FREDRICKSON: Good afternoon and welcome to the Health and Human Services Committee. I'm Senator John Fredrickson. I represent the Legislative District 20, and I serve as the vice chair of the committee. The committee today will take up the bills in the order posted. This public hearing today is your opportunity to be a part of the legislative process and to express your position on the proposed legislation before us. If you are planning to testify today, please fill out one of the green testifier sheets that are on the table at the back of the room. Be sure to print clearly and fill it out completely. Please move to the front row to be ready to testify. When it's your turn to come forward, give the testifier sheet to the page. If you do not wish to testify, but would like to indicate your position on a bill, there are also yellow sign-in sheets back on the table for each bill. These sheets will be included as an exhibit in the official hearing record. When you come up to testify, please speak clearly into the microphone. Tell us your name and spell your first and last name to ensure we get an accurate record. We will begin each bill hearing today with the introducer's opening statement, followed by proponents of the bill, then opponents, and finally by anyone speaking in the neutral capacity. We will finish with a closing statement by the introducer if they wish to give one. We will be using a three minute light system for all testifiers. When you begin your testimony, the light on the table will be green. When the yellow light comes on, you have one minute remaining and the red light indicates that you need to wrap up your final thought and stop. Questions from the committee may follow, which do not count against your time. Also, committee members may come and go during the hearing. This has nothing to do with the importance of the bills being heard. It is just part of the process as senators may have bills to introduce in other committees. A few final items to facilitate today's hearing. If you have handouts or copies of your testimony, please bring up at least 12 copies and give them to the page. Props, charts, or other visual aids cannot be used simply because they cannot be transcribed. Please silence or turn off your cell phones. Verbal outbursts or applause are not permitted in the hearing room. Such behavior may be cause for you to be asked to leave the hearing. Finally, committee procedures for all committees state that written position comments on a bill to be included in the record must be submitted by 8 a.m. the day of the hearing. The only acceptable method for submission is via the Legislature's website at nebraskalegislature.gov. Written position letters will be included in the official hearing record, but only those testifying in person before the committee will be included on

the committee statement. I will now have committee members with us today introduce themselves, starting on my left.

RIEPE: Thank you, Chairman. I'm Merv Riepe, I represent southwest Omaha and the little town of Ralston.

MEYER: I'm Glen Meyer. I represent northeast Nebraska, District 17, Dakota, Thurston, Wayne, and the southern part of Dixon County.

QUICK: Dan Quick, District 35, Grand Island.

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

FREDRICKSON: Also assisting the committee today, to my left is our research analyst, Bryson Bartels, and to my far left is our committee clerk, Barb Dorn. Our pages for this committee are Sydney Cochrane and Tate Smith, both students at the University of Nebraska-Lincoln. Today's agenda is posted outside the hearing room. With that, we will begin today's hearing with LB603. Senator Ballard.

BALLARD: Good afternoon, Vice Chairman Fredrickson and members of the Health and Human Services Committee. My name is Beau Ballard. For the record, that is B-e-- B-e-a-u B-a-l-l-a-r-d, and I represent District 21 in northwest Lincoln and northern Lancaster County. I'm here today to introduce LB603, which I introduced last year in LB1144. Just ran out of time before, before the session ended. Care management services, like those of Area Agencies on Aging, provide an attempt to keep older Nebraskans in their home with a lower level of care for as long as possible. This goal is the one that state should focus on well. Public resources are greatly conserved when older Nebraskans stay in their homes and being placed-- other than being placed in assisted living facilities or nursing homes. Currently, AAA operates by billing their clients on a sliding fee scale used on their income. From 18-- from 1987 to 2018, the department interpreted the law so that the sliding fee was a voluntary system, with the department picking up what the clients did not pay. However, in 2018, the department stopped reimbursing the AAA's unpaid fees, leaving them with a budget shortfall. LB603 simply moves that sliding fee back to a voluntary system, and requires DHHS to pay what the client does not. This is a return to the system that we've previously used for 30 years, and also matches our state managed care policy at other programs offered under federal Older Americans Act. I'll be happy to answer any questions that you might have, it's a fairly straightforward bill, but there are also testifiers behind me that can

answer more technical questions. So with that, I'd be happy to answer any questions.

FREDRICKSON: Thank you, Senator Ballard. Any questions from the committee? Seeing none--

BALLARD: Let me off easy.

FREDRICKSON: Will you stick around to close?

BALLARD: I'll be around.

FREDRICKSON: All right. We will now take proponents for LB603. Welcome.

ROD HORSLEY: Good afternoon, Vice Chair Fredrickson and members of the Health and Human Services Committee. My name's Rod Horsley, R-o-d H-o-r-s-l-e-y. I'm the director of South Central Nebraska Area Agency on Aging, located in Kearney. I'm testifying on behalf of the Nebraska Association of Area Agencies on Aging. In 1987, under LB42, care management services were established through the eight Area Agencies on Aging to aid in the coordination of services for older adults. Care management staff meet with an older adult, complete a comprehensive assessment, help determine what needs the individual may have, and then set up services to meet those needs. This may include transportation, home delivered meals, chore services, to name a few. The purpose of care management is to provide services which will allow an older adult to stay in their own home and avoid premature institutionalization. Providing services in-home is much cheaper than in a long-term care facility, and helps control the rising costs of Medicaid. It's the right care at the right time. Since the inception of the care management program through 2018, there was not a cost per se to clients for the service. A sliding scale was used based upon the individual's income to determine the value of the service. The client was sent a statement but was not required to pay for the service. In 2018, the Nebraska Department of Health and Human Services reviewed the care management statute and determined that the statute had been incorrectly interpreted and that care management clients were required to pay for the service if their income was more than 10% of the fli-- of the sliding fee scale. When clients were advised that they were required to pay for the service, many clients opted not to utilize the service. LB603 adds language to section 81-2234 to state that, quote, care management clients may contribute to the cost of receiving care management services as provided under section 81-2230. A client family income schedule, using the federal poverty guidelines, shall be used

to determine a care management client's voluntary contribution, end quote. This change will allow area agencies on aging to provide care management services to clients, and allow the client to make a voluntary contribution. The services Agencies on Aging provide that are funded under the Older Americans Act allow older adults to contribute to help cover the cost of the services, but they cannot be charged for the service. LB603 would align the services under care management with services provided under the Older Americans Act, by allowing the client to make a contribution towards the cost of the service and not charge the older adult. The Nebraska Association of Area Agency on Aging-- Agencies on Aging, fully supports LB603, and would ask for your support as well. I would take any questions you might have.

FREDRICKSON: Thank you for your testimony. Any questions from the committee? Seeing none, thank you for being here.

ROD HORSLEY: All right. Thank you very much.

FREDRICKSON: Next proponent for LB603. Welcome.

KIERSTIN REED: Good afternoon, Senator Fredrickson and members of the Health and Human Services Committee. My name is Kiersten Reed. That is K-i-e-r-s-t-i-n R-e-e-d. I serve as the CEO for Leading Age Nebraska, which represents governmental, nonprofit, and locally owned providers of aging services. Together, our members serve thousands of Nebraskans across a variety of settings. We thank Senator Ballard for bringing this bill forward as it was introduced last year as well. We've already heard about the language change for these case management services, and we strongly support this change. Care management services are not available on a regular basis through a variety of, of different providers. And this is something that the area agencies on aging do very well. These services include ongoing consultation, assessment, care plan development and referral to a variety of different services. This allows older adults to stay in their home longer. It's important to note that older adults in Nebraska, to be eligible-- have to be eligible for care management services in order to receive service through that Older Americans Act. So those services through Older Americans Act include things like homemaker services, Meals on Wheels, bath aids, chore services, and emergency response systems. The change that occurred in 2018 does seem minor, but it has had unforeseen consequences. Many people have faced the burden of either having their bill or not getting their services. There are many that are happy and financially able to pay for these services through their voluntary contribution, but the mandate has prevented some

people from receiving these services, and it's honestly a risky move for Nebraska, one that could cost the state a lot more money in the future if these folks end up needing a higher level of care. According to the fiscal note for this bill, which I believe when it was introduced last year it did not have a fiscal note. This year, there's $50,000, and that is representation of the fees that were collected. So you can see there's been a very small amount of fees that were collected to pay for this. But it's a small price to pay for the safety and security of older adults living in the community. We would encourage that you move this bill forward and continue to provide care management services to delay the cost of higher needs of care. Happy to answer any questions you may have. Thank you.

FREDRICKSON: Thank you for your testimony. Any questions from the committee? Seeing none, but I have one. So you mentioned the fiscal note. I also had a question on that as well. I, I did look up the legislative history of the bill, and I saw from the last time the bill was introduced that there was not a fiscal note. So is it your sense that, that, that that is an error, or like help me understand a bit more of what you-- your interpretation of that?

KIERSTIN REED: I, I don't know that I can state exactly what it is.

FREDRICKSON: I'll ask the introducer, maybe.

BALLARD: My thought is that because it was done in 2018, no one was really ca-- taking-- figuring out what those fees were every year.

FREDRICKSON: Got it.

KIERSTIN REED: So they just have, since it got introduced to this year--

FREDRICKSON: OK.

KIERSTIN REED: What those fees were.

FREDRICKSON: OK.

KIERSTIN REED: So I'm assuming that what we're looking at is a year's worth of fees. But I think it's important to note that there are a lot of fees that weren't collected because those people dropped out of services. So, you know, the-- they-- no one wants anyone to go without care. So that's really what this is doing, is kind of going back to the way it used to be.

KIERSTIN REED: OK. Any other questions? Seeing none. Thank you.

KIERSTIN REED: Thank you.

FREDRICKSON: Next proponent for LB603? Seeing none, we'll move to opponents. Is there anyone here to oppose LB603? Seeing none. Anyone here to testify in the neutral capacity for LB603? Seeing none. With that, Senator Ballard, you're welcome to close. But before you do that, we did have some online comments. We received four proponents, zero opponents, and zero in the neutral capacity.

BALLARD: All right. Thank you, Vice Chair. I appreciate the committee's time. I'm thankful for their attention, on this bill. I think just-- the, the goal behind this is to just keep older, older Nebraskans in their home for as long as possible. And those that have-- that maybe cannot afford to pay for these services will help with that, will help with paying for those. Yes, to answer, there was no fiscal note last year. I read-- the interesting thing, to me at least, was when they, when they cut off this program in 2018, the Legislature didn't get $50,000 back. So they've, they've had this money, and now they, they just decided they're not-- they don't want to pay it anymore. There-- I, I, I would also like to note that they assume that if-- the majority of these managed care clients, they're going to try, if they can afford it, they're going to pay for these services. The fiscal note assumes that the majority will not. And so I think that, that $50,000 expenditure is a little high in my opinion. But with that, I'd be happy to answer any questions.

FREDRICKSON: Any questions from the committee? Seeing none.

BALLARD: Thank you.

FREDRICKSON: Thank you, Senator Ballard. That will end our hearing on LB603, and we will move on to. LB380.

RIEPE: We are now moving on to LB380, and that is by Senator John Fredrickson, and Senator Fredrickson' you're free to go.

FREDRICKSON: Thank you, Senator Riepe. Good afternoon, Senator Riepe and members of the Health and Human Services Committee. My name is John Fredrickson. That's J-o-h-n F-r-e-d-r-i-c-k-s-o-n, and I represent the 20th Legislative District, which is in central west Omaha. I'm here today to introduce LB380. Over the past year, my office has been contacted by behavioral health providers from across the state, informing me about their experiences with Nebraska's managed care organizations. Throughout discussions with these

providers, it's been clear that there were areas of statute covering these MCOs that need to be addressed to increase transparency, make clear what is to be included in their contracts, and, quite frankly, to bolster taxpayer confidence in what is one of our state's largest line items. There are two statutes that govern our managed care system in Nebraska. One is in chapter 44 called the Managed Care Plan Network Adequacy Act, which is administered by the Nebraska Department of Insurance; and the other is the Medical Assistance Act, which is in Chapter 68. The chapter 44 statute requires MCOs licensed in Nebraska to provide network adequacy, and to maintain a network sufficient in numbers and types of providers, and maintain an access point-- an access plan to meet those requirements. LB380 does not change any directives already in state statute under the Department of Insurance. The concerns that are being addressed in LB380 are the lack of adequate oversight and transparency in our Medicaid program. I'm not sure where the breakdown is, but it is clear to me that the Legislature needs to amend this section of statute so that our expectations are clear to both the Department of Health and Human Services and to the managed care organizations. LB380 provides updated guardrails in our Medicaid program so that we can be assured that we comply with federal laws and regulations, and that we are serving eligible Nebraskans efficiently and effectively. Updates included in LB380 include the following. All Medicaid providers are to be paid the rates that were funded and approved by the Legislature; any changes in MCO contracts are communicated to providers; ensure parity between mental health and substance use treatment services and physical health services per federal law, and make public parity compliance reports; MCOs must apply generally recognized standards of care for health services and make utilization review policies available to the public; MCOs cannot rescind or modify an authorization for a mental health or substance use disorder service after the provider renders the service pursuant to a determination of medical necessity, except in the cases of fraud or violation of contract; ensures MCO compliance with federal and state laws, including early and period-- and periodic screening and diagnostic and treatment services of children and youth in the Medicaid program; and reinforce maintenance of an adequate provider network across Nebraska by defining network adequacy criteria and assessing each MCOs compliance. You will hear today why these updated directives are needed, and that Nebraska has given these state contractors too much leeway in working with providers and patients. While we have implemented a managed care system in our state, giving these contractors the authority to make sure health care services are delivered, we have not handed over the Legislature's responsibility to manage these private insurance companies who are paid by state

taxpayers. I do want to acknowledge that in 2020, Senator Arch brought legislation that created the Medicaid Managed Care Excess, Excess Profit Fund, where surpluses are returned back to the state. But the handout I provided shows the scale of funding we are talking about. I am not alleging that the MCOs are unduly pocketing profits, but simply that more transparency is needed to track these larger line items. Most other states provide strong statutorial safeguards, and it's time that Nebraska does as well. We are placing a lot of trust with these organizations, entrusting them with servicing some of Nebraska's most vulnerable citizens, and I feel that LB380 is needed to spell out what we expect in return for this investment. Advocates and experts will be here to testify behind me to speak to the specifics laid out in LB380. Thank you for your time and attention to this bill, and I'd be happy to take any questions.

RIEPE: Any members of the committee that have questions? Senator Meyer.

MEYER: Thank you, Senator Riepe. So there's no fiscal note on this?

FREDRICKSON: So the fiscal note, if you review it, essentially says that it's indeterminate at this point. So there's a $0 attachment to it. But you know--

MEYER: Yeah, that that's what my-- what this showed. And, and previously I don't think I had an updated fiscal note for the previous bill. So I'm just making sure [INAUDIBLE]--

FREDRICKSON: A double check, yes. It's the question of the year. Is there a fiscal note.

MEYER: Yes. Is there a fiscal note, so. Anyway, thank you very much.

FREDRICKSON: You're welcome.

RIEPE: Any additional questions? I have a question. Historically we used to-- we paid set fees that were set by the Legislature, this is when the state ran the program. One of the reasons that we went to managed care at the time was to try to get better cost control, and in doing that, we allowed managed care to negotiate. And I think that that's where we're running into a snag now. They're maybe being more aggressive, is that what I hear you saying?

FREDRICKSON: Well, thank you for your question, Senator Riepe. I think that you'll hear some testimony, some-- from providers today that speaks a little bit to some of this issue. You know, one of the big

concerns that I've been hearing is that, you know, we as a Legislature, when we vote on our, our budget on a biennial basis, we determine what rates should be for, for Medicaid providers. So, yes, managed care organizations are-- we set that up as a state, so we, we kind of-- we entered those contracts knowing what we were getting into with that. But they're, they're still distributing Medicaid dollars. So, you know, we as a Legislature determined what we expect those Medicaid dollars to reimburse at. And it's my belief that providers should have that transparency and awareness of what to expect for reimbursement from them as well.

RIEPE: OK. Will we be hearing about specific managed care providers?

FREDRICKSON: I can't, I can't speak for my testifiers. But yeah.

RIEPE: Just curious if this was a tell-all, so. Are there other questions? Hearing none. Thank you very much.

FREDRICKSON: Thank you, Senator Riepe.

RIEPE: I assume you'll stay for the close.

FREDRICKSON: I will, wouldn't miss it for the world.

RIEPE: Thank you very much. Now we'd like to have proponents, please. How many people do we have that are-- intend to speaking as a proponent? OK, we have a number. Welcome, Senator. If you will--

ANNETTE DUBAS: Thank you, Senator Riepe.

RIEPE: you will-- as you know the routine, your name and all that.

ANNETTE DUBAS: Sometimes I need to be retrained. Thank you very much, Senator Riepe 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'm the executive director for the Nebraska Association of Behavioral Health Organizations, otherwise known as NABHO. NABHO is a statewide organization representing providers, regional behavioral health authorities, hospitals, and consumer groups. In 2012, Senator Bob Krist introduced LB1158, which was the bill to establish the statutory authority overseeing managed care. At that time, behavioral health was a carve-out, meaning that we were the only service sector involved with managed care. NABHO was extensively involved with the development of these statutes by hiring a nationally recognized consultant, Dr. Andy Keller with TriWest, who researched existing successful models and met with industry experts, health care professionals, consumers,

and advocacy groups to move forward the statutes we have today. The goal was to ensure that successfully moving forward with at-risk managed care would require basic contractual parameters and safeguards to be in place. The original legislation gave Medicaid the guidelines to negotiate such contracts. The legislation created accountability, and prioritized money to be spent on services rather than administration and profits. Since the adoption of LB1158 in 2012, we believe these goals have been successfully met. But a lot has changed over the last 12 plus years. We are now an integrated managed care system that includes physical health, behavioral health, and dental. We now work with these-- with three companies versus the one in the past for behavioral health. But what hasn't changed is the need for continued accountability, transparency, and trust between all stakeholders. An update of these statutes is in line. NABHO, again, recently hired TriWest, asking for research regarding payment of rates as posted, improving communications related to any contract changes, addressing parity, and defining and maintaining network adequacy. The other states-- what-- and review of what other states have done provided background reinforcing these changes. A particular interest to our members is ensuring the rates appropriated by the Legislature and posted by Medicaid are the floor for negotiations. Over the past 20 years, NABHO has worked closely with the Legislature to address woefully low reimbursment rates. Incremental changes each budget cycle have been built into behavioral health system, making it much more responsive to Nebraskans based on cost modeling done by the Division of Behavioral Health to-- in 2016, rates were at that time anywhere from 7 to 35% below the cost of providing services. So the Legislature has made a very conscious effort to get rates built up to allow us to build capacity and improve access to care, and we are grateful for that, for that support. We just simply cannot afford to take any steps backwards in support for capacity building in our system. We believe LB380 updates and builds on the original goals to establish clear direction for managed care companies, and to continue fostering trust between all stakeholders. So I thank you for your time and attention, and would attempt to answer any questions.

RIEPE: Thank you very much. Do we have questions from the committee? Senator Quick. Yeah.

QUICK: Thank you, Chairman Riepe. So like on the-- so like the rates and stuff, there are-- is it negotiated case by case or how does that--

ANNETTE DUBAS: Every provider will negotiate with the managed care company that they're contracting with. So those, those are, those are

private, those aren't things that are, are made public. But there is, there is a negotiation. So what we're asking for is that when they're talking about the rates that they're negotiating, that the rates you approve, you appropriate for, that that be the floor, that the negotiations can't go below those rates and that we go, we go up from there.

QUICK: OK. So could-- Sorry, can I ask another que-- another question would be--

RIEPE: Yes sir.

QUICK: --so like there could be different-- I mean, negotiated cost could be different for every provider?

ANNETTE DUBAS: Yes.

QUICK: For the--

ANNETTE DUBAS: You know--

QUICK: --same type of service? Or--

ANNETTE DUBAS: Well I mean, you know, I'm not privy to, to all of the content of the contracts. You know, all of our providers, you know, they may provide similar services, there may be nuances in the services, but those, those are open to the negotiations that the provider organization and the managed care companies have.

QUICK: And then one final question. Would it be better just to have a standard rate that they would pay, or is it better to have a negotiated?

ANNETTE DUBAS: You know, I hesitate to speak for all of my providers, but I think, you know, again, you know, we want to be able to have services that fit the needs of, of the areas. And so, you know, maybe a provider can, can provide a service that isn't available anywhere else, but we want to compensate them accordingly. I mean, we do-- we are able to do that somewhat with the-- through the division of behavioral health. So, you know, not wanting to speak specifically for what my members would think, I would think we would want to give some, some leeway in the contracts.

QUICK: OK. All right. Thank you.

RIEPE: Other questions from the committee? Senator Ballard.

BALLARD: Thank you, Senator. Thank you for being here, Senator. How, how close are reimbursement rates to actual cost for providers?

ANNETTE DUBAS: Well, as I said, that, that cost study that was done in 2016 showed that 7 to 35%. We have made great strides in closing that gap. I can't give you specific percentages--

BALLARD: OK.

ANNETTE DUBAS: --but I do know we've made a difference. Are they fully covering the full cost? No. And, you know, will we ever get there? Probably not. But we certainly are, are closer than what we have been in the past. And because of that, our members have been able to build capacity in the system. I mean, they still, just like any other business, are dealing with increasing costs through, you know, insurance and, and paying competitive wages, you know, attracting and retaining workforce. So those challenges, as with any business, haven't lessened for them.

BALLARD: OK. And then one more question if I my.

RIEPE: Sure.

BALLARD: Do you have any concern with the Legislature inserting themselves in a negotiation pro-- I'm just trying to figure out-- because you said you want a floor for, for negotiations. So do you think these MCOs will come in and be like, well, that's just a floor, this is what we're going to pay. And so they're not going to negotiate up at all?

ANNETTE DUBAS: I don't think that, that would be the case. What we're saying is the Legislature approves and appropriates money. Over the last ten plus years, we've appropriated some, some much needed rate increases. We would hate to see a managed care company and-- come in and in-- while they're negotiating with providers and saying, well, we're going to go below what, what the, what the Legislature has appropriated as far as covering those rates. So I don't think it's an onerous expectation, and I don't think it would inhibit the negotiations. I mean, the, the MCOs-- we work really closely to maintain a good working relationship with the MCOs, so they understand where the challenges come from, from our members, and we understand what's coming, what they're, they're set out to do. We wouldn't want to do anything to jeopardize that. And our members try to work really closely with the managed care companies.

BALLARD: OK. Thank you. Appreciate it.

RIEPE: Other questions? I think it's a generally accepted medical-- or medical-- management practice that to get competitiveness, you have to have at least three bids in there. You get two, you don't, three, you do. You were here before I was here as a senator. Were you on the Health and Human Services Committee at any of those?

ANNETTE DUBAS: I was not on the Health and Human Services Committee, but I was in the Legislature when LB1158 was--

RIEPE: OK.

ANNETTE DUBAS: --was passed, and I need to go back and kind of refresh my memory on, on that debate. And that was one of the, the biggest concerns about passing that original legislation. Will we inhibit competition? Will we limit the number of, of companies that will come in and bid/ and that's proven to not be the case. We've had--

RIEPE: Nor is the issue of privatizing.

ANNETTE DUBAS: Right.

RIEPE: And I was here when we first started out with managed care. Given that, I would, I would not ask you to be specific, but do you think it's been a-- it's been six years, I believe six. Has it been a good six years or have we gone backwards in your humble former senator opinion?

ANNETTE DUBAS: Well, I think as I said, we've worked really hard to establish a working relationship with, with the companies. And I think by and large, good things have come from that working relationship. Managed care is-- it's the world we live in right now. So to go back to where we were, you know, I don't think that's, that's a possibility. So I think there's been pluses and minuses. My members would probably come forward and say they like the way it's happening here. Maybe they're a little frustrated with some of the other things that are going on. But by and large, I think it's, it's been a good relationship.

RIEPE: OK. Thank you very much for being with us. Are there other proponents? Thank you. Welcome, sir. If you'll give us your name, spell your first and last name.

MICHAEL WASMER: Thank you.

RIEPE: Then you're free to go ahead.

MICHAEL WASMER: Thank you. Thanks for the opportunity to speak today. My name is Mike Wasmer, M-i-k-e W-a-s-m-e-r, and I'm the chief operating officer for the Council of Autism Service Providers. And I'm also the father of a young adult with autism. CASP is a nonprofit trade association of autism service provider organizations that have demonstrated a commitment to promoting and delivering evidence-based services for autism. We represent the autism provider community to the nation at large, including government, payers, and the general public. CASP provides information, education, and promotes the generally accepted standards of care for Applied Behavior Analysis, or ABA for enti-- for the treatment of autism. On behalf of CASP member organizations who provide services to more than a thousand Nebraskans, including Medicaid beneficiaries, CASP supports the passage of LB380. Among other provisions, this bill prohibits contractors from reducing department posted rates, as was proposed for some providers of ABA services in Nebraska last fall. If enacted, this would help to ensure the reimbursement rates for autism service providers remain fair and sustainable, preventing MCOs from imposing excessive rate cuts that could limit rider participation and access to care. Further, this bill requires that MCOs maintain an adequate provider network to deliver mental health and substance abuse, substance use disorder services. This provision would help to ameliorate provider shortages, ensuring individuals with autism and other behavioral health conditions can access medically necessary services with reasonable promptness. Current access standards for MCOs operating in Nebraska require that they provide access to a minimum of two providers, a behavioral health outpatient assessment and treatment services within 30, 45, or 60 miles, depending on whether the beneficiaries reside in an urban, rural, or frontier county. 87% of counties in Nebraska do not meet these criteria for licensed providers of ABA services for individuals with autism. Access standards should be enforced and incentives offered to encourage providers to serve Medicaid beneficiaries in these underserved areas. CASP recommends that the committee consider revisiting access standards for outpatient behavioral health providers as they are defined for MCOs. The current standards do not address time to care for these services. Effective in 2027, CMS will require that appointment wait times for outpatient mental health services be no longer than ten business days. Lastly, this bill requires MCOs in Nebraska apply criteria in accordance with generally accepted standards of care. Payers often utilize criteria published by for-profit entities that do not reflect the generally accepted standard of care for a given clinical specialty. Enacting this bill would help to ensure that treatment decisions align with established clinical best practices, promoting evidence-based care for autism and

other behavioral health conditions, reducing inappropriate denials, and improving health outcomes. If it's the committee's will to advance this bill for further consideration, CASP would value the opportunity to offer amendments for the committee's consideration that provide some definitional clarity around terms related to generally accepted standards of care and their implementation. And attached to my testimony is the model legislation that provide those definitions. Thank you for the opportunity, and I'd be happy to answer any questions.

