HARDIN: --the Health and Human Services Committee. I'm Senator Brian Hardin, District 48. And I serve as chair of the committee. The committee will take up the bills in the order posted. Does our order look the same as what's over here? We had a little switcheroo.

BRYSON BARTELS: Yes.

HARDIN: OK. So Senator Guereca's LB913 is going to come right after the appointment hearing at the [INAUDIBLE]. You know why? It's because of all of you people. He has one person testifying, and so we wanted to help them out on a cold day. So the committee will take up the bills kind of in the order posted. How's that? 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're planning to testify today, please fill out one of the green testifier sheets in these rooms on either side of the commi-- the committee hearing room that are on the table. Be sure to print clearly, fill it out completely. Please move towards the front when it's your turn to come forward. Give the testifier sheet to the page. And if you do not wish to testify but would like to indicate your position on a bill, there are also yellow sign-in sheets on that same 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'll begin each bill hearing today with the introducer's opening statement, followed by proponents of the bill, then opponents, and finally anyone speaking in the neutral capacity. We'll finish with a closing statement by the introducer if they wish to do that. We'll 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 your time is finished. 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's 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. Please note that thumb drives, CDs, DVDs, oversized documents, books, lists of signatures, and similar items will not be accepted as exhibits for the record. Props, charts, and 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 of submission is via the Legislature's website at legislature.nebraska.gov [SIC]. 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. You may submit a position comment for the record or testify in person, not both. I will now have the committee members with us today introduce themselves, starting with Senator Riepe.

RIEPE: Thank you, Chairman. I'm Merv Riepe. I'm honored to serve District 12, which is Omaha, Millard, and the fine, little town of Ralston.

FREDRICKSON: John Fredrickson. I represent District 20, which is in central west Omaha.

G. MEYER: Glen Meyer, 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.

HARDIN: Also on my left is our research analyst, Bryson Bartels; and to my far left is our committee clerk, Barb Dorn. Our pages today are-- ladies, please stand and introduce yourselves.

SYDNEY COCHRAN: Hi. My name is Sydney, and I study history at UNL.

DEMET GEDIK: Hi. My name's Demet. I'm a senior at UNL, and I study political science.

HARDIN: We're going to get started today with an appointment, with Ashley Newmyer, Division of Public Health, Department of Health and Human Services. You are up.

ASHLEY NEWMYER: I am.

HARDIN: Welcome.

ASHLEY NEWMYER: Thank you, Senator. Hi.

HARDIN: You betcha.

ASHLEY NEWMYER: Ready? All right. Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Ashley Newmyer, A-s-h-l-e-y N-e-w-m-y-e-r. And I am the director of the Division of Public Health in the Department of Health and Human Services. I appreciate the opportunity to appear before you today to begin the confirmation process. I am honored to work with Governor Pillen, CEO Corsi, and the dedicated and talented team of public health professionals at DHHS. I would like to start by sharing my background. I am a proud, lifelong Nebraskan. I hold a Bachelor of Science and a Bachelor of Arts in Psychology from the University of Nebraska-Lincoln and a Master of Public Health and Biostatistics from the University of Nebraska Medical Center. I have completed the Chief Data and Analytics Officer Program through George Mason University and leadership training through the Great Plains Public Health Leadership Institute. My commitment to public service began long before my career. I was raised in a family where my-- where volunteering in the community was simply a part of life. This shaped my understanding that strong communities are built when people step up for one another. This belief sits at the core of who I am and how I lead. I have served the state of Nebraska in various public health roles since 2010. This has given me unique experience in many areas across the department. My initial role was with the Nebraska Trauma System, which gave me a clear understanding of the complicated realities facing rural hospitals and providers. I moved on to a role where I led a team focused on efforts to improve patient safety and partnered with other divisions and state agencies to address the leading causes of injury death among Nebraska's children and older adults. Next, I served as a deputy director for health data and coordinated infectious disease outbreak responses and monitored compliance of federal and state statutes around public health data collection and data release. In 2019, I became the chief data strategist. In this role, I established infrastructure across the department which led to an annual savings of $1 million. I also had the honor and challenge of helping to lead Nebraska's pandemic response. In May of 2025, I assumed the role of interim director of the Division of Public Health. As director of Public Health, my immediate priority will be implementing the Rural Health Transformation Program, a once-in-a-generation opportunity to modernize rural health care and ensure its long-term sustainability. This initiative is critical to improving access and quality for

communities across our state. Equally important, I'm committed to strengthening and building upon the strong team culture within the division. A collaborative, mission-driven workforce is essential to achieving our goals and delivering the highest level of service to the people we serve. I bring to this role proven experience leading complex initiatives and a clear understanding of Nebraska's public health needs. Effective public health contributes to cost-saving strategies that strengthen Nebraska's workforce and economy. I am grateful for the opportunity to serve. I respectfully ask for your support and confirmation. Thank you for your time. I'm happy to answer any questions regarding my appointment.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. I am an urban senator.

ASHLEY NEWMYER: Mm-hmm.

RIEPE: I grew up as a farm kid. But I have a serious concern about rural health care in Nebraska. I'm not sure what the real answer is, so I would be interested-- you had said that one of your priorities would be implementation of the Rural Health Transformation Program.

ASHLEY NEWMYER: Yes.

RIEPE: I would ask you just, what would be your first thing? And I won't, I won't say the first ten. Just the first one.

ASHLEY NEWMYER: Just the first one. Yeah.

RIEPE: Do you have some thought on that?

ASHLEY NEWMYER: Yes. So with our Rural Health Transformation Program, as you know, we were recently re-- awarded that grant. The main focus, one, is improving access to care and the quality of care. Within that grant opportunity, we are working to roll out more community paramedicine and community health workers so that we're establishing increased access to care in rural areas but also triaging so that we have access points for people to do preventative screenings to try to catch things early on before they need to go to an ED or, or go to in-- to inpatient care.

RIEPE: Does any of this have to do with making sure that each professional group is working at its highest in skill level?

ASHLEY NEWMYER: Yes, it does. Yeah. I think, as-- I know you're a former hospital administrator, and I know triaging--

RIEPE: Recovering.

ASHLEY NEWMYER: Excuse me? So-- you caught me off guard there, Senator. So triaging in health care is very important. And so, yes, we want to make sure people are getting the right care at the right time.

RIEPE: I also had a 407 bill, which talked about particular roles and trying to, trying to make sure that particular skills were working up to their full capacity. OK. Thank you. Thank you, Mr. Chairman.

ASHLEY NEWMYER: Thank you, Senator.

HARDIN: Other questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here and for your willingness to serve. It's obviously a very important role to have. My-- you know, one of my questions is, you know, in 2026, we live in a obviously rapidly changing world, especially when it comes to public health. There's a lot of movement in the world of health. Just out of curiosity, what, what do you see is one of the biggest challenges we might be facing in, in the coming years or even today that you want to-- you want to tackle?

ASHLEY NEWMYER: Yeah. So thank you for that question. One of the biggest challenges is obesity prevention and chronic disease. So that's another one of the central priorities. That is a key part of the Rural Health Transformation Grant as well. We have also done, done some stakeholder forums, two most recently: one focusing on physila-- physical activity, one on nutrition. We're wanting to bring all of those folks that are working on this issue and really start that conversation and get that environmental scan of what is everything going on in Nebraska so that we can really pool our resources and work together. It is a very complex issue, and so we want to make sure that we're doing it as effectively and as quickly as possible.

FREDRICKSON: Sure, sure. And if-- I may-- one follow-up. Yep. So-- and, and I appreciate your-- I think all of us on the committee, we've had lots of conversation about rural health care, access to care, et cetera. I think we're all invested in, in, in that. I would

be remiss as an Omaha senator to ask what your priorities might be for the more urban areas of the state.

ASHLEY NEWMYER: Mm-hmm. Sure. So I think for the more urban areas of the state, both of the urban areas have really strong local health departments. We have strong relationships with those, but making sure that we're working in a complimentary approach with e-- with each other between those local health departments and the state health department, especially when it comes to, you know, infectious disease or other preventative services, our, our Women, Infant, Children Program-- I'm just making sure that we're really complimenting each other and have really good open lines of communication and that, when we identify that something that isn't working, that we can talk through that.

FREDRICKSON: Sure. Thank you.

ASHLEY NEWMYER: Yeah.

HARDIN: Other questions? Senator Meyer.

G. MEYER: Thank you, Chairman Hardin. Thank you for being here today. I see it was part of your presentation, you were the lead on the Nebraska pandemic response. I assume we're referring to COVID.

ASHLEY NEWMYER: Mm-hmm.

G. MEYER: I actually was-- as a county board chair at that time, Northeast Nebraska Public Health, on that board. I was troubled somewhat of the implementation of, of mitigation of that, of that pandemic. Ha-- have you had an opportunity post-pandemic-- if that's where we're at right now-- to do kind of an after-action report? What worked, what didn't? Because from my standpoint being on the Northeast Nebraska Public Health Board, we did not do that, at least until the time I left that ward to take this particular position. So what worked, what didn't? Kind of retrospect. And I would assume, as part of your new duties, that could be incorporated into somewhat of what we're going to be involved in.

ASHLEY NEWMYER: Sure. Yes. Absolutely. So we did do an after-action report at the state level, and one of the things from, you know, the beginning of when the virus was detected, you know, all the way through-- at the beginning, we, we needed to establish clear roles between the state and the, and the local health department. We need to make sure everybody knew what those clear rol-- roles were. In an

emergency response, that is one of the critical elements. Secondly, something that we did improve upon was making sure that we've got frequent open lines of communication between the state and the local health departments. Things change rapidly on the ground during any kind of emergency, and so it's critical that people know from the local level when they need assistance at the state level when that next touchpoint is and who they have as their point of contact. And both of those things are things that we adjusted and have implemented since, since then. A third thing I would say is just having those strong working relationships between the locals and the state, and that's something that we've-- I believe we vastly improved upon since that time.

G. MEYER: One of, one of the things that didn't seem to work for me and the people in our communities, at least locally, was the top-down implementation of mitigation. We were requiring 85-- 80-, 85-, 90-year-old people to register online-- which many of them are not equipped to do-- just for their vaccinations. We had a number of people falling through the cracks. We repeatedly had said, hey, we need to implement this somewhat differently. And nothing happened. Nothing really changed. So I, I would encourage in the future-- and, and once again, you obviously have a good deal more experience and technical expertise than I do, but I would encourage the state to inquire perhaps at the pointy end of the spear how the implementation is going and to improve that because, from my perspective, it, it needed a good deal of an improvement. And, and so hopefully going forward we can, we can improve on that.

ASHLEY NEWMYER: Mm-hmm.

G. MEYER: Thank you.

HARDIN: Senator Ballard.

BALLARD: Thank you, Chair. Thank you for being here. It's good to see you again.

ASHLEY NEWMYER: Good to see you.

BALLARD: So you have a background in, in data and statistics. And I'm just curious about that push-and-pull between data collection and public health in the name of lowering health care costs. Because I do have concerns about organizations monetizing health care data--

ASHLEY NEWMYER: Absolutely.

BALLARD: --selling data, working with insurance companies. So can you describe that push-and-pull of-- we're going to see in the next decade or so that, that need to-- insurance companies, departments wanting that data to help lower health care costs. How do you think about that? How should we think about protecting consumer and health care data?

ASHLEY NEWMYER: OK. Sure. Great question. So for the Division of Public Health, we have specific statutes that outline what information we have the authority to collect, how that information can be used, who can request that information, and for what purpose. And so as we are collecting information only for those specific qual-- health conditions that we're authorized to, we're very diligent about collecting only what we have the authority to, to, only releasing what we have the authority to. Obviously, data is very powerful. It's used to drive action. But for, for public health specifically, we only have certain authorities to do that for certain things and for certain purposes, always keeping in mind the privacy-- protection of the individuals.

BALLARD: OK. Thank you. And I have one more question [INAUDIBLE]. So it's-- I feel like public health is in-- we have silos. And you have a, a local government background for the last couple years. So you talk about how we break down those silos and make sure our local governments are best equipped to address public health concerns.

ASHLEY NEWMYER: Mm-hmm. Great question. So I would just say it's truly about the relationships that we can build, how those subject matter experts can work with the local health departments, how the local health departments are making sure they're working with their mis-- municipalities, when an issue arises that local municipalities and local health departments and county governments know that they can reach out to us at the state or their local health departments. So it's truly about making sure that the network is there and the relationships are there. You know, as I, as I mentioned in my statement, I really believe that strong communities are built when people step up for one another, and I think in Nebraska we're very good at doing that. And I think in a lot of local communities, that's a strength that we have, is, like-- I know-- my cousin works at the local health department and I work at the city and, and we can come together and we can talk through what the issues are. But I'm always open to making sure that folks know that people can reach out to the state as well if they feel like they need to escalate something or if

they're just not sure where to go to get the quest-- the question answered, so.

BALLARD: Yup. Thank you for being here.

ASHLEY NEWMYER: Mm-hmm.

HARDIN: RHTP.

ASHLEY NEWMYER: Yes.

HARDIN: So as you said, we were very thankful to get $218 million this year from the feds. Yay. I think they gave us both minutes to implement that, didn't they?

ASHLEY NEWMYER: They did.

HARDIN: And so would you kind of, for the sake of everyone here, kind of talk through what that timeline looks like? For those of us who are senators, we twitch when we hear about short timelines because we're familiar with this thing called broadband, which did not go as swimmingly as we was-- we were hoping it might. And so this timeline makes broadband look extravagant in comparison. It's a very short period of time that we need to appropriately, properly go through this. Would you talk about what that looks like this year?

ASHLEY NEWMYER: Absolutely. So with this first year, we have until October 1 to roll out this whole program. Right now, we are in just the immediate post-award phase, where we received our award. We need to go through some budget revisions, get those submitted by the end of this month. The feds will give us their approval or their additional questions. And then we will be rapidly rolling out the, the awarding process, which will look a little bit different depending on the initiatives that we have. But then we have until October 1 to show those outcomes that we need to show to make sure that we can maintain that full award amount.

