chapter 9 of the Nebraska Administrative Code had a simple word change that-- that would have made social work nearly impossible in rural areas by changing the old verbiage, quote, Social work services provided are to be directed by a certified social worker, end quote, to the new verbiage of, quote, Social work services provided are to be directed by a master's degree prepared social worker, end quote. While this may seem like a small change in terminology, it would have been detrimental change for rural Nebraska. There are multiple ways that we can improve these processes, and I appreciate that DHHS spends many hours working on these revisions. There are associations and stakeholders who would be more than willing to assist the department in these initial reviews to help provide up-front subject matter expertise. Allowing early collaboration with-- will help the department preempt inadvertent complication of rules and regulations. Many large organizations use a matrix to help track the changes. I have included a copy with my printed comments on the second page. In short, it outlines the location of the information in the document, shows the old verbiage, recommended new verbiage, and the reason for the change. Allowing this information to be outlined in a standardized format with rationale attached will allow any reader reviewing the material to understand the changes and rationale leading to the change. The Nebraska Hospital Association would be happy to continue conversations on ways to work with DHHS to assist in simplifying rules and regs and utilizing the extensive network of expertise Nebraska possesses. Thank you for the opportunity to discuss this important issue today and I will take any questions.

HANSEN: Thank you. Are there any questions from the committee? I might have one. So--

ANGELA LING: OK.

HANSEN: And this has been brought up in previous testimony. Is there a lot of concern with your ability to get notified of a change?

ANGELA LING: So--

HANSEN: Or more like the process after notification?

ANGELA LING: So when the notification comes out, you have to a lot of times be subscribed to the notification process. And that's how-- that's how I get notified or advocacy team will get notified and then the process starts. We have for the Nebraska Hospital Association, we have a regulatory improvement advisory council that I help facilitate in its member hospitals. And once we get notified of those changes, we talk about it at our advisory council and we try to do as-- have as many eyes on it as possible to do a review. But again, you know, looking through different areas, bigger hospitals have their eyes on very different things. And rural hospitals a lot of times have their eyes on different subjects. So it is difficult if you don't-- even 30 days is very difficult to get through these large documents to understand what truly is changed. And if it was streamlined and understood a little bit better of where this rationale is coming from, was it actually changed or did it just get delayed a little bit in the document and now it's just being restated, those will help allow us to maybe meet that 30 day of, of review.

HANSEN: All right. Thank you.

ANGELA LING: Any other questions?

HANSEN: Seeing no other questions, thanks for coming, appreciate it.

ANGELA LING: Thank you so much.

HANSEN: And there she is. OK. And we have one more testifier, Sarah Maresh with the Nebraska Appleseed. Welcome back.

SARAH MARESH: Thank you. Chairperson Hansen and members of the Health and Human Services Committee, my name is Sarah Maresh, S-a-r-a-h M-a-r-e-s-h. I'm the healthcare access program director at Appleseed testifying on behalf of Appleseed. We're a nonprofit legal advocacy organization, and one of our key priorities is ensuring that all Nebraskans have access to quality, affordable healthcare. And the key piece of that work is ensuring that Medicaid works well for those over 370,000 Nebraskans that rely on this program for their healthcare. I'm testifying on LR190 today to discuss, discuss opportunities for our

state to improve Medicaid state regulatory processes, to increase accessibility and transparency. At Appleseed, we oftentimes have a little bit different perspective when we review regulations. We review them more from a law and policy perspective instead of a provider perspective, just for reference. And while there have been some positive changes made to the Medicaid regulatory process in recent years, we still see opportunities for improvements. Many folks before me have already testified to some of these. First, it can be difficult for people to know when those proposed regulatory changes are up for comment. People do have to subscribe to a specific website or websites to get information about those proposed regulatory changes, and those websites are difficult to find and are really only there if you know where to look. It would be helpful if the proposed regulations were posted in a more prominent place so everyone's easily able to see the regulatory changes that are being proposed when they're notified. Second, the current regulatory process doesn't provide a lot of information that's helpful about the actual changes being proposed. Typically, when regulations are proposed, the posting includes a general description of the regulatory changes and includes a document that actually shows the regulatory changes. And there are opportunities to improve both pieces of that process. First, the general descriptions don't provide much guidance as to what is actually being changed, and they're pretty vague. And so it would be helpful if the explanation at the beginning of those regulatory sections consistently listed the specific substantive changes that are being made. Additionally, it would also be helpful if the proposed regulatory changes that actually show the changes to the document are made more clearly and consistently. So currently, and I provided some examples just attached to my testimony, currently DHHS uses markups or red lines, like others have referred to, to show the proposed regulatory changes, but these really have varied in quality. At times, DHHS will include a markup or red line that shows the exact changes that are being proposed by showing which words will be eliminated and which words are being added. And this is incredibly helpful and makes it really clear what changes are being made. However, DHHS doesn't always take this approach and at other times it doesn't show which specific changes are being made, but rather just completely strikes out a section that is being revised and notes that it is being modified in another section. And that's something that other folks have spoken to before me. And that just makes it really difficult to understand what changes are being made and requires people to spend significant time going through and comparing where the changes are line by line to understand that. And if you take a look at the

attachments that I included on the back of my testimony, the first page, if you flip to the front and back, shows what I would call the good version of the red line. And so you can see, especially on the back, it actually includes very specific strikeouts as to what's being modified and what is being added so it's very clear. But the second example was also-- and these both are just two examples that were taken in the last, like, couple of months so these aren't like long time frames we're seeing here. But these sections here on the second page attached to it, where it includes a large yellow highlight, shows kind of the, what I would call maybe the bad version of the red lines where it doesn't really show the exact changes being made, just notes it's being modified. So we think one way to improve these processes is just to consistently use the red lines that show these exact changes that are being made so people can track those more easily. And finally, Medicaid has had a recent practice of adding an additional opportunity at times to comment on some proposed regulations through what they call an informal comment period, which we really appreciate. However, the time to submit those informal comments is usually really short, like about a week or so, and gives people little time to review and offer feedback. And so we'd suggest an informal comment period that's more clearly posted and also gives extended time for people to give that feedback and for DHHS to incorporate that. We know regulations are key to understanding Medicaid and ensuring that the process is transparent and is accessible as possible. It's really important to make sure people are aware of their rights. So by prominently posting regulatory changes, improving the quality of the descriptions, using the good red lines and extending and using informal comment periods more consistently, DHHS can really make great strides to improve accessibility and transparency in the process. Thank you and I'm happy to answer any questions.

HANSEN: All right. Thank you. Are there any questions? Senator Riepe.

RIEPE: Thank you, Chairman. You mentioned quite often about the red lines.

SARAH MARESH: Yeah.

RIEPE: And my question would be is, has that been suggested that then inconsistently? Because I don't think it's something that we can legislate that mandates that red lines must be there but.

SARAH MARESH: Yeah, that's a great question. So it's my-- a little historical perspective. It's a little before when I started to enter

into this world. But it's my understanding that in the past there was absolutely no red lines that were provided or it maybe happened really inconsistently. And I think about five years ago they started doing some of these like red lines where they were showing markups to some of the regulations. And so I think you can see here and I'm guessing that was based off of stakeholder feedback, but I just wasn't around to confirm that. They just do vary quality right now. And so I think that's something where if it's consistently done, that would really improve the process if they use kind of the good format for that.

RIEPE: At your young age, have you ever known when they didn't red line or have that ability?

SARAH MARESH: Have I known? I'm sorry, what was that?

RIEPE: At your young age, have you ever known a time when they couldn't red line?

SARAH MARESH: When they couldn't, no.

RIEPE: Because the technology wasn't there?

SARAH MARESH: No, no. And I-- at the law firm I worked for before this, we had red line software that was very handy and easy to review changes for that was really handy in reviewing contracts and things like that so.

RIEPE: Now into the good days.

SARAH MARESH: Yep, the handy software. I remember the names of it, too, if they-- if DHHS wants suggestions.

RIEPE: Thank you. Thank you, Mr. Chairman.

HANSEN: Yep. Any other questions? Senator Walz.

WALZ: Thank you. You talked a little bit about the websites. How do people even know what website they're supposed to subscribe to? And then can you give an example of a more prominent place?

SARAH MARESH: Yeah, that's a great question. So there are, if you, like, search the Secretary of State's website, you can subscribe to, like, regulatory changes there. And then there are, like, HHS landing. It's like a landing page that just talks about all of their proposed regulatory changes. And then if you want to subscribe to the informal

Medicaid comment periods, you have to subscribe to a different web page to get notice of the informal Medicaid comment period that I talked about at the end here. And so I think people, I mean, I think people in the industry definitely know, you know, the providers are really on top of it and know where to subscribe. But I think unless you know where to look, you probably won't stumble upon that. And I think there could be a lot of different places people can, you know, more prominently have that posted. One example could be some of, like, the Medicaid landing pages or having, you know, specific banners come up when there are key regulatory changes being made for folks. So I think there's a lot of different ways, and I'm sure a lot of other stakeholders would have some great ideas on that too.

WALZ: Great. Thank you.

HANSEN: Yeah, I believe on-- I think Angie alluded to this on the Secretary of State's page there's rules tracking system that they have in place that-- and you can sign up for email alerts. So whenever they do change something, you just get an email. So it's on the Secretary of State's page.

SARAH MARESH: Yep. Exactly.

HANSEN: All right. Seeing no other questions, thank you for coming. Appreciate it.

SARAH MARESH: Thank you so much.

HANSEN: All right. Well, we will welcome up Senator Frederickson to close if he wishes to.