RIEPE: Good timing. Are there any questions? Senator Quick.

QUICK: Thank you Senator. So I know my son, he works with-- for a company, and he works with a little-- actually a young, young-- Well, he'd be a first grader this year who has autism, and actually in the OPS school system. And there's-- those are opportunities for people and, you know, maybe in Omaha or a bigger community, but maybe you could address more, and I know you talked a little bit about, like, rural Nebraska and how individuals with autism and-- are they available for some of the, some of those services that are--

MICHAEL WASMER: Unfortunately, no. I mean, as-- our EPF government affairs has done extensive studies looking at network adequacy in all 50 states. And, you know, the 87% figure that I pulled is from some of the research that she's done that showed 87% of the counties in Nebraska offered less than two providers in the entire county, which significantly limits access.

QUICK: So what happens? I mean, do they have to travel to get services or what?

MICHAEL WASMER: They either travel or they go without, or, you know, post-Covid there's been an influx more of services being delivered by telehealth.

QUICK: OK. May I have one more question?

RIEPE: Sure.

QUICK: So-- and then too for, like, services, I know just like with insurance sometimes they refuse services, providers may say-- recommend that these services are recommended. Do you struggle with that sometimes with--

MICHAEL WASMER: Absolutely. I mean, that's one of the reasons why the provision in this bill related to adopting generally accepted

standards of care is so important. Because a lot of times when those medical necessity decisions are being made, the guidance that the payers are using aren't consistent with the generally accepted standards of care for a given specialty, like Applied Behavior Analysis.

QUICK: Thank you.

RIEPE: OK. Are there-- excuse me-- any other questions? OK, seeing none, thank you very much. Additional proponents? Thank you. If you'd be kind enough to give us and spell your name, first and last, please?

KRISTEN ROSE: Good afternoon. My name is Kristen Rose, K-r-i-s-t-e-n R-o-s-e, and I'm a licensed independent mental health practitioner in Sidney, Nebraska, with a private practice as well as working with Sidney Regional Medical Center. I'm also the public policy and legislation chair for the Nebraska Counseling Association, and I am a member of the Nebraska Association for Behavioral Health Organizations. I want to thank Senator Fredrickson for introducing LB380, which is vital to ensuring fair and transparent managed care organization practices. I'm here to express support for this bill because providers and Medicaid clients deserve transparency, accountability, and adequate access to care. LB380 provides a needed update to our managed care statute. I've been in regular contact with individual counselors across the state, and they have reported being paid a reduced rate without justification. This has led providers to make difficult decisions in regards to providing care for Medicaid clients. This legislation reinforces that MCOs are held accountable, state and federal laws are followed, and that their compliance standards are transparent, not buried in a 2,000 word-- page contract. As a Nebraska Counseling Association board member, I have received significant feedback from our membership with their difficulties in navigating communications and changes or amendments to the managed care organization contracts. Counselors have expressed frustration with the lack of communication and navigating conflicting communication from MCOs. Nebraska counselorswant a working relationship with MCOs to provide the best mental health care for clients, and have expressed a desire for clarity, consistency, and parity. This bill provides that framework to achieve those goals, and creates a good working relationship-- sorry-- between the counselors and the MCOs. Parity and compliance reports help counselors and Nebraska Medicaid better understand the MCOs' effort to achieve and maintain provider network adequacy. Our state has long been facing a behavioral health workforce problem, and Nebraska Counseling Association and NABHO want to make sure that we have statutes reflect

where we are today with managed care as a contracted stakeholder for our system of care. Especially important for rural and frontier Nebraska is understanding what network adequacy means, and how is being achieved is critical to meeting the needs in a professional and timely manner. There are 88 of 93 counties in the state that are designated as mental health care provider shortage areas. For example, Sidney Regional Medical Center had a mental health therapist position posted for about a year and a half before I applied, and other facilities in the Panhandle face the same issue. Hospitals and other agencies have difficulty recruiting and retaining mental health professionals to rural areas, and there are few clinicians opening private practices in these areas. Nebraskans want to connect to providers that are local and understand the issues they face. If MCOs do not protect an adequate provider network, Nebraskans could face even more reduced access to mental health care. This bill would require MCO contractors to maintain an adequate provider network in the state, and it would require the division of Medicaid to define that network adequacy. I appreciate your time and consideration of this bill, and I'm happy to answer any questions.

RIEPE: Are there questions? Senator Ballard.

BALLARD: You came all the way from Sidney, so I will ask you a question. Some-- I'm curious about this word transparency.

KRISTEN ROSE: Yes.

BALLARD: So we've seen MCOs will just lower your, your reimbursement without any notice, or--

KRISTEN ROSE: I've had reports of members being paid less than what their negotiated or posted rate from the state has been, and there hasn't been a very clear explanation sometimes from the MCOs.

BALLARD: OK. OK. And one more question if I may, Senator.

RIEPE: Sure.

BALLARD: So do you see, especially in the rural communities, do you see a lot of providers just not take Medicaid?

KRISTEN ROSE: It's been very hard for private practitioners to navigate three different companies' policies, trainings. And so this bill would provide that consistency where all three would, would, across the board, have those same things. The websites can be hard to navigate for private practitioners. Usually private practitioners have

a lot on their plate. A lot of them do their own billing, and they get frustrated with the process of trying to navigate the policies, the trainings for all of the documentation requirements. So I see a lot of practitioners get frustrated and either not contract at all with Medicaid due to that, or they usually end their contracts.

BALLARD: OK. Thank you so much for being here.

RIEPE: Senator Meyer.

MEYER: Thank you, Senator Riepe. When you have a deficiency in reimbursements, is there a, a process whereby you can get some clarification of why you were shorted on reimbursement?

KRISTEN ROSE: The practitioners that have reached out to me have had issues with communicating with the MCOs. And this bill would provide for some clarification as to who to contact and get some clar-- clarity with that.

MEYER: And is there any penalty with regard to them not living up to their contract? Are we imposing as part of any legislation prior, or any, any proposal here to hold them to their contracts is-- So that, that is a process currently not in place, something that we are implementing with this legislation? OK. Thank you. You can elaborate on that if you want.

KRISTEN ROSE: Each MCO has their own process, it seems, from the reports that I've heard from counselors across the state, and so navigating what each individual MCO process is has been difficult.

MEYER: Thank you.

RIEPE: Thank you. Are there other questions? I have heard that the absence of standardization creates extra problems back with for providers. You mentioned a couple of times the adequacy of provider network. What is the status of the provider network in your area? It's not good, I can tell by the look on your face.

KRISTEN ROSE: We have had more counselors in my county come in. However, I don't know that it's enough to meet the need. And the three counties surrounding me don't have any therapists at all.

RIEPE: OK. Are there any other questions? Seeing none, thank you very much for being here. Additional proponents please? If you are going to testify, particularly now as a proponent, please come up to the front. We have some seats.

DRU McMILLAN-BEEMAN: I have a copy my testimony. Would that be helpful for all of you?

RIEPE: I'm sorry?

DRU McMILLAN-BEEMAN: I have a copy of my testimony for the legislators if that would be helpful.

RIEPE: If you'd give that-- thank you very much. If you would be kind enough--

DRU McMILLAN-BEEMAN: Yes.

RIEPE: --to give us your name and spell it?

DRU McMILLAN-BEEMAN: My name is Dru McMillan, D-r-u M-c-M-i-l-l-a-n. I'm a licensed independent mental health practitioner and a master social worker here in the state of Nebraska. I am grateful for the opportunity to be here. I have wanted to speak for a long time. Senator Fredrickson, thank you. And thank you to this committee. I am testifying to support these bills because I feel strongly that both Medicaid clients and providers deserve fairness, transparency, and accountability. However, these bills must include language which explicitly states that managed care organizations are required to follow Nebraska's Medicaid statutes, or they will continue to exploit legal loopholes. In the process, they will exploit the clients they purport to serve. In my seven years of owning and operating a private practice, I have undergone three Medicaid audits, two of which have occurred in the past 12 months. The result of the recent punitive nature of the MCO audits has resulted in the difficult decision to forgo serving the Medicaid population. I am appealing to the state to enact legislation that protects clients and protects clinicians. MCOs must be held accountable to Medicaid legislation if they're going to administer it. They are using gaps in current legislation to avoid this. During one managed care audit, the provider took 365 days before returning my results, which is well over the 180 day window required by the statute, at which time I received a letter requesting I repay $20,000. It was defeating that I was held to standards surrounding timeliness that I could not ignore, because Medicaid law only applied to me as a practitioner and not to them as an MCO. MCOs are attempting to recoup payment after services are approved and rendered by auditing those same services and demanding repayment without proof of fraud, and with auditors who are not licensed professionals. When I was audited, it was for services which had already been approved and paid. The special investigator assigned to my case during both recent audits

had no clinical background. In previous audit several years prior with a licensed clinician, the audit was informative and helpful. It was not fo-- it was focused on correcting errors and finding fraud, not on punishment and payment. The MCOs are not utilizing standard compliance criteria, and the scope and frequency of their audits are unsustainable. The MCOs audited me for 12 plus months of record, with over ten clients each, who I was seeing on a weekly basis. That is a huge quantity of data for a single person to pull, costing me my own well-being while recovering from long Covid and caring for my children as a single mother. Most concerning, however, was that at no point were any of my clients involved in this process. If the goal of these audits is to reduce fraud, certainly they are the individuals to whom accountability is owed. While I, as a provider, choose who I serve, individuals with limited resources often do not. I specialize in working with trauma, adoption, and young children. Nearly half of my caseload prior to this last year was Medicaid who needed these specialties.

RIEPE: OK.

DRU McMILLAN-BEEMAN: Failure to--

RIEPE: Can you wrap-- Can you kind of wrap it up?

DRU McMILLAN-BEEMAN: Yep.

RIEPE: We have a red light here.

DRU McMILLAN-BEEMAN: I'm almost done. Failure to protect providers by governing MCOs will result in losing expertise. It's not because we don't care. It is because we are not willing to risk our livelihood and our mental health so that MCOs can put profits back in their pockets at our expense.

RIEPE: Thank you very much. Are there questions from the members? Senator, Senator Quick.

QUICK: Thank you, Senator. Riepe So, you know, like, have you talked to other providers that have had--

KRISTEN ROSE: Yes, I-- there is a large collaborative of providers who went through the same experience. We were given no justification that was tangible, that we could understand why we were getting money taken back.

RIEPE: OK. On this un-- Go ahead.

QUICK: And on the audits, I mean, did they send you prior notice or how does that work?

KRISTEN ROSE: Yep. They send-- they give you have 30 days to pull that number of records.

QUICK: All right. Thank you.

RIEPE: Senator Meyer.

MEYER: Thank you, Senator Riepe. And so is there one or two specific MCOs that are consistently--

KRISTEN ROSE: I was, I was audited by--

MEYER: --violators?

KRISTEN ROSE: --I was audited both by Nebraska Total Care and UnitedHealthCare. Those were the two that audited me.

MEYER: OK. And that's probably uniform.

KRISTEN ROSE: That, that was consistent with my experience of other providers.

MEYER: I--on-- on my peripheral vision I see heads nodding. So it's not your testimony quite frankly.

KRISTEN ROSE: Yeah, but that was my experience.

MEYER: Thank you.

RIEPE: Senator Hansen, please.

HANSEN: Thank you. Are you going to be here testifying on the next bill, too?

KRISTEN ROSE: I won't testify again. This is for both. I mean it is--

HANSEN: It is for both.

KRISTEN ROSE: --applicable for both bills.

HANSEN: OK, because this sounds like LB381.

KRISTEN ROSE: Yep.

HANSEN: OK. All right. Thanks.

KRISTEN ROSE: Mm hmm.

RIEPE: OK. Additional questions? One of the questions I have is, did you have an opportunity to meet face to face with the auditor, to verbally walk through and try to explain a little bit?

KRISTEN ROSE: No.

RIEPE: No.

KRISTEN ROSE: And they were not a clinician, so they didn't understand what they were looking at.

RIEPE: OK. OK. Are there any other questions? Seeing none, thank you very much.

KRISTEN ROSE: Thank you.

RIEPE: And additional opponents [SIC]? Please come forward.

MARY KELLY: Good afternoon, Senators. I'm Mary Kelly, M-a-r-y K-e-l-l-y ally with the League of Women Voters of Nebraska. The League of Women Voters of the United States believes that every U.S. resident should have access to affordable quality in and outpatient behavioral health care, including needed medications and supportive service that is integrated with and achieves parity with physical health care. The league also believes with regard to cost control, methods used should not exacerbate disparities in health outcomes among marginalized residents. Nebraska's shortage of behavioral health providers has been well documented. An article in Nebraska's Flat Water Free Press notes that about 100,000 Nebraskans live in counties with no mental health workers at all, according to numbers from the University of Nebraska Medical Center. More than half a million residents, 30% of the state's population, live in a county with less than five providers. Efforts to train providers and expand behavioral health services have met with some success. However, that success is currently threatened by the billing and audit activities of managed care organizations contracted by Nebraska's Heritage Health Program. In November 2024, a reporter with the Flatwater Free Press interviewed 28 behavioral health providers who believe they've been victimized by new, ultra aggressive Medicaid audits that conflate minor mistakes with fraud. The results of a survey conducted by the Nebraska chapter of the National Association of Social Workers found that of 126 mental or behavioral health care providers, 20% were so unhappy with Nebraska's Medicaid program that they planned to leave it. Providers have complained that auditors have placed arbitrary time limits on treatments, initiated

audits over simple clerical errors, and demanded voluminous records. Often, the audits have been initiated well over a year after payment was provided. Providers have been required to repay large sums for reasons that have been unclear to them. LB380 will assure that contractors reimburse Medicaid providers at the rates posted by Nebraska's Department of Health and Human Services. They will clearly define the amount of profit allowed, and reduce excess administrative spending so that patient needs are primary. The bill requires managed care companies to adhere to utilization review standards that are clearly communicated and available to the public. Importantly, they prohibit these companies from rescinding or modifying authorization for service after that service has been rendered. In addressing these concerns and others, all Nebraskans will benefit from better transparency of care management, including audits and better communication between Medicaid administration and providers. Certainly, we can all agree that Nebraskans benefit from effective stewardship of taxpayer dollars. LB380 assures improvement and fairness, quality of care, and a focus on patient well-being and the process of assuring that Medicaid dollars are benefiting Nebraskans. Please advance LB380 to the General File. Thank you.

RIEPE: Thank you. Are there questions? I have one question.

MARY KELLY: Yes.

RIEPE: Without naming any of the managed care organizations, is there one of the three that's more aggressive in terms of auditing?

MARY KELLY: I am not aware, but I bet some of the providers here--

RIEPE: OK.

MARY KELLY: --could better answer that question.

RIEPE: I think we all know. Thank you very much for being here.

MARY KELLY: Thank you.

RIEPE: Additional proponents? Do we have more proponents coming up? Or if not, the opponents, if there are some, are welcome to move up to the front here so we can keep moving if you will.

SPRING LANDFRIED: Members of--members of the committee. My name is Spring Landfried, and I'm a licensed independent mental health practitioner from western Nebraska. I want to thank you for the opportunity to speak here. We've been wanting to speak to somebody for

a long time. Sorry. I'm really nervous speaking in public. Nebraska needs LB380 to restore accountability to Nebraska, to the Department of Health and Human Services contractors providing medical assistance services. LB380 is important to LB381 to repair unintentional loopholes in Nebraska regulations that the contractors are exploiting with questionable unethical practices. Managed care organizations-- this is necessary to hold managed care organizations accountable for consistent compliance with Nebraska statute, policies, regulations, and services. In the Nebraska Focus Program Integrity Review Final Report, April 2023, cMS identified six findings that create risk to the Nebraska Medicaid program related to managed care program integrity oversight, where I quote, findings represent areas of noncompliance with federal and or state Medicaid statutory, regulatory, subregulatory, or contractual requirements. Lawsuits involving the parent corporation of a current Nebraska MCO contract, and when I say MCO, I mean their parent corporation because the MCOs we're working with no longer exist. They operate like shell corporations right now. They have exposed practices that align with violations of the Racketeer Influenced and Corrupt Organizations, RICO, Act. Allegations that parent corporations have systematically used its subsidiaries to defraud taxpayers. On May 6th, 2024, one of these cases moved forward for all states named except for Nebraska, because, and I quote, Nebraska statute exempts certain activities of heavily regulated businesses. This is done at the expense of consumer rights. I am personally affected by this action, as I was a member of the insurance company named in the lawsuit, and I also am a survivor of one of these predatory audits. I'm asking you today to take immediate action barring questionable practices. Is this too much? Nebraska is already bearing the repercussions of one violations of civil rights case determination by the DOJ. Without protections from LB380 and LB381, it leaves an environment that allows corporations to continue to mock federal and state statutes, which may ultimately leave us to pay the price again. I urge you to support this bill to protect Nebraska constituents from unchecked power of the corporate MCOs, or more specifically, their parent corporations. LB380 is a step in the right direction to ensure fair processes that protects Nebraska taxpayers' accessibility to services and ensures already scarce mental health providers stay in our state. Thank you for your time and consideration.

RIEPE: Thank you.

SPRING LANDFRIED: I'm happy to answer questions.

RIEPE: Before we go any further, would you be kind enough to state your name and spell it so that we have it, first and last, so we have it in the record?

SPRING LANDFRIED: I apologize, it's Spring Landfried, S-p-r-i-n-g L-a-n-d-f-r-i-e-d.

RIEPE: OK, now we'll ask if there are questions from the committee? Will you be cross-- testifying on LB381?

SPRING LANDFRIED: I will.

RIEPE: You will.

SPRING LANDFRIED: Yep.

RIEPE: Will it be the same testimony?

SPRING LANDFRIED: No, it will not.

RIEPE: OK. Are there any other questions?

SPRING LANDFRIED: Because this, this one is really just about letting Nebraska do what Nebraska has always done, that we're being pre-- Nebraska being prevented to do right now.

RIEPE: OK. Thank you. Thank you for being here today.

SPRING LANDFRIED: Thank you.

RIEPE: Thank you for coming so far.

SPRING LANDFRIED: Yes.

QUICK: Other proponents? Is this our last proponent? Are we-- OK. Two more. OK. If you would, please spell your name.

ERICA SCHROEDER: Absolutely. Erica Schroeder, E-r-i-c-a, Schroeder, S-c-h-r-o-e-d-e-r. Good afternoon, Chairman and members of the committee. My name is Erica Schroeder. I'm a licensed independent mental health practitioner for the state of Nebraska, and I work in Lincoln, Nebraska. I'm also a retired U.S. Air Force master sergeant, where I was a security forces supervisor, which is, just to make it clear, I was a police officer. I was also combat arms trained in maintenance, noncommissioned officer in charge-- I was also the noncommissioned officer in charge of quality control, where I inspected and administered corrective actions as it relates to

military regulations, as well as wrote them myself. And I was also a hostage negotiator. That was fun. I hold a B.A. in human relations and a master's in counseling. I share this background because my professional experience has given me firsthand knowledge on how accountability systems work, and what happens when they don't. That is why I'm here today to testify in strong support of LB380. I will-- the bill that is essential to closing loopholes enforcing Medicaid regulations in Nebra-- protecting Nebraska's health care providers and patients. LB380 is critical. LB380 strengthens oversight of managed care organizations that administrate our Nebraska Medicaid program. Right now, these organizations exploit loopholes in their contracts with DHHS, harming providers and limiting access to care for Nebraska's most vulnerable residents. Despite clear state federal regulations, MCOs continue to deny, delay, audit providers unfairly, without facing consequences. LB380 ensures these entitled entities are held accountable for the following the laws that govern Medicaid in Nebraska. The problem. Lack of oversight leaves providers vulnerable. Covid 19 emergency declaration, which was enacted on March 13th, 2020, May 11th--going to May 11th, 2023, was designed to protect access to health care. Yet MCOs ignored these directives and were never held accountable, which is relatable to my situation. Nebraska Revised Statutes 68-974 limits audit record request to 200 within 180 days and gives provider 45 days to respond. However, MCOs are continuing to overwhelm providers, exceeding these limits. Mine exceeded 165 claims within five business days. Nebraska Revised statute 44-8004 requires insurers to process claims within 30 days. This too is not being followed. LB380 will ensure that MCOs follow Medicaid regulations; process claims fairly; audit procedures align with state law, preventing MCOs from abusing their power; providers receive due process when audited, preventing financial instability that forces clinics to close; patients maintain access to mental health providers. The reality: without LB380 providers will continue to struggle. Nebraska's Medicaid laws are designed to ensure transparency and fairness, but without so--

RIEPE: We're-- we've exceeded our time now, so do you have about another sentence or so to wrap it up?

ERICA SCHROEDER: I would say that the one law that they have continued to fall back on is what they refer to as an appeal process, which also has failed. So they are the ones that you appeal to and then in turn tells you that--

RIEPE: OK.

ERICA SCHROEDER: Correct.

RIEPE: Thank you very much. Tell me a little bit about the appeal process. Do you have to travel to go to that appeal process or is it done-- how's that, how's that conducted? Or have you been through an appeals process?

ERICA SCHROEDER: I, I have.

RIEPE: You have.

ERICA SCHROEDER: You will submit identifying where they found errors and you identify why those are not errors. And then they submit back to you that you have either appealed on some, none, or all. And I don't know that I've met any provider currently that has passed an appeals-- disregard that, I've met one individual. No one else has passed an appeals process with the MCOs.

RIEPE: Have you had an auditor who had the conclusion of it said, you know what, I was wrong and you were right?

ERICA SCHROEDER: No.

RIEPE: OK. Any other questions? Senator Meyer.

MEYER: Thank you, Senator Riepe. So it would appear that the providers, the MCOs actually, are violating agreements they have with the Department of Health and Human Services?

ERICA SCHROEDER: Correct.

MEYER: And Department of Health and Human Services, they ignored those violations, or how did they handle them?

ERICA SCHROEDER: I would, I would even go as far to say blatantly ignored. I, I-- in, in LB381 I will actually cover that. But I have gone through a process of talking with my senator, Senator Bostar, I then also spoke-- I was in the process of working with the Ombudsman. The Ombudsman's ability to provide any type of oversight with Medicaid was then revoked in the middle of this procedure, in the middle of, I believe it was 2023, in the summer, after the Attorney General submitted a 83 page report identifying why it was a conflict of interest. Once the Ombudsman was no longer allowed to provide or look at or look into Medicaid MCOs, I then processed and went up to the senator, which is what the Ombudsman's response was to deal with it. I spoke with Senator Bostar. Senator Bostar then advised me that he

would like me and would going to get me an appointment and a meeting with the Governor's Office. I have to look at my notes with the special-- basically rules and regulations investigation, kind of like a quality control as it relates to those things in the state that they can investigate immediately. I was never-- I have called multiple times, and apparently so did Senator Bostar, and I was not granted a meeting. During this time frame, I also had a meeting with DHHS with the Ombudsman, which was with a individual named Ms. Anne Harvey, as well as a Christine [PHONETIC] I won't, I can't recall her name, who was the MCO contract manager. And at the conclusion, Mrs. Harvey continued to identify that if I had not done the appeals process, it was my issue. And her particular position is related to fraud, waste and abuse. So my, my military experience, every individual in this state is responsible, even if it's not written down and handed over, we are responsible to report fraud, waste and abuse, regardless if it's the provider on the outside, or is it the managed care provider on the inside or the managing MCOs. Why? Where does our tax money go? So if they were utilizing this to then brought-- bring back in additional money they're double dipping then, aren't they? Because if they're not identifying that we are fraudulent, who's going to, who, who provides the oversight? We have no oversight. The Ombudsman is not available to us. Our senators can do nothing for us. Well, we're hoping that changes, thank you. And this is why we're here. The only way we're going to create change is to not remain silent. Because silent means consent.

RIEPE: OK. Are there other questions from the committee? Seeing none, thank you very much for being here. Thank you for your service.

ERICA SCHROEDER: Thank you.

RIEPE: Other proponents? We do. Welcome, sir. If you would be kind enough to state your name and spell it, and then you're free to go.

JAMAAL HALE: My name is Jamaal Hale, J-a-m-a-a-l H-a-l-e. I'm a provisional health, mental health practitioner. When I got my license in 2022, I never thought I would be in this position that I'm in right now. In 2023, we were, we were audited. Findings came back when I worked for my supervisor that he would have to pay back $36,000. In March of 2024, they hit me with the same audit for the same clients. Throughout this process. It feels like the movie Flight. Have you seen the movie Flight with Denzel Washington? Where anyone they've audited, you're not going to pass. There's no transparency, a simple fix of upcoding or a signature? You can't fix it, right? It has left the people that I work with underprivileged and at risk, vulnerable as it

threatens my livelihood. I'm hoping that we can get enough support for this bill to pass. And you can see my face is really tough. I got, I got nothing else.