HARDIN: Applications get to start about when?

ASHLEY NEWMYER: We are targeting February that we will start to post things.

HARDIN: OK.

ASHLEY NEWMYER: Mm-hmm.

HARDIN: So we've got to do an amazing job, it sounds like, in getting the word out that you need to get your application in ASAP.

ASHLEY NEWMYER: Yes, we do.

HARDIN: Right? OK. Now, you said at the beginning you grew up in a rural area. Where did you grow up?

ASHLEY NEWMYER: I grew up in Cairo, Nebraska, which is just west of Grand Island.

HARDIN: OK. OK. Well, public health is the thing. So tell us about you in terms of what kinds of things-- do you have a life besides what you do for the 90 hours that you graciously devote to this each week or-- what does your world look like?

ASHLEY NEWMYER: I do. I have a husband and three wonderful children. They are very active in all sorts of things. We live in Crete, Nebraska. And I, I enjoy time with family and friends. And I also enjoy reading books.

HARDIN: OK. Very well. Any other questions? Seeing none. We appreciate you being here.

ASHLEY NEWMYER: OK. Thank you, Senator.

HARDIN: Thanks.

ASHLEY NEWMYER: Thank you for your time.

HARDIN: Proponents. Opponents. Neutral testifiers. Hearing none of those. This concludes our appointment scenario for Ms. Newmyer. We're going to change it up just a little bit if you caught an early agenda for today. And Senator Guereca is here on LB913, to require the Department of Health and Human Services to appoint a dementia services coordinator. We'll wait just a second, Senator Guereca. We'll get the, the shuffling done, the doors closed. I think we're ready to go.

GUERECA: Excellent. Well, good afternoon, Chairperson Hardin and members of the Health and Human Services Committee. My name is Dunixi Guereca, D-u-n-i-x-i G-u-e-r-e-c-a. And I represent District 7, which includes the communities of downtown and south Omaha. So I'm here before you today to introduce LB913, requiring the Department of Health and Human Services to appoint a dementia services coordinator.

LB913 was brought to me by the Alzheimer's Association as a way to clarify the intent of the position created for the Alzheimer's and Other Dementia Council's in Governor Pillens' 2023 biennial budget and maximize the investment made by the state for that position. Currently, there are 35,000 Nebraskans living with Alzheimer's disease. By ensuring that the role of dementia services coordinator is being fulfilled as intended, we can ensure that those living with Alzheimer's and their families and caregivers are receiving equitable access to information, resources, and referrals to care statewide. The dementia services coordinator will be required to, one, serve as a reference point for linking family caring for individuals with Alzheimer's disease and other dementia with supportive services and resources, provide information, counseling, education, and referral about services, programs, including safe, secure environments that support individuals and families dealing with Alzheimer's disease and other dementia, collect and monitor data related to the impact of Alzheimer's disease and other dementia on the residents of the state. That position will evaluate the needs of individuals with the Alzheimer's disease and other dementia and their caregivers and identify the services, resources, and policies required to address such needs. Recommends strategies for coordination of services and resources amongst other agencies involved in delivery of services to individual with Alzheimer's and other dementias. Monitor and assist development and implementation of the state plan for meeting the needs of individuals with Alzheimer's disease and other dementia and their caregivers. Recommend policies, legislation, and funding necessary to implement the state plan for meet-- for meeting the needs of individuals with Alzheimer's disease and other dementia and their caregivers. Increase awareness and create dementia-specific training to facilitate access to quality, coordinated care for individuals with Alzheimer's disease and other dementia in the most integrated setting. Organize community stakeholders and resources to identify proactive and effective solutions. And finally, just to clarify, this legislation is not creating a new position. It is simply clarifying the role and requiring DHHS to assign the duties to an individual within the department. Thank you for your time. And I will-- happy to answer any questions.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you. Thank you for being here. I heard I think at your end that it's not a new position.

GUERECA: That is correct. So the position was originally created in the Governor's 2023 biennial budget.

RIEPE: OK.

GUERECA: So this is just clarifying the role and their duties and sort of codifying what, what the-- this coordinator is supposed to be doing.

RIEPE: So it's kind of a transfer?

GUERECA: I, I believe-- it's not a transfer. The position's there. It's just ensuring that the spirit and the intent of when the position was created is actually down in writing. And there's testifiers coming behind me from the Alzheimer's Association that can talk to the specifics.

RIEPE: I was trying to get to, what was it, a transfer fee--

GUERECA: Oh.

RIEPE: --for the fiscal note.

GUERECA: There shouldn't be a-- so the, the fiscal note is envisioning the creation of a new position. So the position--

RIEPE: But you're saying it's not a new position.

GUERECA: It's already there, yeah.

RIEPE: Then the fiscal note's wrong.

GUERECA: I believe so.

RIEPE: OK. [INAUDIBLE] that in the record. I have no further questions.

HARDIN: Bryson is making a note right now.

GUERECA: He's being noted.

HARDIN: He's noting it.

RIEPE: Inscribed.

HARDIN: What's the difference between this position and, and the current coordinators long-term care?

GUERECA: As to the specifics, I'll, I'll kind of punt that one on to the, to the expert from the Alzheimer's Association. He can talk to the specifics of--

HARDIN: OK.

GUERECA: --kind of what's going on and--

HARDIN: Very good. All right. Will you stick around?

GUERECA: Absolutely, I will.

HARDIN: All right. Any other questions? All right. We'll see you in a bit.

GUERECA: All right. Thanks.

HARDIN: Very good. Proponents, LB913. Mr. DeGarmo. How are you?

ALEX DeGARMO: I'm doing well, Senator. How are you?

HARDIN: Well, I'm fine. Thanks.

ALEX DeGARMO: All right. Well, good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Alex DeGarmo, A-l-e-x D-e-G-a-r-m-o. And I'm the public policy director for the Alzheimer's Association Nebraska Chapter. The Alzheimer's Association is dedicated to leading the fight against Alzheimer's and all other dementias by advancing global research, promoting risk reduction and early detection, and enhancing quality care and support for those affected. The Alzheimer's Association is in full support of LB913. We'd like to thank Senator Guereca for working with us to bring this legislation. In 2023, Governor Pillen's budget appropriated $99,326 to the Alzheimer's and Dementia Council. These funds were used to hire one full-time employee. The purpose of this employee is to carry out administrative duties for the council and act as the dementia service coordinator for the state. The investment made by the state of Nebraska for this position should be seeing a greater return than it currently is, and this is the reason that we at the Alzheimer's Association brought this legislation. LB913 clearly states the job duties for the dementia service coordinator. The DSC needs to be coordinating resources, providing referrals for

care and support, monitoring data related to Alzheimer's disease, and ensuring the state is working towards implementing the council's state plan, increasing awareness statewide, and facilitating developing training. Our goal with LB913 is to ensure that we can maximize the investment the state of Nebraska has made and ensure that Nebraskans are receiving equitable care and access to resources statewide. I'd like to thank the committee for their time. And I'd be happy to answer any questions. Senator Hardin, I think you might have some.

HARDIN: How about that last question, which was just that-- kind of tell us in plain lang-- language. What would be the difference between this position and the current coordinators long-term care? Is there a, a difference?

ALEX DeGARMO: Yeah, this is separate than a long-term care coordinator. This is disease specific.

HARDIN: Disease specific.

ALEX DeGARMO: And we're working with not just those living with the disease, but we're also working to provide information with family members, community organizations. This position will also be working pretty heavily with public health departments, ensuring that we're getting information out to public health departments statewide, work with AAAs. So this is far outside the scope of long-term-- just long-term care.

HARDIN: Forgive me, I haven't had a chance to digest everything you've given us here. How does Nebraska compare to the rest of the country or states around us in terms of how many of those in our senior population are struggling with that? What is the-- are we above? Kind of--

ALEX DeGARMO: Well, not-- yeah. Not just the senior population.

HARDIN: OK.

ALEX DeGARMO: So we're looking at 35,000 Nebraskans statewide living with Alzheimer's disease. Using the Mayo Clinic's numbers on young onset Alzheimer's, there's about 930 Nebraskans under the age of 65 living with Alzheimer's disease. So that's ages 30 to 65.

HARDIN: And how does that compare?

ALEX DeGARMO: I'd have to get back to you with a comparison on-- to other states.

HARDIN: Always thinking about environmental factors.

ALEX DeGARMO: Of course.

HARDIN: Right? Questions?

ALEX DeGARMO: All right. Thank you very much for your time.

HARDIN: Well, I guess we'll let you off that easy.

ALEX DeGARMO: All right.

HARDIN: All right. Thank you. Any other-- proponents, LB913. Opponents. Those in the neutral. Well, Senator Guereca, would you mind coming back? We'll just save the hardest questions for you now.

GUERECA: All right. Well, again, I want to thank the, the committee for their time. I thank the testifier who came in and, and brought this bill to me. And again, the main purpose of this-- that position's already funded. This is just sort of clarifying the rules [INAUDIBLE].

HARDIN: I would say what would probably be good is if we could kind of-- sounds like we might have a SNAFU going on with that fiscal explanation.

GUERECA: We'll chat with them and see if we can't straighten that out.

HARDIN: That would be great. Yeah. Senator Meyer

G. MEYER: Yeah. I, I appreciate the fiscal-- I, I-- it sounds like the person's hired, essentially esta-- salary is established. It's just, OK, you have this job description. Essentially it sounds like a job description where someone is working in a capacity that did not have a specific job.

GUERECA: Yeah. So this is just a little bit of guidance, you know, where--

G. MEYER: If someone new was appointed to that position, then it would generate a fiscal-- whatever's indicated on the bill, so.

GUERECA: Yeah. This, this is about, you know, ensuring the-- this vulnerable population-- again, 35,000 Nebraskans statewide-- are-- we're able to work together, provide them the resource that them and their families need.

HARDIN: OK. Very well. Seeing no other questions. I will point out that there were 3 proponents online, 0 opponents, 0 in the neutral. So thank you.

GUERECA: Thank you all for your time.

HARDIN: This concludes LB913. We're going to move on to LB845. And I think that's my fault, isn't it? OK.

FREDRICKSON: All right. Chair Hardin, whenever you're ready

HARDIN: OK. Thank you, Vice Chair Fredrickson. And good afternoon, fellow senators of the Health and Human Services Committee. I am Senator Brian Hardin. For the record, that is B-r-i-a-n H-a-r-d-i-n. And I represent the Banner, Kimball, and Scotts Bluff Counties of the 48th Legislative District in western Nebraska. I'm here to introduce our committee bill, LB845. LB845 makes a few straightforward but important updates to how the state coordinates advice on aging, dementia, and mental health. First, the bill brings together two existing advisory groups, the Alzheimer's Disease and Other Dementia Advisory Council and the Division of Medicaid and Long-Term Care Advisory Committee on Aging and combines them into one new body called the Aging, Alzheimer, and Dementia Advisory Council. This streamlines the work, updates who serves on the council, and creates a dedicated fund to support its efforts. Second, LB845 removes the Alternative Response Advisory Committee, which is no longer needed. Finally, the bill updates the name of the State Advisory Committee on Mental Health Services to the State Advisory Committee on Mental Health and Substance Use Services. This change better reflects the full scope of the committee's responsibilities. Overall, LB845 is about improving clarity, efficiency, and coordination while making sure our advisory structures accurately reflect the work they're doing for Nebraskans. Thank you.

FREDRICKSON: Thank you, Chair Hardin. Any questions from the committee? Senator Meyer.

G. MEYER: Thank you, Vice Chair. Senator Hardin, is there any change in duties or anything? This is simply a name change--

HARDIN: This is a name change, but there will be brilliant humans behind me who can speak to things far more cogently than I can.

G. MEYER: Thank you.

FREDRICKSON: Other questions? Seeing none. Will you stick around?

HARDIN: I promise I will.

FREDRICKSON: OK. We will now hear proponents for LB845. Welcome.

TONY GREEN: Good afternoon, Senator Fredrickson and members of the Health and Human Services Committee. My name is Tony Green, T-o-n-y G-r-e-e-n. And I am the director for the Division of Developmental Disabilities at the Department of Health and Human Services. Here to testify in support of LB845. And I'd like to thank the committee for introducing this bill on behalf of the department. This bill builds upon the Governor's initiatives introduced last year through LB346 that was aimed at enhancing operational efficiencies within boards and commissions. This proposed legislation introduces three changes. One, to revise the name of the recently consolidated committee through LB346 to the State Advisory Committee on Mental Health and Substance Use Services to better align with its updated responsibilities, eliminates the Alternative Response Advisory Committee, and then merges the Alzheimer's Disease and Other Dementia Advisory Council with the Division of Medicaid Long-Term Care Advisory Committee on Aging to streamline operations. I'm going to focus my testimony on the third point but could answer questions on the other two. The department supports this consolidation as a thoughtful and pragmatic step to strengthen Nebraska's approach to aging policy, planning, and oversight. By bringing these advisory functions together, the state can increase efficiency, reduce administrative burden, and more effectively leverage limited resources to meet the growing and increasingly complex needs of older adults and those experiencing Alzheimer's or dementia and their caregivers. First, the consolidation increases state efficiency by minimizing duplicative efforts across advisory bodies that sometimes serve overlapping populations and address closely related issues. Both groups currently engage in planning, stakeholder engagement, and policy recommendations related to long-term services and supports. Merging these functions would reduce the redundancy of meetings, reporting, and administrative coordination, allowing staff and members to focus their time on developing substantive change and thoughtful policy recommendations to the challenging issues

encountered by our growing segment in Nebraska's population. Second, LB845 reduces the siloed work and supports stronger collaboration on aging-related needs such as employment, health, financial stability, and social engagement that are closely overlapped with the proactive public health, workforce, and caregiver support, and careger-- caregiver delivery approaches required to address the unique challenges associated with Alzheimer's disease and other dementia. Third, the consolidation improves strategic alignment by recognizing that a vast majority of Alzheimer's disease and other dementias are fundamentally related to aging issues, although not exclusively. Integrating those allows the two groups to collaborate much more collectively and comprehensively on those issues. It strengthens the stakeholder engagement, bringing those diverse populations together into a single coordinated advisory committee. Finally, the merged advisory body encourages improved data collection, use of sharing related long-term services and supports. A single coordinated advisory committee can better identify data gaps, promote consistent performance measures, and support data-informed decision-making. We respectfully request that the committee advance the bill to General File. And I thank you for your time. And be happy to answer any questions that I can on this bill.