FREDRICKSON: All right. So I'll keep my close fairly brief. I want to just thank the testifiers, everyone who came here today and the time out of their schedules to testify and to educate us on this. So my intention with this interim study was really to bring a little bit more awareness to some of the issues we're seeing in this area. And my hope is to pursue the least invasive way to improve this process. So, you know, that-- that's kind of the hope of the outcome, as I mentioned in my opening, is really that some of the stakeholders and DHHS can get together and come together to talk about ways that this could potentially be improved. And hopefully we'll see some progress there. So I'm happy to answer any additional questions folks might have.

HANSEN: Thank you. Are there any questions from the committee? Senator Riepe.

RIEPE: John, I have a quick question. Is it your intent to talk with the new incoming CEO of HHS prior to the next session?

FREDRICKSON: I think it would be wise. I think it'd be good to meet together, yeah.

RIEPE: I applaud you for doing that. Thank you very much. Thank you, Mr. Chairman.

HANSEN: All right. Seeing no other questions, thank you for your close. And so with that, we will end the hearing for LR190. And then we will open the hearing for LR202 and welcome back Senator Fredrickson to open.

FREDRICKSON: Thank you. All right. Good afternoon again. Thank you, Chair Hansen and members of the Health and Human Services Committee. For the record, I am John Fredrickson, J-o-h-n F-r-e-d-r-i-c-k-s-o-n, and I represent District 20, which is located in central-west Omaha. So I have to say I am actually super, super excited to be here today to introduce LR202. This has been a bit of a passion project for me this summer and during this interim period. And LR202 is an interim study to examine the mental and behavioral healthcare needs of Nebraskans. So through this study, I seek to determine the severity of shortage, of the shortage of mental health providers that we have in our state, as well as resources to evaluate potential best practices and increase access to mental health and behavioral healthcare statewide. So Mental Health America released a report earlier this year that ranks Nebraska 44th in mental health, meaning that we have a higher prevalence of mental illness coupled with lower access to care in our state. When looking at only youth, Nebraska ranked 49th in this study. According to recent data from the National Alliance of Mental Health, more than 257,000 adults in Nebraska have a mental health condition, and one in six U.S. youth aged 6 to 17 experience a mental health disorder each year. The crisis is real. The impacts of this crisis are everywhere and the need and for a number of reasons, people are not accessing the services that they need. Unsurprisingly, one of the issues hindering our ability to meet the mental health demand is workforce. Nebraska has made improvements in the number of providers as testimony today from the Behavioral Health Education Center of Nebraska will show. But there are disturbing geographic trends coupled with an aging mental health workforce that we're seeing as well. We

need to look at the implications of these numbers, identify what barriers are here, which barriers are in place, a strong mental health workforce pipeline, and create and enhance the proper incentives and educational opportunities to meet the needs of all Nebraskans. One of the other major issues is how we build upon existing successes in our mental health infrastructure and create new touchpoints for access. Several providers will be here today to discuss some of these infrastructures. I'm particularly interested in what the data shows on the 988 suicide crisis text crisis line, which is a year in at this point, and how we can build upon that framework and also the possibilities that are before us with the advent of certified community behavioral health clinics, which we passed into law earlier this year. Of course, much of what we must do is address the cost barrier. According to the National Alliance of Mental Illness, more than 40 percent of adults in Nebraska who did not receive needed mental healthcare did not do so because of cost. In addition to availability, access to cost, mental health stigma also continues to be a significant barrier. This is particularly true among vulnerable populations, including farmers and ranchers. There are nearly two-- farmers and ranchers are nearly two times more likely to die by suicide in the U.S. compared to other populations, according to the Center for Disease Control and Prevention. There are also unique challenges related to other populations as well, including our long-term care community. Some of that will also be covered here today. I have also introduced a companion study to LR202, which is LR201. LR201 is in the Judiciary Committee and it is a study that looks specifically at mental health in our criminal justice system. While we will not be exploring this here today, the extent to which we can address some of the foundational issues of mental health will have enormous benefit for law enforcement, for our correctional institutions, and for the individuals that they serve. Our prisons should not be our largest mental health providers. As a mental health professional myself, I have seen many of these issues firsthand. The struggle is real and we must do more. Never before has this been more important. And I think in Nebraska, we have been uniquely privileged to have a lot of private and public partnerships, specifically as it relates to behavioral health and mental health. And I've recently been meeting with some of the private philanthropists and have been blown away by some of what they've done. But I also think that this is a time that as a state, we also need to step up and meet that need as well. I will end this introduction by saying that we have a strong slate of stakeholders here today to testify. I hope today's hearing will help set the stage for the Nebraska Legislature to move forward

on a strong mental health agenda next session. And with that, I'll be glad to take any questions you may have. Right in time, Senator Riepe.

HANSEN: Thank you. Are there any questions from the committee?

RIEPE: I could ask what'd I miss?

HANSEN: I'll ask one question, though. You give a statistic at the beginning of your opening that we're 44th in the country when it comes to mental health. I think it's a, I can't remember the exact statistic.

FREDRICKSON: Yeah.

HANSEN: Was that before the introduction and the passing of Senator Wishart's LB276, that community behavioral health center, the big bill we did last year?

FREDRICKSON: Yes. The CCBHC bill. So--

HANSEN: What kind of change where we're at statistically with other states, that was a big bill.

FREDRICKSON: Yeah. So NABHO will be here today to talk about where we are with CCBHCs and sort of how that is unfolding in infrastructure. There's a lot of promise with that to be frank with you. I'm, I'm thrilled that we passed that bill. I think that was one of our big successes as a Legislature last year. And so, yeah, I think things like that are going to take some time to sort of go into place, go into effect to see impact. The statistic I cited was specifically kind of looking at the prevalence that we see of mental health conditions in our state coupled with sort of access to care. Right? So how-- I'm kind of taking that into consideration.

HANSEN: All right. Senator Ballard.

BALLARD: Thank you, Mr. Chairman. Thank you for being here, Senator. So in observing, we probably can all agree that mental health is an issue and each-- each organization has a different path forward. So from your experience in your research, have you seen collaboration between nonprofits, government, private sector, or is all decisions come in a silo and then-- and then kind of distribute from that?

FREDRICKSON: It's a good question. I mean, I think sort of whenever you're tackling any issue, I think obviously having collaboration

across all interested stakeholders is, is extraordinarily important. You know, I-- I'll speak specifically to Omaha. I think one thing that we've been fortunate, fortunate for of in Omaha is that we have had a lot of collaboration between the private industry and the public. We've seen a lot of private/public partnerships. An example of this is the new behavioral health hospital that's being built through Children's. That's been done a lot through private philanthropy, which is really kind of enabling that to exist. And so I think if we can continue to see more collaboration. One thing that I've noticed is and this is just kind of anecdotal, but in conversations I've had with folks both, you know, just constituents and neighbors and other parents and kids school to also just the stakeholders in the community, there's, there's a universal agreement that we need to be doing more surrounding mental health.

BALLARD: Thank you.

HANSEN: All right, seeing no other questions, we'll see you at the closing.

FREDRICKSON: You'll see me at the close.

HANSEN: All right. So we will start the list of invited testifiers with Annette Dubasl with the Nebraska Association of Behavioral Health Organizations. Welcome.

ANNETTE DUBAS: Good afternoon. Good afternoon, Senator Hansen and members of the Health and Human Services Committee. My name is Annette Dubas, A-n-n-e-t-t-e D-u-b-a-s, and I am the executive director for the Nebraska Association of Behavioral Health Organizations, otherwise known as NABHO. We represent 57 organizations, including community mental health and substance use disorder providers, the regional behavioral health authorities, hospitals, and consumers. We sincerely thank Senator Fredrickson for introducing LR202 and for your attention today. It really is important that we have this conversation and take this deep dive into what are the behavioral health needs of Nebraskans and determine what we need to do not only to support the existing system, but how do we ensure that it evolves to provide evidence-based care and treatment that is culturally inclusive? As with anything that you build, a strong foundation is critical. Without that, the potential is always there for the building or your system to crumble. For our association, our mantra is adequate rates, ensure the ability to build capacity, which in turn assures there is access to care. So as with any business, if your revenues do not cover expenses, it's

difficult to maintain services, let alone expand them. For those who provide healthcare, and especially behavioral healthcare, and rely on the public sector for compensation, these rates continue to be below the cost of providing services. I want to acknowledge that for the past several sessions, this Legislature has made provider rates a priority and we have seen steady increases each year. Without these increases, we would not have been able to weather the extreme challenges brought on by COVID and the higher than usual inflation rates. Please know that we are sincerely grateful for these rate increases and they have made an impact on providing care and supporting workforce. Attached to my testimony is a summary of a 2021 survey that we did related to workforce challenges and a 2022 member survey where the questions were focused on how were the services supported by the rate increases and the impact of high inflation. Not scientific surveys, just, just information from membership. And the responses also did indicate an appreciation for the rate increases. So while there are many things that we can do to support a sustainable behavioral health system of care, it continues to be our goal-- [RECORDER MALFUNCTION] that provide that strong foundation and it seems to me like the time is right to revisit the Division of Behavioral Health's rate study and consider developing a rate methodology that would support a sustainable, flexible funding mechanism for mental illness and substance use disorder services. Workforce is a challenge across all sectors, and behavioral health is no exception. The ongoing struggle pre-COVID has only been exacerbated. The National Council for Mental Wellbeing did a nationwide workforce research project in March of this last year, surveying 750 mental health and substance use disorder providers. The survey reflects what is happening in Nebraska as well. Nearly half of those surveyed say the shortage has caused them to consider other employment, even though they want to stay where they're at. Sixty-two percent are experiencing moderate to severe burnout. And of those surveyed, 82 percent are concerned about adequate reimbursement rates. I'll be happy to send you the link to that survey that goes into more detail. Through their research, they did identify some specific solution-oriented steps that have a federal focus, but I think that they can also be adopted to state policy initiative, including the CCBHCs that were-- that Senator Fredrickson brought up. That model is already showing that those clinics are able to hire an average of 27 new positions per clinic due to their ability to pay higher wages because they're getting a rate that actually covers the cost of, of services provided. Another key initiative through their, their research is to look at state actions that reduce burdensome