RIEPE: OK. Are, are you completed?

JAMAAL HALE: Yeah. I'm completed.

RIEPE: OK, thank you, sir. Are there questions from the committee? I don't see any. Thank you for being here.

JAMAAL HALE: Thank you.

RIEPE: Thank you for sharing. Are there any other proponents? We have another one. Would you be kind enough to state your name and then spell it for us, please? First and last?

HEIDI SMITH: I will.

RIEPE: Thank you.

HEIDI SMITH: And I have mine together. I'm trying to separate, so. My name is Heidi Smith, H-e-i-d-i S-m-i-t-h. I'm a licensed independent mental health practitioner who has worked over 15 years in agencies guiding clients through processing trauma, developing coping strategies, and improving their lives. I attended an accredited community counseling program at UNO. I passed the National Board of Certified Counselors test. I completed my provisional hours with weekly supervision to become fully licensed, and I completed the required number of hours working with clients with severe and persistent mental illness to earn the ability to practice independently with my LIMHP in Nebraska. I complete the required and more continuing education requirements every two years so I can keep my license. I'm sharing this not to give you my accomplishments, but to make sure everyone knows what the requirements are to be and remain a licensed therapist in good standing in Nebraska. I started in private practice less than one year ago and spent a lot of time researching, documenting, and guessing to-- for the expectations of the MCOs. There's a lot of fear that goes along with this, and wondering if I'm going to fall victim like my colleagues and have clawbacks of thousands of dollars. It makes me consider not taking any Medicaid clients any longer, even though for 15 years working in agencies primarily, that is what we did. And that is where I feel our big need is continued. Again, there's a lot of fear there. It's important to, to know where I came from. But the, the things that, that we have to do to keep our license because the people that are

auditing us are not clinicians and don't understand what we have gone through, and the education that we have. It is important that LB380 is passed to protect providers from this arbitrary, adversarial audit process. It has changed from ad-- from collaborative, where we can work together to help the clients, to adversarial. And it's focused on money rather than client care, in my opinion. So I appreciate you hearing me out today, and I hope that you will advance LB380. Thank you.

RIEPE: Excellent timing. Are there questions from the committee? Seeing none, thank you very much for being here. Are there any other proponents? Those that are supporting LB380? If not, are there any opponents? We know you, good sir, but if you'd be kind enough to state your name and spell it for the record.

DREW GONSHOROWSKI: Sure. Thank you, Senator. Good, good afternoon, Senator Riepe and members of the Health and Human Services Committee. My name is Drew Gonshorowski, D-r-e-w G-o-n-s-h-o-r-o-w-s-k-i. And I am the director of the Division of Medicaid and Long-Term Care in the Department of Health and Human Services. I am here to testify in opposition to LB380. First, this bill restricts managed care organizations from negotiating contracted rates with providers below posted fee for-- fee for service rates. This restriction is written without any limitations and applies to all provided services, devices and materials. For example, MCOs would be prohibited from negotiating rates for durable medical equipment such as latex gloves. Negotiated provider rates can be an important mechanism used to generate value for Nebraskans. MCOs currently negotiate rates with providers and are tasked with balancing access to care, quality of care, and cost efficiency. MCOs are contractually, contractic-- contractually obligated to ensure sufficient access to care. Second, LB380 would prohibit MCOs from applying medically-- medical necessity criteria to mental health or substance abuse disorder, collectively known as behavioral health services. Medical necessity criteria can provide guidelines for appropriate levels of care while ensuring access to critical services for patients most in need. The bill introduces an undefined term, predominant limitations, which does not have a standard clinical or regulatory definition. It also requires contractors comply with federal and state law for coverage of behavioral health services. However, there are no federal requirements regarding coverage of these services. These newly imposed limits impact MCOs' ability to provide timely and appropriate, appropriate care for members. Third, this bill includes several new reporting requirements, including surveys, financial reports, audits, parity reports, and network adequacy reports, which, which often contain

confidential, proprietary information. Finally, LB380 requires the department to define network adequacy, although this term is currently defined in MCO contracts as services that take into account urban, rural, and frontier counties. It is important to DHHS that individuals with behavioral health needs receive quality, appropriate, and timely care. The Medicaid program has prioritized these needs in recent years, which included specific language within MCOs' January 2024 contracts. We continue to work with our stakeholders to develop new strategies to ensure our behavioral health service coverage meets our members needs. We do not believe that this bill is the best way to pursue these priorities, and therefore, I respectfully request the committee not advance LB380 to General File. Thank you for your time. I would be happy to answer any questions on this bill.

RIEPE: Thank you. Are there questions from-- Senator Meyer.

MEYER: Thank you, Senator Riepe. You haven't been with the DHHS very long. I think we saw you, you earlier in, in our session. It would appear, from my position, that you are supporting status quo and a lack of response by the Department of Health and Human Services, and it's pretty obvious we've got some massive deficiencies here. So how can you defend not responding to these folks and defending the status quo and the inadequacies that would appear to be happening, from my perspective, of not holding the MCO's to accountability?

DREW GONSHOROWSKI: I mean it's--

MEYER: And, and, and following up on their contracts?

DREW GONSHOROWSKI: No, and I appreciate that question, Senator. You are correct that I started in December, and I think I was confirmed sometime in January. It's all a blur at this point. I think, I think in, in terms of speaking specifically about 380, there's, there's, these questions about that, that, that you have heard so far about network adequacy and then specifically setting a floor on fee ser-- fee for service rates. Ultimately, this legislation-- in terms of fee for service rates, the MCOs do have latitude currently to negotiate those rates above and below the set fee for service rates. And oftentimes they do negotiate above. I think, to Senator Riepe, Riepe's point earlier, this is, this is a mechanism of why we have MCOs. Ultimately It is, it is not always our responsibility to, you know, put our finger on the scale. And we allow market forces in these negotiations to occur in a way that creates efficiencies. With that, it is entirely true that Medicaid has the ability and the contractual ability to hold MCOs accountable. I think in my confirmation hearing,

especially where I'm, I'm trying to understand specifically what this discussion around network adequacy actually looks like, what the context of behavioral health provider shortage looks like, I think, I think perhaps the definition that I don't believe is addressed in LB380 in terms of network adequacy is, is probably not enough. But that's something that we're actively, now that I'm here, actively trying to understand.

MEYER: May I--

RIEPE: Thank you, Senator Meyer. Yes, proceed.

MEYER: If memory serves, you've got a great deal of experience in Medicaid. And yet, it seems the disconnect here is in the appeals process, and unqualified people running the audits, non-clinicians passing judgment on people that are professionally trained to provide the services, and then in effect, clawing back some of the, some of the resources that they've already been approved to provide and paid for providing. And so how can you, how can you defend essentially sticking up for the MCOs providing untrained personnel to do the, to do the audits, and then you stand behind them and say, hey, you went through the appeals process. Tough. And, and I find that personally totally inadequate. Totally inadequate.

DREW GONSHOROWSKI: My, my understanding of, of Medicaid's processes is that we manually review cases that are referred to us, and we do have clinically trained providers on staff.

MEYER: I have an expectation-- if I may?

RIEPE: Sure.

MEYER: I have an expectation of much greater accountability by the Department of Health and Human Services. And I find a particular lack of that accountability with the testimony I've heard today, and I expect better from us, quite frankly. Thank you.

RIEPE: Thank you. Thank you. Senator Quick.

QUICK: Thank you, Senator Riepe. So I know you haven't been here that long, but has an MCO ever been held accountable for anything like this? I mean, for some of the things we've heard today?

DREW GONSHOROWSKI: In, in terms of the items that we've heard today, I, I won't speak to specific cases. There's ongoing conversations with MCOs about network adequacy, about ongoing audits. We at Medicaid are

referred audits often, and we run them through the appropriate processes, yeah.

RIEPE: Go ahead.

QUICK: So with that view, do you ever actually-- someone from the department ever go out and intervene and actually talk to the providers themselves, and actually like a go-between to see what's actually happening, and you know what like with an appeals process?

DREW GONSHOROWSKI: We, we do have a hearings process. In terms of physical, I guess, visits, I can't speak to that. I, I, I'm not aware of that, and I can check for you.

QUICK: All right. Thank you.

RIEPE: Senator Ballard.

BALLARD: Thank you, Senator. Thank you for being here, Director. You said something interesting. Negotiating provider rates is an important mechanism to provide-- to generate value for Nebraskans. Can you expand on that?

DREW GONSHOROWSKI: Yeah, I mean ultimat-- ultimately-- it happened before I got here, but the move to, to managed care and Medicaid often can be broadly described as, you know, harnessing market forces. One of these items is specifically negotiations. The Legislature, Medicaid will set rates. Often these managed care companies are, are national entities, and they have understanding of rates across state lines. They have rates-- understanding of how rates are set in other places. And often they bring that knowledge into the-- into our state and negotiate with these providers in terms of acknowledging what's going on on the ground there, but also acknowledging what, what is paid similarly in other places in the country. That's just a, a small example of this. It also separates Medicaid and the Legislature from the process of picking winners and losers when it boils down to it, right? If we, if we trust in that-- these negotiations people enter into these agree-- these arrangements together, it is something that we're not necessarily saying this is how we want it to look and this is where we're going.

BALLARD: OK. Thank you.

RIEPE: Senator Meyer.

MEYER: May I again please? Thank you. Thank you, Senator Riepe. I guess from the-- my ears haven't heard today in any of the testimony, any complaints as far as the negotiated rates. And perhaps that's a discussion for another day. What I'm hearing is the lack of, of competency in the excessive number of audits, and then the requirement to pay back some, some funds that the provider had already been approved to-- had, had been approved for the service, had provided the service. And now through the audit, they're being required to pay some of that money back. And, and correct me if I'm wrong, but I don't believe I heard anybody protesting the, the negotiated rates that they're getting, although that might be an argument for another day. But it's the excessive audits and the lack of, of competent, I'll use that word, my word, not yours, not theirs, competent auditor to come in and not understand the process of what services they're providing, disallowing the services they provide, and requiring to pay back some funds that they'd already been approved for and, and provided those services for. And from my understanding, they have appealed to the Department of Human Services. And I understand there's an appeal process. It does not appeal-- appear to me that the Department of Health and Human Services had any adequate supervisory role in hearing their appeals, and then finding out why the MCOs were not accountable, and why they did not fulfill their contract to these providers. Because from my perspective, it's the MCOs that have violated the contracts, and the Department of Health and Human Services has not held them accountable. That's, that's what I'm hearing in the process of what I'm hearing today, and your representation of the process representing the Department of Health and Human Services. So I have a great expectation that we should do much better, much, much better. I know perfect does not exist in this world, but this process has been very, very far from that, quite frankly.

DREW GONSHOROWSKI: No, and I, and I appreciate that perspective. And I think some of this verges into discussion on LB381 in terms of the, the audits and look backs. I can, I can think of an example here where, you know, you, you find, you find sort of evidence or any sort of cases of improper documentation. It's in the state's interest and in the MCOs' interest to understand the context of that, correct? So with that look back period, you might capture things retrospectively after you've found cause for investigation. That's ultimately not only how Medicaid here views this. This is also obligations from the federal government. Oftentimes, federal audits will generate charges to the state level that have recoupment of funds. Maybe I'm foreshadowing a little on LB381, but any sort of restrictions on how much recoupment we can actually do if the feds come in and have

findings that extend past a year, that is a full cost to the state at that point under LB381.

MEYER: From what I've heard today, if I may just briefly, I know we need to move on, and I apologize for the length of my questioning. From what I'm hearing in testimony from, from our, from our providers, is that the infractions found, or improper date or, or some clerical error, not, not a failure to deliver services, not a failure to be professional in providing those services, but a nitpicky reason to pull back justifiable disbursement to these providers. And perhaps I, perhaps I-- we, we've fallen over into LB381, I'm not sure, but, but quite frankly, I just, I just find your defense of this, although you haven't been in place very long, quite frankly and I think we in fairness, I need to give you, allow you an opportunity to get the departments in shape and doing what they're supposed to do. But I, I just expect better from our department, I expect better from our state, and quite frankly, recently, and it had absolutely nothing to do with your department, but our auditor posted a letter that it had found a misplacement between years, certainly not a misappropriation of funds, but misplacement in, in accounting in Health and Human services and various sections of $165 million. And so I find a little bit pot calling the kettle black here that, that you are nit picking providers when our own house probably needs to be looked at first, quite frankly. So once again, you haven't been here very long, but I feel very strongly about this, quite frankly, and we need to do better. We have to do better. So thank you.

RIEPE: Senator Quick.

QUICK: Thank you. Thank you, Senator. So on, like on the negotiations you were talking about picking winners and losers, but-- so who, who would they be picking, the clients that they serve? Or you're talking about the providers between winners and losers? Because really, it's the clients that they serve, and they're the most important part of this whole process, so.

DREW GONSHOROWSKI: Yeah, I mean, I mean, ultimately efficient provision of services should be a priority not only of the, the Legislature and Medicaid, but also in terms of the MCOs. They-- it is a balancing act when it boils down to it, right? We want, we want the best product, for the best price, serving the most people. And, and those three pieces are often at odds, right? Oftentimes bills can be brought to the Legislature that say, hey, this provider, we, we want them to have a rate that's two to three times higher than anywhere else in the country. That's, that's picking a winner, right? When,

when you have people actively engaging in negotiations, I, I tend to think that that probably has a little better and a little less dis-- it doesn't just leave up to, to discretion that sort of arrangement, right? It's, it's something that we would hope that if we are charged with making sure that we ensure network adequacy, that, that we're getting the most cost efficient service for our dollar. Given our current context, that's a very important thing. Not having our, our hands pushing that needle in, in different directions, I think, is an ideal situation. All right, thank you.

RIEPE: Any other comments from the committee? I guess I would say this history is both a blessing and a curse. Six years ago I was chairman of this committee at the time when we introduced managed care. What we did to do some-- every two weeks we had the managed care organizations come in front of a special meeting of this committee, and we also forwarded it to the public. And so we had a number of providers that would come, and it was an opportunity for us to hear both-- from all three of the managed care organizations, and we did it every two weeks to just-- first of all, because it was new we wanted to understand if we had a, you know, a real challenge on our hands here. But it was very productive in the sense of providers to have an opportunity to kind of share with us in a three-way deal with the senators on the committee, the managed care organizations, and those that were the providers. And we had some people that were just interested that-- who were allowed to sit in because it's a public hearing Anyway. That's just a-- I don't know whether-- what your process is right now.

DREW GONSHOROWSKI: No. And I would just say on, on your point about history, history's-- can be just this great lesson, especially on the MCOs, right? Since you've been here a long time, you've, you've observed that the MCOs had multiple years prior to the pandemic where, where they didn't post pro-- profits, correct? And throughout the pandemic, it was very clear that the, the Excess Tax Fund, or the MCO Fund grew, in part because of the Covid pressures, continuous eligibility provisions, and Medicaid expansion. 2019, they didn't-- we didn't pull any money back into that fund. And moving forward, we're, we're returning back to that sort of normal. Just in the context of this profitability of MCOs question that, that sort of come up more, more, I guess less directly.

RIEPE: OK.

MEYER: Just briefly.

RIEPE: Senator Meyer.

MEYER: Just, just very briefly.

RIEPE: Of course.

MEYER: We, we are not-- we are not against the, the MCOs not being profitable at all. If, if they're not profitable, then they're not here to provide the managed care, quite frankly. But it, it just seems like a matter that in difficult times when they were not profitable, it would appear that they tried to find some profitability by clawing back legitimately delivered services, by finding inadequacies that in all probability, were not there. And so, once again, we want the managed care organizations to be profitable. Otherwise they, they are not, they're not going to be here to provide the services that we need. So I just wanted it understood, I'm not against them being, being profitable at all. But, but any other activities are totally unacceptable.

DREW GONSHOROWSKI: No. And and to that point, we do, we do limit their profits in Nebraska. Nebraska is unique in this in the country that they, they are limited at 2% profit.

RIEPE: OK. Thank you very much for your input, guys. And thank you for being here. Are there any additional opponents? If there are other opponents, we have a few seats up here at the front. Just to keep us rolling. It's now 3:00. Thank you for being with us, sir.

JAMES WATSON: Thank you. Thank you for having me.

RIEPE: If you'll be kind enough to state your name and spell it.

JAMES WATSON: I will. My name is James Watson, it's J-a-m-e-s, and the last name is W-a-t-s-o-n. I'm the executive director of the Nebraska Association of Medicaid Health Plans, and I do appreciate the opportunity to appear and testify before the committee. I have my written testimony on this bill, I have 16 copies, if-- would you like them now or-- sorry, I forgot to hand that out first, but. I'm going to limit my testimony to LB380 I, I have-- I'm also going to testify against 381. But with regard to, I guess, the first point that the association finds very concerning is the limitation on the abilities of the MCOs to be forward-looking in network contracting to negotiate these network contracts with providers. And in particular, with regard to the fee schedule. The Medicaid fee schedule is adopted by virtue of regulation, public hearing, which precedes the regulation by the Nebraska Health and Human Services Department. It is a fee for service fee schedule primarily, and as such it is volume based. So what our

companies trying and do, and that would be Molina Health Care of Nebraska, Nebraska Total Care, and UnitedHealthCare Community Plan is to negotiate things that are in addition to the base rate level, but that are quality related. To require us to guarantee a certain base rate is really not something that, with respect to managed care organizations anyway, that the state of Nebraska had anticipated in adopting the Medicaid fee schedule in the first instance. It also is going to hamper our practices in trying to find a quality-based incentive somewhere in there, and to move away, which the health care industry has done for many years, from volume based practices, because the volume based practices actually provide an incentive for additional visits. And at the end of the day, they cost more. So as good citizens, as good stewards of the citizens' dollars, we're trying to find a way to reimburse adequately in a way that the providers are taking care of, but also to add quality incentives which add additional reimbursement to that, rather than putting them in a position of having to do more procedures, for example, to get paid more, which doesn't really add up. The other part of LB380 that we have issues with as an association are the contract requirements, which we think are unnecessary afterthoughts to the RFP. If you look at the request for proposals that was issued for this 2024 contract, it's extensive. It's almost 300 pages just in the contract part in and of itself.

RIEPE: Sir, we do have a red light, so maybe a sentence or three to wrap up.

JAMES WATSON: I'll do that, Senator, for sure. And so with regard to parity, with regard to network adequacy, which I note two thirds of the citizens in Nebraska live in the eastern third of the state. That's a problem for anybody, you know, that contracts in this environment. And with respect to prior authorizations, all of these things are contained in that contract, and that's what we are relying on when we administer it on behalf of the state of Nebraska. So I'm happy to take any questions and thank you.

RIEPE: Thank you, we'll see if we can-- Senator Meyer.

MEYER: Thank you, Chairman Riepe. I haven't heard anyone complaining about the details of the contract, which is what you were representing. What I've heard is the MCO's not honoring the contract for various reasons, some minor, probably some major. But I haven't heard the CEOs or yourself say we found glaring fraud, we found glaring deficiencies in the providers in providing those services. What I'm hearing is defending a contract, which is fine. And, and, and

certainly, you know, there's lots of moving parts and you ob--you have to be profitable. I, I'm, I'm a free trade guy. However, that's not the issue. The issue is the MCO's not honoring the contracts and finding various, perhaps unrealistic expectations for the providers on the audit side and, and making demands and finding nit-picking, if you will, for lack of a better term, reasons to claw back some funds. And, and-- so I don't hear the MCOs saying we found massive fraud, or we found total inadequacies, or the providers did not provide what they contracted for. What I'm hearing here is a defense of the, of the contract itself, which they are not-- to this point, I haven't heard anyone complaining about the contract, so maybe this is for another bill, I don't know, maybe it's for the next bill, but I appreciate your representing the contract, but it doesn't appear that that's the issue that we have here. It's actually the MCOs honoring the contract that they did sign with the providers. So that, that's my perspective--

JAMES WATSON: Right.

MEYER: --and what I've heard today.

JAMES WATSON: In the contract that I was referring to, my testimony is the contract between the MCOs and the state of Nebraska, which is exhaustive. I mean, it's, it's part of a request proposal process that started with public tours, and as Senator Riepe mentioned, you know, public comment before the RFP was even done. There is always two sides to every story, Senator, and, and I know that we're going to talk about some of this in LB381. But I, I do think that the MCOs are doing a good job in looking at this stuff. And one of the reasons they look at it is in addition to any reference to profit, for example, the profit is capped by statute.

MEYER: Yeah.

JAMES WATSON: So, you know, not much to look at there. Secondly, we have data requirements in the contract where we file our encounters with the state of Nebraska every week. Part of that data that we need is technical. You could call it nit-picky, but I don't think that's really what's at work. We submit the data to actuaries who determine rates, for example, for the next reimbursement period. There's a lot of accuracy required, no doubt. But I can't really speak to whether there's been actual fraud as part of that because it's, it's pretty confidential. And I don't think even in the interest of transparency anybody wants to rule any of that kind of stuff out today.

MEYER: I would hope that the MCOs, if there's a wrong date or, or some, some minor discrepancy as far as accuracy for the reporting purposes, that part of the appeals process would be they'd have the opportunity to correct that. And it would appear, based on what I've heard today, that that is not what is happening. And so I, I would hope, as part of the appeals process in, in the consideration that those processes are being properly followed, and I would hope the Department of Health and Human Services would follow up on that and make sure these things are, are properly adjudicated, for lack of a better word, so.

JAMES WATSON: I understand.

MEYER: We all want to work together. We want to--

JAMES WATSON: Definitely.

MEYER: --to provide services.

JAMES WATSON: No question about that.

MEYER: And so, you know, we all got to try and be on the same team here. I appreciate your time today. Thank you.

JAMES WATSON: You're most welcome.

RIEPE: Thank you, Senator Meyer. Any other questions? Seeing none, thank you for being here.

JAMES WATSON: Thank you. thanks for having me.

RIEPE: Do we have any additional opponents? Last call for opponents. Seeing none, do we have any that want to testify in the neutral capacity? Seeing none. Senator Fredrickson, will you close for us, please?

FREDRICKSON: I would love to close for you. Thank you. Well, thank you, Senator Riepe and members of the committee, first for, first for your engagement on on this bill. And I want to thank the testifiers who all traveled from throughout the state to make their voices heard on, on this important issue. There's a few things that I want to just kind of underscore and highlight here. I know the department had expressed some concerns about some of the areas of this legislation. The reality is, we know that other states have similar language in statute. So what we're trying to do here is not out of the realm of what is typical for MCO regulation and transparency. I know that one

of the concerns that was brought up by the department was related to the actual what rates we're talking about with Medicaid. So I'm happy to work with the department on language that would specify that we're specifically looking at behavioral health services and substance abuse treatment services. I don't think that's a problem. We're not talking about, you know, reimbursement for latex gloves here. We're talking specifically about behavioral health services. One of the other issues, Senator Meyer, you were asking about is it's, it's really important to be able to set a floor rate. And the reason for that is that-- for a couple things. One is that some providers are actually contracted at rates, as you heard from testimonies with MCOs, and they're not getting the rates that they're contracted to. So there's a complete lack of transparency there, and a lot of getting the runaround when trying to follow up as to why they're not getting that rate. So that to me is a big concern. That's a contract violation, frankly. The other thing I want to bring the committee's attention to, if folks remember, there was quite a bit of news last fall, right before session, actually, that the MCOs were actually going to attempt to cut reimbursement rates for ABA services, which is an evidence-based intervention for autism, by 50%. And that is an egregious cut. I think, I don't think anyone would, would sit here and say a 50% cut in reimbursement is reasonable. And that really affects providers, especially in parts of the state where there are limited services available. And so there was a lot of pushback and they sort of backpedaled on that. But that just really underscores the importance of why this type of legislation is really important. Because there have been attempts and, and, and signals out there to cut these services and cut, and go against the contracted rates. This is really about reinforcing transparency and, and being clear about what we expect. There was a number of things brought up in the opposition that don't, frankly, I don't think really were in line with what this bill does. So I would encourage committee members to, to read the bill again. This is all about having very clear terms of engagement for the providers, so they know if they are going to contract with Medicaid and MCOs, that they know what the terms of engagement are. It also requires MCOs, if they are going to change that contract to communicate that change to the providers. We had a number of providers who had mentioned that there seemed to be change, whether that was in reimbursement rates, never communicated what that was. So this is really about being clear, transparent. It's, it's frankly, I think very reasonable. And we'll be talking more about some of the auditing in LB381 which has been another concern. But I think especially, and this goes to both of the bills, one of the biggest themes we've been talking about this year in this committee is, is

health care deserts. And as you've heard from some of the testifiers today, you know, when we are engaging in this type of lack of clarity with our contracts, we are jeopardizing, you know, providers, especially in, in, in rural areas who are Medicaid providers. And, you know, as a provider myself, you know, if you are going to accept Medicaid, that's in many cases a sacrifice for providers to do. That's something you do as, as, as a service, because you aren't necessarily being reimbursed at rates that you would, whether that be through private pay or private insurance. So I'd be happy to answer any questions. I know we're going to continue this conversation in the next bill as well, but happy to answer any questions.

RIEPE: Thank you. Very good. Senator. Senator Quick, please.

QUICK: Yeah. Yeah. thanks, Senator Riepe. You know, is there any-- and maybe there is a mechanism because I don't know, you know, how this all works. But as far as negotiating in good faith, is there anybody that kind of oversees, like DHS do they over-- the department, do they oversee that, or who, who actually makes sure they're, you know, negotiating in good faith?