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

RIEPE: Thank you, Chairman. Welcome.

TONY GREEN: Thank you. Good to see you.

RIEPE: My question is this: with the advisory committee-- I don't know the size of it exactly, but with that, will you have subcommittees or subcouncils that deal with aging specific and-- so that they don't just get totally lost and, and, you know-- Alzheimer's or, or dementia, if you will, and whatever other categories? Or, or have you thought that far about how to-- how you will then manage this, this larger advisory-- I assume it's larger advisory committee.

TONY GREEN: Yeah. So let me-- I'll speak to that a little bit. The, the committee-- each committee currently has its own established membership numbers, right, which is, probably in total-- if you look at the voting and nonvoting members between the existing statutes-- about 27 members between the, the two separate committees. The original bill as written identified 15 members would be on this

combined committee. We-- we've been working with both committees over the last several weeks in making sure that we have the membership exactly right, that it includes all of the professionals that folks want at the table. And there are a couple that we are, are willing to have a conversation and look at an amendment to increase that to 17 for the, the entire committee. Your question on subcommittees is, is, is accurate. That's exactly what can happen. We look forward to-- once the, the bill is passed and, and we have the new committee and the membership, they then will kind of drive what will those subcommittees be. That's a common practice in many of our advisory boards, is that they'll set up subcommittees to tackle very specific issues or to look at very specific populations of issues. And I would, I would anticipate this committee will do the same thing.

RIEPE: Are most of those or all of those committee advisory committee meetings held here in Lincoln or do you at times journey to east and west?

TONY GREEN: Yeah. We-- in, in all the various committees-- and speaking to these two specifically-- they, they do rotate. There-- it-- it's-- really is up to the membership of the committee. Sometimes we're in Kearney to make that drive easier for those members that are coming from west, but they do rotate around the state.

RIEPE: OK. Thank you.

TONY GREEN: You're welcome.

FREDRICKSON: Other questions? Senator Meyer.

G. MEYER: Thank you, Vice Chair. Thank you for coming in today.

TONY GREEN: You're welcome.

G. MEYER: I am of-- strongly support anytime we can eliminate redundancies, and I appreciate that very much. I see there is no fiscal, and I understand that it's creating a new cash fund. What, what source of-- what, what moneys are coming into the new cash fund? Where does that-- how does that get money into it?

TONY GREEN: I, I don't-- I think it's there as, as a placeholder so that if there is, as the, as the committee gets established, if there were-- would be grants or things that the committee would want to go

for, the fund would be there that they can begin to, to have a place for those.

G. MEYER: --specifically now coming in the, the-- there's nothing specifically now. There's no, no money stream coming in, no, no funding-- state or federal funding?

TONY GREEN: Not that I'm aware of, no.

G. MEYER: OK.

TONY GREEN: We reimburse all of the committee members out of the division.

G. MEYER: OK. Well, just curious. Thanks.

FREDRICKSON: Other questions? Senator Quick.

QUICK: Yeah. Thank you, Vice Chairman. One of my questions-- and I might have two, but-- so for the makeup of the committee-- so for each individual committee now, are most of the people who are on the-- like, on the memory care side of that, are they all from that area? And then wha-- or are there some that serve on both committees? Or, you know, for the long-term care side, it would be maybe a different set of people that are on those committee-- on that committee.

TONY GREEN: Yeah. Today, they are, are separate memberships. I'm trying to remember if we have a position or two that might overlap. Obviously, the department and personnel are on both committees as nonvoting members generally, but the, the new structure has representation from all the different groups, whether it's the triple-- each of the AAAs will have a seat at the table so the entire state of aging will be represented. We have numerous members, as you can see, specific to Alzheimer's issues specifically, and then just broader provider Issues. So I think it'll be a, a well-represented statewide cross-function.

QUICK: OK. And maybe this next one won't be so much a question, but, you know, I-- no-- I know, like, in Grand Island area, I visit some of the nursing homes and some of them don't provide-- they're-- they don't have a memory care unit, so. And so there's maybe a separate menor-- memory care unit in our community that maybe only can provide a, a-- very few people that opportunity to have that service. So-- you know, I'm just making sure we have good representation so we can

make sure that the people who, who need those services are-- have that voice at the table, so.

TONY GREEN: OK. Perfect.

FREDRICKSON: Other questions? I have a couple for you. So I-- you know, I, I-- I've heard a couple things or, or I've gotten a couple-- bit of outreach about the bill itself. The first I think you addressed with Senator Riepe's question, which is sort of the membership of the combined committee. It sounds like there might be some flexibility there, which is great. The other thing I've, I've heard from some folks about with some concern is the elimination of the Alternative Response Advisory Committee. And I'm just kind of curious if you could maybe elaborate a bit more on that suggestion or that-- and, and-- yeah, speak to that.

TONY GREEN: Yeah. So it, it was identified within our Children and Family Services Division as an area that, that could be cleaned up in statute. As, as you all know, Alternative Response has been around for a number of years in our, in our child welfare system. The committee itself had not been meeting. I think they had last met in February of '25. In addition, we're already required to report many data elements out of our alternative response system within child welfare. And some of the requirements already in statute require us to give those reports to some of the members that are actually even on the advisory committee. And so it was seen as duplicative and, and not needed to have an advisory committee because there's an advisory role already. One of the folks that get all of that data is the Inspector General, who has the authority and responsibility to make recommendations based on that report. And so we saw the advisory committee as just a duplication and not needed.

FREDRICKSON: OK. So it's your belief that the, the, the advisory committee-- in other words, the, the, the reports are already getting to the needed sources.

TONY GREEN: Yes.

FREDRICKSON: OK.

TONY GREEN: Yes.

FREDRICKSON: All right. Thank you. Other questions? Seeing none. Thank you.

TONY GREEN: You're welcome.

FREDRICKSON: Next proponent. Welcome.

RANDY JONES: Thank you. Thank you, Senator Fredrickson and members of the Health and Human Services Committee. My name is Randy Jones, R-a-n-d-y J-o-n-e-s. And I'm the director of Aging Partners. And I'm here to represent the Nebraska Area Associations on Aging, the AAAs. Our association is called NE4A. And I'm testifying in support of LB845. We appreciate the intent of the legislation and would welcome the opportunity work-- to work with the bill's sponsor and the state agency to add clarifying language that would strengthen the bill and provide more clarity to define the roles of the newly formed advisory council. As currently written, the bill places primary emphasis on continuing the implementation of the Alzheimer's state plan. While this work is critically important, we anticipate recommending additional language that ensures a balanced and inclusive role for the advisory council, one that reflects responsibility for both the Alzheimer's plan-- which is a good plan and needs to move forward-- but also does not diminish the broader needs of Nebraska's older adult population. This approach would preserve the intent and scope of combining the two committees, ensuring continuity, clarity, and comprehensive representation on aging issues as well as Alzheimer's issues across the state. We greatly appreciate the committee's continued support of aging adults in Nebraska. Thank you.

FREDRICKSON: Thank you for your testimony. Any quest-- questions from the committee? Seeing none.

RANDY JONES: Thank you.

FREDRICKSON: Thank you for being here. Next proponent. Welcome.

TRACY LICHTI: Thank you. Good afternoon, senators. My name is Tracy Lichti, T-r-a-c-y L-i-c-h-t-i. I am the chairperson for the Alzheimer's Disease and Other Dementia Advisory Council. And I am here today to testify in support of LB845 with some suggested changes to the membership of the combined Alzheimer's Council and Advi-- Aging Advisory Committee. So I have provided for you on the second page our, our proposed membership changes. But the Alzheimer's Disease and Other Dementia Advisory Council supports the consolidation of these advisory bodies and the streamlining of the administrative operations to maximize the staff resources. However, we do believe the proposed membership needs to be adjusted to 17

members from the proposed 15 members to ensure that the most qualified stakeholders with expertise and knowledge represent the diverse needs of Nebraskans. I have provided you the recommendations to show you the current bill members, and then secondly the proposed membership representation that we fill-- feel will serve the combined interests of both the Alzheimer's Council and the Aging Advisory Committee. We also do support the language changes that were presented from the AAA agency that was presented by Randy to clean up that language, so. If you have any questions, I would be open to those as well.

FREDRICKSON: Questions from the committee? Seeing none. I have one quick question. So I, I see your suggested membership. It sounded like from the department's testimony that they were open to--

TRACY LICHTI: Correct.

FREDRICKSON: --exploring some alternatives. Have you had the opportunity to speak with the department or the introducer about--

TRACY LICHTI: Yes.

FREDRICKSON: --the changes? OK.

TRACY LICHTI: Well, I-- what I can say is Ton-- Tony Green was part of our discussion that day, so we're hopeful that the, the department is supportive of all of those adjustments that we have made, so.

FREDRICKSON: Great. Thank you.

TRACY LICHTI: Mm-hmm.

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

TRACY LICHTI: Thank you.

FREDRICKSON: Next proponent. Hi.

JINA RAGLAND: Hi, Chair Jac-- or-- Chair Jacobson-- Chair Fredrickson-- I've been Banking today-- Vice Chair Fredrickson and members of the Health and Human Services Committee. My name is Jina Ragland, J-i-n-a R-a-g-l-a-n-d. I'm here today testifying on LB845 on behalf of AARP Nebraska. Specifically, my comments today are-- pertain to Section 4, which has kind of been the, the theory of what we've heard today in testimony, which creates the Aging, Alzheimer's,

and Dementia Advisory Council and designates voting members as apponen-- appointed to the council by the Governor. In discussions earlier this week with Director Green as well as Chair Hardin, it is our understanding that dis-- those discussions have taken place around the recommendations that you've heard, not only from the area agencies on aging but also for Ms. Lichti, who just came up as the chair of the Alzheimer's Task Force. Based on that and those recommendations, we are here to support with those, with those amendments being brought forward that would propose to move from 15 to 17 total members. Again, I won't list all of the membership out because you were given that by Ms. Litchi [SIC], but that is what we would be supportive of with the changes of that membership. AARP supports L-- LB845-- again, with that understanding the changes listed above would be included as part of the committee amendments as this bill advances to the floor. We support the bill with the amended list of the designees. And we feel that this amended list ensures a better overall representation of aging issues in general and not just being reflective of aging as it relates to Alzheimer's or dementia. And I think that's really an important point that we make because not all older Nebraskans have dementia or, or Alzheimer's, and we really don't want to become one silo where we're just dealing with the disease and not the prevention side, which I think is where a lot of-- you'll see that aging focus. Thank you for the opportunity to comment and for consideration the-- these proposed potential amendments. We do support the bill. And I would ask you to do those-- support those amendments as well and move it to the floor. And I'd be happy to answer any questions.

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

RIEPE: Thank you, Chairman. Are you getting any feedback of a concern that the alignment with an Alzheimer which is more of a dehabilitating, kind of an aged person? So the image of the agency helping aged people is not necessarily the same as really aging people and people in trouble and need you.

JINA RAGLAND: Senator Riepe, I think that's a great comment that you make, and this kind of goes across a lot of what we've seen this week in a lot of the hearings as-- even your bill earlier this week with combining aging and disability into one division. I understand why that's being done-- and certainly we want to save the state money and be efficient and all of that-- but I do think that connotation sometimes does come across-- people are less likely to take advantage

of any of these or be in-- active in anything that is associated with that kind of a disability. And I think, again, from our perspective-- you know, we know 90-year-olds that are healthier and aging very healthily in the community sometimes better than 50-year-olds. And so I think that healthy aging prevention concept is really what's really important for us. And I-- there has to be that distinction. I'm glad you also brought up the cu-- the question about the subcommittees with Director Green because I think we share that also, that we don't want aging just to get sucked into, again, dealing with just Alzheimer's and dementia and not being foreseen as a disability, because aging isn't a disability. They're an asset to our community, and we want people to understand that. So thank you for the question.

RIEPE: Thank you, Chairman.

FREDRICKSON: Other questions? Seeing none. Thank you for being here. Next proponent. Seeing none. Any opponents to LB845? Welcome.