administrative requirements. A lot discussed in the previous LR. So much time is being spent by these providers on data reporting and different procedures for each managed care company. Some, some duplicative and it's taking away from patient care. Another area we can look at as well is our licensure process. Right now, there is a significant delay in getting provisional license applications through the process. We're hearing upwards of three months. And if these individuals aren't licensed, they aren't out in the communities providing care. So looking at that would be helpful as well. There is no single answer to how we ensure a strong and sustainable system of care for behavioral health. But if you look at the issues identified in this LR: workforce, integration, access to care, especially for underserved populations, adoption of best practices, and barriers, in general, they all have some connection to how we pay for services. If rates do not cover costs, it's very difficult to look beyond just what's being done to maintain. Rates are the bread and butter of every behavioral health providers' ability to provide care. Rates speak to and support every purpose of this resolution. So while we're watching the impact of CCBHCs, I believe they are showing us that if you take a community approach to providing a whole person care and then pay those providers for the actual cost of services, it's a win for everyone. Citizens who are mentally and physically healthy are better able to engage in their communities and schools in a positive manner. And we look forward to working with Senator Frederickson and this committee to find ways to continue support for mental health and substance use disorders in our state. Thank you.

HANSEN: All right. Thank you. Any questions from the committee? Senator Riepe.

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

ANNETTE DUBAS: Yeah.

RIEPE: As a sideline observer, my sense is that particularly in mental health and maybe more so in rural Nebraska there are more, if you will, leaders than there are followers, that there are a lot of mom or pop or rosy kinds of little operations which then make it very difficult. I recall that when we first introduced managed care to Medicaid, we had hues and cries of people that couldn't get billed because prior to that they would submit their bill they got paid. Now they had to get prior approval. And just the, the magnitude of the onesies, "twosies," and maybe that's what-- and maybe that's all there can be in smaller markets. I don't know. I'm an urban guy, obviously,

and but with some rural roots, if you will. But how do we address, how do we address-- because my concern gets to be is there is so many providers and as the old saying goes, everyone wants cooperation but no one wants to be cooperative. So how do we streamline this without having a total government takeover? That I don't want either. I don't know. I'm not sure that was a good question. I'm not even sure it was a question.

ANNETTE DUBAS: Well, it's, it's not a, not a question that has a simple answer, that's for sure.

RIEPE: That's correct.

ANNETTE DUBAS: That is for sure. And if there was a simple answer, we, we would have probably had it already. But you are right about especially in the more rural areas with our smaller providers. You know, we mentioned the administrative burden, you know, dealing with managed care companies. You've got, we're, we're-- in Nebraska, have three managed care companies who have three ways of doing things. And so if you're especially a small shop, you don't have a lot of extra staff, so you yourself are devoting the time to the authorizations and the appeals and the denials and all those other things. That adds costs to care and it impedes access to care as well. So as an association, we are always in conversation with the Division of Medicaid and with the managed care companies asking how, how do we help you help us, you know, do a better job and, and streamline and speed up, you know, payment. You know, I-- we're, we're having some conversations now. We have providers who are looking at 60, 90, and even longer delays in getting paid. You can't pay your bills if your revenues aren't coming in so these are ongoing conversations.

RIEPE: I think at some time we had suggested at least exploring a clearinghouse that maybe everyone would pay some hopefully nominal fee to get a concentrated group who does this on a daily basis and they know how to deal with managed care A, B, and C with some determination to get collections. I'm, I'm just--

ANNETTE DUBAS: Everything's worth a look.

RIEPE: I'm just an old recovering administrator, so.

HANSEN: Any other questions from the committee? All right. I have one quick question, I guess,--

ANNETTE DUBAS: Sure.

HANSEN: --I just thought of. It seems like a prevailing theme we have among healthcare organizations when they come to the state is, you know, increased provider rates, you got low repayment programs so more of the financial aspect of what the state can do to help them out. You mentioned a little bit about administrative tasks, you know, red tape, you know, rules and regulations. I think it's something we don't really-- it seems like we don't want to address as much as what can we do to help you get rid of rules and regulations to make your job easier, more enjoyable? You can actually see more patients per hour maybe, you know, be more effective, I guess. And it seems like, it seems like from a legislative perspective that's where we get more bang for our buck, I guess, instead of just addressing Medicaid as a small section or maybe not small and, you know, mental health but when we can now affect the rules and regulations affect all patients, I guess, from our perspective. Is there something in particular that you think is, like, one thing you wish the state would get rid of? A rule or regulation and you say, gosh, only got rid is this one thing, it's a lot less paperwork we have to do because I hear this a lot in hospitals and everything else. Is there anything [INAUDIBLE]?

ANNETTE DUBAS: There isn't anything that I'm aware of. I'm sure if, you know, a provider that comes up if you asked them that question but there are so many rules and regulations that picking one particular one. But I think it goes back to the previous LR, if we can engage earlier in the process to really help Medicaid or whoever we're working with understand this is the impact of that regulation and make it be a workable regulation before it's implemented, because then we spend a lot of time trying to figure out how do we help you [INAUDIBLE]? We have to live with this regulation now and it's costing us time and energy. So I think if we can figure out ways to engage sooner and be a more active part of the process, I think that could go a long way to saving money, streamlining processes, and making, making care the priority.

HANSEN: [INAUDIBLE]. OK. Seeing no other questions, thank you for coming.

ANNETTE DUBAS: Thank you.

HANSEN: All right. Next on the list we have Marley Doyle with the Behavioral Health Education Center of Nebraska.

MARLEY DOYLE: Hello.

HANSEN: Welcome.

MARLEY DOYLE: Good afternoon, Chair Hansen and members of the Health and Human Services Committee. For the record, my name is Dr. Marley Doyle, M-a-r-l-e-y D-o-y-l-e. I'm a psychiatrist and the director of the Behavioral Health Education Center of Nebraska or BHECN. And I'm appearing today on behalf of the University of Nebraska System. Thank you to Senator Fredrickson for inviting us to participate and bringing attention to this important issue. For background, BHECN is the state-funded Behavioral Health Workforce Development Center that is housed at the University of Nebraska Medical Center. Our mission is to recruit, train, and retain the state's behavioral health workforce in order to improve access to behavioral healthcare for all Nebraskans. According to our 2023 preliminary workforce data analysis, the behavioral health workforce has increased by 44 percent since BHECN's inception in 2009. This is great, but it's not enough, and there is still much work to be done. In your handout, there's a bookmark here that has a QR code that will give you more information about the status of the behavioral health workforce. And you can even get information by county about the number of providers in each area of the state. But I'll just give you a couple of highlights about pinch points that we're still feeling. So first of all, according to the Health Resources and Services Administration, Nebraska has only 48 percent of the behavioral health providers needed to adequately meet the need. And 88 of our 93 counties are considered mental health professional shortage areas. In addition, our workforce is aging. For example, in licensed alcohol and drug counselors, over 50 percent are over the age of 56. We also continue to see disparities between urban and rural areas, with urban areas outpacing rural in the supply of providers. This is especially true for psychiatrists and psychologists. So BHECN works with and is in close contact with behavioral health professionals across the state through many of our programs. But we've seen the need be exacerbated since the COVID-19 pandemic, and we've been in close contact through the dissemination of the Behavioral Health Workforce ARPA Awards. In 2022, BHECN received $25.5 million in ARPA funding to address workforce challenges related to the COVID-19 pandemic. With this funding, we instituted a competitive application and review process in order to disseminate the funds to all providers and organizations across the state. Since that time, we've awarded over 110 projects to behavioral health professionals and organizations, and 55 of those projects take place in rural areas. So we've learned a couple of things through this process. So one example that we've heard is that providers that

received awards are really surprised at the demand and the interest in their awards. So one of our award recipients is a rural community college, and they received funding to provide stipends to students receiving their alcohol and drug certification. They were shocked by the demand for these stipends, and many students would have been eligible for these awards had there been more funding available. And this is something that we've heard over and over again from the award recipients. They keep telling us that they could immediately use more funding to implement their projects, and they continue to be surprised at the demand for the projects, particularly in training and education. And we've seen this at BHECN as well. So when we announced the awards, we were inundated with applications. We received over 300 applications requesting nearly $75 million in funding for workforce projects. So obviously there is a great need for continued workforce development funding and programming throughout our state. So while the pandemic has waned, the impact and effect on the behavioral health of Nebraskans and the behavioral health professional community still has quite the impact. At BHECN, we will continue to work to address the disparities that we see in order to improve access but we know that we can't do it alone. And we appreciate your attention today and I'm happy to take any questions you may have.

HANSEN: Thank you for your testimony. Are there any questions? Senator Riepe.

RIEPE: Thank you, Mr. Chairman. Thank you for being here. I have a question, and I am looking at your handout here. Can you help me out with what is a prescribers and what is nonprescribers? Is that pharmaceutical prescriptions and is that all it is?