FREDRICKSON: Yeah, that, that's a good question, Senator Quick. And, you know, it's, it's interesting because so, you know, one of the things that we talked about when it was sort of MCOs having a bit of autonomy with the rates provided, you know, I think that there is, there's, there's different ways to view that. One of the ways I view that is that, you know we as a Legislature, when we, we'll be doing this in a few weeks, when we start debating the biennial budget, we decide what we appropriate for Medicaid, because that's public dollars, those are state funds. And so when we kind of agreed to what a reimbursement should be expected or what that should be for a service, and then you have an MCO come in and say that they don't necessarily have to adhere to that? Well, MCOs are giving out Medicaid dollars. You know, they're not giving out private dollars, this is, this is Medicaid dollars. So that's, that's for me, the part that we, we, you know, we don't want that part of our decision-making process. We hold the power of the purse in, in this body. So when we make a decision about what we want funded and appropriated, we should expect that that is followed through with these, with these organizations.

QUICK: And that's be why we were setting that base rate, right?

FREDRICKSON: Yes. Correct.

QUICK: Ok.

RIEPE: Are there any other questions? Thank you very much. But before we close on LB380, I want to read into the record that we did have 54 proponents that had written in and 0 opponents, and none on the neutral si-- side, but don't go too far because we have LB381.

FREDRICKSON: Thank you.

RIEPE: So if you'd like to, let's move right on into that.

FREDRICKSON: We'll move right on. Yes.

RIEPE: Thank you.

FREDRICKSON: OK. Good afternoon, Senator Riepe and members of the Health and Human Services Committee. My name is John Fredrickson, John Fredrickson. I represent the 20th Legislative District in west central Omaha. I'm here today to introduce LB381. So this is the second piece. So the second piece to addressing my concerns with our managed care organizations comes down specifically to the audit process. So this is really where a lot of the conversations we had during this last bill really started for me. So over the past year, I have heard from many behavioral health providers from across the state, literally all corners of the state, who were subject to audits from the MCOs. Most of these providers are solo practitioners, and as part of their audits, they were asked to submit years worth of documents for review, usually resulting in huge clawbacks of payment for services that they actually completed. So I want to just underscore that, again, clawbacks for services that the audit did not say, come back and say this is fraudulent. This is a service that wasn't provided. There was agreement the patient was seeing this service was provided, but the clawbacks were, were still occurring. These clawbacks were often due to clerical errors like miscodings a session. So for example, if something was recorded, as you know, 52 minutes or 53 minutes. It was billed for a different amount of time. Instead of being given a chance to correct the error, the entire payment for the 60 minute session was clawed back, even though the code for 60 minute sessions is actually approved for sessions that are 53 to 60 minutes long. Or even if the session was actually 60 minutes, the audit determined there was no way a provider could have served back-to-back clients, determined fraud with an opaque appeals plate-- I skipped a page-- could not serve back-to-back clients, and was determined that fraud was happening within a-- without a, a clear appeals process with not ending in the same decision. So these audits can go on for months to years, resulting in clawbacks anywhere from $20,000 to $100,000. Providers can try to negotiate down their amounts due back to the MCO, but often

they are expected to pay back the full clawback because they do not have the resources to hire counsel to help assist them in fighting the findings of the audit. This has resulted in multiple providers choosing to no longer accept Medicaid, and to even close their practices. Many are from areas of the state that are already lacking in mental health providers, and leaving Nebraskans without access to this care is, frankly, unacceptable. So earlier this fall, I met with the Department of Health and Human Services to discuss my concerns. I had several meetings with the department, and ultimately they determined that no changes were needed to the audit process, but agreed to provide more education to providers on things like filling out paperwork for reimbursement, proper supporting documentation, and coding. While I do agree that more education is always welcome and helpful for providers, there are still glaring changes that are needed to protect providers from predatory audits. LB381 and makes several changes to the audit process between providers and all program integrity contractors or managed care organizations, including providing clear justification in writing for the audit; completing audits within 180 days; limiting the window a contractor can audit to one year from the date of payment; limits-- limiting the records requested to document relevant to the audit; provide detailed explanations of errors, and allow for adjustments from the provider; allowing for a proper appeal process and states, and states that the contractor cannot seek recovery of overpayment until all appeals are exhausted; and finally, it bolsters the definitions of errors and credible fraud. I do truly want to thank all of the providers who have contacted me, those who went public with their stories and those that submitted comments online. Why am-- I-- While I am hopeful that many providers can come forward and have come forward, I know that there are many who have not come forward. And part of that is out of concern I've had in conversations with providers of fear of retaliation, frankly, of, of going public with, with their experiences. So I would urge the committee to take the steps laid out in LB381 to protect these providers, to protect vulnerable Nebraskans. And with that, I'd be happy to answer any questions the committee might have.

RIEPE: Thank you very much. Are there any questions from the committee? I see none, but my question would be, is, is it more difficult because mental health services are a little bit less specific than you would see in physical medicine? You know, in a, in a, an audit with physical medicine is a surgical maybe, or a medical, it's pretty, pretty definitive, but-- So my experience in--

FREDRICKSON: Sure.

RIEPE: --mental health.

FREDRICKSON: Yeah, it's, it's a good question, Senator Riepe. So there are, there are standards of documentation that are expected for audits. So I want to actually be-- I appreciate that question because I want to be clear with LB381. The goal of this is not to eliminate the purpose of audits. I am actually a big, we spoke about this earlier, I'm a big fan of audit. It's I think that when we're appropriating dollar-- public dollars, we need to make sure we're doing so responsibly. My concern is that we are-- we've, we've seen a number of audits and clawbacks where fraud actually wasn't found. So they, they didn't come back and say, this is actually fraud, this is-- this patient was never seen, so we're going to take back this, this, this reimbursement. What we're having happen is yes. You saw this patient. Yes, they were enrolled in Medicaid or an MCO. But-- I'm just throwing an arbitrary example, but maybe the zip code on the bill was off by a digit or something, and so clawing back the entire reimbursement for that service. And then when a provider would go back to resubmit the claim for maybe correcting the zip code or whatever it might be, they were denied reimbursement because they were outside of the 180 day time frame for a timely reimbursement. So that's one of the reasons why we put in here, for example, guardrails on when audits can occur, because we want to be able to give providers the opportunity, one, if they had an issue with administrative issues, those, those need to be corrected. And I think you'll hear from providers in here more than happy to, to, to address and make sure that their, their submissions are accurate and correct, but just asking for it to be fair to them that when they do resubmit, that they are still eligible for reimbursement for the actual service that they did provide.

RIEPE: Thank you for the clarification. Any more questions before we go forward? Thank you very much. You'll be staying I hope?

FREDRICKSON: I'll be here. Yes.

RIEPE: Thank you. And we would like to now hear from proponents. If you would be kind enough to state your name and please spell it for us first and last and then proceed on.

CARMEN SKARE: Good afternoon, Senator Riepe and members of the Health and Human Services Committee. My name is Carmen Skare, C-a-r-m-e-n S-k-a-r-e, and I serve as the executive director for the Nebraska Psychological Association. I'm here on behalf of NPA to express strong support for LB381, which introduces key amendments to the Medical

Assistance Act aimed at improving program integrity audits. While I may not be able to answer some of the more technical questions about this bill as I am not a psychologist, I am here to speak on their behalf, as they are reluctant to publicly discuss and advocate for these issues due to fears of heightened scrutiny, claim denials, and audits. Our member psychologists and other mental health providers have voiced growing concerns about an increase in overly aggressive audits. Over the past year, NPA has met quarterly with Medicaid leadership to address several pressing issues, many of which this bill aims to resolve. We were informed there has been a greater focus on audits of smaller practices, and that the first level of audits are being conducted by coders, not clinicians. Additionally, discrepancies remain in reported reclaimed dollar amounts and clarification is needed on whether quoted figures represent, requested or received clawbacks, along with data on reclaimed amounts relative to practice size. Questions about the number and outcomes of appeals, including settlement, settlements, remain unanswered. We are deeply concerned by full clawback requests for minor billing errors and a complete lack of transparency through required NDAs. The presumption of malicious billing and the suspension of reimbursement until audits are formalized is alarming. Many experienced providers who previously navigated small scale audits successfully re-- report that recent audits are significantly more extensive and burdensome, and now raise documentation of practice related issues that were never problematic before. They appear designed to force repayment of large sums, despite no dispute that the services were provided. We need stronger legal protections to ensure a fair and reasonable process. Unnecessary bureaucratic barriers are compounding the problem by reducing providers. For example, psychologists uniquely trained and licensed to perform assessments are increasingly opting out due to Medicaid reimbursement challenges like insufficient authorized hours, repeated denials despite authorizations, and audits triggered by atypical distribution of billing codes. These patterns stem from fewer psychologists remaining in the system, unwilling to endure excessive administrative hurdles for inadequate compensation. It is crucial to recognize that the audits demand a significant amount of clinician and staff time, directly reducing the hours that are available for patient care. The very unclear appeals process and the lack of HH guide-- HHS guidance often requires costly legal assistance. These audits and potential clawbacks, six figures in the case of one of our members, impose substantial physical, mental and financial strain, leading some small practices to bankruptcy. While we definitely recognize the need for responsible government spending, reclaiming funds rightfully paid to mental health providers is not the answer. Nebraska. Small,

independent clinics that lack the backing of large hospital systems are particularly vulnerable and unfair audit practices are pushing providers to stop serving Medicaid patients or simply close their practices altogether, ultimately leading to longer wait times and fewer care options, worsening Nebraska's access to care crisis, particularly in rural areas that are already identified as medical deserts. Due to time constraints, I encourage you to review my full written testimony for details on how LB381 will strengthen Medicaid integrity, safeguard public funds, and support health care providers, while ensuring fair and transparent audits that are aligned with established medical standards. I urge the Committee to advance LB381 and recommend its passage. I thank you for your time and your consideration.

RIEPE: Thank you. Are there questions from the committee? Seeing none, thank you very much.

CARMEN SKARE: If I, if I may make one additional comment, Senator Fredrickson did mention--

RIEPE: Under 30 seconds.

CARMEN SKARE: OK. Senator Fredrickson indi-- indicated that there has been some off-- offers of HHS training, and we have had several of our members seek that training with no results. They've been met on deaf ears. They have not been able to get any of the responses back from HHS that they've been willing to do the training, but it's not been offered to them.

RIEPE: OK. Thank you very much. Are there additional proponents?

CARMEN SKARE: Excuse me.

RIEPE: Thank you.

JESSYCA VANDERCOY: Good afternoon. My name is Jess--

RIEPE: If you would be kind enough to spell your name and then and go forward.

JESSYCA VANDERCOY: My name is Jessyca Vandercoy, J-e-s-s-y-c-a V-a-n-d-e-r-c-o-y. I'm the executive director of the National Association of Social Workers, the Nebraska chapter. Our mission is to protect and unify and advance the social work profession in Nebraska. Over 60% of our members are clinical social workers providing direct care. Nationally, we are a voting block of 700,000. There are many

clinicians here today who will have powerful stories of impact. What you will hear from them is that there a special group of professionals. They're resourceful, they're documentarians, they're professionals that witness both the worst and the best of humanity. They navigate complicated systems of care because healing clients, healthy communities, and maintaining their livelihood depends on it. In May of 2024, I received an influx of calls from clinicians across Nebraska reporting predatory audits by managed care organizations demanding thousands, sometimes tens of thousands of dollars in repayments for services provided in years prior. These clinicians have made, made calls, sent emails, requested meetings and the people-- from the people in the systems meant to provide oversight and solutions, including DHHS, the Ombudsman, contract integrity staff, MCO regional supports, and non-clinical case reviewers. Clarity was sought, workable solutions were proposed, but efforts were not met with solutions but blame and often retaliation from these institutions. In response, we conducted a survey and gathered data from clinicians across Nebraska. 85% of them responding saying that they-- because of the lack of collaboration and transparency, they were either going to end their relationship with Medicaid or reduce their Medicaid client caseload. In May of 2024 also, the Department of Justice, Civil Rights Division exposed Nebraska's mismanagement and underfunding of community-based behavioral health services. They found individuals with serious mental illness were too often institutionalized instead of receiving care. Law enforcement was overburdened and the carceral system was used to house and delay treatment. This is actually waste. Opposition to LB381 will argue that audits haven't changed and remain a tool of accountability, and as a clinician with more than 15 years experience, I can tell you there is a lot that has changed this process and what has happened in the last year. But also providing care for people in poverty has been politicized. The relationship between payer and practitioner has shifted from collaboration to conflict. Terms like waste, fraud and abuse are no longer about ensuring accountability but have been weaponized for cuts and, quite honestly, financial gain. Clinical social workers support audits, ironically in this divisive time, social work code of ethics, contract agreements between the Nebraska MCOs and the state all align, affirming that compliance reviews and audits should serve as protective and responsible practice. LB381 restores audits as a tool for accountability, not control. It addresses the provider stop-- It addresses bureaucratic overreach, preventing a system where DHHS Heritage Health contracts are so risky that providers stop accepting Medicaid. Without these safeguards, mental health crises will continue to funnel people--

HARDIN: You're in the red, but can I ask you.

JESSYCA VANDERCOY: --into the most expensive service systems. Yeah.

HARDIN: Yeah. And forgive me, I don't mean to put words in your mouth.

JESSYCA VANDERCOY: Yeah.

HARDIN: I'm trying to catch up.

JESSYCA VANDERCOY: Sure.

HARDIN: You said that today we have a characterization between payers and providers of conflict. We-- Paint a picture for me. Give me an example of that.

JESSYCA VANDERCOY: So historically, actually, if you remember many years ago when Magellan was around and managed things, there was a process where, in the spirit of service, was that Magellan would work with providers to establish a way of going forward. If there were errors, there was a corrective action plan process. And what I hear from, from members is that it was really a relationship set out to say, how are we going to do this work together? Right? We, we hold the money for the contract and are going to pay you. You're going to provide the service. If there's errors or there's things that we disagree on, let's find a way to, to work that out. And now what's happening is it's, it's absolutely conflictual. There's an assumption that if you have questions, there's an assumption if you are challenging or appealing, that in fact, you are in opposition of the payer, that there's this adversary role, as opposed to how do we come together with the money that that's been allotted and the rates that we've agreed upon to provide good quality care to people who get their mental health services through Medicaid?

HARDIN: How do you think that happened? How did that world migrate to get where it is from where it was?

JESSYCA VANDERCOY: I think-- I mean, I think there's a, there's a lot of things. I think we are in such a divisive time in, in many, many things. I think the pursuit for greed, to be honest with you, I think there's been a priority put on making, making money than providing potentially high quality services for people who hold these contracts. I think you'll hear testimony today that, that the money that, that you know, and to your point that making a profit isn't, isn't the issue, but it's-- things have gotten really gamey on, on lots of levels and in lots of spaces on a lot of issues, and I don't think

that this is anything different. But it's not collaborative anymore. And I know the people that, that I've spoke with, they want to collaborate with the payer, with the way that the contract has been developed by DHHS. These are, you know, people who, who want to work the system because their livelihood re-- you know, relies on it. That's, I mean, that's what we want to do. However, the, the way the system's been set up has made it very difficult for, for us to move forward with that.

HARDIN: OK. Other questions. Senator Riepe.

RIEPE: Thank you. Have you seen a degradation in the culture, if you will, between providers and payers?

JESSYCA VANDERCOY: It just, it starts--

RIEPE: And maybe that's based on personalities of leadership.

JESSYCA VANDERCOY: Well, and it's, it's entities, right? Almost. It's not an even an an individual person. But I'll give you an example of a call that I got from someone who had tens of thousands of dollars, had gone through all of-- gone through the contract, said, this is step one, this is step two, this is step three, and, and was left on deaf ears, was left on not being able to get any resolution. So, so turned to DHHS and said, hey, you're the liaison in this relationship. I'm providing the services. This is what the contract says. This is not what's happening. And the response from DHHS and the person that's, that's in charge of this relationship and managing this had said, you know, basically you have to do what they've said you have to do. Their rule is final. And in fact, anything over $10,000 could have potential criminal charges, could have--

RIEPE: Against you?

JESSYCA VANDERCOY: Not against me personally, against a member that had called. And I think you'll hear more testimony about that today. So doubling down on, on not only will you do as you are asked to do and follow this the way that they have set this out, you might be mindful that, you know, it-- fraud in the amount of over $10,000 could potentially get you jail time. That's not the language of a collaborative partner to say, hey, let's all come together with state dollars with your expertise and make sure that people who get their mental health services through Medicaid are served appropriately and efficiently.

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

HARDIN: Yes, Senator Meyer.

MEYER: Thank you, Mr. Chair. I just have a comment. I appreciate your, your comment that this needs to be a collaborative relationship. And obviously we've gotten away from that from the appearances of what we've heard previously in the previous bill's testimony. So I have a real appreciation for that and hopefully we can find our way back to that, quite frankly. So I appreciate that very much.

JESSYCA VANDERCOY: Yeah, I hope so too. And in fact, you know, I've been around a long time and there used to be complaints about Magellan. But I'll tell you, the spirit right now is, gosh, can we just go back to Magellan? And so history is, is fun, right? So thank you very much.

HARDIN: Other questions? Seeing none, thank you. Next proponent, LB381. Don't be shy. How many LB381 testifiers do we have here today? OK. Welcome.

ERICA SCHROEDER: Thank you. You missed my entrance last time, so I'll just let you be able to read it. It's quite a bit.

HARDIN: Well, thank you.

ERICA SCHROEDER: I'm here today to speak about L-- LB381. I'm going to just cut to the situation that I experienced, which occurred and is technically still occurring for 2.5 years. I've been caught up in a cycle of continuous audits from Nebraska Total Care. In September of 2022, my payments were abruptly halted with no communication from the MCO. When continuous contacts and communications escalated through the MCOs, the-- certain individuals from the MCOs then finally reached out and I was notified via email that I was--

HARDIN: I'm sorry. Can I get you to spell your name--

ERICA SCHROEDER: Right.

HARDIN: --for the recorder.?

ERICA SCHROEDER: I apologize. Erica, E-r-i-c-a, Schroeder, S-c-h-r-o-e-d-e-r.

HARDIN: Please continue.

ERICA SCHROEDER: Thank you. I was contacted by the MCOs, and stated I was placed on what's called a prepaid audit. After doing research

because of my background, that's exactly what I'll do, I'll go look for the rules, regulations to identify what is a prepaid audit. In my discovery, there is no such animal listed in either the billing or codes that providers use to identify what are the requirements and what is it. So there is no such animal within their, their regulations for prepaid audits. In essence when an prepaid audit occurs, they just stopped paying you. They don't tell you and you are left continuing providing service, not knowing that you-- they have no intention of paying you. I was at this point required to provide 164 notes in 5 days. I had to cancel an entire week's worth of sessions with clients to actually finalize and get the product to them. What makes this worse is what I was not aware of is prior to this occurring, I was actually being audited for an additional 1.5 years. There were three additional audits that I was involved in and they did not stop. So I was under audit for five months. This paused, and then for four days I was put into another audit. All of these audits I passed. They were verbal. They would call up, they addressed the clients they wanted to discuss, we'd go over the information, and then they would sometimes actually identify-- they wanted us to decrease our service or it was fine. This did not happen in this situation. So after the 1.5 years is when the prepayment audit incurred, and this is when I sought out the Ombudsman, like I discussed in my prior testimony. We are now facing, at least with just the people that have come, we have created our own coalition and we want to be heard. When we have 40 providers-- this is only 40 providers in the last two years and maybe less. I didn't collect information--

HARDIN: I can encourage you to wrap up your thoughts.

ERICA SCHROEDER: It was over $1 million collected. And these are not hospitals. These are small, privatized companies.

HARDIN: OK. Questions? Yes, Senator Quick.

QUICK: Yeah. Thank you, Chairman. Could you talk a little more about the-- what you were just saying? You know, you were-- because you talked about that in your last testimony at the, on the last bill, and just go into detail a little bit more about what you were facing with that. What you faced with the audits.

ERICA SCHROEDER: I'm, like, trying to gather my words. It's never been my experience, especially with my prior law enforcement experience, that if there's an expectation that there are rules and regulations that govern those expectations, and once-- it's checks and balances. Those checks and balances are not available, essentially making the

audits impossible to pass. And when you ask for clarification on what it is that they want from the audits, you are-- there's no information provided. When you ask for clarification who has been conducting the audits, and that you want clarification that they have a specialty within your scope of practice, they refuse to provide us with any names, or that those individuals have any expertise within our scope of practice.

QUICK: OK. All right. Thank you.

HARDIN: Can I get you to expound on that a little bit more when you say those audits are impossible to pass? Ca-- Give us an example of that?

ERICA SCHROEDER: I submitted the 165-- technically there was more than that, I was going with the original. And a lot of them cited time. So they not only want, say it'll state 50-- 56-- I'm sorry, the 53 to 67 minutes is considered a 90837, which is an hour long session. So if you're within this minute, these, this time frame, then right below that you'll need to address that you started your time at say 0900, and that then you concluded, say, at 1000 hours, they will come back and say that this is a perfection, it is impossible, fail, give us our money back. Or in my situation, we're not going to pay you for services. I was never investigated for a special-- with a special investigation, which is what is required in the event that they find fraud. I was never identified as having conducted or been involved in fraud. Yet I was treated as though I had.

HARDIN: Gotcha. Ok. Other questions? Senator Meyer.

MEYER: Just briefly-- Thank you, Chair. And so is this one of the things that you discussed with the Department of Health and Human Services personnel?

ERICA SCHROEDER: Correct. After the Ombudsman had their ability to oversight, provide oversight into Medicaid practices, Stephanie Bean, Beran, who is my ombudsman, had discussed with me that at this point she could not really get involved. However, there was a response from Anne Harvey with DHHS who's in charge of the fraud, waste and abuse looking outwards, not inwards. And the response stated that she found issues with Nebraska Total Care and that she would be addressing them herself. I asked the ombudsman at that point, she's identified these issues, I'd like to know what these issues are that she's been tasked to do so, right? And when she responded to that email, the email stated, I was only tasked to identify the issues. I was not tasked to

do anything further. So there was a refusal to assist me in trying to recoup my $22,000.

MEYER: OK. Thank you.

HARDIN: Seeing no other questions. Thank you.

ERICA SCHROEDER: Thank you.

HARDIN: Proponents, LB381.

MARY KELLY: Nine copies. Thank you.

HARDIN: Hi.

MARY KELLY: Hi. I'm Mary Kelly, M-a-r-y K-e-l-l-y, with the League of Women Voters of Nebraska. I'm just going to ask right at the top. The first page of my testimony is kind of a repetition of the page that I already read you for LB380, and in the interest of time, I'm thinking I will maybe just jump to the back. OK. Providers have complained that auditors have placed arbitrary time limits on treatment, initiated audits over simple clerical errors, and demanded voluminous records. Often the audits have been initiated well over a year after payment was provided. Providers have been required to repay large sums for reasons that have been unclear to them. LB381 will provide specific requirements related to contracted managed care audits of behavioral health care providers. It will require that auditors provide written justification for the audit to the provider. Importantly, it also requires that reviews of claims beyond a year of payment will only require a payment adjustment in the event of fraud, not in the event of clerical error. LB381 limits the record request to relevant documents. It requires auditors to give pro-- pro-- providers procedures for resubmitting the claim. Contingency fees are limited so as to limit any incentive for overzealous and/or unjustified audits. It assures that a determination of fraud is established as credible, and that all avenues of appeal are exhausted. In harmonizing all provisions with the Medical Assistance Act, LB381 assures that providers have a clear understanding of their rights and responsibilities, and that Medicaid managed care organizations will have clear parameters to conduct ethical, effective fraud audits. Please advance LB381 to General File. Thank you.

HARDIN: Thank you. Questions? Seeing none. Thank you. Proponents, LB381. Well.

LINDSAY KRAMER: Good afternoon. My name is Lindsay Kramer, L-i-n-d-s-a-y K-r-a-m-e-r, and I'm a mental health therapist in Elkhorn. I want to thank Vice Chair Fredrickson for his work with LB380 and LB381. This bill is a necessary step forward toward fairness for providers, and I urge you to advance it out of committee. For the past three years or so, Nebraska's Medicaid audit system has been unfair, unpredictable and devastating for us. When I opened my practice 15 years ago, I did what any responsible therapist would do. I searched for documentation guidelines. I looked online, nothing. No official requirements, no templates, no examples. I asked Magellan and then the MCOs directly. And do you know what I was told? Nothing. They refused to provide clear guidance. So, like many others, I did my best to create forms from scratch. But how do you succeed in a system that sets you up to fail? In 2021, after providing therapy throughout Covid, while I had two little children at home, I was flagged for an audit on those clients. I sent in all the requested files, and then silence for two and a half years. No response, no updates, nothing. Then in May of 2024, I finally got my audit results. My documentation, documentation based on rules that were never clearly defined, wasn't good enough. And for that I was slapped with a claw back for thousands. Can you imagine having to pay back your hard earned dollars for work you did, not because of fraud or wrongdoing, but because your paperwork didn't meet invisible standards from five years ago? This system is broken and providers like us are paying the price. Just last fall, a different MCO launched another audit. This time, they blatantly violated state law, demanding 260 records even though the legal limit is 200. So I pushed back. I cited the law. Their response? That doesn't apply to us. A corporation paid with taxpayer dollars, openly dismissing legal limits as if they don't exist. I pointed out that their request also exceeded the four year look back limit. It was five. And again I got the same response. That doesn't apply to us. This wasn't a mistake. This was deliberate, calculated disregard for the law. And what happens? Providers like me are left powerless. We have no recourse, no protection. Just endless audits and crushing financial penalties based on rules they make up as they go. If this isn't predatory, then what is? These audits have forced me to make a heartbreaking decision. I closed my doors to Nebraska's Medicaid population because I refuse to ever again put myself in a position to be abused, disrespected, and financially devastated by a system designed to punish and not protect. We're not asking to eliminate audits. We understand their purpose. But let's be honest, this isn't auditing. This is a weapon. Audits should be used to help providers improve, to educate, to correct, not to entrap and destroy. Right now, providers live in fear, never knowing when the next letter will come,

and when the next baseless clawback will wipe out their income, when they'll be accused of wrongdoing simply for doing their job. So I ask you, how many more providers have to walk away before something changes. Thank you for your time.