CHLOE FOWLER: Hello. I have a long testimony, so I might speak a little quick. All right. Vice Chairman and members of the Health and Human Services Committee, my name is Chloe Fowler. That is C-h-l-o-e F-o-w-l-e-r. And I am the child welfare policy analyst for the Children's Commission. And I'm here to testify on behalf of the commission in opposition to Section 1 of LB845. The Children's Commission was created by the Legislature to provide independent, cross-system oversight of child-serving systems, particularly where children and family are affected by complex, high-risk decisions made outside of the courtroom. Alternative response is one of those areas. Under current statute, DHHS must determine whether a reported case of child abuse or neglect is handled through traditional response or alternative response. Because alternative response diverts cases from traditional response system, it shifts significant decision-making authority to DHHS administrative processes. These cases are not subject to judicial oversight or routine review by county attorneys or the courts. For that reason, the Legislature has repeatedly recognized the importance of external, structured oversight for this practice. The Alternative Response Committee was established through LB1061 in 2020 under the umbrella of the Children's Commission, not the Department of Health and Human Services, to provide said oversight. It is codified in Nebraska Revised Statute, Chapter 28, Section 712. The de-- the statute examines, A, how reports of abuse or neglect are screened; B, the use of alternative response and traditional response; C, the provision of services in noncourt cases; and, D, whether child safety is being insured and risk reduced in

these noncourt involved cases. The committee's multidisciplinary membership includes representatives from DHHS, law enforcement, county attorneys, child advocacy organizations, family representatives, the Foster Care Review Office and the Office of the Inspector General of Child Welfare. These ensure diverse expertise shapes ongoing evaluation. The elimination of this committee would remove the only standing body charged by statute with ongoing policy-level review of alternative response practices. And this comes at a time when independent scrutiny is especially critical. In both the recent report from the summer and the annual report, the Office of the Inspector General of Child Welfare identified several aspects concerning the screening of alternative response cases, including the inappropriate assignment of cases not limited to low- or moderate-risk families, limited review of family history and screening decisions, errors in risk assessment tools affecting safety outcomes, and gaps in data necessary to evaluate at-- alternative response effectiveness. These findings reflect the ongoing need for sustained and structured oversight, not its elimination. More broadly, Section 1 of LB845 should be viewed in the context of ongoing efforts in recent sessions to narrow or eliminate external oversight mechanisms related to DHHS child welf-- welfare functions. While incremental, these reductions collectively weaken transparency, reduce independent accountability, and increase risk to some of Nebraska's most vulnerable children and families. Eliminating the Alternative Response Advisory Committee does not improve child safety. It removes an essential check on administrative discretion, limits multidisciplinary evaluation, and undermines the legislative-- the Legislature's intent to pair flexibility in practice with robust, external oversight. If adjustments to the committee's structure or operations are needed, the Children's Commission stands ready to work with the Legislature to revine-- to refine statutory language. However, outright elimination removes the accountability framework that this body was created to uphold. For these reasons--

FREDRICKSON: You are in the red, so if you could wrap up your thoughts.

CHLOE FOWLER: Yes. Sorry. For these reasons, we urge you to amend Section 1. The-- our concern is primarily just Section 1 of this bill. We're not under DHHS authority either.

FREDRICKSON: OK.

CHLOE FOWLER: [INAUDIBLE] to answer any questions.

FREDRICKSON: Thank you for your testimony. Questions from the committee? Seeing none. I have a-- I have a couple. So-- first of all, thank you for being here and for, and for testifying. So, so a previous testifier had mentioned that the last time this committee met was in February 2025. Is that correct?

CHLOE FOWLER: That is correct, and I can do some explanation behind that. I have been the child policy-- child welfare policy analyst for about seven months now. That-- the delay in the Alternative Response Advisory Committee meeting is because there had been significant turnover within my position. I am the third or the fourth analyst to have this position within two or three years. So we have been doing a lot of jump-starting and reactivating and engaging. So we were supposed to meet over the summer, but because it would be about a month or two into me starting the position and having to start with writing four annual reports due in September, we have been in a bit of a delay. We are activating the workgroup. And you will hear from Monika Gross after me, and she co-chairs the committee. And the other co-chair, Susan Thomas, should have submitted comment as well.

FREDRICKSON: OK. And how often-- so it sounds like there might have been some "extrenuous" circumstances that, that have prevented the meetings. How often would the committee meet typically?

CHLOE FOWLER: I believe it would be quarterly.

FREDRICKSON: OK. OK.

CHLOE FOWLER: As the rest of our advisory committees meet quarterly.

FREDRICKSON: OK. And my last question for you is, one of the previous testifiers had mentioned that they feel as though with the elimination of this that there's sufficient reporting and that the, you know, appropriate sources are informed, you know, already. Do-- can you share any insight or thoughts on that?

CHLOE FOWLER: Yeah. So with regard to the lack of, I guess, individuals thinking that there's not a need for this advisory committee, I'd just like to clarify that, by removing us, the only other alter-- alt-- not alternative-- oversight mechanism would be through the Office of the Inspector General for Child Welfare. But tho-- alternative response cases are typically only reviewed whenever there is a tragedy or something that triggers an investigation, which then forward would change our response from examining cases to an

investigation and would be reactive instead of preventative to-- you know, if a child dies, then it would trigger an OIG investigation. But if nothing happens, then there's no active ongoing oversight.

FREDRICKSON: Sure. Thank you. Other questions? Oh. Senator Quick.

QUICK: Yeah. Yeah. Thank you, Vice Chairman. So what's-- how many people are on the committee now?

CHLOE FOWLER: I do not have the, the number off the top of my head, but Monika after me should.

QUICK: OK. OK. And then you had also had-- I think you'd mentioned the makeup of it. So people-- like, county attorneys and--

CHLOE FOWLER: Yeah. So all of the Children's Commission advisory committees, not just our Alternative Response, we compi-- we compile individuals from the entire child welfare spectrum to bring together and to advance better policies and recommendations. So our Alternative Response Committee does include individuals part of DHHS. We do have them involved with everything, as well as the Foster Care Review Office, families. We have typically individuals with lived experiences who are-- who participate on these committees, which is very crucial when understanding what's actually being faced and experienced within these families and children within the child and abuse system-- the neglect and abuse system.

QUICK: OK. All right. Thank you.

CHLOE FOWLER: Mm-hmm.

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

CHLOE FOWLER: Did Senator--

FREDRICKSON: Did you have a question?

G. MEYER: Yeah. I was just kind of looking through here, and you said strike Section 1. Essentially, you want to restore Section 1. Is that--

CHLOE FOWLER: Yes. Basically, that's our entire opposition, is just Section 1.

G. MEYER: Section 1 was stricken, and I just wanted clarification on that, so.

FREDRICKSON: Great.

CHLOE FOWLER: Great.

FREDRICKSON: All right. Thank you for being here.

CHLOE FOWLER: Thank you so much.

FREDRICKSON: Next-- opponents to LB845. Welcome.

MONIKA GROSS: Thank you, Vice Chair Fredrickson and members of the Health and Human Services Committee. My name is Monika Gross, M-o-n-i-k-a G-r-o-s-s. And I'm the executive director of the Foster Care Review Office. My opposition is related to Section 1 of the bill only. I serve as the co-chair of the Alternative Response Advisory Committee, and I'm an ex officio member of the Nebraska Children's Commission. Administratively, the Nebraska Children's Commission is located within the Foster Care Review Office, and the commission's staff report directly to me. The Children's Commission provides staff and administrative support for the AR Advisory Committee, schedules and organizes meetings, posts required notices, agendas, and minutes, and drafts and submits committee recommendations. The committee's responsibilities include monitoring the use and effectiveness of alternative response and traditional response in keeping children safe and supporting families to be able to meet their children's needs. DHH-- DHHS staff serve on the committee and its workgroups, sharing data and information regarding the use of alternative response and traditional response as specified in statute. Since its inception, the committee has grappled with questions such as, is AR reaching the right families? Is AR reducing maltreatment and further involvement in the system? Are families receiving the services they need? How does AR affect child safety? Is staffing adequate, both structure, quantity, and training? Is AR understood by professionals and families involved? Do families understand their legal rights? One recommendation the AR Advisory Committee has made to DHHS is to make more data regarding alternative response publicly available. According to the most recent DHHS Point-in-Time Report, 21.2% of the children served by the Division of Children and Family Services are involved with alternative response. If the AR Advisory Committee is eliminated, there will be no oversight or ongoing monitoring and review of alternative response unless something bad happens and the

Inspector General gets involved. During the last fiscal year, the Foster Care Review Office began collecting and tracking data on children in out-of-home care who previously had been involved in alternative response. Of the children reviewed, 14.3% were involved in alternative response in the 12 months prior to their current episode in out-of-home care. An additional 14.5% of the children had other noncourt services provided in the prior 12 months. Because the FCRO does not have authority to review cases of children receiving noncourt services or alternative response, there is little transparency or oversight for children and families receiving such services. I would note that there woul-- there were 470 families currently receiving services in alternative response. Rather than eliminating the committee, I suggest you consider strengthening the oversight authority of the committee by requiring DHHS to provide relevant data and outcomes to the committee. I'm asking you to amend the bill by deleting Section 1 and allowing the committee to continue its work. I'm happy to answer any questions.

FREDRICKSON: Thank you for your testimony. Any questions from the committee? Senator Quick.

QUICK: Yeah. Thank you, Vice Chair. I would ask that question earlier about the makeup of the committee and how many people are-- actually serve on it. Do you have the--

MONIKA GROSS: It's approximately 12. There are required committee members, representative DH-- of DHHS, law enforcement, county attorney, parents' attorneys, guardians ad litem, and families with experience in-- lived experience in the system, family caregivers, and then Foster Care Review Office and the Inspector General.

QUICK: OK. One other thing too. Like-- I know, like, our-- we have a child adver-- advocacy center in Grand Island, and they do a lot of great work with kids who go to do-- through domestic abuse or dom-- domestic violence in the home and, and-- so If we don't have this, this, this advisory board, do you see that maybe some of their services-- maybe, maybe could be hurt by this or the services that we do for kids-- I don't want to see more kids end, end up in the juvenile justice system and end up in our YRTCs. We need to do more for our kids at younger ages and help them get through the process and not have them be in the system, so.

MONIKA GROSS: Right. It shouldn't impact the work that the child advocacy centers do. Some of the child advocacy centers coordinate

multidisciplinary teams that review individual cases. What this-- what the AR Advisory Committee does is kind of look more at, at the system and the processes. And the, the way the statute is written, we don't look at individual cases. We, we look at the ongoing use of alternative response, the ongoing use of traditional response. We review and examine the processes of the department. So it's concerning to me when the department comes in and says, it's not needed; nothing to see here. That's, that's a concern to me. And I think the reason that the committee was established in the first place is, is because different parts of the system-- our friends in law enforcement, in the county attorney's office, in-- those attorneys who represent parents were all concerned about the lack of visibility in the system. There's no court oversight of these cases.

QUICK: OK. Thank you.

FREDRICKSON: Other questions? Senator Riepe.

RIEPE: Thank you, Chairman. I guess my question would be is, I-- you have very clearly stated your concerns. Have you had an opportunity to try to negotiate this and to maybe get some modification to the bill?

MONIKA GROSS: I did contact every member of the committee last week when I learned about this bill. Nobody contacted me before this bill was proposed. Nobody at the department talked about me-- talked to me about this. It sounds like that was an internal decision that they made that they didn't need it anymore.

RIEPE: OK. OK.

MONIKA GROSS: So I'm, I'm willing to-- I'm willing to talk to anybody.

RIEPE: Thank you. Thank you, Chairman.

FREDRICKSON: Other questions? Senator Meyer.

G. MEYER: It doesn't appear there-- as has been testified before, there's no fiscal advantage. There's no efficiency realized here. Wha-- what's the motivation? And, and I know we heard about redundancies and that type of thing-- which I have a great appreciation for trying to eliminate that-- but what do you-- what, what would you say would be the motivation to do away with the AR?

MONIKA GROSS: I'm not sure. I, I think they just don't want to deal with it. They, they-- maybe they think it's too much work, but obviously there's minimal cost involved because there's minimal cost savings to be realized.

G. MEYER: So there's a benefit to continue as is with no real advantage to making a change?

MONIKA GROSS: Yes. I, I, I support continuing, continuing the work of this committee and really, you know, being able to look at these processes and follow these processes as they-- as Children and Family Services looks at changing their safety assessment models, that can change what we've already-- what the committee has already learned from the department. Things are always changing. So it's not a static situation. And the, the, the statute says that recommendations-- the committee's to make recommendations to the Legislature first. The Legislature is listed first in the statute. So it's not primarily an advisory committee to DHHS, although we can make recommendations to DHHS. It's primarily to make recommendations to the Legislature.

G. MEYER: Thank you.

FREDRICKSON: Other questions? I have a couple. So I-- so alternative response will still exist whether this advisory committee exists or not. I-- I'm-- I guess I'm curious. Do you have any familiarity with what that-- I mean, I'm gathering from your testimony. It sounds like, prior to this committee, there was a lot of-- it, it, it-- there wasn't a lot of transparency maybe on what was based on lack of oversight, based on being outside the court system, et cetera, as to what was happening with these families. Is-- I, I, I mean, do you have any insight into what it was like before this committee was established?

MONIKA GROSS: Well, I was not involved, but my understanding is that alternative response was a, was a pilot program. It was the Title IV-E Waiver Demonstration Project in Nebraska. And so it was being rolled out, you know, slowly throughout the state. And so I think there was a lot of concern from law enforcement, from county attorneys, from child advocates because of the lack of any kind of court oversight or any kind of oversight body. So I think when the, when the, the waiver-- the Demonstration Project ended and alternative response was being implemented statewide, they shifted kind of from an implementation committee to this advisory committee.

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

MONIKA GROSS: Thank you.

FREDRICKSON: Next opponent to LB845. Welcome back.

ALEX DeGARMO: Thank you. Good afternoon, Vice Chairman Fredrickson, members of the HHS Committee. My name's Alex DeGarmo, A-l-e-x D-e-G-a-r-m-o. I'm the public policy director for the Alzheimer's Association Nebraska Chapter. We are opposed to LB845. We do not believe that the Alzheimer's and Other Dementia Council should be combined with the Aging Council. This-- two very different subject matter areas. We don't believe that there's redundancy between the two. The Alzheimer's and Dementia Council is dealing with a issue that we believe to be a public health issue, not a normal part of aging. For these reasons, we're opposed. I would like to say we do appreciate the work on the amendment for the membership. That was one of our concerns. But we are still opposed to the combining of the councils. We also have some concerns about potentially becoming ineligible for federal funding by combining the councils. With BOLD funding, one of the basic requirements is that there is a Alzheimer's and Dementia Council. If we combine, we may no longer be eligible for those federal funds. Thank you.