MARLEY DOYLE: No. So this, this terminology is, is basically to kind of try to separate out the behavioral health professionals that are able to prescribe psychiatric medications and then the ones that do not and just primarily do therapy. So in the prescriber category are psychiatrists, psychiatric nurse practitioners, and psychiatric physician assistants. And then in nonprescribers, we have counselors, we have psychologists, marriage and family therapists, drug and alcohol counselors. And so that's kind of how we separate them. And then we try to look at distribution and try to figure out what we can do to make sure that we have enough of each provider in all areas of Nebraska, so. It's, it's-- but there are, like I said, there are disparities, especially in the prescriber category in rural areas it's quite a challenge.

RIEPE: Having been in health administration for more years than I will confess to, I'm troubled by the fact that a nurse practitioner or, in essence, a physician assistant would have any prescription authority that wouldn't also be the authority of a psychologist, a qualified licensed psychologist within a scope of certain prescriptions. So, you know, I don't see a nurse practitioner, and I love them dearly, would be over a psychologist, a well-trained psychologist. That's just an issue that I have. And I think that plays to the supply and demand in terms of patient access and how patients can be treated. So just more of a comment, you're, you're welcome to respond.

MARLEY DOYLE: Yeah, I mean, other states have looked into that as a workforce strategy as well, so.

RIEPE: Less progressive states?

MARLEY DOYLE: There's been a few, I mean, but yeah, I know that that's definitely when we-- when you hear about people kind of putting out new ideas that definitely is something that has been floated and other states have looked into. Yeah.

RIEPE: OK. Thank you.

MARLEY DOYLE: Um-hum.

RIEPE: Thank you, Chairman.

HANSEN: Any other questions from the committee? I just have kind of a broad question, maybe a statistical question.

MARLEY DOYLE: OK.

HANSEN: Has the use of psychiatric medications for treatment gone up every year--

MARLEY DOYLE: It's, it's--

HANSEN: --even pre-COVID?

MARLEY DOYLE: --it's really hard to study that because the demand for services has gone up since COVID. So we're seeing more alcohol use. We're seeing more depression, more anxiety. So there is a, like, a higher demand for services and then treatment. So it's hard to say whether that's because-- like, it's, it's hard to know what came first. But I don't think-- there isn't anything that I know of that's

unrelated to the demand. So I am not aware of any data that says that prescribing rates have just gone up just for no reason, you know, it's, it's always tied to the demand.

HANSEN: OK.

MARLEY DOYLE: Yeah.

HANSEN: Just curious.

MARLEY DOYLE: [INAUDIBLE]

HANSEN: Thank you.

MARLEY DOYLE: Yeah.

HANSEN: Seeing no other questions, thank you for coming to testify.

MARLEY DOYLE: Yeah. Thanks.

HANSEN: All right. We'll take our next testifier and that will be Michelle Nunemaker, Nunemaker with DHHS Division of Behavioral Health. I knew I was going to butcher that name. Welcome.

MICHELLE NUNEMAKER: Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Michelle Nunemaker, spelled M-i-c-h-e-l-l-e N-u-n-e-m-a-k-e-r, and I am a system of care and 988 Nebraska administrator for the Division of Behavioral Health at the Nebraska Department of Health and Human Services. I'm here today to provide you information on the 988 Suicide and Crisis Lifeline. In 2020, Congress designated the new 988 dialing code for the National Suicide Prevention Lifeline with expansion to include access to a crisis line for any behavioral health issue. After a year of collaborative planning with stakeholders, including persons with lived experience, 988 Nebraska went live on July 16, 2022. Nebraska has one call center in Omaha with services provided by the Boys Town National Hotline. Boys Town was the previous call center for the National Suicide Prevention Lifeline. Vibrant Emotional Health administers the national line and 988 calls are first answered through Vibrant's automated recording. Calls are routed to call centers based on the caller's area code. The Federal Communications Commission has not approved the use of geolocation for 988 calls. If a caller lives in a state different than their area code, the call center still assesses the safety of the caller and then warm transfers the caller to appropriate call center. So, for example, if someone has a Nebraska

area code of 402, 308, or 531 and they now live in Arizona and they call 988 they will be routed to the 988 Nebraska call center and will be assessed for safety. And then if appropriate, they will complete a warm transfer to the appropriate call center in Arizona. During the 2021 calendar year, the Suicide Prevention Lifeline in Nebraska received 8,777 calls. Call volume for 988 Nebraska was forecasted based on this data, and although there was an expectation of the call volume increasing there was a significant increase with 988 Nebraska receiving 18,300 calls in its first year of operation. A 90 percent answer rate was set as the goal during the implementation planning and the average answer rate was 95.53 percent, 988 Nebraska also answers text and chats to 988 and the goal answer rate was 80 percent for chat and text with a total digital chat and text answer rate of 88.3 percent. The top three reasons people identify for contacting 988 are suicidal ideation, anxiety, and ongoing support. Usually frequent callers use 988 as a coping mechanism. The top three age ranges using 988 are 18 years and younger, 30- to 39-year-olds, and 60- to 69-year-olds. These age groups align with the top three age groups at risk of dying by suicide. The majority of callers are in the Omaha and Lincoln geographical areas. Boys Town crisis counselors can triage, de-escalate, and make referrals for further services and support doesn't stop after the phone call. In the first year, crisis counselors managed 96.3 percent of calls to Nebraska 988 without incidence. Of the remaining 3.7 percent of calls, crisis counselors contacted emergency services or mobile crisis response teams to check on a caller's safety. Mobile crisis response teams include licensed mental health professionals who provide in-person or telehealth risk assessment and assistance and is a voluntary service offered to callers who are in crisis. The Department of Health and Human Services Division of Behavioral Health contracts for mobile crisis response through regional agreements. In summary, implementation has been successful. It is too early to determine the overall impact of 988 Nebraska, but preliminary data and unsolicited feedback from callers indicate that 988 Nebraska is helping people struggling with suicidal ideations or resolving a behavioral health crisis. I have provided you a copy of the 988 Nebraska fiscal year '23 report, 988 Nebraska is providing a vital resource to Nebraska. Thank you for your support of 988 Nebraska and for the opportunity to be here today. I would be happy to answer any questions.

HANSEN: Are there any questions from the committee? Got a question, I guess, if you can answer, maybe you can or can't, you have on one of the pages here monthly phone service levels. Does that-- is that using

indicative-- I know we only do this for a year, right, I think, so, and I know it's hard to tell, like, yearly trends because I've always heard that during the spring for some reason people typically tend to have more suicidal thoughts. I think it's because other people are getting out and they stay in their home. I know it's just something weird about the spring and it seems to follow a pattern and you have here with amount of calls presented. Is, is, is that kind of follow the trend nationally, typically, do you know?

MICHELLE NUNEMAKER: I'm not 100 percent positive on that one. I'd have to check on that and get back to you.

HANSEN: Cool, just kind of wondering. Yeah.

MICHELLE NUNEMAKER: Yeah.

RIEPE: I think it might be tax day.

HANSEN: That's true, yes, April was pretty high. All right. Any questions from the committee just to make sure? All right. Seeing none, thanks again for coming. Appreciate it.

MICHELLE NUNEMAKER: Thank you.

HANSEN: All right. So with that, we will take our next testifier Kyle Kinney from Boys Town. Welcome.

KYLE KINNEY: Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. For the record, my name is Kyle Kinney. That's K-y-l-e K-i-n-n-e-y. I'm the manager of the Nebraska Family Helpline and the 988 Nebraska Suicide and Crisis Lifeline at Boys Town and a licensed mental health practitioner in the state of Nebraska. I'm here today to provide some information regarding the trends that Boys Town has seen in need for mental health support of Nebraska youth and families. First, Boys Town would like to thank Senator Fredrickson for introducing LR202 and for his commitment to the health and well-being of Nebraska's children and families. As I understand it, this resolution seeks to do three things: examine the mental and behavioral healthcare needs of Nebraskans, determine the severity of the shortage of mental and behavioral healthcare providers, services, and resources in Nebraska, and evaluate potential best practices to increase access to mental and behavioral healthcare. Boys Town provides an array of quality, physical, mental, and behavioral healthcare services that meet each child and family where they are so they get the right kind of care at the right time in the right way.

The Boys Town National Hotline is a crisis call center receiving crisis calls, texts, and chats in order to de-escalate crisis, triage concerns, and link callers to appropriate community-based mental and behavioral health resources. Under the hotline, Boys Town supports the Nebraska Department of Education Safe2Help Program, helps parents through the Nebraska Family Helpline, and provide suicide, mental and behavioral health, and substance abuse crisis prevention as a crisis center for the 988 Suicide and Crisis Lifeline. Even before the COVID-19 pandemic, our country was facing mental health challenges on multiple fronts. Across our country, people are stressed and Nebraska is no different. According to the CDC, suicide is the second leading cause of death among adolescents. Our families, schools and communities are impacted by this crisis every day as they work to help the many students and families experiencing mental health challenges. The following data snapshot illustrates the scope of the mental and behavioral healthcare challenges of Nebraskans. In 2022, the Boys Town National Hotline responded to 128,335 contacts; Safe2Help, Nebraska's K-12 anonymous reporting system, received 2,446 safety tip reports with 35 percent of those reports being critical in nature. In the last fiscal year, the Nebraska Family Helpline received 5,332 calls for families seeking parenting support and resources to help their children experiencing mental health crisis. In its first year, the 988 Nebraska Suicide and Crisis Lifeline received over 23,000 calls, texts, and chat messages with the top self-reported reasons people calling being suicide ideation, ongoing support for severe and persistent mental illness, and anxiety. Boys Town's intention in responding to these calls for help extends beyond de-escalation and triage. Our objective is to help individuals identify and connect with community resources to improve their long-term well-being and prevent future crisis. However, there are times when there are limited or no supports within communities to provide local services for those in need or those situations where families experience the barrier of long wait times for higher acuity services regardless of where folks live. Expanding the available mental and behavioral health services for children and families is key to improved well-being and safe, healthy communities for all Nebraskans. Boys Town believes that when youth and families have what they need to address their mental and behavioral health needs they are better able to enjoy the quality of life we've all grown to appreciate. We want to thank the state of Nebraska and the Department of Health and Human Services for the initiative and support in making the first year 988 crisis system one of the best in the country. In the same way as the state considers potential solutions to these issues discussed today, we urge policymakers to

ensure that services are adequately and sustainably funded. Issues such as increasing the pool of qualified mental health providers, utilizing telehealth or other innovations to improve access for rural and underserved communities, and strengthening the array of interventions to include care for acute and long-term mental and behavioral health needs. Together, we can improve the way we address these needs for Nebraskans but it's going to take some innovation and investment. Again, thank you for the opportunity to testify today and contribute to this important conversation. I welcome any questions you may have.