HARDIN: Thank you. Senator Riepe.

RIEPE: Thank you, Chairman. Early on in your letter here, or comments, it says, and I quote, for the past three years, Nebraska's Medicaid audit system has been unfair.

LINDSAY KRAMER: Yes.

RIEPE: And it goes on. But my question there is what changed? Because you're very definitive like almost implying that something happened after three years. Is that a change in providers or--

LINDSAY KRAMER: Thank you for the question. I-- you know, anything I say would be speculation because it's all, it's kept all ve-- private from us. They won't-- they don't share. There's no transparency. I do know that they started using AI to go through and find providers to flag. So if you did all your billing on one day, you might be flagged. Or if you billed for all 60 minute sessions, you might be flagged. So that's one example that I can think of. There might be other providers that would know more about that too, so thanks.

RIEPE: Has anyone brought a, a legal challenge to the managed care organizations?

LINDSAY KRAMER: To my understanding--

RIEPE: Maybe collectively as a group?

LINDSAY KRAMER: --there have been-- Yes, there too-- whoever-- there have been a few providers who have taken the appeal process all the way to the state board, and they hire-- they have to hire attorneys for that. And I know there was one recently, within the last two months or so, who went all the way, and they still had to pay back the clawback, plus the attorney fees. So they lost their case. We've talked, I've talked to a lot of lawyers personally, and they say with the amount that you're going to spend to defend yourself, you might as well just pay the clawback. Thank you.

RIEPE: We're all aware of legal fees, so thank you.

HARDIN: There are questions, so don't go away too long.

LINDSAY KRAMER: Thank you.

HARDIN: Senator Meyer.

MEYER: Thank you. Thank you, Chairman Hardin. In the process, and I'm sure you probably go to professional conferences, things of that nature, nationally, certainly regionally and probably nationally. Are you finding some of the same problems, are people in other states sharing the same experiences you are?

LINDSAY KRAMER: Thank you for the question, yes. This is happening all across the country with the same MCOs. So these MCOs are-- they dominate, and they, they do the same predatory clawback things. And I'm trying to think of, of states that I can use for an example. But I know like Massachusetts had this problem and they've passed already legislation to protect their providers. So this has been going on for years. And Colorado also has passed legislation to, to protect their providers. So.

MEYER: I appreciate your perspective on that. And one thing that troubles me about all of this, and it's something this committee deals with almost on a daily basis is we have underserved communities, many underserved communities in this state. And in an attempt to try and improve our medical delivery, we're, we're scratching our heads and trying to provide opportunities for people to come to our underserved communities, and certainly in our, even in our, our more urban areas. And it pains me that we are seeing an attrition rather than increasing those services available. And it appears to me that it's totally preventable. And so I appreciate your perspective on this. Thank you.

LINDSAY KRAMER: Thank you.

HARDIN: Thank you.

RIEPE: Oops.

HARDIN: Proponents. Oh, I'm sorry. We had one more question for you, but we'll have to throw it through your window with a brick. Oh, you're back.

RIEPE: I suppose I could have held it for someone else. But my question is because I think we're moving more and more, and have to, to a population-based delivery system, where we walk away from fee for service to a per diem, and you're prepaid to take care of a population. Do you have, do you have any that are prepaid that you get a per diem every month, or--

LINDSAY KRAMER: No, I don't.

RIEPE: You're all on fee for service.

LINDSAY KRAMER: I's a good question. We're all fee for service still. Yeah, I don't have any experience with that. There might be other providers that do, but not to this point. I haven't done that.

RIEPE: Personal opinion, I think that that's the direction we'll go in the next five, ten years. Thank you, Chairman.

HARDIN: OK.

LINDSAY KRAMER: OK.

HARDIN: Proponents, LB381. Welcome.

ERIN MASCHING: Thanks. My name is Erin Masching, E-r-i-n M-a-s-c-h-i-n-g. Did you know that out of just 45 audits, a total of $1.017 million has been ordered to be recouped from small business behavioral health providers? 45 audits, $1 million. And these are just the ones that I'm personally aware of. I'm an independent, licensed independent mental health practitioner in Omaha. I was audited by an MCO company in 2024 for over 200 claims dating back to 2022. My determinedly-- my determination letter notified me that I was to pay back $34,798 within 30 days. You may wonder why that much. That's a lot for one person to have to pay back. I must have done something wrong. No. This letter stated that I lacked detail in my notes and that EMDR was a non-covered treatment service. It did not question whether or not I had done my job. It did not question whether or not the service had been rendered. It was based on false, misrepresented, and subjective reasoning. EMDR is a covered treatment service in Nebraska, by the way. You can find it in Title 471, chapter 20. Which brings me to my next point. These MCO companies are blatantly disregarding Nebraska laws and statutes. During my appeal process, I requested an informal consultation, as is my right per the statute. I was denied. The MCO stated that this statute did not apply to them. We need language in this bill that does not provide any loopholes for the MCOs. I can't speak to what happened post appeal with my case, but I can say that I'm still bleeding financially and trying to recover mentally from this audit. There have been some who have not been able-- Thank you. I think you've heard a lot of our stories. And it's just crazy to wake up one day and say that your boss-- like, if your boss came to you and said, like, we don't like the way you documented your data two years ago. You have to pay us back over a third of your

salary right now, or else we aren't paying you anything moving forward. It was awful. Thank you for listening.

HARDIN: Thank you, Ms. Masching. Any questions? I appreciate your testimony. Thank you. LB381, proponents. Welcome.

SPRING LANDFRIED: Thank you. My name is Spring Landfried, S-p-r-i-n-g L-a-n-d-f-r-i-e-d. Providers support fair and transparent audits and reviews. I've experienced them since Magellan. They're an important part of program integrity and meant to help guide providers in Nebraska, improving quality and compliance, but this is not happening. Instead, the current atmosphere of re-- of reviews is creating severe injustice, perpetuating fraud on Nebraska providers, and compromising an already strained provider network. I'm from western Nebraska. It's getting worse out there. You can't find a provider to take Nebraska Total Care right now. Providers across Nebraska are experiencing an alarming trend. Disallowing claims on arbitrary grounds, with subjective interpretations of clinical work that hinge on non licensed reviewers personal judgments with pressure to disclose psychotherapy content that is federally protected. Work that requires a license to prove competencies to complete, but now that same expertise is no longer required to substantiate clinical work. Over a million denials have been reported-- $1 million in denials have been reported through these reviews in a short period of time from private practice, outpatient behavioral health services alone. This can be financially ruinous to sole providers and small practices that run on a narrow margin, where the average clawbacks can equal half of their annual W-2, and where these denials come out of their paycheck. MCOs are becoming bolder, going so far as to have an attorney represent the MCOs accusations of fraud, waste and abuse against providers at state provider hearings that do not have a license to practice law in Nebraska. That attorney and that company knew the legal protections and still blatantly disregarded them. This is what we're up against. That was at an HHS hearing. These practices also involve mandatory signings of non-disclosure agreements, which is opposite of transparency, being these are government reimbursements and ensuring compliance and transparency. Am I wrong to question, if these MCOs are confident in their of their clawbacks, and this is about compliance, why are they requiring nondisclosure agreements? Nebraska prepared me well to be a practitioner. They did not prepare me well, nor my peers, to defend that work with the intensity of a criminal defense attorney, nor should they have had to. I hope you, in good conscience and in good faith, will demonstrate a strong bipartisan support, because to not do so would support current predatory practices that leave constituents suffering and vulnerable. I believe Nebraska, being a

state built on integrity and strong values, would not allow this. LB381 proposes necessary steps towards fixing the unintentional injustices. These predatory practices are obstructing the ability to deliver and receive needed care. And I ask you, as fellow Nebraskans, is this a cause worth enough for you to stand up with us and send a message that says our policies are not cheese and Nebraska constituents are not prey? Thank you for your time and consideration. I'm happy to answer any questions you have. I put about 1,600 hours into researching what compliance means now, but I have successfully passed several audits back from the Magellan days. I can't tell you now, up under one of these audits that I would come out compliant.

HARDIN: Questions. Seeing none. Thank you.

SPRING LANDFRIED: Was I too intense? That's a big thing. I'm sorry.

HARDIN: Thanks. Proponents. Hi.

AMBER FRY: Hey. My name is Amber Fry, A-m-b-e-r F-r-y, and I have been a therapist since 2001. My license-- I have a licensed independent mental health practitioner license. Before I started my own private practice in 2012, I worked at a JCAHO accredited nonprofit in Lincoln and for a large health system in Omaha. I am testifying today in support of LB381, because it is essential for providers to have protections against predatory audits, which seem to aim at recouping fees for use each session provided rather than addressing genuine cases of fraud, waste, and abuse. Several years ago, I had the experience of an audit that was fair and transparent through UnitedHealthCare. A licensed mental health provider gave me a detailed list of the standards she would use to audit the five requested charts. She then spent a day at my office reviewing the charts and discussing how my documentation met or didn't meet those standards. I received the results in a reasonable timeframe, I think like 30 days, and was given the opportunity to create a corrective action plan to update my paperwork in order to meet those standards going forward. Unfortunately, as, like, others have testified today, they have undergone audits by Medicaid MCOs that have not been fair or transparent, and these audits have led to aggressive clawbacks. These bills provide essential protections for mental health providers, ensuring that audits are conducted by another mental health provider, and that clear standards are in place for documented services that are provided in good faith while adhering to legal and ethical requirements. Additionally, this bill ensures that there is not an undue burden on providers who are being audited by placing reasonable limits on the number of records requested. Thank you for the

opportunity to testify today. In conclusion, it is crucial that mental health professionals are supported by policies that promote, promote fairness and transparency in the audit process. The experiences of both myself and colleagues demonstrate the significant difference between audits that foster accountability and those that impose undue financial strain, without clear guidelines or ethical considerations. This bill will provide critical protections that enable providers to work in good faith, ensuring that services are properly documented and reviewed in a constructive manner. As a small business owner and a mental health professional, I urge you to support this bill to protect our ability to provide quality care to our community without the threat of unfair financial penalties. Thank you for your time.

HARDIN: Thank you. Questions? Seeing none.

MEYER: Just, just--

HARDIN: Oh, there is a question. Wait. Hold the phone.

MEYER: You had experienced a-- If an audit can be a positive experience, you have experienced a, a positive outcome from a previous audit.

AMBER FRY: I mean, was it--

MEYER: If you can classify it.

AMBER FRY: I mean, it was really scary, right? I mean, it's hard when you're like, I know I'm a great therapist, right? Like, my clients tell me that, like, I, I know I do good work. I'm always going to be like, am I documenting it? Can other people see that work from my documentation? And right? Like the provider from United Healthcare came in, she met with me. You know, it's like some of my-- some of the things were like, they were requirements now, but it wasn't when I did my initial, like, assessment. So I got linked in for that, really good, like I'm like, well, I can't go back and you know, in, in time and put what you want me to in if it's a new requirement. But right, like, the documentation that I'm still using is this, like, documentation that went through an audit, I'm doing what they asked. And, you know, looking at my other colleagues, like, my notes are much more long-- they're longer, they're more thorough. And based on their experiences, it's terrifying to not know, like, what will that pass? Is that going to work? I mean, so I mean, it's a, it's a very scary time to be a mental health provider, you know, to--

MEYER: You, you did not have a negative experience at all like some of the others have.

AMBER FRY: No mine, mine was like, because, like-- and as people started talking about it, like I shared my experience, and they're like, oh no, no, this isn't, this isn't what we're seeing anymore. Because again, I don't-- like, those-- I understand that, right? We want-- show me how to do my job better. Right? But, but also don't put these undue burdens on paperwork like, like, like four page notes, you know, like, like the-- there's some providers that have shared what they're doing, like the note that they have, like, that's, that's been able to pass one of those audits, it's-- I don't know how people can do that every single session. And, and so that's, that's my experience. So yes, I mean, what I, what I experienced before, and I think it was probably 2013, is very different than what people are experiencing now. Yes.

MEYER: Thank you very much. Appreciate that.

HARDIN: Senator Quick.

QUICK: Thank you, Chairman. So just about the notes now. I think I don't know how much detail they go in but would never violate HIPAA laws? I mean, to provide that information to--

AMBER FRY: I--

QUICK: An MCO, or what?

AMBER FRY: I, I don't feel comfortable speaking to that. I think that is certainly a concern that they are, I think, trying to, like, mandate treatment, and, and like, like, one person said, right? Like EMDR is approved, and that-- it's very explicit, I think it's at 471. And for them to say, well, that's not-- like, that's, that's not a good enough treatment, we're, we're not going to pay for that. Like, that, that's what's-- that, that's what makes-- that's what's terrifying as a provider.

QUICK: OK, thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you. Do you attempt to limit the number of Medicaid patients through MCOs that you take?

AMBER FRY: I--

RIEPE: To balance your practice?

AMBER FRY: I mean, I've been in practice for a really long time. I also specialize in treating like trauma disorders. So because of that, I don't have to take a lot of new clients. As, like, people wrap up, like old clients will come back a lot. So that's a lot of what I do. At this point, I'd be very hesitant. I would prioritize other payer sources just because of the security of knowing, if I provide the services in good faith. I will be able to keep that, that money.

RIEPE: OK. Thank you. Thank you for being here.

HARDIN: Other questions? Seeing none. Thank you.

AMBER FRY: Thank you.

HARDIN: Proponents, LB381. Welcome.

JACI PEKAREK: Hi. Good afternoon. Chair, members of the committee. My name is Jaci Pekarek, J-a-c-i P-e-k-a-r-e-k. I am a therapist and a co-owner of Monarch Counseling and Monarch Integrative Care. I'd like to thank Senator Fredrickson for introducing these bills. I am a proponent of these bills. My heart is in this for several reasons. First off, as a business owner, we have had two audits that are requesting back around $55,000. We were told that 0% of the services we provided were supported. This is after we had faxed in thousands of pages of documentation. We currently have had another audit requesting 335 dates of service, the biggest one yet. This is what I would call abusive audits and clawbacks. This is not about Medicaid fraud. We have provided a service for these clients, documented it, and billed it. Personally, I feel it is a crime for them to attempt to take back money that we have already worked for. As a therapist of 25 years, I am insulted that my work would be deemed waste and abuse. I know what the standard of care is and that's what I provide. So I have asked these MCOs, if we continue to choose to contract with you, how will you protect us, your providers, who work with the most vulnerable people of our state? Still waiting to hear back on that. However, we have this bill now, these bills, so let's hope it doesn't come down to choosing between continuing to serve our Medicaid clients and our livelihood. My practice, Monarch Counseling, is one of the largest ones in Lincoln. We have 18 providers and served 505 Medicaid clients last year. We already have a shortage of therapists. Even less that are choosing to accept Medicaid due to these abusive practices. We have waiting lists. Our state is in need of more community based mental health resources, not less. Instead of all the energy on

audits, I wish I can continue to grow my business according to the needs of the community, which would include outreach to our rural Nebraskans who are most needing of mental health providers through telehealth services. So I invested in these bills, as a business owner, as a therapist. But even more than that, I am a watchful citizen. I am a Nebraskan, born and raised, and I believe in the good life. I believe that it is-- as Nebraskans, we care about each other and we help each other, those-- the people that need help. I am also a taxpayer and I want to support mental health and healthier communities. The alternatives are not cost effective or healthy for Nebraskans. More incarcerations, homelessness, drug and alcohol abuse, deaths, violence, homicides, suicides, increased health care costs, higher rates of disability and unemployment. So as a business owner, a therapist, a taxpayer, and a Nebraskan, I am a proponent of these bills. Please help us to continue to serve those most in need, and let's, let's keep the good life good. Thank you.

HARDIN: Thank you. Questions? Senator Meyer.

MEYER: Thank you, Chairman Hardin. You've been a health care professional for 25 years. Have you-- Was there a particular time period when you have seen an increase in audits and a change in the audit process? Was there, was there some, some specific event or some specific time period that things changed?

JACI PEKAREK: Yeah. In my experience, I've seen nothing like this. I've never had clawbacks before. During the times of Magellan, I heard of clawbacks during that time, that was before my time practicing here, and I heard of people having to shut down their businesses at that time. That-- but that's my knowledge of that.

MEYER: So we've had a positive If-- once again I-- poor, a poor characterization of an audit was a positive audit or a-- I don't even want to use friendly audit. I, I don't know how you describe an audit that wasn't a train wreck, quite frankly, but--

JACI PEKAREK: Yeah.

MEYER: --but was there a particular time, 2013 I believe was mentioned, 2014, somewhere in that--

JACI PEKAREK: Yeah, we did have a corrective audit where somebody came out and told us how our notes-- you know, and I was told that you do good work, you're just not showing-- given credit for it. They're very behavioral. And you're right, therapy is a little bit-- it's not the

same as physical, right? It's pretty subjective. I think of it as a science and an art. So I know what I'm doing, but they want me to say it a certain way, which I'm not even a behavioral health therapist, and that's not my orientation. So they want you to say it a specific way. At that time, they just gave us corrections and said that they would be watching. And then actually, that's-- then they came back and audited again, but then they said, don't do anything more with these charts, but that's some of the money they want back now, right? They're like, these charts are fine. So that's some of them that they want back now.

MEYER: I was just, I was just curious--

JACI PEKAREK: Yeah.

MEYER: --if there was some particular time period or some, some, some change or something that could be attributed to a change in policy.

JACI PEKAREK: Yeah.

MEYER: Evidently there wasn't really anything at that particular time.

JACI PEKAREK: Yeah, I can tell you there-- like, like UnitedHealthCare, there are-- there have been lawsuits that have been won in other states like New York for things like this, where they're using algorithms to find outliers. And also they're trying to define medical necessity, right? Which they're talking-- goes against federal parity laws that we have to somehow, you know, go within these things that physical health people don't have to do. So that has been a suit that's been won in other states. Yeah.

MEYER: Thank you very much. I appreciate that.

JACI PEKAREK: OK.

HARDIN: Further questions? Thanks for being here.

JACI PEKAREK: Thank you.

HARDIN: LB381, proponents. Proponents, LB381 opponents. Welcome.

DREW GONSHOROWSKI: Hello, sir. Good afternoon. Good afternoon, Chairman Hardin and members of Health and Human Services Committee. My name is Drew Gonshorowski, D-r-e-w G-o-n-s-h-o-r-o-w-s-k-i, and I am the director of the Division of Medicaid and Long-Term Care in the Department of Health and Human Services. I am here to testify in

opposition to LB381. DHHS has significant concerns with LB381. This bill would significantly limit the Nebraska Medicaid program's ability to perform program, program integrity related work required of state Medicaid programs, as established in federal regulations. This bill would prevent, limit, and discourage the program and its contractors from responding to actions that could be defined as provider abuse under federal regulations. The bill would not allow the department to recover payments that were determined a clerical error, or to initiate the recovery of improper payments more than one year after the payment was made to the provider. The department's contractors often identify erroneous billing, which could be interpreted as clerical errors. This bill would prevent the department from taking any action. Individuals should not be awarded additional taxpayer-- tax dollars to-- due to their errors. Errors ought to be corrected and not subsidized. Furthermore, the one year limitation in LB381 is inconsistent with industry standards. The process of performing program integrity reviews is lengthy, and often requires time for both providers and the department to gather, review, and follow up on documentation of services. Because of this, LB381 effectively puts a much shorter look-back period in place than one year. The department is obligated to participate in several federally required audits and reviews of the Medicaid program, such as the payment error rate, rate measurement audit, and audits performed by the federal Unified Program Integrity Contractor. Nebra-- Nebraska's participation in these programs resulted in recoveries of improper payments in calendar year 2024 worth $376,750, and identified $455,987 in collections for 2025. DHHS has a responsibility to return the federal share of any identified improper Medicaid payments to the Centers for Medicare and Medicaid Services. This bill would put the department in the position of identifying improper payments, returning the federal share to CMS, and then not recovering the payment from the provider. In other words, maintaining compliance with federal law and identifying improper payments would create additional costs to the state. Nebraska taxpayers will be indemnifying providers for poor billing practices. Finally, I would like to clarify that DHHS does not determine if fraud exists, but instills-- instead refers credible allegations determined through its program integrity audits or investigations to the Nebraska Attorney General's Medicaid Fraud and Patients Abuse Unit. The Attorney General is responsible for investigating and prosecuting Medicaid fraud, as well as all violations of state laws relating to the provisions of Medicaid services and the activities of providers. We respectfully request the Committee not advance LB381 to the General Fi-- General File. Thank you for your time. Happy to answer any questions you may have on this bill.

HARDIN: Thank you. Just want to point out that you're new to this position.

DREW GONSHOROWSKI: Yes, sir.

HARDIN: So you're getting to sit in that fascinating place of speaking for and taking responsibility for things that happened before you got here as a result of that newness. And so just kind of wanted to get that on the record. Is AI being used in selecting where audits happen, or are used exclusively, or can you kind of speak to that for us?

DREW GONSHOROWSKI: No, I think that's a great question. I, I can speak to Medicaid's processes, and every recoupment is verified manually by a, by a clinician within Medicaid. So our-- we, we actually confirm them. We do not use AI in-house on verification, verification. I can't speak to the MCO practices, but I've, I've had that conversa-- confirma-- confirmation with my team.

HARDIN: OK. Questions? Senator Meyer.

MEYER: We probably had this conversation just a little bit ago and I--

DREW GONSHOROWSKI: Yes, sir.

MEYER: --I think I've, I've probably used most of my ammunition there and I beat up on you pretty good at that time. But I kind of think you had it coming. Maintaining compliance with federal law and identifying improper payments, shouldn't that cut both ways, maintaining, maintaining compliance with federal law? Shouldn't we be holding the MCOs to the same standard that apparently we're trying to hold our providers to?

DREW GONSHOROWSKI: No, I would agree with that. And, and to the point of LB381, CMS doesn't have a limit on how far they look back when they pursue improper payments. So LB381 putting a one year limit on that puts us in a situation where the federal government can look back as far as they want. If they find issues, we're on the hook for anything outside of what we're allowed to pay back under this law.

MEYER: then maybe we need to be contacting our federal representatives. One of the things that troubles me, and once again, I-- Senator Hardin has an absolute valid point, and, and I, I shared that point initially that you're new on the job and, and you're, you're defending actions from-- activities and actions from people prior-- being in your, your prior position. And so it, it's probably unfair on my part to, to kind of be jumping all over you the way I am.

But I would have an expectation with the complaints we've had both on the previous bill at LB380 and LB381, along with the party line, which you have provided very well, that you would, you would at least offer-- be in a position to offer that, I hear there's some very real concerns and I'm going to look into this, and I am going to-- I'm going to try to get to the bottom of this and improve the process and improve the experiences of our providers. And-- but I haven't heard that from you yet. And quite frankly, I'm, I'm very disappointed in that, because once again, we are struggling to provide medical services in this state of which Department of Health and Human Services has a, a big part to contribute to that. And I have heard the party line and no, no attempt to try to share an understanding of the problems that these folks have, have, have experienced, and quite frankly, to run home to the default of, well, AI is picking this stuff out, it's beyond my control, I find totally unacceptable, quite frankly, so.

DREW GONSHOROWSKI: No, I, I appreciate the opportunity. I think, I think some of the providers that are in the room today might have heard this too. One of my, one of my deputies has a, has a great saying and, and I, and I think moving forward, one of my, one of my main views is Medicaid's always open for comment. And when there are issues, we, we definitely want to hear them. There's currently an, an amendment in the MCO contracts. Specifically, I think that probably either was in parallel or through conver-- conversations with Senator Fredrickson about the C-- the MCOs' being more proactive in education around documentation. Because ultimately it is really about a partnership. I know I came in and talked really aggressively about the federal government's role here, but, but ultimately we have to answer to, to them as well. We have to make sure that we provide the best path and the easiest path possible to get providers into compliance on documentation, so that when the federal government comes, our house is in order, their house is in order. And just as an aside too, I, I think that we all really recognize that there is an ethical obligation to really, you know, robust documentation. And we want to make that process as smooth and as open as possible.

MEYER: It does not appear to be the case. And actually, I heard a testifier today say that the Department of Health and Human Services had offered training for our providers so that they can submit correct paperwork, and yet no training has been provided by the Department of Health, Human Services. And quite frankly, I'm troubled by that. And it appears to me that we're perpetuating a status quo without trying to address the concerns of our providers, because, quite frankly, we're losing providers at a time when we need to enhance our

providers. And I don't see anything demonstrated from the Department of Health and Human Services that they're trying to stop the flow outside of the profession, and just start to enhance. And it's certainly something that troubles me a great deal and something that has to be addressed. And I hope, I hope in your position that you begin to address that very vigorously, quite frankly.

DREW GONSHOROWSKI: No, in--

MEYER: In fact, I expect, I expect that. I will expect nothing less than that, quite frankly.

DREW GONSHOROWSKI: Yeah. And, and in that spirit as well. One issue that was raised here, particularly that that sort of sparked my interest was the providers expressing concerns about not being aware of contractual changes. It's my understanding that MCO's should be notifying them. And if that is something that is coming up, I fully encourage the providers to reach out to Medicaid. You know, you can, you can find my email, you can find someone in Medicaid's email, it will come to me. That is one specific issue that out of this, if that is happening, I, I want to see it.