FREDRICKSON: Questions from the committee? I guess as-- relates to the federal fund. One question I had is, is, is that something we could-- I don't know what that would look like, but that might merit some looking into to ensure that doesn't compromise the funding. How much federal funding do you currently get that might be compromised?

ALEX DeGARMO: It varies by what we put in an application as a state. So right now, public health departments are applying for BOLD funding. The state can apply for BOLD funding, but that money is variable by what project they want to do.

FREDRICKSON: OK. Do you get, like, a ballpark of--

ALEX DeGARMO: I'll get you that information later.

FREDRICKSON: OK. All right. Thank you. Other questions? Senator Riepe.

RIEPE: Thank you, Chairman. I was struck by your comments that some of your Alzheimer's funds may be compromised. Do you have some

information that you could share with the committee that would either--

ALEX DeGARMO: Yeah. I'll send you-- I'll send you information regarding federal funding potentially being compromised by doing this.

RIEPE: We're very sensitive to dollars this session.

ALEX DeGARMO: I, I know we are.

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

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

ALEX DeGARMO: Thank you.

FREDRICKSON: Next opponent to LB845. Welcome.

CORRIE KIELTY: Thank you, Senator Fredrickson, members of the committee. My name is Corrie Kielty, C--o-r-r-i-e K-i-e-l-t-y. And I serve as the executive director of the Nebraska Court Appointed Special Advocate, or CASA, Association. I'm here to testify in opposition to LB845 and specifically to the elimination of Section 1. Nebraska CASA specifically opposes the elimination of the Alternative Response Advisory Committee under the Nebraska Children's Commission. Eliminating this committee would remove the only standing body providing ongoing oversight of the front end of Nebraska's child welfare system, where some of our most vulnerable children first enter care. The Alternative Response Advisory Committee is uniquely positioned to provide external review and accountability. It is co-chaired by the director of the Foster Care Review Office-- who just testified-- and a long-time CASA volunteer. Two perspectives that are deeply rooted in child advocacy: data and experience in the system. Without this committee, there will be no consistent, independent oversight of alternative response cases. This matters because, today, more than one in five children served by the Nebraska Department of Health and Human Services Child and Family Services are in alternative response cases. These children have no court oversight and no CASA volunteer appointed to advocate for them. While alternative response may be appropriate in some circumstances, these children are still coming from situations involving abuse or neglect and significant trauma. CASA volunteers exist to ensure children are seen, heard, and not forgotten in an overburdened system. They provide judges and professionals with critical child-centered

information to support safe and timely decisions. When court involvement is intentionally removed from the process, it becomes even more important, not less, that strong accountability and oversight mechanisms remain in place. The advisory committee provides a critical forum to identify trends, flag risks, and recommend improvements before children fall deeper into the system. Children in alternative response cases already experience uncertainty. Removing one of the few safeguards designed to monitor that part of the system increases that risk that children's needs and warning signs will be missed. For these reasons, we respectfully urge you to not advance LB845 or to reinstate Section 1 of the bi-- the bill. Thank you for your time and your continued commitment to Nebraska's children.

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

RIEPE: Thank you, Chairman. In the past, I had a legislative aid that-- who-- actually a legal aid-- who volunteered in CASA. My question is this: how does CASA relate to foster care?

CORRIE KIELTY: So--

RIEPE: Is it in addition to, or before, higher, below, avera-- how's, how's it fit into the puzzle for me?

CORRIE KIELTY: Yes. How we fit in is, in state statute, a CASA volunteer can be appointed by a judge as the friend of the court in a juvenile case. And then it is our volunteer's job to provide a report every time that there's court about meeting with the kids and investigating the case and what we're seeing is going on in that child's life. CASA was started by a judge because that judge went, you know what? These cases are really complicated. The caseworkers have so many cases, the attorneys have so many cases. If there were just a vol-- someone, a volunteer who's trained who could give me more information when I make judgments about these children's lives, that would be helpful. And that is what we do.

RIEPE: Are you able to go into the home?

CORRIE KIELTY: Yes.

RIEPE: Only if the-- is-- would this be on a foster child or would this just be on a regular-- a family that has a child that--

CORRIE KIELTY: If there, if there is--

RIEPE: Or both of them.

CORRIE KIELTY: --a case-- yeah. If there's a juvenile case opened and the court appoints us, the court appoints us to have information in the case. So we would request if we want to do visitation in a foster home, in a parental home.

RIEPE: Yeah.

CORRIE KIELTY: Sometimes our volunteers go to the schools to meet with kids in other places.

RIEPE: So the judge gives you a letter that you kind of can present that says, I'm here legally. I'm not just a nosy neighbor.

CORRIE KIELTY: Yes. It's a court order, yes.

RIEPE: Do you feel any insecurity or threats in going to-- into these homes? I mean, you're kind of--

CORRIE KIELTY: Honestly-- no. We've ha-- we've had a couple of situations. Yeah.

RIEPE: --mind your own business kind of thing.

CORRIE KIELTY: Not very often, because, honestly, our first intent is reunification of a family. So our volunteers go through 30 hours of initial training before they're appointed to a case. And they're supervised by our staff who have much more training. And what they learn is our first objective is to reunify these families. Families are meant to stay together, and children are best off if they remain with their families.

RIEPE: I agree.

CORRIE KIELTY: So I think that they understand that that's why we're there.

RIEPE: OK. Fair enough. Good. Thank you. You've been helpful.

CORRIE KIELTY: Yeah.

RIEPE: Thank you, Chairman.

FREDRICKSON: Question-- other questions? Seeing none. Thank you for being here.

CORRIE KIELTY: Thank you.

FREDRICKSON: Next opponent to LB845. Seeing none. Moving on to neutral testimony for LB845. Hello.

JENNIFER CARTER: Hi. Good afternoon, Vice Chairman Fredrickson and members of the Health and Human Services Committee. My name is Jennifer Carter, J-e-n-n-i-f-e-r. And I serve as the Legislature's Inspector General of Child Welfare. You've heard a bit about our office.

FREDRICKSON: I'm sorry, can you spell your last name as well?

JENNIFER CARTER: Oh, did I not? Sorry, C-a-r-t-e-r. Pol-- apologize for that. I wanted to testify in the neutral capacity just to explain about Section 1 and the intent to remove the AR Advisory Committee. What the OIG's role is-- because we do have an oversight role as it relates to alternative response and to understand what that is and, and what it's not. So as mentioned, we were-- our core to our duty is to investigate deaths and serious injuries in the child welfare system. That would include deaths and serious injuries that occur in an AR case. I'm passing out a, a summary of the report we put out last August because we did have, starting in fiscal year 2022-23-- for the first time, we had deaths and serious injuries related to AR cases reported to us. And that has continued. So we consolidated those, and we're able to take a broader, systemic look at AR. And that's what that report is. And our findings, our recommendations are there. But generally speaking, if we're just investigating one case, while we're always looking with a mind to systemic policy change, it would not result in sort of an overall look at how the AR program is working. Separately, we do have to also include in our annual report summaries of reviews, is the language in the statute, that we do on anything we hear about an AR case. So that may come in as a complaint or it may be another incident that didn't require a full investigation. But again, that's not, like, a full systemic review of the system. We are able to ask for data, and we did in relation to the bigger report that we did. But I did want to clarify one thing: there is no data that is required to be sent to the IG's Office. We, we can look at the reports that they put out and we can request that data, we just at this point don't do that as a matter of course, which is frankly a, a capacity and a resource issue. So it's something that we could do but-- and we love information, but, right now, we're, we're not getting that just automatically sent to us. So, so I just wanted everyone to understand that we do provide oversight

in certain ways, for sure, and, and we're happy to participate in that in any way that we can or need to. And we obviously are very dedicated to oversight, given that's our whole purpose. But it's-- we, we don't necessarily do a regular full assessment or monitoring of the AR program. It's coming up more in terms of deaths and serious injuries and the reviews that we do. So we just want to-- as you decide whether to keep this committee or not, we wanted to make sure you were aware of what else was out there in terms of oversight.

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

RIEPE: How do you proceed if you have a-- what appears to be-- and ye-- if it appears to be child abuse? Do you have a mandatory reporting responsibility? Or is that reporting to you?

JENNIFER CARTER: So-- no. So the mandatory reporting goes to the Department of Health and Human Services' hotline. We are also-- I mean, we are all mandatory reporters, but na-- the Inspector General's Office is specifically a mandatory reporter listed in statute. When we receive notifications of deaths or serious injuries, that has already been investigated by HHS, likely investigated by law enforcement, and, and it's just-- we are notified so that we can take a look purely from a government agency administrative perspective to see how the department handled the case in terms of following policies, procedures, rules, and laws, and whether there are things that can be improved. And, and sometimes, as we've said, we find that the department did everything that they needed to do but we identify a gap in the system and then we can come back to the Legislature and to the department and say, here's a way we think maybe we can do this better. So we would only recall the hotline if we were separately receiving, as we sometimes do, a call that is concerned for a child's safety. We always direct people to the hotline. And then if we have enough information, we sort of make a multiple report to make sure it gets there.

RIEPE: As the Inspector General, do you then pursue a prosecution?

JENNIFER CARTER: We do not. We have zero law enforcement authority. It is purely an advisory, sort of a transparency perspective. And then we can offer recommendations to the department. And we are here to help the Legislature understand what changes might need to be made in the system. But we have no prosecutorial, no law enforcement authority at all.

RIEPE: I've been on this committee a lot. This is my eighth year. And a few years ago, I said, does anyone ever get fired for negligence when we lose a child? And no one had an answer, so.

JENNIFER CARTER: Yeah. And we cannot rec--

RIEPE: That's-- yeah. It's a frustration of mine, is nonperformance will get you the door, but.

JENNIFER CARTER: Yeah.

RIEPE: Thank you, Chairman.

FREDRICKSON: Thank you, Senator Riepe. Other questions? Senator Quick.

QUICK: Yeah. Thank you, Vice Chair. So as far as someone contacting you, do you get a re-- I mean, would you get a report in every single case? Like, where-- if, if there is harm to a child or no?

JENNIFER CARTER: Any case that-- where there is an actual death or serious injury which is defined as something needing-- li-- likely the result of maltreatment that needs urgent medical attention, so. And so the department is very good about sending us critical incident reports when those happen. And then we have to review them to make sure they are within our jurisdiction and then to-- can open up a full investigation if they are.

QUICK: OK. All right. All right. Thank you.

JENNIFER CARTER: So-- but we wouldn't hear about every AR case, obviously. It would only be the cases where something unfortunate happened.

QUICK: OK. All right. Thank you.

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

JENNIFER CARTER: OK. Thank so much.

FREDRICKSON: Other testifiers in the neutral capacity? Seeing none. Senator Hardin, you are welcome to close. While you come up, we did have some online comments for LB845: 1 proponent, 1 neutral, and 17 opponents. Thank you, Senator Hardin.

HARDIN: If I can respond to Senator Riepe. As it regards YRTC Kearney, there were firings that took place. Just to level that one out. The department is glad to discuss these issues that came up, particularly with Section 1, with anyone. And so-- nothing in stone here. We're trying to get the best outcomes possible. So that's a-- an open invitation that I, I just received on my smartphone a little while ago. Again, this bill addresses three things, and the concerns of the Children's Commission for the AR Oversight Committee, Alternative Response Committee is one of those three things. It's not the intent to remove oversight. And-- so they're very much open to those discussions. Also, there is a need that was brought up early on to make sure that we have a, a practical working balance between aging and, and Alzheimer's, as the emphasis here is on-- with, with this bill, is in that context of aging, Alzheimer's. And so we'll make sure that there is proper emphasis in healthy prevention that's going on there as well. Also, there will be an amendment to support the 17-member versus the 15-member committee change, so.

FREDRICKSON: Great. Any questions from the committee? Seeing none. Thank you, Senator Hardin. That will wrap up our hearing for LB845. You're next? Yes. I think, I think Senator Hardin-- I think, Chair Hardin, you are next as well. So we'll give folks a few moments to transition. I think they are mostly transitioned, so you are welcome to open.

HARDIN: Thank you, Vice Chair Fredrickson. And good afternoon, fellow senators of the Health and Human Services Committee. I'm Senator Brian Hardin. For the record, that is B-r-i-a-n H-a-r-d-i-n. And I still represent the Banner, Kimball, and Scotts Bluff Counties of the 48th Legislative District in western Nebraska. I'm here to introduce our other committee bill, LB867. LB867 is an omnibus measure that makes a series of targeted updates across several Health and Human Services programs to improve clarity, efficiency, and alignment with current practice. The bill updates the rules governing special needs trusts and modifies fingerprinting requirements under the Uniform Credentialing Act while also redefining a statutory term to eliminate ambiguity. It makes changes to the Title IV-D-- not 40, but IV-D-- Child Support Customer Service Unit and revises funding rules for child care grants. LB867 also adjusts eligibility criteria for young adults in the Bridge to Independence program, simplifies and removes certain requirements for assistance to the aged, blind, and disabled, and modifies a requirement within the Commodity Supplement Food Program. In addition, the bill updates responsibility requirements for the Division of Children and Family Services, eliminates outdated

provisions concerning spousal assets under the Medical Assistance Act, removes obsolete provisions related to the Maternal and Child Health and Public Health Work Fund, repeals an outdated nurse licensure compact, and allows wholesale drug distributor license fees to be used to support the Prescription Drug Monitoring Program, PDMP. Thank you.

FREDRICKSON: Thank you, Chair Hardin. Are there any questions from the committee? Seeing none. Will you be sticking around?

HARDIN: I shall.

FREDRICKSON: All right. Thank you. We will now hear from proponents for LB867. Welcome.