HANSEN: All right. Thank you. Are there any questions from the committee? Senator Walz.

WALZ: Thank you. Thanks for coming today, Kyle.

KYLE KINNEY: Absolutely.

WALZ: On page two, you said that there are times when there are limited or no supports within communities to provide services for a situation or families experiencing a barrier of a wait time. Do you have data on the number of people who are experiencing those barriers?

KYLE KINNEY: I don't have the data. I'm sure there is someone out there compiling that. I can, I can speak anecdotally. Prior to COVID, I could, by and large, get an outpatient counselor and a traditional therapist pretty readily in your more populated areas. Out west, it would be a little more creative, but probably within a week or two, by and large. Post-pandemic that has stretched, right, it is-- there a little bit longer waits, still reasonable for an outpatient therapist, though, reasonable. You start to look at those more higher acuity services, the wait time gets pretty extensive if there's even availability. In [INAUDIBLE], outside the, the hotline role, but in my, my personal practice just recently had helped a client needing just a psychological evaluation. There's a, there's a three-month wait, which is pretty standard, everybody would expect this, right? Go to the initial evaluation, after three months, they're referred on to an additional functional assessment evaluation at six months out. So we're, we're nine months into the process of figuring out, hey, what should we do about this? And so you see that that's a, that's a fairly common narrative, that availability for those higher-end services is problematic.

WALZ: In-- can I ask one more question? In the cases that are acute, what are the alternatives then that you find?

KYLE KINNEY: So, OK, speaking from a what we would experience in the various, in the hotline-- Nebraska Helpline, 988, we're talking day-to-day maintenance, we're talking those community support resources where how do we figure out today and then it's how do we figure out tomorrow? That maintenance that one of the hotlines, 988 can provide and, and, frankly, is, is appreciated, the callers are looking for that, that service relationship where you're part of my safety plan but that's a daily maintenance, that's not a long-term solution for those, those, those folks. And so what, what's the right solution? I, I think that's why probably we're all here. But when it, when it isn't available, it's, it's daily maintenance planning which you help, you help parents, you help families understand that. They don't love that, though,--

WALZ: Right.

KYLE KINNEY: --so what are the alternatives?

WALZ: OK. Thank you.

HANSEN: Senator Ballard.

BALLARD: Thank you, Mr. Chairman. Thank you for being here, Mr. Kinney.

KYLE KINNEY: Absolutely.

BALLARD: Can you walk me through, an individual calls 988, and then what happens?

KYLE KINNEY: Yeah, that's, that's great. So the vast majority of callers that are calling 988 at this point, because, again, we're one year in, probably we're, we're utilizing the Suicide Prevention Lifeline before as part of their managing their daily suicide ideation. These are folks that probably are suffering from long-term, severe, and persistent mental illness. And so it becomes part of that daily maintenance, that safety planning, that de-escalation, and then connecting to resources as, as appropriate. A lot of those callers, they're very, what we would say, is resourced up. They have a lot of the services in place, it's part of the plan. For those that don't have resources, we're going to work with them to connect with the right services, whether that is outpatient therapy, what's available.

We have a resource database of over 1,600 Nebraska services that provide mental health behavior healthcare across the state. So we're ready to connect them to the right services statewide, partnerships with, with the different providers, the behavioral health authorities, your mobile crisis response providers, those kinds of things to get the right service in place in a timely enough fashion. For those higher-end calls, so those where they are escalated, they're in a behavior health crisis, we're not able to safety plan, we're able to de-escalate. But there's not that imminent risk, at that point we're going to attempt to connect them with a mobile crisis response provider who's going to connect with them largely at the direction of the caller, whether that's a face-to-face response, that's a phone response or a telehealth response or even at a centralized community location. They're going to meet with them, whether that's a peer support specialist, a mental health therapist, different kind of professional roles as a team and they're going to meet with them and they're going to de-escalate and then they're going to connect them to a series of aftercare services that are individualized for that person that are available through that mobile crisis service. And then for the last kind of the most high, that's where we are experiencing imminent risk, their imminent risk of harming self or others, and so that point we're going to use the, the emergency system, whether that's 911, local law enforcement, emergency medical services, where they've done something, an act in their life, those kinds of things, and that's right around 2.5, 3 percent of all calls. The vast majority of calls are resolved over the phone with a connection to local services which is a good thing, I think.

BALLARD: Thank you.

WALZ: Can I ask one more question?

HANSEN: Senator Walz.

WALZ: Thank you. So in, in the crisis situation, I guess this is the question I was trying to ask before, do you or how many times do you utilize law enforcement or detention centers as being the provider temporarily?

KYLE KINNEY: Yeah, so right around 2.5 to 3 percent of the calls result in an emergency services system response, whether that's just emergency medical or local law enforcement or most likely it's going to be a combination of the two through your, your local 911 center who's going to navigate that with us.

WALZ: OK. Thanks.

KYLE KINNEY: So that's, yeah, about 2.5, 3 percent give or-- kind of month by month. Going back to the seasonal question, there are definitely seasons where you see some of those more high-acuity calls where there are higher rates of suicide. September and October, which we're right in the middle of, does tend to be our, our busiest season of the year, and coming up the holidays, of course, and then spring certainly can be a high-acuity time.

HANSEN: Yeah, I think according to-- it's kind of misnomer of everyone always thinks that more people have suicidal ideology or, or tendencies around the holidays and winter but it's actually during the spring.

KYLE KINNEY: Yeah.

HANSEN: It's just kind of a weird thing, so.

KYLE KINNEY: Yep. Yeah, exactly.

HANSEN: Any other questions from the committee? All right. Thank you for coming.

KYLE KINNEY: Thank you much.

HANSEN: All right. And with our next invited testifier is Tami Lewis-Ahrendt from CenterPointe. Welcome.

TAMI LEWIS-AHRENDT: Thank you. Good afternoon, members of the Health and Human Services Committee. My name is Tami Lewis-Ahrendt, T-a-m-i L-e-w-i-s-A-h-r-e-n-d-t. I'm the executive vice president and chief operating officer at CenterPointe. We're a Nebraska nonprofit celebrating 50 years of providing mental and physical care, substance use treatment and services, supported housing, crisis intervention, and street outreach with locations in Lincoln and Omaha. We're also a CCBHC. I'm here today to represent the provider voice. When the COVID pandemic swept through the nation in 2020, many industries shut down and went home to wait. Not community behavioral health providers, we kept our doors open providing support and services to those struggling with new issues of isolation and loss of normalcy. We innovated on the fly, figured out new ways to respond to people, and held up healthcare workers, first responders, teachers, families, students, and more. Financially, we survived through the generous programs like the CARES Act and increased philanthropy. We made it work. Here we are three

years later, and while the virus may be less worrisome, the aftermath of that global crisis is not. We continue to see increases in behavioral health symptoms across all age groups, increases in substance use, anxiety, depression, and suicide. Our work has only just begun. Unfortunately, our workforce is depleted, burned out by the extensive response to the pandemic, choosing retirement, moving into less intense and higher earning roles in private practice, or getting out of the field altogether. The nursing shortage got national and even global attention, but there's an even greater shortage in licensed clinical therapists. Job postings that used to have two to three applicants will now sit untouched for weeks and even months. And it's not just clinical positions, it's all of the roles impacting our entire system. Staff shortages mean we can't serve everyone waiting at the door. We can't respond to all the phone calls for help or even open up new programs and spaces to meet the needs of the community. We will have to work together to address this shortage through innovative approaches to service, improving our licensing process, addressing barriers to reciprocity, and by thinking about new ways about who can help and how they can help. Licensure can take months to process an application. This is the starting point for a clinician, and no billable services can be provided without this. In a world where I can apply for a $100,000 loan in a few clicks on my phone, it's difficult to understand why an electronic application for licensure can take as long as six months. Let's investigate the process and figure out ways to streamline and standardize the work. Reciprocity is also a challenge. The behavioral health world has come to rely on telehealth providers to fill the workforce gaps. This typically means employing or contracting with someone from another state. If they're able to bill CMS, the Center for Medicaid and Medicare Services, in Missouri, Georgia, and South Dakota, it shouldn't take months of waiting after completing all the additional requirements to provide care in Nebraska. We need to dig into reciprocity requirements and evaluate a more streamlined method for provider validation. One other consideration that impacts licensure and may improve the workforce shortage is to license master-level social workers separately from other clinical professionals. This is a common practice in other states and fits within the federal payment model for Medicare. It's a complicated system to explain, but ultimately means that we lose social workers who are skilled therapists to other systems in states where their degree and scope is recognized. There's hope on the horizon for some of us in the form of CCBHCs, these integrated health clinics provide a bundled payment mechanism that ensures coverage for services that are currently unrebur-- unrebur-- reimbursed. Sorry. In

addition, providers are exploring new ways to partner and collaborate to increase capacity and serve those waiting for help. We've developed partnerships with law enforcement and school districts, collaborated with primary care providers, critical access hospitals, and other types of organizations to improve access and quality of care. Rate increases help, but we need to look at systems that ensure regular adjustments to rates, something stable and secure. We also ask that you consider reinstating the $10.3 million in the DBH funding to the regions and give them the flexibility they need to better support providers and the community behavioral health network. And finally, we want to be part of the solution. We're skilled at innovating under pressure, being creative in response to needs, and most of all doing a lot with a little. Thank you for your time today.