MEYER: I'm going to give you the benefit of the doubt and, and encourage you to follow up on this and make every effort to try to remedy some of these problems. So once again, I, I wish you luck and I fully expect a, a very positive outcome out of this, quite frankly.

DREW GONSHOROWSKI: Appreciate it.

MEYER: Thank you.

HARDIN: One of the testifiers earlier talked about, and answered the question, how are things going on nationally, either with our three MCOs or others? And I kind of get this in the insurance world because of HIPAA and so on and so forth. The bullets always fly one way with any kind of insurance carrier. That's because of PHI, private health insurance information. In other words, the bullets fly towards the carriers. The carriers are not allowed to shoot back publicly. And so I, I get that dynamic. But from your perspective, because you've been writing on these and researching on a number of these kinds of things nationally for a long time, is it your sense that Medicaid MCOs across the country are, are struggling to be able to keep up with the way the world works right now? I mean, what is, what is your sense of-- do we have a better situation? I mean, could it be a whole lot worse than it is here in Nebraska? Is it happening much better in other places? Is

it happening worse in other places? I, I guess is some of the sense I'm trying to get.

DREW GONSHOROWSKI: No, I think that's a, that's a great question. Looking at the, the sort of federal focus, I think coming out of the pandemic, at least on the federal side, it seems like everyone's trying to understand the, the precipitous growth in utilization of behavioral health services, kind of across all, all sort of aspects. This, this has a lot to do with telehealth. And it seems to me that, that the federal government has, has sort of created an interest in even doing audits. And the OIG, there's a lot of reports directly related to behavioral health over the past year, and there's probably more to come that really directly go at this issue of improper payment and improper documentation, duplication of services, more hours billed in a day than is physically possible, and trying to get heads or tails of understanding this, this growth in, in cost, but also whether or not it's, it's in service of the patient when-- at the end of the day.

HARDIN: Is billing while you're in jail problematic as a provider? I'm just tossing that out as a for instance.

DREW GONSHOROWSKI: Well, I mean, I, I think it's safe to say that. Yeah, that's problematic.

HARDIN: It's problematic. OK. Just, just checking. Any other questions? Yes, Senator Quick.

QUICK: Thank you, Chairman. So I know you talked about following the federal guidelines. But we, we heard from testimony today about some of the MCOs going above what state statute requires for reporting and the time frames. So how do-- you know, isn't that the, the department's responsibility to o-- an oversight to make sure you're checking on those things?

DREW GONSHOROWSKI: Yeah, of course. And at least to my understanding, the department hasn't encountered protocol or appeals protocol even that's out of line with statute.

QUICK: OK. Well. And then, you know, I can't remember the other question I was going to ask, but yeah, I'll finish here.

HARDIN: Other questions? Thanks for being here.

DREW GONSHOROWSKI: Thank you.

HARDIN: Opponents, LB381 one. Welcome.

MARK COLLINS: Thank you. Senator. I'm Mark Collins, members of the committee. I am Assistant Attorney General-- M-a-r-k C-o-l-l-i-n-s. I'm Assistant Attorney General, and I'm the director of the Medicaid Fraud and Patient Abuse Unit in the Nebraska Attorney General's office. And I'm here to testify on behalf of our office concerning LB381 in opposition. Our unit is a federally mandated law enforcement entity, and our primary responsibilities are investigation and prosecution of fraud that is perpetrated by providers of Medicaid services, and the investigation and prosecution of resident abuse, neglect, and exploitation in facilities that receive Medicaid funding. Our unit was created back in 2004. Since that creation--

MEYER: Sir, could you speak a little louder please?

MARK COLLINS: Sure.

MEYER: Thank you. I appreciate that very much.

MARK COLLINS: Since we, since we were created, we've opened over 2,600 files for investigation. We've had 143 criminal convictions, recovered nearly $98 million in settlements and judgments on civil Medicaid fraud cases, and obtained court orders for an additional $18 million in criminal restitution. We can pursue cases either criminally or civilly, depending on the evidence. And the statute of limitations for prosecuting Medicaid fraud, fraud case criminally is five years. Civil cases are pursued under the False Claims Act that's in our statutes, and it has a limitation period of six years from the date of discovery, but no further than-- looking, looking back no further than ten years. Provider fraud is not simple to prove. It requires a careful investigation, which can take months to complete, and we believe LB381 would hamper our office's anti-fraud investigation and enforcement efforts. Many of our investigations begin with a referral from DHHS' Medicaid Program Integrity unit, or through their contractors. And those entities, the MCOs, and Program Integrity do the initial reviews, and we can start our investigation with a solid understanding if a wire fraud case exists, the time frame for a fraud, and how much money is at risk because of the work that those entities do. This bill limits the review of claims by program integrity contractors to only one year from the date a provi-- of a provider pay-- was paid, and it disincentivizes and dissuades review of claims by those entities. And fraud can often go undetected because it appears to be an innocent mistake at the beginning. But without, and without a review of those older claims, or claims that appear to be clerical errors, then it's less likely that a, that a fraud by a provider is going to be uncovered, so that a more thorough review can

be done. Limiting the time frame for those reviews means that older claims, if they're going to be reviewed, are going to have to be reviewed by the Medicare fraud unit rather than by Medicaid Program Integrity, and they're better equipped to do those initial reviews. And it just further slows the investigation process down. We have to remember that provider fraud harms Medicaid by knowingly taking money away from others that could pay providers who perform necessary and important work. It can harm recipients themselves because of limitations on payments to providers, because that can result in less care to recipients if there's less money. And if I can briefly conclude. The work that we do to prevent Medicaid fraud helps everyone, it's in the interests of all Nebraska, it's required by the federal government. Those long statutes of limitation that are in place that I mentioned before are because this kind of fraud is difficult to detect and it needs to be properly investigated. And we believe that this bill would hinder that work and cause some providers who commit fraud to go undetected and unpunished. And for that reason, we would ask that the bill not be advanced. I thank you for your time, and I welcome your questions.

HARDIN: Thank you. Senator Riepe.

RIEPE: Thank you chairman. My question would be, what's your relationship to Mike Foley as the State Auditor? Your division's.

MARK COLLINS: We get, we get the reports.

RIEPE: OK.

MARK COLLINS: From the auditor.

RIEPE: Does he, does he have any role in auditing any managed care organizations?

MARK COLLINS: I don't have the answer to that question.

RIEPE: OK, OK.

MARK COLLINS: I'm sorry, Senator.

RIEPE: Ok. Thank you. I'll follow up on that on my own. Thank you.

HARDIN: Other questions? Yes, Senator Meyer.

MEYER: Thank you, Chairman Hardin. I have every confidence that there is fraud in the Medicare program, Medicaid program. Pick a, pick a

program, there's fraud in it, quite frankly. But that's not the testimony we've heard here today. And to the best of my knowledge, and the testifiers we've had, no fraud has-- none of them have been charged with fraud. It's just been a concerted effort by the MCOs to deny payment or clawback legitimately owed, legitimately earned payments for services rendered. And so I guess from the standpoint, and I have an appreciation for your job and and I absolutely want you to go after Medicare, Medicaid fraud, any fraud that's involved with the state or the federal government, if it's abso-- if that's within your purview. But that's not the case of what we have witnessed and what, what the testifiers have been today. So to equate what we have heard today from our testifiers and lump that in with the, the numbers of fraud and the clawbacks and stuff, it is probably not something we can couple together, quite frankly. But I do appreciate the fact that you are in the business of, of finding fraud when it's re-- reported. You do have to investigate when, when the possibility of fraud is reported. But that's not actually what we've dealt with here today, with the testimony we've gotten from these providers. So I just wanted to make that point, quite frankly. It's not in the form of a question, but it just appears that we're, we're looking at two different things with regard to the previous, previous bill and this bill in regard to what, what their experience has been. So.

MARK COLLINS: I appreciate--

MEYER: I appreciate your offer, your, your, your, your testimony and everything and the job you do, I appreciate that very much.

MARK COLLINS: Thank you, Senator, and I appreciate your comment. Sometimes, though, what happens is that the discovery of a fraud is based upon an innocuous blip in, in data that, that is found by a program integrity contractor. And if you look at it just in isolation, it might not appear to be anything. And if you can only look back a year, you might not be able to uncover a pattern of how a fraud can be perpetrated. And so our concern with the bill is that by limiting the amount of time that, that this look back can occur, it is possible that we will only see the blip. And by we, I mean the Medicaid program and all of us involved in fraud. That we'll only see the blip and will miss the pattern because we can't look back far enough. And so that's the reason that we have concerns about the bill.

MEYER: So your concern, if I may, Mr. Chairman. So your concern's primarily with the time frame as far as the look back is concerned, not, not specifically whether-- it's the time frame that you're concerned with primarily with this bill?

MARK COLLINS: It is, that's, that's our primary concern. And, you know, the Legislature gave us five years to look back on criminal cases. And usually it's only three for a felony. But, you know, they realized that in investigating fraud cases, it takes a long time and there's a lot of stuff to go through. And so that's why the Legislature gave us five years on that. And the Legislature gave us a look back period of six years from the date of discovery of a fraud to pursue a case civilly. And we can go back then as far as ten years. And the rationale is the same. Fraud is complicated, there's a lot of data, there's a lot of documents, etcetera involved. And because of that, it, it takes a while, you know, because we're not-- we don't want to be in a, in a position where we're accusing someone of a crime, for instance, where a proper, thorough investigation has not been done. And so that's the reason primarily that we are concerned about this bill, is that that one year look back period can result in fraud cases not being discovered.

MEYER: With-- I'll set the fraud part of it aside. Do you think it's, it's appropriate for some of these providers to go two and a half and three years having clawbacks, having investigations on previously approved services provided, and then three years later they're come back and there's a clawback, and there's really no discrepancy. It might be an accounting error, it might be-- I certainly know from my own medical experience that if something's not properly coded, you might get a surprise in the mail where you owe an awful lot of money for a medical procedure. And all it was was a coding error and it gets corrected. So I guess a time frame of five or six years and people are going back and getting cl-- approached to have funds clawed back at really an unreasonable amount of time. And I know it's difficult to determine the fraud. But no-- to the best of my knowledge, none of them have been accused of fraud. It's just a matter of nit picking, a poor word perhaps on my part, but a very, a very loosely conducted, in my opinion, from what I've heard, audit and analysis of what, what was appropriate and what was not with providing their billing, and so-- I-- it's almost like we're looking at apples and oranges here with regard to fraud and what actually has happened to many of our testifiers here, so-- But once again, I-- you're in a different very difficult spot and I appreciate that, so, thank you.

MARK COLLINS: Thank you, Senator.

HARDIN: Other questions? Senator Quick.

QUICK: Thank you, Chairman. So do you ever-- You know, so we heard today maybe, some testimony that maybe even the MCOs have violated

state statute. Now, do you ever investigate them for maybe misuse of their authority? Or does it say that providers have been mistreated? I mean, I'm going to guess you probably wouldn't represent the providers against the MCOs in any of those cases either. That's two questions.

MARK COLLINS: That's-- Can we investigate fraud in the administration of the Medicaid program? The answer to that question is yes. Federal law gives us the authority to do that. I'm not sure that we-- I know that we haven't had any allegations brought to us that fraud is being-- by an MCO is being perpetrated against the Medicaid program. But if, if there was, we have the statutory authority that we could look at that, yes. As to your second question, in, in representation of Medicaid providers against the MCOs, the answer to that question would be no, we can't, we can't do that.

QUICK: OK. All right. Thank you.

MARK COLLINS: You're welcome.

HARDIN: Other questions? Senator Hansen.

HANSEN: I know sometimes we put stipulations in bills like this to allow you to conduct investigations of fraud. So if there's a stipulation in this bill said this, this would not hinder your ability to conduct an investigation. Would that alleviate your concerns?

MARK COLLINS: No, Senator, and the reason for that is because it's not my group that does the investigations. Those preliminary investigations are done by the MCOs and by Medicaid Program Integrity. And, and that's who this bill is directed at.

HANSEN: OK. All right. Thanks.

MARK COLLINS: You're welcome.

HARDIN: Other questions? Seeing none. Thank you.

MARK COLLINS: Thank you. Appreciate your time.

HARDIN: Opposition to LB381.

JAMES WATSON: Good afternoon.

HARDIN: Welcome.

JAMES WATSON: Again, my name's James Watson, I'm the executive director of the Nebraska Association of Medicaid Health Plans, which

consists of Molina Health Care of Nebraska, Nebraska Total Care, and UnitedHealthCare Community Plan. Since the proponents have graciously sort of, I guess, pared back their time. I'm going to do the same and just raise a couple issues here. And I am thinking of the previous testimony on this bill, in particular when it focused on fraud. And I'd like the committee to understand that while fraud is certainly very, very important, and required by federal law to be investigated, required by state law to be investigated, from an MCO perspective, we also have an additional duty to preserve the accuracy of claims submissions. Accuracy isn't necessarily due to fraud. Inaccuracy can be due to incompleteness, it can be due to a myriad of other things that have been discussed. But the problem is, is our organizations have, by contract, to submit our encounters weekly to the state, and those encounters have to be 98% acceptable by state standards. And so many of the investigations that we've talked about today sound to me like situations where there has been incompleteness or inaccurate coding. And as you mentioned, Senator Meyer, in the medical world, accuracy, it can cost money. Accuracy is very, very important. It controls the capitation rates that the state pays us on an annual basis. It controls how much we pay the provider for sure, and ensuring that that accuracy is there is a big part of this, and it may not necessarily involve fraud. And, and so that to me is a, is a very critical point. Also, in 2020, in the Covid year, we did have a bill and it was LB956 that came out right at the end of the session, that pretty much detailed how a managed care organization is supposed to let the providers know what contract changes come up, and the original bill actually required, I believe it was an orange envelope to be sent. And at the end of the day, it required us to specify in a notice that there is a contract change in this, and we're required to send the notice to the person in the provider contract that's designated by the provider as a contact person. So, you know, there are things in place, and maybe there are things that we have to look at to do them better. But I think the basic tools are there, and that's what I wanted to make the committee aware of. Any questions you have, I'm happy to do my best.

HARDIN: Thank you. Senator Meyer.

MEYER: I just have something very brief. Thank you. Chairman, I think-- I appreciate the fact that we need absolute accuracy, and I know it's almost impossible to, to achieve, but the, the appeals process should provide for any clarification of those things and without penalty, quite frankly. And I think each of our providers will do everything they possibly can to be as accurate as they can on, on their reporting. I hear that Department of Health, Human Services have

talked about the possibility of providing training so we can improve accuracy. Evidently, none has been offered. Perhaps none has been requested. I believe it has been requested but-- So that training hasn't happened. And, and quite frankly, the MCOs probably should offer some training if this is how we want the forms filled out. But once that's established, don't come back on them and say, well, we were wrong, this is wrong, and so we're going-- we got audited. And so I-- everybody wants this to be accurate. I would like to see a collaborative effort to where we work together, the MCOs, Department of Health and Human Services, and the providers to try to get as accurate as possible. And if that, if that is some additional education on filling out the forms properly and certainly clarification when, when those forms change or what you're looking at, how they need to do that, let's, let's collaborate, let's do that. Other-- We don't have to be here discussing this, quite frankly. We should have these things in place to where the accuracy is, is, is the general rule and not the exception. So I appreciate--

JAMES WATSON: I couldn't agree more.

MEYER: I appreciate your time very much.

JAMES WATSON: We'll do our part too.

MEYER: Thank you. I appreciate that.

JAMES WATSON: Any other questions?

HARDIN: Other questions? Seeing none, thank you.

JAMES WATSON: Thank you.

HARDIN: Opponents, LB381. Those in the neutral, LB381. Senator Fredrickson, are you familiar with LB381?

FREDRICKSON: I am. OK. Thank you, Chair Hardin. Thank you to the committee as well. I know this has been a long day of both LB380 and LB381. So lots of good discussion, I appreciate the committee's attention to the testifiers. I also am grateful to the testifiers who came to share their experiences and their stories. A few things I wanted to touch base on. So both DHHS and the AG's office expressed some concerns. So DHHS actually reached out to me about their opposition, which I appreciate. This is the first time hearing from the Attorney General's office. So some of the concerns that they expressed, I think those are things we could have possibly worked out and possibly could work out. Would appreciate some heads up from them

in the future if they're going to be in opposition to a bill coming in before the moment of. But I want to talk a little bit about DHHS has expressed some concern about whether or not this might compromise our ability to audit on a federal level. This is not-- we're not going to be the first state to do something like this. This is-- these types of protections, and these types of guardrails are in place in a number of states and have been for a number of years. In those states still do you perse-- prosecute fraud with Medicaid. So this idea that it's going to possibly compromise something on the federal level or our ability to investigate, I think is frankly, inaccurate. And I'd be happy to clarify what the-- the opposition related to that in other state statutes and how they're still able to prosecute against Medicaid fraud, if that would be helpful for the opposition. One of the thing is the look back window, I, I heard what the AG's office said about wanting to sort of see patterns there. Part of the reason we did the one year look back window was actually as a result of a conversation with DHHS. So one of their concerns was that there's a, there's a time frame for when the feds will reimburse the state for Medicaid payments. So we did a one year look back because we wanted to ensure when providers were resubmitting for the reimbursement that the state wasn't on the line for the full reimbursement, that we would still get that federal side of the reimbursement. Now, if they want to expand that, the risk of that, of course, would be that the state would be in line for the full reimbursement. We would be forgoing the federal funds there. So that's just something to kind of consider when we look at that look back period. The bill does also explicitly pretty clearly allow for fraud investigations. So I want to be 100% clear on that. This is not a bill that says fraud should not be investigated. In fact, I think you heard from a lot of the proponents of the bill that audits are something that the proponents are supportive of. I'm supportive of audits. I think auditing is, is responsible, I think it's prudent, I think, when audits are done correctly. And I think we had a great example of what that looks like from one of those providers who talked about that collaborative approach of reviewing the charts, reviewing the areas of concern, talking about ways to improve for the future in a collaborative collective action plan. I've been audited in the past, not here in the state of Nebraska, but in another state when I was working. And that was exactly what that looked like. It was very much a collaborative approach that said, these are the concerns we have, these are the fixes that would need to occur. It was never this sense of, you know, trying to reach out for clarity, not having any response, reaching out for guidance on how to improve things and sort of being stonewalled. And I think that's the reality of what we're hearing from providers, is that we're hearing on

one hand that they're open to-- they help providers reach out about these things. Well, you heard a number of providers who said that they have reached out multiple times through multiple venues, through the department, through MCOs, through even the Ombudsman, and have still not been given any clear answers. And so I think we need to really hone that down a little bit and get clear on that. I think the committee kind of picked up, it seems like there's also been a clear shift over the last 3 or 4 years or so. That's happened with how we're conducting these, these audits. And again, I don't know exactly what that, that shift is, but It seems like that, that's been one of the biggest concerns and one of the biggest issues. The final thing I'll say is, and I said this in the last bill as well, is I think one of the big themes of the committee this year, again, has been this idea of health care deserts. We've heard a number of bills on how to ensure that we are mitigating those deserts and, and ensuring that there's access to care. One-- The thing that really, you know, makes me want to cook with gas on this issue is that there are providers who are stopping to take Medicaid. And I've gotten calls from providers, especially I had one, I'm not going to name which legislative district, but the senator from that district is, is fired up about this as well. He lost one of his only Medicaid behavioral health providers because of these practices, and that-- those are the things that, you know, I think we need to really --this is why this type of legislation is important. This legislation isn't saying fraud shouldn't be prosecuted. Fraud should absolutely be prosecuted. This legislation allows for fraud to continue to be prosecuted, as we've seen from how this has been done in other states. And if there's things that we need to adjust to ensure that that's airtight and, and very clear, more than happy to have those conversations. This bill is really about ensuring that providers who are providing the services, that fraud is not found, that they are seeing the patients, that they are able to if there is a clerical error or an administrative error, that they're given the opportunity to correct that, to resubmit the claim and to be reimbursed for the care that they did provide, that no one's disputing that they provided. So if we don't do that, again, I think we, we generally do risk people not wanting to take Medicaid. I mean, I certainly would not want to do that if I had no guarantee that I was going to be reimbursed for a service that I, that I did provide. So with that, I'm happy to take any questions from the committee.

HARDIN: Questions. Senator Riepe.

RIEPE: My only question was, is there, or should there be a statute of limitations in terms of how long you can go out to--

FREDRICKSON: to request record matter?

RIEPE: --perform the audit, and maybe submit the audit, and then declare some clawback?

FREDRICKSON: I mean, that's a, that's a fair question. I mean, I think that, you know, you heard from some providers that spoke about, I think one practitioner said that they were audited and then they didn't hear anything, I think it was for almost, for almost two years. And then were told, like, you owe back $30,000 from two years ago, or I don't remember what the exact number was, but I mean, that, that, again, that's, that's part of the reason why we put the safeguards in on look back periods, because, you know, there has to be some level of reasonableness with that.

HARDIN: Other questions? Seeing none. Online, there were 51 proponents, 1 opponent, 0 in the neutral. Thank you. This--

FREDRICKSON: Thank you.

HARDIN: This brings LB381's hearing to an end. And we're going to transition to LB610 and Senator Bostar. And Senator Bostar, we'll wait until the room is done with the shuffle. Welcome to the most exciting committee that Nebraska has to offer.

BOSTAR: This is my first time here this session, and my second time here ever.

HARDIN: Wow. You've picked your own pocket. You're welcome back.

BOSTAR: Well, it's good to be back. And with that, good afternoon. Chairman Hardin, members of the Health and Human Services Committee. For the record, my name is Eliot Bostar, that's E-l-i-o-t B-o-s-t-a-r, representing Legislative District 29, here today to introduce LB610, legislation that will provide a measurable increase in the federal Medicaid reimbursement rate to ensure advanced life support transport providers can financially maintain service levels over the coming years. Between 2019 and 2023, the cost of emergency transportation increased significantly, outpacing inflation even though utilization remained relatively stable. This is ultimately unsustainable for our state's public providers. Medicare and Medicaid do not cover the full cost of providing ALS transport services by our local providers. For most departments, Medicaid, for example, covers as little as 30% of what other insurers pay, despite the additional costs falling to local government providers. Simply put, our communities and rural volunteer departments are growing broke providing lifesaving services for all of

us. Definitive care evaluations have shown that care and high quality treatment at first contact with emergency medical service responders make a difference for a patient in terms of less emergency room intervention, shorter hospital stays, and less expensive post hospital care. This equates to a lower total cost for care to the Medica-- Medicare, and Medicaid system, and part of the foundational reasons why the federal government makes ground emergency medical transport programs available to states. Publicly owned ambulance services cannot turn down a 911 medical call, even if the financial loss will eventually put the department out of business. Through GEMT, the centers for Medicare and Medicaid Services recognize the need for a supplemental payment program for these public providers. GEMT is not a new program, and while Nebraska has participated in Medicaid for over thirty years, our current state plan does not recognize first responder ambulance services as part of the higher reimbursement allowable under the regulations administered by CMS. LB610 offers a minor change to the language in the state plan that will allow CMS to reimburse departments based on their actual costs through supplemental payments. Without this change, under Medicare and Medicaid as a state, we are leaving money on the table with each and every ambulance ride. GEMT programs are cost neutral to the state Medicaid agencies, and the state's reasonable costs directly associated with the program are reimbursed through the process. Participation in GEMT is not mandatory, and local agencies may choose to participate or not to participate. However, the statutory change must be adopted statewide in order to qualify under the federal regulations, GEMT is estimated to provide between $15 million and $30 million in revenue to local fire and EMS departments, allowing these providers to bridge the gap for the current deficient federal payment structure. 23 other states have already enacted GEMT programs, including our neighbors in Iowa, Kansas, Colorado, and Missouri. It's clear that current trends are unsustainable. LB610 offers a simple and effective measure to fairly compensate local departments for lifesaving services essential to the safety and good health of our communities. I thank you for your time and attention, and I would appreciate your support for LB610 and be happy to answer any additional questions.

HARDIN: Thank you.

BOSTAR: Oh, additionally, I passed around a amendment that does just a few simple things, and it was, the amendment was worked out with the department. So the amendment will make portions of the language permissive, thus ensuring that there's adequate flexibility in order to have this program meet the individualized needs of various

communities across the state. And there was a date change of 2025 to 2026, in line with what's necessary for the bill. But that's it.

HARDIN: Questions. Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Senator Bostar, for bringing this bill. I think it's a good bill. I-- so I want to make sure I'm understanding this fiscal note correctly, and I wonder if you could maybe elaborate on it a little bit more, but from what I understand from your-- this is-- this bill has the opportunity, it sounds like, to bring in more funds. I'm seeing the fiscal note that's saying something maybe a little bit different. So can you maybe thread that needle for me a little bit or--

BOSTAR: Sure. The fiscal note actually does do it right. So if you look at the cash funds line on the fiscal note, you see equivalent money in and out. Right? So it's, it's holding our state-- Well, let me, let me take one step back. There's nothing on the General Fund line, right? No General Fund impacts whatsoever. There are cash fund impacts, but the money out and the money in are equivalent. So it's all neutral. And the only thing that's, that's, net not neutral is federal funds that we are pulling down.

FREDRICKSON: Got it.

BOSTAR: So does that answer the question?

FREDRICKSON: That fully answers it, thank you.

HARDIN: Other questions. Senator Hansen.

HANSEN: I think the amendment dramatically changes the bill, doesn't it? It pretty much says you shall, and now you may. So you've pretty much given the department the decision to do this if they want. Correct?

BOSTAR: So yes, I mean, that's true. Because all communities are different and it's, it's-- this effort has been in the works for years. And we've really been working with the, with the Governor's Office and the department on ensuring that we have the right way of doing this. There are understandings and agreements in place for how-- for communities that really want to see this happen, ensure that they are able to participate in the federal program. And so this just gives everyone the flexibility to execute on what we've all agreed to.