NICOLE BARRETT: Thank you. Good afternoon, Vice Chairman Fredrickson and members of the Health and Human Services Committee. My name is Nicole Barrett, N-i-c-o-l-e B-a-r-r-e-t-t. And I am the director of Legislative Services at the Department of Health and Human Services. I'm here to testify in support of LB867. Thank you for the-- to the committee for introducing this bill on behalf of the department. This time last year, I sat before you to testify on another committee bill, LB376. As you may recall, that bill was trimmed down after negotiations on General File. At that time, we agreed to work with the Speaker and chairman over the interim on the pieces removed before enactment. What has been introduced in LB867 this session is a result of those conversations. I appreciate the willingness of Senators Arch and Hardin to invest their time and expertise in crafting a strong piece of legislation. At its core, this bill aligns with the Governor's "clean the closet" efforts and is still about government efficiency, removing antiquated obligations from statute to allow the department to better focus on its mission of helping people live better lives. The statutory changes included in this bill fall into a few categories: removing conflicts with federal law from statute and correcting conflicts within state statute, aligning state statute with current departmental practices, and streamlining governmental efficiencies. There are three new pieces added to the bill this year: fixing the Bridge to Independence program for tribes that have an age of majority of 18, changing the fingerprinting language for occupational licenses to appease the Federal Bureau of Investigation, and eliminating an antiquated compact from statute brought to DHHS from the Revisor's Office. Attached to my testimony is a section-by-section analysis explaining all of the changes in more depth. We respectfully request that the committee advance the

bill to General File. Thank you for your time. I'd be happy to answer any questions on the bill.

FREDRICKSON: Thank you for your testimony. Any questions from the committee? I have one. I think that I answered this by reading your handout, but for the changes for the special needs trust specific aspect-- it's Section 3 on your handout. It, it appears that that, that is-- am I reading this correctly, to see that that's just aligning this with federal policy? There's not going to--

NICOLE BARRETT: Correct. It changes no practices because we follow federal law anyways, but we'd like the statute to align.

FREDRICKSON: Got it. No other questions from any other-- oh. Senator Quick.

QUICK: Thank you, Vice Chair. On that Section 12 with the assistance, what does that actually change or what does that do then?

NICOLE BARRETT: So this means instead of sending a check-- which is what the warrant is-- we can use, like, the ReliaCard, the debit card. That's standard practice now today. That's what most recipients are, are-- would prefer for any benefit, right, instead of getting a check in the mail.

QUICK: Oh, OK. All right. All right.

NICOLE BARRETT: Yup.

QUICK: Thank you.

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

NICOLE BARRETT: All right. Thank you.

FREDRICKSON: Next proponent for LB867. Seeing none. Is there anyone here to testify in opposition to LB867? Welcome.

NICK HALBUR: Thank you, Senator, members of the committee. My name is Nick Halbur, H-a-l-b-u-r. I'm an attorney.

FREDRICKSON: Can you spell your first name as well, please?

NICK HALBUR: Nick, N-i-c-k.

FREDRICKSON: Thank you.

NICK HALBUR: Is what I go by. I'm an attorney. I'm licensed to practice law in Nebraska and Iowa. I'm an elder law attorney, so I work with the elderly and disabled members of our community. The-- that is my client base and that's whom I'm here to advocate for today. I've been practicing for about 20 years. I-- my first position was a-- is a elder law instructor at a legal clinic at my law school at the University of St. Thomas in Minnesota in the Twin Cities. I taught there for three years, instructed on a variety of elder law issues, including guardianships, Medicaid. And, and Medicaid is the, the issue before-- pa-- that's on you today. I've been-- and now-- since teaching, I've been in private practice in the private sector for 15 years in the elder law area in Omaha, Nebraska. I'm currently at Koukol, Johnson, Schmit, and Milone, where I've been for the last two years. Member of the NSBA, various-- wealth council and other various elder and estate planning organizations. The-- I dispute the statement regarding the pooled special needs trust section, Section 3 on page 4 of the, the PDF of, of the statute. I, I have experience in other states that do allow individuals to fund pooled special needs trusts after the age of 65. So that elimination, I, I would dispute that that is in-- to conform to federal law. They are-- I, I believe both positions are allowed, but we are directly discriminating against individuals 65 and older by taking that back out of the legislation and, and, and, of course, those, those options to fool-- to fund that pooled special needs trust is only for the people 65 and older, so you would be eliminating an option, a new-- relatively new planning option, since this was just passed, I think, two legislative sessions ago. And so you would be putting the 65 and older population back to their second, second rate status or second tier status. If you're a disabled elder, you have fewer planning options in that regard than other individuals with-- who can use a first-party, or (d)(4)(A), special needs trust. The, the, the main concern that got me down here this morning as I first read this bill at about 10:00 at night were the elimination in Section 19, the outright repeal of a number of sections related to the spousal impoverishment rules. There may be other offsetting legislation or other-- or, or, or other things which I'm not aware of, but if it is the desire of the department to, within Section 19, to outright repeal Sections 68-921, 68-922, 20-- 68-923, 68-924, and 69-925, this would be a very significant change in policy and one that would adversely affect many, many of my clients, both clients in the future and ones who are depending on this rule for their current eligibility. The spousal impoverishment rule--

FREDRICKSON: And you're in the red, so if you can just finish up your thoughts.

NICK HALBUR: Sure. The, the repeal of these sections would essentially reverse a part of federal law that's been in place since 1988. There-- every state follows those sections, as I believe are required by federal law. You will increase the rate of silver divorces because there will no, no longer be these protections for the elderly. And other, other planning strategies which, which I think will be adverse to the elderly population, and specifically the elderly and disabled population of the state of Nebraska.

FREDRICKSON: OK. Thank you for your testimony. Let's see if there's any questions from the committee. I am not seeing any. But-- so my belief is in a, a-- so I'm, I'm just kind of reading over this a little bit. So to your point with the state spousal impoverishment program, the, the federal program is, is mandatory as I understand, so I--

NICK HALBUR: Yes. The--

FREDRICKSON: --that would supersede state--

NICK HALBUR: Some of the-- some of the provisions of-- that are being asked to be repealed are required to be in, in the state law for participation in the program, so this should-- I suppose there would be a fiscal note on whether this will affect Medic-- federal contributions to our DHHS funding so that-- because when you don't conform to federal law within your Medicaid program, you can be penalized and reduce the amount of that budget that is provided for by the federal budget, is my understanding.

FREDRICKSON: OK. Sure. Gives us something to look into. So thank you. Any other questions? Seeing none. Thank you for being here.

NICK HALBUR: Thank you.

FREDRICKSON: Other opponents to LB867. Seeing none. Is there anyone here to testify in the neutral capacity of LB867? Welcome.

JINA RAGLAND: Thank you, Vice Chair Fredrickson and members of the Health and Human Services Committee. My name again is Jina Ragland, J-i-n-a R-a-g-l-a-n-d. Here today testifying on behalf of LB867 on behalf of ANAR-- AARP Nebraska. I am testifying in the neutral capacity, I did speak with Chair Hardin this morning. We actually

were going to come in, in opposition, but we are coming in neutral this afternoon specifically as it relates to repealing Section 68-921 through 68-925 of the public assistance statutes specifically as it addresses spousal impoverishment as outlined in the bill. And I also would like to address Section 1 of the bill. It is our understanding that the intent of striking the language in the mentioned sections is due to inferred duplication from state law to federal law and therefore it is being deemed as not necessary, but our question whether or not having that redundant language in place is really causing any problems to the state. And if not, then why not leave this extra layer of protection in play? Nebraska's spousal impoverishment law does not replace federal law; it implements it, and we feel it's necessary to leave it in place to avoid unintended consequences. The spousal impoverishment protection law is designed to protect the financial well-being of the spouse who remains in the community when the other spouse enters a nursing home. This law allows for the division of assets and incomes to ensure that the community spouse does not become impoverished while the institutionalized spouse receives care. The protections were esab-- established, as you heard, under the Medicare Catastrophic Coverage Act, MCCA, of 1988, which created new federal income and resource rules for married couples when one spouse requires Medicaid-funded long-term care. These rules became effective October 1, 1989. Nebraska follows the federal rules but sets state-specific guidelines each year which ensure these protections are applied consistently. When community spouses are required to spend down their assets, they're not as well-equipped to address any future needs that might arise. And allowing community spouses to keep more of their assets and income provides them with the financial cushion they need to take care of themselves in the community and plan for their own future care and well-being. It's important to note, lastly, we're also concerned with Section 1 that removes the use of these rules as an exception to the crime of spousal abandonment. In Nebraska, we have made clear that couples who utilize these rules will not need to worry about potential criminal liability for spousal abandonment when they're already facing so much of a challenge. So simply put, spousal impoverishment protections are sensible public policy designed to prevent the community spouse from becoming reliant on public de-- de-- benefits. And I am out of time, so-- Vice Chair, I will take any questions there might be.

FREDRICKSON: Thank you for your testimony. Questions from the committee? Just one question I have. So-- it-- and, and, and-- it

sounds like with-- the previous testifier as well expressed some of the concern wi-- with the spousal impoverishments, so that sounds like something we might want to-- I guess more of a comment than a question.

JINA RAGLAND: Yeah. I mean, I just-- it's a protection. Again, yes, we follow the federal-- what's established in federal law. But I guess for us, it's-- there's, there is not a problem right now that we're aware of, and so-- to us, it should stay in play. That way, you have more flexibility within the state law to make any changes that might occur.

FREDRICKSON: Sure.

JINA RAGLAND: And by taking it out, we feel it's a risk for those spouses that are having to depend on some assistance when they have spent down their income and assets. They-- there no-- there's no way they could live in the community without-- if they were having to pay their entire income to supporting someone in a long-term care facility at roughly $10,000 a month.

FREDRICKSON: Right. Right. Other questions? Seeing none. Thank you for being here. Anyone else here to testify in the neutral capacity?

CINDY KADAVY: Good afternoon, members of the Health and Human Services Committee. My name is Cindy Kadavy, C-i-n-d-y K-a-d-a-v-y, senior vice president of policy at Nebraska Health Care Association. On behalf of our skilled nursing facility and assisted living community members, I'm here to testify. Originally, it was going to be an opposition to LB867, but we had requested clarification from the department on some of our concerns, and we did receive it a few minutes ago. So we're testifying in the neutral capacity. As Jina said earlier from AARP, our main concern was the elimination of Nebraska's spousal impoverishment program. That is a cost-effective program for Nebraska. It's also a compassionate program because it allows one of-- if one spouse needs perhaps nursing home care but the other spouse can live independently, they're able to divide their assets. So the individual in the nursing home can rely on Medicaid for their care, but the person living at home, that spouse can use their own a-- their own assets and resources to support themselves independently. So it is cost-effective. It's been a great program for Nebraska. If it's eliminated and there's still federal program, that's great. We would hope that if that ever goes away that Nebraska would have a state program in place. I've been around for a long

time, so I remember before this was in place in Nebraska, couples would have to divorce in order to get the same outcome. And there was a famous case in Nebraska. It was a minister who was a man of faith and didn't want to take that step, but that was the only way he could get care that was needed for his wife. So on behalf of our members, we'd urge you to take another look at LB867, specifically the spousal impoverishment.

FREDRICKSON: Thank you for your testimony. Any questions to the committee? Senator Riepe.

RIEPE: Thank you. Thank you for being here. It sounds like the division of assets is an easy process, but, quite frankly, I don't believe that it is. Much like in a divorce, you know, certain things are prot-- protected, inheritance and other things. And so you're going to have to have some legal advice when you start slicing down. It's not a simple 50 here and a half here and half there. Not going to work that way. Not, not legally, it won't. In my opinion. I'm not an attorney. Thank you, Chairman.

CINDY KADAVY: Was that a question? Sorry.

RIEPE: Pardon?

CINDY KADAVY: Was that a question or--

RIEPE: I guess not. More of a therapeutic relief thing.

CINDY KADAVY: Because I was just going to say mostly it's used by people of pretty modest means. I mean, people that have extensive resources usually don't need to go that route, but.

RIEPE: My response to that would be, is, with the nursing home prices, there's not enough money for anybody.

FREDRICKSON: All right. Thank you, Senator--

RIEPE: That was another statement.

FREDRICKSON: Thank you, Senator Riepe.

RIEPE: Thank you, Chairman.

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

CINDY KADAVY: Thank you.

FREDRICKSON: Any other testifiers for-- in the neutral capacity for LB867? Seeing none. Chair Hardin is invited to close. While he comes up, looks like we had some online comments. We had 0 proponents, 2 opponents, and 0 in the neutral capacity. Chair Hardin.

HARDIN: Well, we certainly need to address the spousal impoverishment concerns with the attorneys at the de-- department and make sure we're responding appropriately to federal law and independent living. As chair of this committee, I deeply appreciate getting all of this input so that we can make sure we have the wordsmithing to address these complex realities. The department attorneys have already notified me. They're very glad to take a, a deeper dive and, and make sure we're doing everything we need to do to make that happen, so. Questions?

FREDRICKSON: Questions from the committee? Seeing none. Thank you for being here.

HARDIN: Thank you.

FREDRICKSON: All right. That'll end our hearing for LB867.

HARDIN: We will wait, Senator Hansen, until the spawning of the salmon has completed. I think we are ready.

HANSEN: All right. Good afternoon, Chairman Hardin and members of the committee. My name is Senator Ben Hansen. That's B-e-n H-a-n-s-e-n. And I represent Legislative District 16. Today, I'm introducing LB832 to delay the addition of long-term care services and support to the Medicaid managed care program. As introduced, LB832 would extend the date to July 1, 2030. Conversations with managed care organizations have been ongoing, and until recently, a compromise date was agreed on. This date is included in AM1724, an amendment that was drafted and filed on January 16 to reduce the amount of time by two years. Yesterday, I was made aware that, despite the agreed-upon date, managed care organizations have come in opposition to the bill-- I'm assuming at the behest of the Department of Health and Human Services. I am still willing to bring this amendment in good faith, though. As for the reasoning behind the bill, I'd like to provide you with a little background on this issue. Medicaid capitated at-risk managed care began in 2017 in Nebraska. Because long-term care services are more complex in terms of reimbursement and the needs of

the population served, they are not included at this time. The original statute, 68-994, was passed by this committee in 2019 with a date to delay, delay the implementation. This date was further extended to 2021-- from 2021 to 2023. LB832, as amended, would extend this date again to the agreed-upon date of July 1, 2028. Based on the experience of other states, it makes sense to take a gradual and considered approach to including long-term care services and supports under managed care. With that, thank you for your consideration. And I would be happy to answer any questions. However, there will be industry-specific testimony following to provide greater insight as well.