HANSEN: Thank you. Are there any questions from the committee? Senator Walz.

WALZ: Thank you. I'm asking a lot of questions. I'm sorry. First of all, I have a couple of questions. Do you know what the waiting list looks like for people who are waiting to get their licensure processed and then why? Do we know what the holdup is?

TAMI LEWIS-AHRENDT: You know, I wish I could answer that, Senator Walz, but I've sent three emails in the last month and have gotten zero responses from the licensure division so I don't know what the holdup is. We have an individual who we've literally been waiting six months for them to get their license that says in process on the website and we can't get a response from anybody in that department, so. I wish I could tell you.

WALZ: All right. Well, thank you.

TAMI LEWIS-AHRENDT: Um-hum.

HANSEN: Any other questions? Seeing none, thank you for coming.

TAMI LEWIS-AHRENDT: Thank you.

HANSEN: All right. So with that, we'll take our next testifier Patrick Kreifels with Region V. Welcome.

PATRICK KREIFELS: Thank you. Good afternoon, Chair Hansen and members of the Health and Human Services Committee. It is my pleasure to be with you today and talk about the behavioral health needs across Nebraska. My name is Patrick Kreifels, P-a-t-r-i-c-k K-r-e-i-f-e-l-s,

and I am the administrator for Region V Systems. I'm here today on behalf of the Nebraska Association of Regional Administrators and the Region V Systems Governing Board. Thank you to Senator Fredrickson for bringing LR202 forward and continuing to advance the conversation around these important topics. The regional behavioral health authorities play an important role in the recovery-oriented system of care provided across Nebraska. Each region encompasses a set of counties across the state. For example, Region V is comprised of 16 counties in southeast Nebraska. Behavioral health needs vary across the state, and decisions are best made at the local level. The Region's infrastructure provides specialized coordination functions that are unique and not available from any other entity or organization. These efforts include problem solving, working across various systems to develop partnerships, providing education to the community, advocating for improvements and changes as needed, and understanding the inner working details of the system to contribute to its success. Providing a true oriented-- recovery-oriented system of care continues as our primary focus to include promotion, prevention, treatment, and recovery supports. There are fundamental differences between Medicaid, Probation, and the Division of Behavioral Health regions, and all systems are needed to create a complementary payer system in Nebraska. Medicaid is a state and federal partnership to provide health services to low-income families, seniors, and individuals with disabilities. Reimbursements to providers are made after services are delivered based upon set fee schedules and covered mental health and substance use services defined by a state plan which is approved by the federal government. Nebraska Probation focuses on rehabilitation and accountability, accountability to improve community safety and provide services to adults and juveniles to become productive citizens. As discussed above and previously, the regions focus on a recovery-oriented system of care. The behavioral health system continues to experience workforce shortages with the provider network with significant turnover rates of employees ranging from 10 to 44 percent within one region. Providers did receive a behavioral health workforce stabilization grant from the regions across the state to help preserve and recruit a skilled workforce so they may meet the ever-emerging behavioral health demands. Every 30 hours a Nebraskan dies by suicide and it remains the second leading cause of death among 10-to 24-year-olds. The Office of Inspector General of Nebraska issued a report stating 27 percent of youth involved in the child welfare system are at imminent risk for suicide having current suicidal thoughts, plans for suicide preparations, and means. Regional behavioral health authorities are expanding their crisis continuums to

include somewhere to call, the 988, including crisis lines with providers; someone to respond, mobile crisis response across the regions; and somewhere, somewhere to go, youth and family crisis response centers and adult voluntary crisis stabilization centers. We have an aspirational goal of reaching zero deaths by suicide and efforts are focusing on implementing the zero suicide framework within provider networks and throughout the community behavioral health continuum. We are expanding evidence-based practices with dialectical behavior therapy, motivational interviewing, and cognitive behavioral therapy safety aid to aid with increasing confidence and confidence of the workforce while supporting youth and adults with creating a life worth living and moving forward in their recovery. Other initiatives across the regions include youth systems of care, local disaster response, mental health residential treatment, peer support, and a planning coordination to disburse the opioid remediation settlement funds to help abate opioid use. We continue to monitor the Medicaid unwind and ensure the Region's funding is available to provide for the public safety net of vulnerable adults with severe, persistent mental health conditions and substance use and youth with serious emotional disturbances. Continued flexibility in our budgets and reimbursement methods that will help us address the varied and local needs across the rural frontier and urban communities are desired. We are pleased that the Division of Behavioral Health has begun exploring different methodologies to achieve this and we appreciate their partnership. Lastly, de-emphasis on the most vulnerable populations in our community has natural consequences and outcomes. Jails are experiencing an increase in people who are presenting with SPMI and substance use conditions who need treatment in the confined environment they find themselves is not conducive for them or the people managing these settings. People are waiting on average in jail over 100 days for inpatient competency evaluation and restoration. Additionally, access to the regional centers continues to decrease and recently the regions are being asked to further reduce our bed allocation from 100 to 40 beds for people who have a mental health board commitment. The rippling effect this has on the system is confounding and the hospitals experiencing times of being at capacity as well as the crisis centers and, therefore, that results in people having to be trans-- transported over 100 miles away for care. Historically, there were-- was more collaboration to ensure there was flow and throughput with the Regional Center and so that people didn't languish. With the decrease of access to 60 inpatient beds and no funding dispersed to the regions to bring up community integration services, this equates to a significant impact on the system. Thank

you for take-- for allowing me to discuss these issues and I would be happy to answer any questions and I look forward to the further conversation.

HANSEN: All right. Thank you for your testimony. Are there any questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman. I'm trying to define in my own mind organizational structure. Now within your region, do all of the activities of mental health, are they coordinated with you or what, what is the overall authority or control, if I may use that word, of mental health delivery within your region? Because it's my understanding years ago when the six regions were set up, they cover the entire state--

PATRICK KREIFELS: Yes.

RIEPE: --and it's like each one is to coordinate in mental health delivery in that region but I'm not sure that's the way it works.

PATRICK KREIFELS: That is the intent and that is our focus in charge and we have many coordination areas so we coordinate prevention efforts and promotion efforts. We coordinate the emergency system for behavioral health, work with law enforcement officers to educate them on how to respond to if they encounter an individual or a person that has behavioral health needs. We do much training across the state in regards to that. There are additional rental assistance, housing coordination. We create a network, so that complementary payer system, Senator, that I talked about where Medicaid primarily pays for and a fee for service and a lot of people are on Medicaid, it's that other catchment area, that public safety net, so individuals who are not on Medicaid than we-- and are financially eligible we will pay for those individuals.

RIEPE: You've used the word we coordinate a lot, so, you know, not to try to be too disrespectful, but it sounds like the regions, all six of them are, are toothless.

PATRICK KREIFELS: Are-- excuse me?

RIEPE: Toothless in terms of someone that goes off and does their own thing is irrelevant, there's no penalty for it.

PATRICK KREIFELS: Senator, could you tell me more about that in regard--

RIEPE: I'm saying if you don't have some overriding authority within the mental health services provided within your region then you've got a lot of people that are out there just doing what they feel is free market to them. So my original thought was these six regions were to be fundamentally in charge and to be in charge you have to be in change-- charge of the reimbursement.

PATRICK KREIFELS: We do receive an allocation from the Division of Behavioral Health.

RIEPE: Yeah, but do you pay anybody or deny payment?

PATRICK KREIFELS: Yes, we do have contracts with the provider network so there are approximately 13 providers in the Region V Systems network that provide an array of services from an acute hospitalization all the way down to an outpatient level a service for mental health and substance use. And those providers are accountable to that contract, and we work with them on that utilization and shifting funds throughout the year. Last year, we did talk a little bit about the restrictions that the Division of Behavioral Health were putting on us in regards to not allowing us to do shifts. That has been removed and we're able to do more monthly or real-time shifts to meet the demands and needs of the providers and the people that they're serving.

RIEPE: OK. Fair enough. Thank you, Mr. Chairman.

HANSEN: Senator Day.

DAY: Thank you, Chairman Hansen. And thank you for being here today, Mr. Kreifels, your testimony is very sobering, I think, for many of us here on the committee. A previous testifier, Ms. Arendt, had mentioned potentially looking at reinstating the $10.3 million in Division of Behavioral Health funding to the regions. Do you by chance, and maybe I should have asked her this question, do you by chance know what happened to that $10.3 million? Where did it go? When was it cut? How did-- how was that removed?

PATRICK KREIFELS: I don't know if I can answer all of the question.

DAY: OK.