HANSEN: OK. Thanks.

BOSTAR: But you're not wrong.

HARDIN: Other questions? To your point, as you stated earlier, this bill has been around a while. And so. What's the federal government's disposition?

BOSTAR: Well, they created the program for states to take advantage of.

HARDIN: OK.

HANSEN: And so--and, and, you know, they created the program for the states to take advantage of because these are critical services that otherwise aren't being reimbursed at a rate that has any sustainability whatsoever.

HARDIN: OK.

BOSTAR: And so we are just-- we are-- by doing this, we were able to participate and acquire those federal funds for those reimbursements. What historically the department, HHS here, has been in opposition to the bill. This-- That's no longer the case. So we've been able to work this out and get to a place where everybody should be good with this.

HARDIN: Will you stay so that we can see you again at the end?

BOSTAR: You know, I would really be disappointed if I didn't, so I, I will. I'll stick around.

HARDIN: Wonderful. Proponents, LB610. Welcome.

DAVE ENGLER: Thank you. Good afternoon, Senator Hardin and members of the Health and Human Services Committee. For the record, my name is Dave Engler, D-a-v-e E-n-g-l-e-r. I'm the fire chief of the city of Lincoln, and today I'm speaking in support of LB610, calling for the implementation of a ground emergency medical transport program, or GEMT program in our state. And I'd like to thank Senator Bostar for introducing this bill. The reimbursement from Medicare and Medicaid for ambulance transports is significantly lower than the cost to provide the services, especially for public providers like my department, who are obligated to respond to all 911 calls received without regard for the patient's ability to pay. To bridge the gap, EMS providers end up charging patients with private insurance or those who are uninsured more and needing a standard subsidization for the municipalities we serve through local taxpayer funding, primarily sourced from property taxes. Around 70% of my department's transports,

over 22,000 total per year, are, are for a Medicare or Medicaid recipient, which in turn creates a multi-million dollar deficit in reimbursement. GEMT programs like those current-- like those currently drawing down funding in our neighboring states, allow for public or municipal based career and volunteer departments to submit cost reports for their unreimbursed expenses to help offset the underpayment. These programs are alleviating the financial burden on patients and local taxpayers. For my department, this funding will help us to achieve a healthier fleet of ambulances and equipment to ensure we have enough paramedics on duty to respond quickly to our growing call volumes and to provide adequate training and reduce our reliance on overtime staffing. I want to recognize that the Medicaid leadership has continued to meet on GEMT over the years, and seems amenable to a solution. We are very much looking forward to working with them on the next steps. Passing this bill is necessary to get GEMT the priority it needs to be implemented. In summary, I ask for your support of LB610. A vote for this bill is a vote for-- a vote to support Nebraskans who experience emergencies and need ambulance transport, a vote for the public based EMS providers across the state to ensure they are able to sustain the levels of service, with soaring costs and staffing shortages, and a vote to meaningfully provide relief for local taxpayers as municipalities attempt to alleviate the resources needed to preserve life saving EMS care in their communities and among other needs. Thank you.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you. Chairman. First of all, thank you for your patience. I know you waited a very--

DAVE ENGLER: I've been here a while.

RIEPE: --long period of time. I think you were here at 1:00, and so bless you for that. How does this relate to, like, the fire department in terms of the funding for the, for the firefighters versus the rescue squads. Is it all in one big group?

DAVE ENGLER: It depends on, it depends on the individual organization. Lincoln is a little bit unique in that we are an enterprise based EMS system, which means that we don't use any taxpayer dollars to support that operation. So it's all user funded. So for Lincoln this is going to be different and very meaningful to our operation. But in each organization it's going to be different. So some of these funding-- some of this fund in some organizations could come back and help with fire operations as well or offset those EMS costs. In Lincoln, this

will be specifically for EMS because that's the structure within the city ordinance.

RIEPE: OK. Thank you. Thank you, Chair.

HARDIN: Other questions? Chief, paint a picture for us. What's life look like in a year if this passes? What's it look like in a year if this doesn't pass in Lincoln.

DAVE ENGLER: Well, if, if this passes, in Lincoln in a year, what, what we do see is the ability to, as I said, put more units on the street to respond to the calls, and our call, our call volume continues to go up.

HARDIN: And about how many, how many?

DAVE ENGLER: So this year we were-- we-- the, the call volume rose by 5.4%. So it increased. And we're around 30-- we're nearing 35,000 calls a year, which, which about 80% of those are EMS. So-- and like I said in my testimony, about 22,000 are actual transports where we're taking a patient to the hospital. So what this does is it, it helps with equipment, it helps with adding staffing to respond to those calls, and it also helps with recruitment retention because we've got to train paramedics. And so that training of paramedics, where it used to be, you'd hire in paramedics and there was an abundance of them, we're having to resort to training them from within. That requires us to backfill, overtime, and all of that. So, so these funds are really critical in assisting us in our operation and, and meeting the needs of the community.

HARDIN: Thank you. Seeing no other questions. Thanks for being here.

DAVE ENGLER: Thank you.

HARDIN: Proponents, LB610. Welcome.

GARY BRUNS: Good evening. Chair Hardin and members of the Health and Human Services Committee, my name is Gary Bruns, G-a-r-y B-r-u-n-s. I'm here today as the president of the Nebraska Professional Firefighters Association, representing 1,400 paid municipal firefighters, EMTs, and paramedics across the state. We'd like to express our gratitude to Senator Bostar for introducing LB610. Our association has consistently stood by in solidarity with our management teams and volunteer partners in support of LB238, LB578, LB1100, and we're here once again today to support LB610, which proposes changes to the provisions related to supplemental

reimbursement for GEMT. It is important to note that GEMT is not a new program. Nebraska has been participating in the Medicaid for over 30 years, and however, the current state plan does not recognize first responder ambulance services as a part of the higher reimbursement allowed under regulations administered by CMS. Minor change to the language in the state plan would allow CMS to reimburse at the higher rate, which is crucial for maintaining high level of emergency services our community relies on. As Nebraska's front line defense, we believe it is critical for DHHS to pursue all available funding sources to ensure that we can continue to provide a high level of service that Nebraskans have come to expect. Thank you, I'm happy to answer any questions.

HARDIN: Thank you. Questions? Seeing none. Thank you.

GARY BRUNS: Thank you.

HARDIN: Proponents, LB610. Thanks for being here.

MARK HOWERTER: Thank you. Thank you. My name is Dr. Mark Howerter. I-- it's M-a-r-k H-o-w-e-r-t-e-r. So good afternoon, Chairman Hardin and members of the committee. You've had a long day. I'm an emergency physician. I'm also the director of the emergency department and the chief medical officer at Columbus Community Hospital, Columbus, Nebraska. I'm here on behalf of the Nebraska Hospital Association to testify in support of LB610, and we thank Senator Bostar for introducing this bill. I'm going to take a little bit of a left turn. I'm going to talk a little bit more about interfacility transport, which may be a little bit more of a dire situation in our state than rescue. And, and I say that with some trepidation, because I'm also the medical director of Columbus Fire and my fire chief, Chief Gray is over my left shoulder. But at Columbus Community Hospital, where I've served as the ED director for more than 20 years, we depend very heavily on medical transport companies and their skilled paramedics. We're a hospital that-- and I've listed all the services we have on a 365 day basis. And we, we do provide a fairly robust level of service, but we still need to transport roughly 35 to 45 patients per month to hospitals that produce or can provide higher levels of care than we can provide. The vast majority of these are ground ambulance transports. The number of options for ground transport in our area has reduced to one. That provider recently was forced to sell out to a larger, non-local company due to its inability to sustain the business given current reimbursement issues. The other ambulance services in the state have dried up rather quickly. Twenty years ago, when I started, finding an ambulance service was easy. Now it's, it's almost

impossible. The ability of transport services to provide good, qualified paramedics, or attract them has degraded over time, really because they can't pay them terribly well. This has resulted in fewer paramedics and increased transport waiting times. An RED is, is averaging 2 to 4 hours on most days. Our, our transport, our current transport company, is considering a payer of last resort clause in their hospital provider contracts, which would be a new thing for the state of Nebraska. Because of poor reimbursement, we cannot afford transports where there is no, where there is no payer. The, the average reimbursement for a Medicare transport does not pay for the gasoline and the paramedic's salary incurred during the run, let alone the cost of bricks and equipment and training. In this environment it's easy to understand why transport companies are vanishing as opposed to developing or growing. And frankly, if I were to invest in a company today, it would not be a medical transport company. At this current trajectory, I see a day within five years where there are no medical transport companies in our state. I have talked about the hardship this creates for providers of medical care, but the real victims are patients and patients. Those are our loved ones, family members, neighbors, and even governors of our state. Thank you for your time, and I encourage you to advance LB610, an incredibly important piece of legislation for our hospital and our patients. I'll take any questions.

HARDIN: Thank you, Doctor Howerter. Questions? And so, how does someone get from here to there if those companies are gone? I'm just-- does it fall to loved ones to basically figure out how to make it happen?

MARK HOWERTER: That, that is a great question, and one that keeps me up at night a little bit. So, you know, we're, we're left with, do we lean on our, our local 911 jurisdictions to provide that kind of service? They're already cash strapped, and then we would be leaning on them to do more. And, and they're different services. 911 services aren't really required to run ventilators. They don't do multiple I.V. drips. They don't transfuse blood en route. So it would be a different level of training, it would require more equipment, that sort of thing. The alternative is that every hospital in the state would have to have their own ambulance service to get patients from point A to point B. And so, you know, what that creates is a, a lot of expense for each hospital to have enough paramedics, to have two paramedics per shift, have two rigs, all the equipment necessary, all the training necessary. And then you multiply that times 100 hospitals across the state. And you're, you're talking about a lot of expense is going to be run unreimbursed, you know, at a time where hospitals now,

50% of the hospitals in the, in the country are under water. So there aren't a lot of hospitals are going to be able to actually do that.

HARDIN: OK. Senator Meyer.

MEYER: Thank you, Chairman Hardin. Probably less of a question than just a weigh-in on what you just said. I come from a rural community. We have volunteer fire departments. And we interact with our-- we have two Native American tribes in our county, the county where I'm from. One has three transport units. The other has at least one, they may have two. And then each of our town generally has a rescue unit, you know, as part of the fire department. And yet we are terribly short on medical personnel to, to man those. And so often rather than an emergency call, I don't know the percentages, but probably very, very close to what you have, we are transporting. And so we, we are in the business of transporting, people are coming off their jobs. You know, certainly we are cooperative within that. But, but we actually took a look at possibly trying to contract locally, outside the county but relatively locally. The costs are prohibitively expensive, it simply isn't feasible for our, our, certainly our fire departments, our hospital. And maybe it's something where we have to consider getting the counties involved to some extent, because the, the main responsibility is public safety, and this certainly falls into that category. But it's a real problem out there. And so it's, it's a struggle we're all having. From a cost standpoint, I'll just share, I've-- it's not-- this isn't about me, but I, I recently had a heakth event, and rather-- it was not, it was not life threatening. At least I didn't view it that way. But rather than haul me down from Pender, Nebraska to Omaha, Nebraska to the Med Center, they had to call a helicopter out of Norfolk. And just simply not having something available to take me by ground, the difference in cost is staggering. And, and quite frankly, it's probably an unnecessary cost that was incurred to haul me down to Omaha. And so it's, it's, it's something we have got to address, certainly in our rural communities, but certainly in your community also. And I really don't know what the answer is, but we've got to find a solution that's quite frankly [INAUDIBLE].

MARK HOWERTER: That, that resonates a lot with us. We have times where we have no transport providers available, we don't have paramedics available, and we do send things by helicopter simply because we don't have another way to get them there. And, you know, the difference is about $60,000 in, in costs. And it's not clear that the insurance companies will always cover that when they see what the reason was. But, you know, if it was an acute stroke that needs a thrombectomy,

and we can't get them there by ground, we have to get them there somehow.

MEYER: Yeah.

MARK HOWERTER: Yeah.

MEYER: So I, I truly don't know what the answer is either, but we've got to find some solutions to this. And, and there's definitely going to have to be a price tag on it. There's just nothing happens without a price tag on it. But I certainly empathize with your position. And it's, it's, it's universal in the state and probably universal in the country, quite frankly.

MARK HOWERTER: But if there's federal money on the table, I think we're foolish not to at least, at least explore that.

MEYER: I concur. Thank you.

FREDRICKSON: Thank you, Senator Meyer. Other questions. Senator Riepe.

RIEPE: Thank you for being here. I know you're a physician, but you may have some idea of how many flying days can a helicopter not fly?

MARK HOWERTER: Oh, I, I actually am well aware of that because we talk about this a lot. So in fact, I had to do some research on that because we were, we were actually looking at, you know, the justification for having a cath lab in Columbus, Nebraska. And what we, what we discovered is that 35% of the time they cannot fly.

RIEPE: They can?

MARK HOWERTER: Cannot.

RIEPE: Cannot?

MARK HOWERTER: 35% of the time they cannot fly. And that actually exceeds the national, the national statistics. The national statistics are closer to 37 to 40% of the time. So yeah, I thought Nebraska would be worse. But 35% of the time we cannot fly.

RIEPE: Maybe we just live more dangerously.

MARK HOWERTER: Yeah, it could be, could be. But, you know, it's, it's snow, it's thunderstorms, it's icing. Icing is a real big problem with helicopters. And. Yeah. So that's, that's-- the helicopter is not always the answer.

RIEPE: I assume, you know, you really can't do double use, it does crop dusting on one day and hauls patients the next.

MARK HOWERTER: There we go. That's stretching the envelope a little.

FREDRICKSON: Thank you, Senator Riepe. Other questions from the committee? Seeing none. Thank you for your testimony.

MARK HOWERTER: Thank you.

FREDRICKSON: Next proponent for LB610. Welcome.

ROBB GOTTSCH: Thank, thank you all for letting me speak on this important topic. My name is Robb Gottsch, R-o-b-b G-o-t-t-s-c-h. I'm the Papillion Fire Chief, and I'm here representing our mutual finance organization of Papillion, La Vista, and Rural Fire Board in the south of the county. Papillion Fire Department responds to all those areas. That's why we're a mutual finance organization. And just so-- for the record, we respond to both fire and EMS calls, what we would call fire based EMS system, which we, we see as the most opportunist and efficient way of providing services. Of those calls that we respond to, 80% are EMS related. And if you can see in my document here, of that the EMS revenues that we get from responding to EMS calls, that makes up 11% of my budget. And so budgets are very tight. I'm in a community that's growing very rapidly. When you look at Papillion Fire Department, when you look at Sarpy County as a whole, we're growing. And just a quick picture of in 2023, it doesn't look like a lot but we responded or gave EMS services to 3,100 patients. In, in the last five years, we've been going up at a rate of about 7 to 9% in call volume. So that does impact our services, when you look at 80% of them being EMS related. Making up 11% of my budget, getting the revenues from these services is very key. You'll see kind of the loss of revenues of about $52,000. For me, that may not seem like a lot, but when you look at year after year as call volume goes up, that's going to grow for us as well. And it does go back to providing proper services, the training. The biggest issue for us is infrastructure. When it costs us $500,000 just to buy one new medic unit and they last between 5 and 7 years of good service, those things break down pretty quickly, and now we're ready to buy another one. So you'll see at the bottom of my document here the differences between the pay in Medicare and Medicaid and what we could bill and what we're really receiving. The difference there is just between the Medicare rates and Medi-- Medicaid rates. Those monies would be very useful to me, particularly in a very fast growing department that needs to maintain its infrastructure. And it's

getting expensive. Thank you for letting me speak. I'll answer any questions.

FREDRICKSON: Thank you for your testimony. Questions from the committee? Senator Riepe.

RIEPE: Thank you. Chairman. I'm guessing that your crew gets called out on some borderline medical situations where maybe an obese person falls and they have to be helped up. Nobody out, no-- no-- nobody in the neighborhood can do it?

ROBB GOTTSCH: Correct.

RIEPE: So those are not real medical calls, but you still get called on them I'm sure.

ROBB GOTTSCH: Absolutely. Absolutely. A majority of our calls are what you'd call basic life support. They'd say about 80%. And it's those types of calls that impact us the most. That-- yeah, those people need assistance. As our population gets older, the lift assist as you're referring to become inundated. In my community, we have many independent living retirement homes that we spend a majority of our time there. And those people need the help. And I want to provide the assistance. That's what we should do.

RIEPE: Again, thank you for your patience and waiting all day.

ROBB GOTTSCH: Absolutely.

FREDRICKSON: Other questions? Seeing none. Thank you for being here.

ROBB GOTTSCH: Thank you.

FREDRICKSON: Next proponent.

JERRY STILLMOCK: Thank you.

FREDRICKSON: Good evening.

JERRY STILLMOCK: Sir. Mr. Vice Chairperson, members of the committee. My name is Jerry Stillmock, J-e-r-r-y S-t-i-l-l-m-o-c-k, testifying on behalf of my clients, the Nebraska State Volunteer Firefighters Association, the Nebraska Fire Chiefs Association, in support of LB610. Thank you. Tip of the hat to Senator Bostar for introducing legislation and putting it back in front of all of you again to get this done. You saw the origination date, 2017. We need a kick. We need

a boost. We need a push. And we're counting on you to push that out there. Senator Hard-- senator Hardin had to step away, but he's so close to a situation that happened in '24. Maybe others, you are aware of it. Region West. It was a for profit organization, covered great parts of great, great many places in western Nebraska. For profit. They ceased operation. When that happened, all the smaller communities that relied on them outside of Scottsbluff-Gering, which where they were also based, other smaller communities had to do something quickly. Ogallala had to form what, what you suggested, Senator Meyer, with the formulation of county becoming involved, county and city got together along with the hospital associat-- or the hospital in Ogallala. But most importantly, it provides a gap, the gap that you've heard already this evening, that what Medicaid is paying, what is available on the table that-- the federal government has already passed it, as, as you heard Senator Bostar state. It's there, it's ready, it's no General Fund money. We just need a mechanism. And the mechanism is LB610. We, we need that help, we need that assistance, because everything that you've already talked about with the, the falling down and, and is, is it Medicaid reimbursable? That's not a part of the why the question was asked. It's just-- look, recruitment and retention on the volunteer side is a key part of the puzzle that Nebraska is facing. The other element is funding. I cannot tell you a single city or village that I'm aware of in the state of Nebraska that the utilities department, gotta love the villages and cities for what they do, they don't go out and have fundraisers to get a new utility truck to put a bucket truck up on the power lines. But I guarantee other small communities that have volunteer departments, thank goodness, are doing those fundraising to make this happen. Is this going to take away the fundraising that they do? No, it's has been a part of the history for 100 years. Not a hundred years, since 1950s. It's going to continue, the volunteer fundraising. But this will be a huge component for the volunteers, those that decide to participate. A 5 to 10, 30 call a year on EMS probably isn't going to participate in a program like this. They have to participate, they have to declare they want to be a part of it, sign a contract and other items that others behind me will, perhaps, share with you. But for the larger communities, ones that they see the, the value in doing this, it'll be a tremendous asset. We urge you advance LB610, and thank you for your, for your doing so should you decide to do so. Thank you.

FREDRICKSON: Thank you for your testimony. Questions? Seeing none, thank you for being here.

JERRY STILLMOCK: Very good. Thank you, members.

FREDRICKSON: Next proponent. Welcome.

DOUG KOOPMAN: Good afternoon. Good afternoon, committee members. My name is Doug Koopman and I am the fire chief of the South Sioux City Fire Department. The South Sioux City Fire Department is a combination fire department, very small, with a staff of 13 full time firefighters supplemented with eight volunteers. In 2024, the South Sioux City Fire Department had 1,559 emergency responses--

FREDRICKSON: I'm sorry to interrupt you. Could you-- would you mind spelling your name for the record?

DOUG KOOPMAN: I'm sorry. Yes. D-o-- Doug Koopman, D-o-u-g K-o-o-p-m-a-n.

FREDRICKSON: Thank you.

DOUG KOOPMAN: My pleasure. In 2024, the South Sioux City Fire Department responded to 1,559 emergencies, which of 84% were emergency medical calls. I am presenting in front of you this afternoon as a proponent to LB610 as a firefighter that has benefited directly from GEMT funding at my previous employer. Fire departments nationwide are experiencing tighter and tighter budgets as expenses like vehicles, air packs, radios, EMS supplies, etcetera continue to rise at the highest prices that they have ever seen. Fire departments are trying to do everything possible to find new funding revenues to ease the tension between operating budgets. GEMT funding for the state of Nebraska would help this take the strain off of our operating budgets. In addition, it can add some money in other general funds within other city departments to benefit from. Over the last eight years, my previous employer, a fire department, directly benefited from $32.7 million of reimbursement from GEMT funds, not to mention the other departments in the city that also benefited from splitting of some of these funds. With this money, on the, on the sheet that I handed out, are a lot of the replacement items that they were able to purchase with that. I will let them go through those. I won't go through them here for the sake of time. In closing, I would like-- I am speaking for all the fire departments in the state. This funding would help all the fire departments plan appropriately to fund operations and to be able to replace the lifesaving equipment as it times out. If this funding does not get approved, the citizens in the cities and the communities will have to bear the burden of tax increases to help offset these expenses and provide their-- and provide-- that provide for their safety. I know we're all here to protect the citizens and

keep them safe. Please do not leave the money on the table. Thank you very much for your time and I'll answer any questions you may have.

FREDRICKSON: Thank you for your testimony. Questions from the committee? Senator Riepe.

RIEPE: I'd simply like to say thank you for coming as far as you did. And--

DOUG KOOPMAN: My pleasure.

RIEPE: --it's important to us. Thank you.

FREDRICKSON: Senator Ballard.

BALLARD: Thank you, Vice Chair. Thank you for being here. Thank you for spending your day with us. Can you-- you said you had-- you worked for a previous employer?

DOUG KOOPMAN: Yes.

BALLARD: That used GEMT? Can you explain how that benefited your department?

DOUG KOOPMAN: Yeah. That-- Over-- I, I originally I did 34 and a half years with the fire department with Henderson, Nevada. Nevada is a GEMT state. With that, as our reimbursements for our medical calls with that, that funding allowed, allowed us to, you know, as equipment times out, the gurney systems, they're like $54,000 apiece there-- to outfit them out. We were able to do all the ambulance, almost $1 million worth of that. Air packs, the radio systems, the mannequins that provide for continued training, just they're, just they're pretty much capital expenses. Now, they have-- the previous department also used them to fund positions for a certain period of time until the city could, could, could find the full time funding for it. But for the most part, they're capital expenses. There's a the big, big expenses like your cardiac monitors. A cardiac monitor will run $35,000 easy. And as they time out, it's hard to come up for, for any department anymore nowadays to replace out your whole, your whole set of of equipment like that.

BALLARD: So this is equipment, you use this funding for equipment that's critical to the department.

DOUG KOOPMAN: Absolutely, yes. And as they sit down and when they when-- as the GM-- you know, when they estimate what funds are coming

in, they actually proactively plan to leave X amount in, in as an emergency fund, like $200,000 at my last department, per year just for anything that came up. And then they would, they would highlight everything that they were going to use that year for the, the funds coming in.

BALLARD: OK. Thank you.

DOUG KOOPMAN: Yes.

FREDRICKSON: Senator Meyer.

MEYER: Thank you, Vice Chair. I just wanted to say welcome. Thank you for coming down here today, and I'm looking forward to working with you.

DOUG KOOPMAN: My pleasure.

MEYER: Doors always open, phones, phones always ready to answer the call. And so I'm looking forward to, to working with you. And you and I need to get together and, and have a good conversation.

DOUG KOOPMAN: Look, looking very forward to it, sir.

MEYER: Thank you.

DOUG KOOPMAN: Thank you.

FREDRICKSON: Seeing no other questions, thank you for being here.

DOUG KOOPMAN: Thank you.

FREDRICKSON: Next proponent.

HARDIN: Welcome.

MICHEAL DWYER: Is it good evening or good night?

HARDIN: For sure.

MICHEAL DWYER: Good evening. Good evening, Chairman Hardin and members of the Health and Human Services Community [SIC]. My name is Micheal Dwyer, M-i-c-h-e-a-l D-w-y-e-r, and I appreciate the opportunity to testify in strong support of LB610. Thank you, Senator Bostar, for bringing this important bill that would provide some funding into the Nebraska EMS system. I'm a 40 year veteran of volunteer fire and EMS with a resumé of nearly 2,800 calls, the author the fourth version of

The Future of EMS in Nebraska report, a member of the Nebraska State Volunteer Firefighters Association Legislative Committee and co-chair of the Nebraska EMS Task Force. As everyone in this room knows, certainly the members of this community [SIC], pre-hospital emergency medical services have been and continue to be under significant stress, particularly in rural areas. As I, the EMS Task Force, and the entire EMS community continue to work to craft solutions, the conversation quickly turns to funding. Imagine that. LB610 is certainly not the entire solution, but improving the ridiculously low Medicare reimbursement rates for services is a piece of that puzzle. I personally believe the solution to be the proverbial three-legged stool with local, state, and federal contributions, and that's where LB610 comes in. The 2024 Ground Ambulance Data Collection System report from the Center for Medicaid and Medicare Services revealed that the mean cost of an EMS response is $1,845, and the mean reimbursement is $975. My own experience suggests that the typical reimbursements are much lower than that, somewhere in the neighborhood of 20 to 30% of the actual cost. Current data suggests that many of the EMS calls, and Senator Riepe, you referred to this in your question, with lift assists don't transport. Consequently, they can't bill. And of the 419 EMS agencies in this state, 49 are non-transport agencies. So the same math, if you will, applies. And that gets no reimbursement. The National Association of EMTs says that, quote, when the cost of delivering the level of EMS that the community expects exceeds the revenue that is generated from user fees, the local communities are forced to use tax revenue or other public fundings as a method to cover the gap. What I and many others are trying to do is to reinforce the entire system so that local communities aren't faced with the $500,000 or more in cost for an individual service, and so that the state of Nebraska doesn't have to spend the $174 million annually, which, by the way, I believe is low, that the EMS assessment from the Nebraska EMS agency seems to suggest a switch to a regionalized system would cost. As above, EMS in Nebraska and around the country is under serious stress, and LB610 is a small but important piece of the solution. I appreciate your time and I would be happy to answer any questions, including softballs or not.