HARDIN: Very well. Questions? Will you stick around?

HANSEN: Yes.

HARDIN: Wonderful.

HANSEN: Closing is my favorite part.

HARDIN: Awesome. Proponents, LB832. Hi.

JOHN TURNER: Hello. Chairman Hardin and senators, my name is John Turner, J-o-h-n T-u-r-n-e-r. I am the executive director at Newport House in the Immanuel community in north Omaha. I'm here to express support for LB832. As you know, the-- we are currently concerned about the managed care system right now. Managed care does not provide the care the providers do. Managed care organizations are administrative entities focused on their end only. And long-term care inserting a third-party payer between the state and providers does not improve quality. It increases complexity, delays payment, and forces communities to determine whether it's worth taking more Medicaid residents. We currently have a managed Medicaid system run by DHHS that formulates allowable payment that pays out consistently on a monthly basis when we submit com-- when we submit claims for Newport House. We only have to deal with one vendor, the state, to get paid timely. Managed Medicaid has a documented history in other states that delayed payments, denied claims, retroactive authorizations, and lengthy appeals. When payments are delayed 60 or 90 days, facilities are forced to function as a bank. That's not sustainable. Newport House serves a population that's approxima-- approximately 50% Medicaid. For providers like us, even modest payment dun-- de-- delays or denials under managed Medicaid would have an immediate and significant financial impact, creating greater

financial stress on how we operate. Managed Medicaid will also increase its administrative burden, prior authorizations, documentation requirements, and contract disputes expand without increasing reimbursement and placing additional strain on our already stressed workforce. Nebraska's long-term care system is already under strain from workforce shortages and rising costs. Managed Medicare adds financial uncertainty and administrative complexity at the worst possible time. If the goal is stable access, quality care, and responsible use of taxpayers' dollars, managed Medicaid is not the right model for long-term care. LB832 delays this until a better system can be formulated. Thank you. Questions?

HARDIN: Thank you. Questions? Senator Ballard.

BALLARD: Thank you, Chair. Thank you for being here. Can you talk a little more about the, the, the payment cycle? So you're-- so-- so you're saying that you're billed at the-- you pay at the-- billed at the first of the month and then it's supposed to take--

JOHN TURNER: Correct.

BALLARD: --30 days?

JOHN TURNER: Correct. So currently, yes. So when we make our-- when we, we bill the state, we'll get-- put our billing in at the beginning of the month, we'll get paid at the end of the month. So we have experiences with other Advantage plans, as I'll use as, as example, that those payments will get delayed out because they'll either want authorizations checked or, or what have you. So anything that delays payments-- you know, we have bills to pay too. So that, that becomes a, a bigger challenge for us as well too. And just from prior experience from a couple other states-- Kansas is one that transitioned to the, the managed Medicaid-- I mean, I can tell you that from a person that I knew quite well, they had difficulty getting paid in a timely manner, creating greater stress on that entity to continue to operate, so.

BALLARD: OK.

JOHN TURNER: So that's, that's a huge concern for us.

BALLARD: OK. And what percentage of your population would you say is on Medicaid?

JOHN TURNER: 50%. 50%.

BALLARD: 50%. OK.

JOHN TURNER: Yes.

BALLARD: So you have private, private residents subsidizing--

JOHN TURNER: Correct.

BALLARD: [INAUDIBLE].

JOHN TURNER: Correct. So-- and again, as, as you well-- all well know as well, you know, if, if those costs impact us negatively, we pass the costs back onto our private pay at some point in time to offset that impact too.

BALLARD: OK.

JOHN TURNER: And then we just transition them faster to Medicaid. And that's the problem there too.

BALLARD: OK. Thank you.

HARDIN: You mentioned Kansas. Can-- in your experience, can you give us a-- kind of a wider taste? What other states are you familiar with?

JOHN TURNER: Kansas and Iowa are the-- are two primary states, but I'm going to defer to a couple people behind me that have current experience from that, more detailed.

HARDIN: OK.

JOHN TURNER: But-- so my office manager was a biller in-- for, for Kansas properties and had huge problems getting paid after they switched over, and that caused a-- revenue coming in to pay their bills, so. Significant impact.

HARDIN: Was it an ongoing problem or just a new problem and that went away? I'm just curious.

JOHN TURNER: The, the problem didn't go away.

HARDIN: It didn't go away.

JOHN TURNER: No.

HARDIN: OK.

JOHN TURNER: No.

HARDIN: Very well. What else do we need to know? What have we missed?

JOHN TURNER: I'm advocating that you don't go into managed Medicaid.

HARDIN: OK. I got that part.

JOHN TURNER: Pretty clear.

HARDIN: All right. Very good. If there-- oh. Senator Quick.

QUICK: Thank, thank you, Chairman. First, I want to commend you on, you know-- 50%, 50% of your clientele are-- or, your patients are Medicaid, and that's something really-- I don't see that in my district. I went and visited some of my facilities and there was a couple of them that don't-- won't even take Medicaid.

JOHN TURNER: Correct.

QUICK: So I, I know that's a big issue. And the, the reimbursement rate is pretty low, so.

JOHN TURNER: Correct.

QUICK: I guess one of my questions would be about-- so-- I should know more about how, how MCO has worked, and maybe you can tell me, but is it like-- like, when I have private insurance and I file for a claim, can they refuse a claim too or--

JOHN TURNER: Absolutely. They can deny a claim, so. Absolutely. They can-- you know, what the-- they can say, you know, it wasn't filed correctly. You know, we're missing information from that standpoint, so. The, the nice part about-- were-- we're truly in a managed system already that the state controls the dollars that we're being paid. So-- I mean-- so we're in a true managed system anyway. We're not just saying you need to pay us this amount of money, you know. So now you're going to add a third-party paying system in here-- then you're not going to save money. You're going to increase your cost to the state. That's what you're going to do in the end.

QUICK: OK. All right. Thank you.

HARDIN: Other questions? Thank you.

JOHN TURNER: All right. Thank you.

HARDIN: Next proponent, LB832. Welcome.

BRIAN STUHR: Thank you. Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Brian Stuhr, B-r-i-a-n S-t-u-h-r, chief financial officer of Vetter Senior Living. I'm here today to testify in support of LB832. Thank you to Senator Hansen for introducing this legislation. Vetter Senior Living is a Nebraska-based company founded 51 years ago by Jack and Eldora Vetter. We own and operate 21 skilled nursing facilities, 4 assisted living facilities, and are privileged to serve more than 1,700 residents daily. 40% of those are Medicaid-eligible residents. By advancing this bill, you are supporting all long-term care providers in our state. It is no secret that Neb-- number of nursing homes in Nebraska are struggling with labor shortages and underfunding. Including nursing facility services in Medicaid managed care would only add to the struggle. Previously, Vetter operated three skilled nursing facilities in Iowa. Due to a changing regulatory environment as well as the implementation of Medicaid managed care in nursing facility services, we made the difficult decision to exit the state. When Medicaid managed care was implemented, we experienced significant delays in payments for services, often exceeding 45 to 90-plus days after services were provided. We experienced unnecessary prior authorizations as well as post-payment clawbacks for services already provided. Just last week, we received notification from a managed care company in Iowa attempting to claw back a payment made to us for services provided in 2020, over six years ago. Just as we have experienced, when other states have moved too quickly, providers have gone for long periods without payment while the managed care plans have attempted to make modifications. These providers without the resource-- those providers about the resources to go 30, 60, or even 90-plus days without payment are not able to sustain operations and have closed. Rather it is a wiser decision to make gradual and considered approach [INAUDIBLE] solution for several reasons. The complexity of the Medicaid reimbursement methodology currently makes it very challenging for new payers, specifically Medicaid managed care companies, to adopt the same payment structure. I ask you to think about the person needing nursing home care and their families, the vulnerable nature of those receiving and in need of nursing facility care. They have enough challenges to manage, and to have them worrying about another layer of approvals or denials and care and payment isn't right. We are not opposed to change. We have Vetter team members who are part of a committee with the Nebraska Health

Care Association team to modify the methodology in a way that simplifies the payment structure. Allow us as providers to be part of the solution moving forward. There are examples of states across the country who have taken a knee-jerk approach to implementing Medicaid managed care and long-term care, and the results are disastrous. It takes time to make changes in a way that does not jeopardize Nebraska's access to care. Our seniors in Nebraska deserve for us to take a collaborative and well-thought-out app-- strategy. Thank you for your time and consideration. I'd be glad to answer any questions.

HARDIN: Thank you. Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. My question is on the example that you used with the clawback in Iowa after a five-year case, was the burden of proof then on the home or--

BRIAN STUHR: Yeah. Yes.

RIEPE: --so they could claim any time something and you, you had to go back and dig into files and research this thing and to, to prove that you had provided the service, which could go back to medical records. And a lot of-- it could be very time-consuming.

BRIAN STUHR: You're absolutely correct.

RIEPE: Is that right?

BRIAN STUHR: Yes, it is. You're absolutely right. Yeah. The burden's back on us to make sure that we try to keep the money--

RIEPE: Is there anything like a statute of limitations on it that--

BRIAN STUHR: Typically within the contracts, but they always still try to come back and claw things back. Just-- no different than even prior authorization. Just the, the administrative burden of, of going through all that.

RIEPE: OK. Well, thank you very much. Tough business.

BRIAN STUHR: Thank you for the question.

HARDIN: Senator--

RIEPE: Thank you, Chairman.

HARDIN: We'll take Senator Meyer.

G. MEYER: Thank you for being here today. On this clawback, I'm just curious. Is it a one-time payment clawback? Is it a clawback concerning someone over a long period of time?

BRIAN STUHR: It can definitely vary. In this case, it was two individuals that they were trying to claw back. Sometimes, they-- they'll try to claw back an entire month, potentially. Every situation's different.

G. MEYER: So it's, it's not like you're clawing back a year or anything along those lines.

BRIAN STUHR: Typically, you don't see that.

G. MEYER: It's just kind of a specific-- perhaps a coding error or something along those lines.

BRIAN STUHR: Correct. Yeah.

G. MEYER: Thank you.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. So I, I just want to make, make sure I'm understanding ki-- kind of some of what you're saying. So what I'm hearing is, like, obviously, payment in long-term care facilities can be pretty complex, right? There's individual providers, agency providers. It kind of goes across the spectrum. I, I guess in my hearing, I-- like, your concern is that if there was a transition to MCO payments rapidly that that could possibly compromise-- help just tease that out a bit more for me. I just-- I, I came in a bit late, so I apologize--

BRIAN STUHR: Yeah. No, absolutely. And I think to, to my previous colleague, it really delays payments in general.

FREDRICKSON: OK.

BRIAN STUHR: So typically in the state of Nebraska now, when we bill at the end of a month or the beginning of the next month, we receive payment fairly quickly. Usually, it's in 7 to 10 days, definitely within 30 days. What we've seen in other states-- specifically when we operated in Iowa-- we saw those payments extend all the way out anywhere from 45 to 90 days plus.

FREDRICKSON: OK.

BRIAN STUHR: And so it definitely affects cash flow of an operation and really does put your operations in jeopardy to, to sustain uper-- operationally.

FREDRICKSON: OK. And do you know other states that have gone through a process like this?

BRIAN STUHR: Yes. Well, of course Iowa. Minnesota, I believe, also has Medicaid-- of course Kansas. I believe Illinois does as well.

FREDRICKSON: OK.

BRIAN STUHR: There's several states that have gone down that route.

FREDRICKSON: And any kind of key lessons we can learn from those transitions?

BRIAN STUHR: Definitely not to transition to Me-- Medicaid managed care for long-term care services, but it's pretty consistent across the board from, from what we've seen personally with other states. And, and things have not gotten better from what-- our understanding.

FREDRICKSON: OK. Thank you.

HARDIN: Senator Riepe.

RIEPE: Chairman. I'd like to focus on Iowa a little bit.

BRIAN STUHR: Mm-hmm.

RIEPE: How long have they been doing this? And have this kind of--

BRIAN STUHR: That's a great question. I have to refer to my colleagues that may know behind me, but at least, at least probably seven years, I would say.

RIEPE: Yeah. How many nursing homes have closed because of the cash flow issue?

BRIAN STUHR: In Iowa? I, I don't have that number.

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

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chairman. Just curiosity. And you might have addressed this and I, I might have missed. Your average population of Medicaid patients, is there--

BRIAN STUHR: 40% of our population. So a little over 4-- a little, little over 700. Yep.

G. MEYER: I know you have-- I believe you have a facility in Emerson, Nebraska, which is in my district, so. And I did tour that. Very, very nice facility. Very impressive. So--

BRIAN STUHR: Thank you.

G. MEYER: --as far as, as having-- for cash flow purposes, is there an average that you need as far as percentage of beds filled to make a particular facility cash flow? Or does it vary between, vary between facilities?

BRIAN STUHR: Definitely varies between facilities depending on the location of that operation, of course the wages and the-- where those wages are.

G. MEYER: [INAUDIBLE] private, private pay--

BRIAN STUHR: Absolutely. The, the payer mix is a huge component of that as well. You know, we try to serve as many patients as we can. And at-- you know, payer source we try to take every, every patient that we possibly can.

G. MEYER: Thank you.

BRIAN STUHR: You're welcome. Thank you.