PATRICK KREIFELS: I'll do my best to answer some of the question, hopefully, Senator. Last year, the regions worked to try to inform senators in regards to that $10.3 million because it was initially

included in our budgets as a result of a rate increase, a 15 percent rate increase. That was included in our budget for one year and we-- if you think about a, a time for a system to be able to respond to additional funds coming in we need time to be able to plan and coordinate and contract with providers to get the funds out into the system and so we had one year of that, of that $10.3 in our system. And because of that, the not continuing and carry on in the budget, we lost an additional $346,000 just in my region in county-matched funds for people in behavioral health. Where the funds went, I am not exactly sure.

DAY: OK. So it was essentially just cut from the budget?

PATRICK KREIFELS: That's-- yes.

DAY: OK. OK.

PATRICK KREIFELS: I appreciate you asking that question.

DAY: Yeah, no, that's helpful to know.

PATRICK KREIFELS: And when we talk a little bit about, you know, the decrease of access of acute beds in the state hospital by 60 and no additional funds are coming out into the community to offset that and to bring up services to serve those people that are on mental health board commitments it's going to be a very sobering year.

DAY: Yeah. Thank you.

PATRICK KREIFELS: Thank you for asking.

HANSEN: Any other questions from the committee? All right. Seeing none, thanks for coming.

PATRICK KREIFELS: Thank you for your time. I do appreciate it.

HANSEN: All right. We'll take the next invited testimony on our list and that will be Kierstin Reed with LeadingAge Nebraska. Welcome.

KIERSTIN REED: Hi. Good afternoon. Chair Hansen, Senator Fredrickson, the committee members, thank you so much for having me here today. My name is Kierstin Reed, K-i-e-r-s-t-i-n R-e-e-d, and I serve as the president and CEO for LeadingAge Nebraska. We're a membership organization supporting long-term care providers and we represent 76 long-term care providers across the state that provide a variety of

services, including housing, home and community-based services, assisted living and skilled nursing. I'm here to talk to you today about the needs of older adults with mental and behavioral healthcare needs. Nationally, Medicare enrollment is growing by 10,000 beneficiaries per day and it is projected to continue to rise over the next 30 years. Additionally, we're seeing an explosion of chronic medical diseases that account for 99 percent of the Medicare spent nationally. From 2000 to 2020, we saw a 43 percent growth rate in the population over 80, and it is projected that between 2020 and 2040 the growth rate for that same group is going to be 113 percent. So in Nebraska, we are on track to match that same growth rate in our population. Our current population over the age of 65 is 16.9 percent, and it's expected to increase to 22 percent by 2050. While the growth of the younger population is beginning to decline, that's going to lead to less support for those that are aging, this combined with chronic illness that is going to lead to a population that is aging that is going to require care in long-term care facilities. So just like chronic health conditions, the rate of mental illness and behavioral health in older adults is expected to continue to rise over the next several decades. The World Health Organization states that 20 percent of adults that are age 60 and over suffer from mental or neurological disorders. And currently 6.3 percent of adults that are over the age of 65 report that their mental health was not good, 14 or more out of the past 30 days. The percentage of those with severe mental illness in this age group is also continuing to rise. The Nebraska long-term care system of nursing homes has 198 skilled nursing facilities that provide care for those that need some kind of ongoing medical support. Of those facilities, only 17 of them are designated as being able to support someone with behavioral health needs. Four of those are actually within our state correctional system, lowering that number available to the public down to only 13 facilities across the state. Assisted living and other community-based providers support do not provide a designation regarding behavioral health supports in Nebraska. There are few, there are very few options for older adults in terms of geriatric psychiatric professionals to address any ongoing mental health concerns and this results in older adults being unable to find placement in suitable long-term care programs. The Medicaid reimbursement system for long-term care fails to meet the basic needs of care and there is absolutely no differential for providing support to someone with complications from mental health or behavioral health in our long-term care settings. There's also a considerable risk for our nursing facilities to be able to provide services to those with behavioral health conditions. These

facilities are obligated to provide for the safety and security of all individuals receiving services, and that means that they have to protect them against others that may intimidate, threaten, or physically injure them due to a behavioral health crisis. There are very few facilities in Nebraska that have a safe place and the advanced training for staff to be able to provide these services. Overall, our healthcare system is not prepared to support these folks with significant mental health or behavioral health concerns. In closing, I'd like to point out the report that was handed to you that was a report that was completed by DHHS on our three state-operated adult facilities, a study that was completed in November of 2021, and investigating how to redesign the state-operated facilities to address the changing needs of those with complex medical and behavioral needs. I provided you each copy of this study and I'd be happy to point out a couple of highlights if we have additional time. Thank you again for having me today. On behalf of LeadingAge Nebraska, I appreciate the efforts on this issue.

HANSEN: Thank you. Are there any questions from the committee? Senator Day.

DAY: Thank you, Chairman Hansen. Thank you for being here today. I would love to hear the highlights from the study if you would be willing to share.

KIERSTIN REED: Absolutely. I was hoping someone would ask that question. So this was a report that was contracted by DHHS with Myers and Stauffer and it was to develop a plan for the Beatrice State Developmental Center and the two psychiatric hospitals. We have Lincoln Regional Center and Norfolk Regional Center. The premise of the report was to identify opportunities that will further advance the focus and supports provided by these facilities into the future and be able to respond to the current needs in Nebraska and the report breaks down three key areas. So first is the development of an older adult, an older adult system of care, then the second one is a forensic system level of care, and then the third one is a sex offender system level of care. So for our population, we're really looking at that system for older adults. There are many folks that are at these community-- or these facilities that are aging. And so on page nine and ten of the report, it talks about assessing-- there's a four-step plan for this. So the first one is assessing the needs of the population, and then the structural capacity and licensing requirements that would be needed, redesign and development of the program to meet the needs, and then developing administrative and

operational facility resources to support those needs. Step three of that process describes the growing needs of the older adult population, particularly those who are aging, but also have significant behavioral and mental health conditions. One of the things that I think is really important to me is that as we're looking at that, you know, these facilities used to be the safety net when we had a nursing home or other community places that weren't able to fill the need for that person due to their, their situation and there's really nowhere to go. So once someone enters a nursing home and they determine that they can't handle their behavioral health needs, there's nowhere for them to go because they can't go to one of those institutions. And once they've been admitted to the nursing home, it's the nursing home's responsibility to continue to provide care. So it, it, it goes on to talk about, you know, that, that piece that there's really no where to refer those patients to and then that's also compounded with the limited amount of community-based services that are critical in this hurdle to kind of handle the entire population. Page 12 of that also talks about the care for older adults, which it points out that the need, needs of the community have changed and DHHS, as I said, used to fill that role as being an alternative setting when things are not feasible, such as safety, cost effectiveness, or willingness of providers. And as such, that we need to have a comprehensive long-term care plan for addressing the needs of older adults with complex conditions and considering placement and treatment of aging Nebraskans with co-occurring medical conditions, behavioral or severe and persistent mental illness in an ongoing state system for the future. I could go on.

DAY: Thank you. I really appreciate that.

HANSEN: Any other questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman. Is there some confusion between dementia and mental health in terms of you're this or you're that?

KIERSTIN REED: Great question. I'm not a medical provider, but I would say that there's-- in the long-term care area, I don't think there's as much confusion but I think there is among the general public. So there is a difference and what we're seeing in folks that are being admitted into nursing facilities, they understand what dementia is and they know that they're going to have complications and behavioral issues that may come from dementia. But what we're seeing now is more and more of the population entering a nursing facility due to medical issues that actually has what I would call severe and persistent

mental illness. So there's a difference but, you know, just because you're aging does not mean that mental health conditions go away. So as people are growing older, we're seeing more and more of that in our long-term care system.

RIEPE: OK.

KIERSTIN REED: Yeah.

RIEPE: Thank you. Thank you. Thank you, Chairman.

HANSEN: Seeing no other questions, thank you for coming.

KIERSTIN REED: Thank you.

HANSEN: We'll take our final testifier and that will be Sharen Saf with Assistant Inspector General for Child Welfare. Welcome.

SHAREN SAF: OK. I know it's been a long afternoon so I will go as quickly as I can. Good afternoon, Chairperson Hansen and members of the Health and Human Services Committee. For the record, my name is Sharen Saf, S-h-a-r-e-n S-a-f. I serve as an Assistant Inspector General of Nebraska Child Welfare under Inspector General Jennifer Carter. I'm here today to provide testimony on her behalf as Inspector General Carter regretfully is unable to attend. The Office of Inspector General for Nebraska Child Welfare, or the OIG, was created in 2012 by the Nebraska Legislature to provide accountability for and oversight of Nebraska's child welfare and juvenile justice systems through independent investigation, identification, and monitoring of systemic issues and recommendations for systemic improvement. I appreciate the opportunity to speak before you today regarding the pressing issue of mental and behavioral healthcare needs among Nebraskans. The OIG acknowledges the importance of addressing this issue, particularly in the context of suicide prevention within Nebraska. While these topics are related, they are distinct with suicide prevention serving as a crucial component of mental and behavioral healthcare. It is important to recognize that mental illness, on its own, does not directly lead to death by suicide. However, it is a significant risk factor that can elevate the likelihood of individuals experiencing suicidal thoughts or attempting suicide. My testimony today has a particular focus on suicide prevention, especially for youth involved in Nebraska's child welfare system. In June of 2023, the OIG issued a report of investigation into the suicides of three system-involved youth titled: Death by Suicide,