HARDIN: Questions? Senator Riepe.

RIEPE: Thank you. Micheal, good to see you again. Thanks for being here. I truly believe that EMS is a part of what we have going as a rural health care crisis. I mean, not just on the EMS side. We have in a lot of spots. And I don't have any answer. I wish I did. I don't know, you work a lot with the older volunteer firefighters, I believe? And at some point--

MICHEAL DWYER: Personally, I don't qualify that. For [INAUDIBLE].

RIEPE: No, I, I --you're a young guy. I, I identify with that. But what are your thoughts about, you know. I mean, what kind of a plan, what kind of a-- what-- how do we, how can we get around this thing? We have a state that's very big in territory, unlike Iowa, for example. And I don't know, I just-- I'm interested in thoughts, not only from you, but anybody else.

MICHEAL DWYER: Yeah. Thank you for the question, and I, I appreciate that, and that's the heart of what I do at retirement. I'm not a lobbyist, don't get paid anything for this. But I believe that it, it is a crisis. And in rural areas, and certainly I can speak to that from a suburban sort of small community area of Arlington, that EMS is becoming, by default, the first line of medical. We've taught people across the country, if you-- God, if you need any kind of help, if anything we can do for you, just pick up the phone, dial 911, and in 78% of Nebraska, that's a rural volunteer that's got a family and job and A, B, C, and D, and it's just harder and harder to recruit those people. The heart of the problem, and the heart of the solution is funding and staffing. We have to figure out a more consistent way to fill the back of the rigs. With all that said, at the risk of touting that horn, I, I have great confidence in the new EMS task force that's sponsored by the Nebraska Hospital Association. I was happy to tell the group on our first meeting in December that I'm the dumbust guy, the dumbest guy in the room, and I mean that strongly, only because there's a lot of really smart people in that room that have tremendous breadth in health care in general and are really passionate about fixing this. I believe that we'll have a solution that we-- it's not going to be perfect, but that that'll try to present to this committee some solutions that won't cost a $250 million a year to try to implement. I have been real clear that even though my report, the last seven pages of recommendations of what to do, I've been real clear, I hope I was with everybody in this committee, to ignore that and let the task force do its work. If they come up with that, fine. If they don't, that's fine too. But I am confident, our meeting, our second meeting's tomorrow, actually, that we-- given a little bit of time and some arm wrestling, we'll come up with some solutions. I hope that answers--

RIEPE: Will we have someone that's going to speak on this from the Nebraska Hospital Association?

MICHEAL DWYER: Say that again?

RIEPE: I'm wondering if we're going to have a testifier from the Hospital Association.

MICHEAL DWYER: I think the, the doctor from-- it's my understanding, and I haven't met him before, the doctor from Columbus was here.

RIEPE: Oh, he was also with the Hospital--

MICHEAL DWYER: He's certainly a member, an active member of NHA. And so I think he, he, he repeated a lot of things that I have heard both from inside NHA, but also that this is the common refrain, if you will, from rural Nebraska.

RIEPE: I'm just interested in what their task force is doing and how fast they can do it.

MICHEAL DWYER: Again, I, I, I'm confident and I-- believe me, I'll share that comment tomorrow. And I'm confident that at some point we'll come up with a solution that doesn't cost $250 million. Because I, I know what-- if I go to you guys or Revenue, or Appropriations and say, hell, we can fix this, we can solve that problem. I just need $250 million annually. How, how is that going to work?

HARDIN: Senator Hansen.

HANSEN: Maybe anybody who volunteers for, for fire or EMS should be excluded from property taxes. You know how many volunteers you'd get then?

MICHEAL DWYER: You're, you're right.

HANSEN: That'd be a local thing. A local [INAUDIBLE]

MICHEAL DWYER: It would be a local thing. And--

HANSEN: A city or a county or school could decide if they want to do that or not.

MICHEAL DWYER: I think that [INAUDIBLE].

HANSEN: Maybe they're, maybe they're listening, Micheal.

MICHEAL DWYER: Let's hope.

HANSEN: Probably not.

MICHEAL DWYER: Did you hear that? I will make the general comment, I'm gonna sound like a conservative here, but I'm not convinced that money alone will solve this. Even if we go to a regionalized system, which, by the way, Missouri, Kansas, Oklahoma have, Wyoming and certainly South Dakota are moving to, with a lot of money, the issue with trying to recruit people, as Chief mentioned, into EMT and paramedic services, into public service, particularly in rural communities, is still there. Even if you-- we somehow magically paid them $100,000 a year, you're still going to have some trouble getting them there. And I would argue, and we'll continue argue, that you get better care, better care from a volunteer who knows you and knows your family and knows your community than from-- If you have a thoracic surgeon that shows up, which is awesome, and I want to say this with great respect to the, the doctor that spoke from Columbus and everybody else. But there's just a level, a different level of humanity that shows up at your door when it's someone that, you know. With that said, we, as an EMT, we-- I just don't provide the same level of clinical care that in 8 or 9% of the calls you really need. I hope that answers your question.

HANSEN: Yep. Yep. Thanks.

HARDIN: Questions? Senator Riepe.

RIEPE: Micheal, while I appreciate your love and affection for your volunteers, I will still take a highly trained physician over love and care. I, I want outcomes, I don't want experiences.

MICHEAL DWYER: Yeah, and I-- you make a great point. And I apologize-- if my comments went sideways of that comment at all, I apologize. It's not my intent. Personally, and I'm not speaking for anybody else, I'm in favor of a, of a, of a tiered system that if you need an EMT to help you up, up the floor and lift assist, you've got your neighbor to do that, a volunteer EMT like me. On the other hand, if I get to the house and, and-- the first person that gets to the house discovers that she's on the floor because she's got chest pains and shortness of breath, and pain--

RIEPE: Or he.

MICHEAL DWYER: --in her left arm-- Or he, thank you. Then I can quickly tier the rest of that system so they get the best care.

RIEPE: OK. Thank you, Chairman.

HARDIN: Other questions? Thank you.

MICHEAL DWYER: Thank you.

HARDIN: Appreciate it. Proponents, LB610. Welcome.

CHRISTY ABRAHAM: Thank you, Senator Hardin and members of the Health and Human Services Committee. My name is Christy Abraham, C-h-r-i-s-t-y A-b-r-a-h-a-m. I'm here representing the League of Nebraska Municipalities. We first want to think, Senator Bostar, for introducing this bill. I know you've had a long afternoon, so I just want to say the league has strongly been in support of this kind of legislation since it was first introduced in 2017. We've been here every time this bill has been introduced to give our support. As you have heard, this is a state-wide concern. The league itself has sort of formed its own informal EMS committee, because we've been hearing so many concerns about this issue. I also want to just lift up that while LB610 is a very important piece of the puzzle, LB115 is another piece of that puzzle. That is increasing the income tax credit from $250 to $1,000 for volunteer emergency responders. So I think there's a lot of pieces that need to fall into place. This one is a very, very important one. And I'm happy to answer any questions you might have.

HARDIN: Senator Hansen.

HANSEN: OK, I'm, I'm blanking on the, the committee. Is it LB680? Is it the cities can use a half cent sales tax for like business development?

CHRISTY ABRAHAM: LB840.

HANSEN: LB840, yes. I was [INAUDIBLE]

CHRISTY ABRAHAM: You were very, very close. I knew exactly what you meant. Yes. Yes.

HANSEN: They can't use that for volunteer firefighters or EMS, you know, towards an ambulance or towards equipment or facilities at all? Can they use that?

CHRISTY ABRAHAM: That's a great question. LB840, just for a little bit of background for the entire committee, is when municipalities can use local sales tax or property tax for private entities, for private businesses. Like let's say, for example, Pender needs a grocery store. LB840 funds can be used to help bring a grocery store into their community. It cannot be used for something for a public entity, so it's only for private businesses.

HANSEN: OK. And how about the property tax idea. Would you guys get rid of property taxes on people volunteering? I'm thinking I can't get rid of property taxes [INAUDIBLE].

CHRISTY ABRAHAM: Yeah. No I, I, I love we're all about the property taxes. I, I will, I will lift up again LB115 which does increase the, the, the income tax credit. I mean, we are looking for ways to incentivize people to volunteer. And I I think there's other things we need to look at, like the training requirements I think are very difficult for a lot of people to get through all the training requirements. So like I said, I think there's a lot of pieces we need to look at. I don't want to shut down any idea you have, Senator Hansen.

HANSEN: I like the idea now. It's growing on me. So, thank you.

CHRISTY ABRAHAM: Thank you.

HARDIN: Other questions? Seeing none. thank you.

CHRISTY ABRAHAM: Thanks so much.

HARDIN: Proponents, LB610. Welcome.

MICHEAL DESPAIN: Good evening, senators. Welcome. My name is Micheal Depain, M-i-c-h-e-a-l D-e-s-p-a-i-n, and I was the former fire chief with Lincoln, Nebraska here prior to 20-- 2020. And I brought LB578 to, to GEMT originally in 2017, and Senator Riepe was kind enough to help us carry that bill. Since I've left Nebraska, I should say I, I have a private business where I do consulting for fire service agencies. I do this from agencies all over the United States. But I am here on my own dime, on my own expense. My business is domiciled within Nebraska, so I love Nebraska, I love doing business here. But my experience dealing with agencies all over the United States, almost 100 now, has given me the experience to see GEMT from the inception in California back in the early 2000s to where it's at now. When we first brought the bill, it was-- there was 6 or 7 states that we were counting which one would be next. And now you're up to 26. And really, I think you're at, what, 32 if you look at who's got programs in place. So the bottom line is it's my experience working with these other states when I come in to agencies to help them with their deployment, my, my first question is always a very customer centric piece is, hey, are we, are we being efficient so we're providing the best service for the lowest amount of tax money possible. And the first question we ask is, do you have GEMT, do you have access to

GEMT? That used to be a big question. Now it's down to there's only a few states left that do not have that to answer that question. And part of that is the federal government, whether they intentionally do it or unintentionally do it, is they are subsidizing the federal Medicaid, Medicare program on the backs of agencies that don't take advantage of these type of programs. So I guess my bottom line is you're going to have to adopt GEMT eventually. Community outcry will probably drive it, but at this point is there's a substantial amount of money that would give you, it doesn't solve all the problems, but for sure it would give breathing room for probably the next five years to a decade for other solutions to come about. So with that, I will close my, my testimony and answer any questions if you have any.

HARDIN: Questions? Seeing none. Thank you.

MICHEAL DESPAIN: Thank you very much. Appreciate it.

HARDIN: Proponents, LB610. Opponents, LB610. Those in the neutral.

JEREMY BRUNSSEN: Thank you.

HARDIN: Welcome.

JEREMY BRUNSSEN: Good evening, Chairman Hardin and members of the Health and Human Services Committee. My name is Jeremy Brunssen, J-e-r-e-m-y B-r-u-n-s-s-e-n. And I am the Deputy Director of Finance and Program Integrity within the Division of Medicaid and Long Term Care at DHHS. I'll probably use a little brevity in my comments, because I think the, the purpose really here was to come and really just make sure that I could cover some of the technical operational components of this program and then just be available for any questions on maybe how this would work within the state of Nebraska and within the Medicaid program. At a high level. I think the things that I want to make sure I hit on are to ensure that you know, that, as mentioned, this program is voluntary for governmental providers, so it's really up to them whether or not they want to participate. If they participate, they would be required to participate with the intergovernmental transfer of funds, the IGT, and they would have to file cost reports and work with us in order to implement the program. As covered, I think other things I want to make sure that are clear are there are no impacts to General Funds with this. We would collect-- so what would happen essentially is we are allowed to reimburse up to actual and allowable cost. And we would determine that differential between the Medicaid payment as billed and paid and the cost reports, what the cost of providing the services. That

differential becomes that supplemental or directed payment. The provider would do an IGT of the nonfederal share. So in an example, say there's a $100,000 gap. If the mix of services to the pro-- to the clients under-- underlying that required a 35% state share match, they would provide $35,000 to us, and we would pay them back $100,000, so they would benefit $65,000, which is that federal payment amount. There are also some costs associated with implementing the program and operating the program. But again, we would not anticipate that there would be a direct cost to the Ge-- to the General Fund because the actual underlying statute does allow us to retain a small portion of that to, to cover those costs without creating an obligation against the General Fund. So the, the other comment that the department have is we wanted to just call out that the one date that I think Senator Bostar had mentioned was updated in his green-- in his proposed amendment. We cannot implement a program kind of retrospective, it has to be prospective in nature. So it would need to be on a go forward basis only. So that concludes my comments. I'm happy to answer any questions you guys may have about LB610 and how we'd operationalize it.

HARDIN: Senator Hansen.

HANSEN: Thank you. Any concern about the federal funds in the future?

JEREMY BRUNSSEN: I, I do not have any concern about the federal funds in the future. It's-- of course, there, there's a lot of potential changes on the landscape. But there are a lot of programs like this operating. Nebraska actually has other supplemental or directed payment programs in place today for physicians and dental providers. It would take a regulatory change at the federal level to change that for, for every state.

HANSEN: I thought you might have an inside scoop to tell us.

JEREMY BRUNSSEN: No inside scoop.

HANSEN: OK.

JEREMY BRUNSSEN: Nothing, nothing beyond what is publicly available.

HANSEN: All right. Thanks.

HARDIN: Other questions? Seeing none. Thank you.

JEREMY BRUNSSEN: Thank you.

HARDIN: Neutral testifiers, LB610. If there are no others, Senator Bostar. Welcome back.

BOSTAR: Thank you. Chairman Hardin, members of the Health and Human Services Committee. Thank you for your time and attention to this. This, to me, seems pretty straightforward. Like I said, this bill has been introduced repeatedly, going back to 2017, I would like to take this opportunity to thank Senator Riepe and Senator Quick for their votes of support previously on this legislation in 2017. So thank you both for that. Look forward to that continuing. And, and again, the difference here is in the past this bill had opposition. It no longer does. I would ask-- and it has no cost to the state. And frankly, as was stated before, we are paying for this indirectly for other states. By us getting 30% cost reimbursement while other states are getting full cost reimbursement, the money that the federal government is saving on us is what is funding everyone else. And I think it's time that we took advantage of this program. And so I would, I would ask the committee to please take action on this bill. It, it seems like a no brainer to me. And I think it's been a long time coming. So with that, I'd be happy to answer any final questions. And again, thank you to the Health and Human Services Committee.

HARDIN: Any final questions? Seeing none. Thank you.

BOSTAR: Thank you.

HARDIN: Online, there were four proponents, zero opponents, and zero in the neutral. And this concludes our hearing for LB610. We're moving on to LB365 once the room transitions.

It's worth waiting for. Another person in her role? Yes, chief.

Speaker 4: Great to. Good to see.

Speaker 1: You.

Speaker 4: Operator.

Speaker 3: Thank you.

RIEPE: I think you're on your own, [INAUDIBLE]. Unless you have family members coming in.

HARDIN: Captain, would you like to testify today? It'd be-- OK. We got some for you. We got some for you. You're good. OK, Senator Quick.

QUICK: OK. Thank you, Chairman Hardin. And good afternoon, members of the Health and Human Services Committee. My name is Dan Quick, D-a-n Q-u-i-c-k, and I represent District 35. LB-- I'm here today to introduce LB365. It codifies existing Medicaid coverage of self measuring blood pressure devices and an extra, and an extra cuff. The bill also adds coverage of clinical support services. Clinical support services are ongoing in management services that require review of patient data, in this case, in this case, blood pressure measurements by a physician or qualified health care professional to make treatment decisions based on that data that are then communicated back to the patient directly or through a clinical staff. Self measured blood pressure, or SMBP, monitoring the regular measurement of blood pressure by the patient outside the clinic setting, either at home or elsewhere, is a validated approach for out-of-office blood pressure measurement. Several national and international hypertension guidelines, including that of the American Heart Association and American Medical Association, endorse the use of SMBP monitoring for diagnosis and management, management of high blood pressure. High blood pressure usually has no signs or symptoms. That's why it's so dangerous. Nearly half of-- half the American population over the age of 20 has high blood pressure, and many don't even know it. That is why high blood pressure is often referred to as the silent killer. Not treating high blood pressure is dangerous as it increases the risk of heart attack and stroke. According to projections from the American Heart Association, high blood pressure will increase from 51.2% to 61 point-- 61%, and since high blood pressure is a type of, is a type of cardiovascular, cardiovascular disease, that means more than 184 million people will have a clinical diagnosis of cardio-- cardiova-- vascular disease by the-- by 20-- 2050, compared to 120-- 128 million in, in 2020. SMBP monitoring is associated with a reduction in blood pressure and improved blood pressure control. Lack of coverage for clinical support services remain a barrier to the broad use of SMBP monitoring. LB365 addresses that barrier and will help the patient, in combination with his or her health care team, better manage their blood pressure. There are testifiers behind me that can-- that will be better equipped to answer some of the technical questions, but I'm happy to answer any questions that you might have.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. Excuse me. Senator, thank you for being here in your, in your committee. Would this require an R-- a prescription from the physician so that it's not just everyone gets one as a souvenir. And you know, a physician has to fundamentally--

QUICK: Yeah. And they might add-- maybe they would be able to answer it.

RIEPE: [INAUDIBLE].

QUICK: Yeah, I understand that question, though, if I'd be prescribed, yeah, that type of prescription for that.

RIEPE: The other concern I have is because it, it is an expansion of Medicaid, which is always a problem with me.

QUICK: Yeah.

RIEPE: And so I look and say, you know, cannot the average consumer come up with $80 for a blood pressure cuff?

QUICK: Yeah. I, I think the one other thing that's through this, too, is that as that data that's provided to that, to the, to the physician. I know I think about even like my mom. So she had high blood pressure, and they discovered actually after she'd had a bleed in her spine, she ended up being paralyzed from the waist down, that she'd had, like, two or three strokes and we didn't even know it.

RIEPE: Yeah.

QUICK: And so I think that, that continued monitoring and making sure that data could get to maybe a physician somehow. And they can probably answer those questions on how that data is, is given to them.

RIEPE: Could you amend this that all the committee members here get one as well?

QUICK: I have one, but it records my own-- you know, and I, I can provide that information to my doctor. You know, I have one at home and I-- that because I had-- I take high blood pressure medication for that and, and-- but it doesn't transmit it to my doctor, you know. But I can actually download the information and take it to my doctor. But I think for some patients it really may be, especially maybe some of the, you know, maybe who are older patients, they don't always understand that technology. And maybe having that access to that would be important for their critical care. I've seen people who had strokes, who end up in wheelchairs and maybe are-- it's, it's an added expense now for Medicaid, where it may be just the blood pressure monitor, maybe it saved that patient from, from maybe some of those conditions. So just might be.

RIEPE: So, thank you.

QUICK: Yeah.

RIEPE: Thank you, Chairman.

HARDIN: Senator Hansen.

HANSEN: He took my question.

HARDIN: Oh, dang it. Other questions? Will you stick around?

QUICK: I will.

HARDIN: Great. Proponents, LB365. Welcome.

JILL DUIS: Thank you.

HARDIN: Here in Nebraska, we like the color.

JILL DUIS: Chairman Hardin and members of the committee, my name is Jill Duis, J-i-l-l D-u-i-s. I'm a retired medical professional. I'm a wife, a mother, and a grandmother. And I am also a stroke survivor. I want to thank Senator Quick for introducing this legislation. And I am here to support LB365. Stroke is a leading cause of death and disability, long term disability. And it's interesting to me that this bill was given the number 365, because that is exactly the number of days in a year that I spend taking care of myself and others like me. We take care of ourselves so that we can live long and productive lives. Most of the people who have had a first stroke also had high blood pressure. The easiest way for me to explain high blood pressure is to have you think of putting a garden hose on a fire hydrant. High blood pressure damages arteries throughout the body. It creates conditions that can make arteries burst or clog easily. Weakened or blocked arteries in the brain create a much higher risk for stroke. In addition to stroke, uncontrolled high blood pressure can also result in a heart attack, heart failure, or kidney failure. And this is why managing high blood pressure is critical to reducing your risk of stroke. LB365 includes Medicaid coverage for essential, essential clinical support services such as data collection and interpretation. This allows a patient's physician to analyze patient readings, provide guidance to that patient, and then modify a treatment plan so that the improvement of management of high blood pressure and better outcomes can occur. In part due to my stroke, I now am required to take, among other measurements, a daily blood pressure reading which is made available to my physician so that alterations in my treatment plan can

be made if needed. An example of how this would benefit others is to think of a woman who has pre-eclampsia, which is a condition that occurs during pregnancy for a woman. She could record her daily blood pressure measurements, transfer that data to her physician, thereby altering her treatment plan and decreasing the risk to not only herself but her unborn child. From personal experience, I know how expensive a stroke can be. It's not only medical transport, medical treatment, and pharmacological support while in hospital, but it's the cost for the continuation of rehabilitation. And this doesn't even include the time for lost work for the stroke patient or their sur-- their family. There's also a burden that's placed on the family for their support in the recovery process. I can't give you a specific dollar amount for the cost of each stroke because it varies so much depending on the severity of stroke, but it can cost anywhere from $30,000 to $120,000 per stroke. If we were to be able to prevent just two to three uncomplicated strokes--

HARDIN: you're in the red, but please finish.

JILL DUIS: Oh, I'm sorry. Two to three uncomplicated strokes, it would cover the cost of the fiscal expenditure for this legislation. This bill would require a small upfront investment which could provide a lifetime return on investment. Thank you for your opportunity to testify, and I respectfully urge your support of LB365. I would be happy to answer any questions.

HARDIN: Thank you. Questions? Seeing none. Thank you.

JILL DUIS: Thank you so much.

HARDIN: Proponents, LB365.

MICHEAL DWYER: Chairman Hardin, Hardin and, again, members of the Health and Human Services Community [SIC], Micheal Dwyer, M-i-c-h-e-a-l D-w-y-e-r, author of The Future of EMS report and co-chair of the EMS Task Force, I'll make it very short. This is a really, really good idea for EMS. It helps our patients understand and manage what their symptoms are. It can help us on the scene by having a baseline vital. From my perspective in the back of a rig, this is a pretty easy no brainer system. Be happy to answer any questions. Thank you.

HARDIN: Thank you. Questions? Seeing none.

MICHEAL DWYER: Thank you.

HARDIN: Thank you. Proponents, LB365. Welcome.

BRIAN KRANNAWITTER: Well, looks like I'm closing it down, here. Good evening, Mr. Chairman, and members of the Health and Human Services Committee. My name is Brian Krannawitter. It's spelled B-r-i-a-n, last name is spelled K-r-a-n-n-a-w-i-t-t-e-r. On behalf of the American Heart Association, I want to express our strong support for LB365, and I want to thank Senator Quick for introducing this legislation. We do commend Nebraska Medicaid for the coverage they, they do have of self measuring blood pressure devices. And we feel this legislation is a critical step in empowering patients to manage their blood pressure effectively. LB365 strengthens the commitment by codifying the coverage into law and expanding it to include essential clinical support services such as data collection and interpretation. With my own experience, I do use a self measure blood pressure device. It's been very helpful for me personally, keeping my blood pressure under control. With respect to stroke and stroke costs, as Jill alluded to, I've had experience in my own families. I'm sure some of you have had as well. My mother-in-law had a very severe stroke, and I can tell you the-- in addition to, obviously, the toll on an individual itself, the health care costs are absolutely enormous. And the same with my grandmother as well. So with that, I would end by just saying LB365 is a critical step forward. Research shows that it leads to significant reductions in blood pressure and improved control, particularly when paired with clinical support. On behalf of the American Heart Association, I respectfully urge the Committee to advance LB365 and I thank you for your time and consideration.

HARDIN: Thank you. Questions? Seeing none. Thank you--

BRIAN KRANNAWITTER: you bet.

HARDIN: --for being with us. Any more proponents? Eric [PHONETIC], would you like to be a proponent? OK. Opponents, LB365. Neutral. Well, Senator Quick, would you mind? We had eight proponents online, one opponent, zero in the neutral.

QUICK: All right. Thank you, Chairman Hardin and members of the committee. And I think, you know, we think about this, the the cost of addressing, you know, a stroke or a heart attack is far more costly than what, than what these-- the device and the data would be. And I still, I still go back to my, to my mom, and had we been able to maybe do a better job of monitoring her, her blood pressures, I know there was some times she'd go to that clinic and she'd be so high they'd make her just sit there and wait. And a couple of times, she probably

just needed to go to the hospital, that's my personal opinion. But, but she would have to wait till her blood pressure got back down to where, where, where it was, where they'd allow her to go home. And so I know maybe this bill wouldn't have addressed her needs because she wasn't on Medicaid, she was on Medicare. But I know there are people out there who, who are on Medicaid, and I think it would be important, important for them to have this so we could, we could help them, keep them out of a, out of a, a heart attack or a stroke that would really be devastating for them and, and really costly for the state as well. So thank you for your time and, and hopefully we can pass this bill out, so.

HARDIN: Thank you. Questions? Seeing none. This ends our hearing today on LB365, and our hearings for today for HHS. Thank you.