a 3 Case Review. A copy of that report has been included with my written testimony. The report offers recommendations aimed at addressing the issue of suicide among youth in the child welfare system. These findings articulated that the OIG did not consider the agencies or the employees working with them responsible for the deaths. The review also identified that the Department of Health and Human Services, or DHHS, and their partners across the state are committed to reducing instances of suicide in Nebraska. However, the report highlights the need for suicide awareness and an impactful response within DHHS, particularly with regard to youth in the child welfare system. One undeniable reality is that adolescents as a group are already at an increased risk of death by suicide. When we shift our focus to youth involved in the child welfare system, we find an even higher level of vulnerability. These youth report higher rates of suicidal ideation and self-harming behavior. It is concerning to note that a youth made a ward of the state and placed in foster care is three times more likely to attempt suicide than a peer who is also involved in the child welfare system but not in foster care. I want to emphasize that the heightened risk does not imply that all adolescents in the child welfare system will experience suicidal thoughts or behaviors, but it does underscore the critical need for an awareness and an impactful response. The National Strategy for Suicide Prevention advocates an approach that includes identifying a vulnerable population and then building capacity within the system that serves them. In this context, child welfare staff, foster care providers, and case managers play a pivotal role as they are uniquely positioned to identify youth at risk of suicide and connect them to life-affirming resources and effective treatment services. With this in mind, the OIG recommended that DHHS and then their Division of Children and Family Services, or CFS, develop a comprehensive suicide prevention plan to be implemented through policy and procedure and that the division actively participates in that-- in the suicide prevention coalition. In addition, the OIG made the following three recommendations: the OIG recommended that DHHS mandate the completion of gatekeeper training for all CFS case managers before they have independent contact with youth and families. Gatekeeper training has been proven effective in increasing knowledge, developing a positive attitude towards suicide prevention, and enhancing confidence in the ability for someone to intervene with an individual at risk. Gatekeeper training has been successfully integrated across schools, healthcare settings, juvenile justice settings, and law enforcement settings along with based-- faith-based settings. Nebraska law already requires that all public school employees who interact with students

receive annual suicide awareness and prevention training. Furthermore, yearly booster training for all case managers should be required to ensure ongoing confidence. This training should not be limited to case managers, but should be extended to all newly hired division staff within their first year of employment. This training should be standardized and incorporate evidence-based practices.

HANSEN: Sharen?

SHAREN SAF: Um-hum.

HANSEN: Could you just narrow it down a little bit because you're out of time?

SHAREN SAF: Oh, sorry.

HANSEN: I want to make sure--

SHAREN SAF: I was reading.

HANSEN: Yep, yep, I just want to make sure you finish your thoughts so at least maybe narrow it down a little bit.

SHAREN SAF: OK, yep. The OIG also recommended that they establish very similar recommendations as far as training and implementation for child-placing agencies within the foster care system and just as importantly enhancing those suicide prevention efforts with foster care parents both licensed and unlicensed. With the unlicensed foster care providers, we recommended that they find a way to provide that at no cost, whereas licensed providers can do it through their preservice licensure. And I think the-- probably the last thing I will close with that's extremely important is that DHHS did accept all of our recommendations with a commitment to implementing them by 2025. And with that, the OIG would like to express gratitude to Senator Fredrickson for bringing this legislative resolution and I thank you for your time today.

HANSEN: Thank you. Are there any questions from the committee? Senator Walz.

WALZ: Thank you. I just want to make sure I understand. So currently there, there is no suicide plan in place in the CFS system. Is that what you're saying, like, there's no training available for foster care parents right now?

SHAREN SAF: So as the report articulated, CFS, independent of all of the other parts of DHHS, does many things that would fall under suicide prevention but they are siloed. So what we recommended is that they take all of these things that they're doing and put it together in a single organized plan that then has very specific policy and procedure to go with it. So they have lots of elements that speak to suicide prevention, they don't have an organized plan and they lack maybe some overarching coordination with resources such as regions, Division of Behavioral Health.

WALZ: OK. And then you said that DHS-- DHHS would not be implementing this or coming up with their plan until 2025?

SHAREN SAF: So in their response to our report they along with accepting all of our recommendations which was the overall plan, policy and procedure to back that up, and then those three separate recommendations, which is including this kind of training for caseworkers, foster parents, and integrating it into child-placing agency contracts that in doing that they would have that in place and integrated with a rollout date of December 2025.

WALZ: OK. Thank you.

SHAREN SAF: Um-hum.

HANSEN: Any other questions? Senator Riepe.

RIEPE: Thank you, Chairman. My question is this, did the investigation explore gender dysphoria and associated risk of suicide?

SHAREN SAF: No, Senator Riepe, it did not.

RIEPE: It did not?

SHAREN SAF: No. It was based on three critical incidents reported to our office so our scope was limited only to those three suicides and none of those deaths by suicide incorporated the issues that you questioned about.

RIEPE: OK. I just thought given the issues of last session it might have.

SHAREN SAF: No.

RIEPE: Thank you. Thank you, Chairman.

HANSEN: Any other questions? Seeing none, thank you--

SHAREN SAF: Thank you.

HANSEN: --very much. All right. So with that, that will conclude the invited testimony for LR202 and we'll invite Senator Fredrickson back up to close.

FREDRICKSON: All right. Thank you, Chair Hansen and members of the Health and Human Services Committee. I really appreciate you all taking the time, especially during the interim, to be here to engage with the testifiers, to ask questions, and, and to, I think, facilitate a space where all of this could come out and we could speak to all this. I also want to thank all of the testifiers who took time out of their day and their schedules to be here today. I think it was incredibly important to hear from everyone. This is something that my office has been working really hard on this interim as you could see from the testimony we heard. I think sometimes when we-- so here's what I'll say. I think sometimes when we, we think about mental health and we hear a lot about mental health, it can kind of feel sort of grim. And this is a crisis, you know, I'm not trying to be Pollyannaish or sugarcoat this at all. I will also say that I do want to highlight some of the successes we heard about today. And, you know, for example, DHHS has accepted all the recommendations from the OIG's report. You know, whenever there's a death by suicide, that's, that's tragic. And I think that it's fortunate that we had the report that investigated those three deaths and the fact that DHHS is willing to sort of take on those suggestions I think is really, really encouraging. Other things that I think are really, you know, our folks from Boys Town testified a little bit about the 988 hotline. They were being very humble. We have done really well in Nebraska with the 988 rollout, especially when you compare our rollout to other states. So that's something that as a state we can be really proud of. And part of that has to do with the infrastructure we had in place with the Family Helpline, for example, we were able to plug and play pretty quickly with that. So 988 on a federal level is a tall ask, but we've done really, really well in Nebraska and I think that's something we should be really, really proud of. The other thing I'm going to say is that, you know, what's clear is that we have a real diverse set of stakeholders who are really interested in mental health. And I think that we are at a time right now as a society, I think nationwide, but I think certainly in our state as well, where we're seeing a broad spectrum of support for behavioral health and mental health initiatives. And I think that this is something that we as a

Legislature can really come together on and hopefully move the needle on a little bit. Again, there was a lot that was highlighted today that was really important. There are three things I want to really kind of point out. One is, is, is the licensure backlog that we heard about a little bit. I mean, that, that is really concerning and I think something that we need to look into. Again, I'm a proponent of the least, the least restrictive or the least prescriptive kind of paperwork, Senator Walz says paperwork, but I'm, I'm, I'm a proponent of, you know, if we can solve these things without putting it into statute, great. You know, if, if it's something that would benefit from legislation, excellent. I think we should pursue that as well. But, you know, you talk about workforce, the lack of providers, you know, folks who are waiting six months for licensure, those are folks who are ready to go, who are ready to see patients and so that's something that we need to be really kind of considering. Another thing that was really fascinating for me in the study was that I learned and I believe, and I don't want to misspeak, but I believe we have 19 educational programs in our state that train behavioral health providers and that's the whole spectrum, anything and everything from psychiatrists to drug and alcohol counselors, like, the whole spectrum of folks who provide behavioral health services. And one thought that I had was, well, how do we get more potential students interested in this as a career path? But what I've also learned is that we have interest in this, in this profession. We have interest in this field. And I think the testimony we heard from BHECN today highlights that when they were giving out grants, you know, those dollars are sucked up quickly for these opportunities and for these, these positions so part the issue is the question becomes not so much how do we ensure that people are interested in this field, but how do we ensure that there are spaces in educational programs or seats in these programs for people to be trained because there is an interest in the, in the industry and in the field. There's no question about that. The final thing I'll highlight before I open it up to questions is so part of, like I said earlier with the Boys Town testimony, we've done really well with 988. So around, I think folks maybe have heard, like, around 2.5 to 3 percent of the 988 calls require the involvement of law enforcement. And I think that's a really nice relationship to have between 988 and law enforcement to be able to have that immediate response. I do think it's worth noting that in the way, the way we currently have it is that with 911 we don't have that reciprocal relationship with 988. So if someone calls 911 simply out of familiarity with 911, for example, but it might be a more appropriate call for 988, we don't currently have that transfer going the other

way as well. And so my other interim study I mentioned earlier, LR201, which is in Judiciary takes a look a little bit at that as well so just wanted to highlight that for the community-- the committee, additionally. So with that, I will wrap up. Again, thank you all for the time and thank you to Chair Hansen for facilitating this and I will be happy to answer any questions people have.

HANSEN: Are there any questions from the committee? A whole bunch of them. None? All right. Well, thank you for bringing this--

FREDRICKSON: Of course.

HANSEN: --and thank you for coming--

FREDRICKSON: Yep.

HANSEN: --and bringing all the testifiers. So with that, that will conclude the hearing for LR202 and that will conclude our hearings for today.

FREDRICKSON: Thank you.