HARDIN: Seeing no other questions. Thank you.

BRIAN STUHR: Thank you.

HARDIN: Proponents. Welcome.

MARK SROCZYNSKI: Hello. Good afternoon, senators. My name is Mark Sroczynski. That's M-a-r-k S-r-o-c-z-y-n-s-k-i. I'm the chief operating officer for Emerald Healthcare Consulting. I'm testifying today in support of LB832. LB832 proposes a two-year review period allowing post-acute and long-term care nursing homes and managed care organizations to work collaboratively to prevent unintended

disruptions to patients and operations. Emerald Healthcare provides consultant services to nine post-acute long-term care facilities across Nebraska, including Omaha, Lincoln, Columbus, Grand Island, and Cozad. Our services include expert advice based on best practices, policies, procedures, ongoing clinical and operational advice, and guidance. Our teams include a chief nursing officer, regional nurses, administrators, directors of business development, and other key leaders. This-- facilities we support care for approximately 800 individuals each day, 80% to 85% of whom we have are Medicaid beneficiaries. These facilities routinely accept patients that other providers won't do due to behavioral, social, or clinical complexity, relieving the hospitals from overcrowding. Let me make this point: these facilities care for patients who would otherwise remain in a hospital. These facilities operate under-- un-- under significant financial pressure. Current Medicaid reimbursement rates fall below the actual cost of care, and a rapid transition to managed care-- managed Medicaid could cause a disruption. Potential risks include financial instability, administrative burden, delayed care, challenges with high-cost patients, lack of transparency, claims denial, audits, and clawbacks. Financial stability is a critical concern. Under Medicaid, payments are typically received within seven days. Under managed Medicaid, payments could be delayed beyond 7 days to exceed 90 days. This could create a cash flow challenge affecting payroll, vendors, and other services. There is also concern that MCO-negotiated contracts may reduce reimbursement rates much below the Medicaid levels. Administrative burden and care delays are additional concerns. Facilities would need contracts for multiple MCOs, each with unique requirements. Preauthorizations required for post-acute and long-term could delay patient transitions. High-cost patients and transparency are also at risks. MCOs may hesitate to reimburse severely acute patients, and it is unclear whether they would be required to publish payment methodologies or comply with the same transparency rules as Medicaid. Claims denial, audits, and clawbacks would further disrupt operations. LB832 provides a two-year period for stakeholders, including Emerald Healthcare, to work collaboratively with the MCOs to address these concerns. This is not an argument against managed Medicaid. This is a testimony to ask for a smooth transition without disrupting patient care or facility operations. Questions?

HARDIN: You mentioned a couple of times-- and if you'd just unpack it for us for the record-- high-cost patients. Obviously, we're not all the same size and shape and have the same list of challenges, but can

you kind of give us an overview of what that range of-- can look like in improving cost?

MARK SROCZYNSKI: Yeah, sure. So a, a-- in Nebraska, we have a, a case mix index, a CMI. That rates the acuity of the patients. Your high-cost patients will be people on psychotropic medications. Your cancer treatments, your IV medications, those would be considered very high acute patients.

HARDIN: OK. And to give us kind of a back-of-the-envelope idea, when we're talking high cost, are we talking twice as expensive as the lowest end, three times as expensive?

MARK SROCZYNSKI: We take patients that we don't make any money on. First of all, we are $20 below, based on our cost reporting, of all nursing. It's about $20 dollars below what the-- what Medicaid pays us.

HARDIN: OK.

MARK SROCZYNSKI: So you will have patients that come in and they'll be high-cost medications through pharmacy, for example. It is not uncommon for us to be on the opposite end of revenue for a patient. Not uncommon.

HARDIN: Other questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for your testimony. So I, I, I guess what I'm trying to terse out from what I'm hearing a bit is, do, do you have a sense of what would be a preferred timeline for this? I mean, what, what do you think would be, like, best practice?

MARK SROCZYNSKI: Within seven days.

FREDRICKSON: Within seven days.

MARK SROCZYNSKI: If Medicaid can do it, then MCOs should be able to do it.

FREDRICKSON: OK. Thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. You listed the-- your consulting group. A number of hospitals-- or, hospitals of-- nursing homes.

MARK SROCZYNSKI: Right.

RIEPE: Are those all in the state of Nebraska?

MARK SROCZYNSKI: They are.

RIEPE: Do you have any, any clients that are under Medicaid management?

MARK SROCZYNSKI: Do we have any current--

RIEPE: Like Iowa. Do you have any in Iowa or Kansas?

MARK SROCZYNSKI: Well, Emerald Healthcare is, is primarily based in Nebraska, but we have other consulting responsibilities in Oklahoma, Kansas, and Kentucky.

RIEPE: So you have some experience in working with nursing homes that have to get preapproved by managed care organizations.

MARK SROCZYNSKI: Ye-- yes, when those come about.

RIEPE: Then that leads me this way. On a preapproval, every time the acuity changes of the patient, do you have to get a preauthorization from the managed care organization? Or would your clients, I mean.

MARK SROCZYNSKI: Each time that there's a change in service and care of that patient, we would need preapproval. I don't think so.

RIEPE: You-- OK.

MARK SROCZYNSKI: I don't think so.

RIEPE: [INAUDIBLE] concerned about denials. What do you do?

MARK SROCZYNSKI: Well, well-- yeah, what do you do? So you're going to get a audit, you're going to get a, a request for more documentation. Think about your HMOs that you have. If you have a UnitedHealth plan now, it is not uncommon for any HMO to come through and explain that we need more documentation to support the payment that we're-- you're asking for. Well, OK, but that takes a lot of effort and a lot of time and a lot of heavy lifting. You need a-- your standalone organizations are going to struggle the most. They

don't have the bandwidth that a larger corporation would ha-- or company would have or consulting company would have. So those-- i-- if, if that answers your questions. I, I-- is-- does that answer your question that you're looking for?

RIEPE: It does answer my question that ou-- if you upgrade their care and start billing it, that they're-- they want to approve it before you do it.

MARK SROCZYNSKI: Yeah. Let's take it on the reverse end. Worth-- with Medicaid now when we have a change in service when a patient becomes immu-- more acute, for whatever reason, we can capture that appropriately through our MDS, multidata set, and we would bill Medicaid for those services. And whatever we're doing more would equal the reimbursement more for that patient. Underneath a managed Medicaid, I am unclear what that would look like.

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

HARDIN: Other questions? Thanks for being here.

MARK SROCZYNSKI: Thank you very much.

HARDIN: Proponents, LB832. Welcome.

TYLER JUILFS: All right. Good afternoon. And thank you for the opportunity to speak today. My name is Tyler Juilfs, T-y-l-e-r J-u-i-l-f-s. And I represent Ambassador Health, a family-owned health care organization that has served Nebraska for over 50 years. Nebraska has a history of prohibiting managed care organizations from over-- overseeing traditional long-term care. And as a result, most nursing homes in this state are not subject to M-- MCO oversight. Ambassador Health is different. Because of the highly specialized, medically complex care we provide-- particularly pediatric, ventilator, tracheostomy, hemodialysis, and rehabilitation services-- we are one of the very few providers in Nebraska that routinely operates under managed care review. This gives us a unique perspective on how MCO policies function in practice and why extending protections through LB832 is necessary to prover-- to preserve access to high-quality care in Nebraska. Like many providers, we have adapted to decades of health care policy changes. One of the most significant was the rise of managed care organizations introduced to control cro-- cost primarily through prior authorization. Research shows prior authorization can reduce

short-term spending, but it also frequently delays medically necessary care, creates major administrative burden, and shift cost on to providers. Ambassador Health provides around-the-clock nursing and respiratory care for medically complex infants and children with the goal of stabilizing them safely, transitioning them home. Yet we repeatedly face denials from MCOs claiming continued care is not medically necessary. In most cases, those denials are overturned on appeal by independent medical reviewers, raising serious questions about the initial decision. Today, Ambassador Health employs over 500 people and cares for approximately 300 pat-- for 300 patients, each covered by different payers with different rules. Every MCO maintains its own provider manuals, documentation standards, portals, timelines, and appeal processes, often updated with little or no notice. Minor technical errors or missed deadlines can result in nonpayment even when the care was appropriate and successfully delivered. MCOs do not provide care. They do not staff facilities or manage ventilators or medically fragile children. They control cost, often by shifting administrative and financial risk onto providers, particularly independent ones. Family-owned, high-quality providers don't consolidate because they fail on quality. They consolidate because policy-driven complexity makes independence nearly impossible. I support LB832 and urge the committee to extend the prohibition of long-term care services to managed care. Thank you.

HARDIN: Thank you. Questions? Senator Meyer.

G. MEYER: I, I don't mean to be facetious about this, but given all the testifiers and the challenges you face, why do you do this?

TYLER JUILFS: Yeah. We, we love to provide compassionate care. Yeah.

G. MEYER: I, I, I, I figured that was the case, but given, given the, given the operational complexities of it, all I can say is bless you for doing what you do.

TYLER JUILFS: Thank you.

G. MEYER: It seems like everything's a roadblock, and doing-- helping people probably is the one thing that you get certain satisfaction out of, so. I don't know if I-- I don't know if I could do that, so.

TYLER JUILFS: Appreciate it. Thank you.

G. MEYER: Once again, not trying to make fun of this and not, not trying to be facetious about it, but it-- thought it was a fair question.

TYLER JUILFS: Yeah.

HARDIN: Paint a picture for me. You've got 500 profi-- providers for 300.

TYLER JUILFS: Yup. 500 amazing associates. Yup. Yup.

HARDIN: So you handle, as you say, medically complex situations for kids.

TYLER JUILFS: Mm-hmm. Yep. And I'll, I'll clear that up. We have one ca-- we have one campus, and it's called the Ambassador Omaha.

HARDIN: Uh-huh.

TYLER JUILFS: It's north of Creighton Prep.

HARDIN: OK.

TYLER JUILFS: And we take care of about 45 medically complex kiddos.

HARDIN: OK.

TYLER JUILFS: And that's real, real high acuity care. They're on ventilators. They might have a tra-- trach. Again, med-- medically complex. And so, you know, your staffing, you have respiratory therapists. You have RNs. You might have one nurse for every four or five patients, one respiratory therapist for-- one for every, you know, six, six or-- you know, patients. So it's, it's much more acute. There are a lot more resources for those kiddos.

HARDIN: Right. The only one in Nebraska?

TYLER JUILFS: Yeah. We-- the wo-- the only one in Nebraska. We take care of kiddos pretty much in all the bordering states, South Dakota, North Dakota, Wyoming, Kansas, Iowa, Colorado. Yeah. We've do-- we've done a lot of patients. Yup. Dif-- various states.

HARDIN: Very well.

TYLER JUILFS: Yeah.

HARDIN: Questions? Senator Riepe.

RIEPE: Thank you, Chairman. I just want to test out a little. On your prior authorizations, is that similar to the way that medical care and ho-- phys-- physicians and hospitals work? If you get a denial from-- and usually, it's not a medical-- may not be a medical person that gives you the data. Then it gets appealed to a physician who reviews it.

TYLER JUILFS: Yeah.

RIEPE: How much time are we talk-- can that happen in 72 hours?

TYLER JUILFS: Yeah. It's, it's-- no. Well, it's-- depends. I mean, each, each scenario's a little bit different, but for us, every state's different in, in how you work with them. We'll, we'll go to Iowa. Iowa's mentioned a few times. When we get a referral from a, from a patient, we enroll as a provider. So Ambassador Health enrolls with the state of Iowa. There's a, there's a contract. And the state of Iowa is an MCO state. So they have three MCOs. So once you're enrolled, then you give the lovely opportunity to go to those MCOs a-- and have a provider agreement. And based on if their member is a referral, then you say yes or no and you start to-- you know, you provide care. The prior authorization in most cases, which, which is unique-- the prior authorization for us for one patient is you get a prior auth to take care, room and board direct care. You need a prior auth for PT, physical therapy. You need a priority auth for OT, occupa-- occupational therapy. You need a prior auth for speech therapy. So in a lot of cases, these kiddle-- kiddos are very complex. So we will need four prior authorizations. Throughout that stay-- for-- that stay can range from a year to three years, six months. I mean, it-- it's a big range. It's, it's very complex. The goal is to get that kid a home with mom and dad, to educate them to go through our entire process. But almost every time, we will receive a denial at some point. So when you receive that denial, you do a peer-to-peer, right? Or you go through what most states call a QIO. A QIO is an independent medical reviewer. The MCO in most cases will issue that denial. So you're sitting there. They're creating fear because, if that denial holds up, that's extremely problematic for the provider, for the family. Where does the patient go? No one really has an answer. They might have case managers, but I've never had a case manager say, we have found placement for this kiddo. Also, you need a physician order to sign a safe transition home. If the

physician's not saying they're safe to go home, you're kind of in a pickle.

RIEPE: Mm-hmm.

TYLER JUILFS: But also, all those cases, as I testified here, those QIOs approve that care. They provide the prior authorization. They ultimately authorize that, and that is-- that's a long process.

RIEPE: They may impose a fee less than what you think is reasonable [INAUDIBLE] prior authorization? Is that fair to say?

TYLER JUILFS: No. I mean, the fee's the fee for us.

RIEPE: OK.

TYLER JUILFS: You know, I've never seen the fee-- now, they don't pay. I know that might be different. But as far as the fee, most states-- most MCOs will adhere to what the state rates are, in, in our experience.

RIEPE: The other concern, if I may, Chairman, is if the state contracts it out and in essence, by turning it over to a managed care organization, they're going to have a return on investment of probably 5% or 6%, maybe.

TYLER JUILFS: Yeah.

RIEPE: The question that I have here is, give me the names of the number of state employees that have been doing this and-- you know, so we can have a going-away party for them.

TYLER JUILFS: Well, I've--

RIEPE: Because otherwise, all we've done is layer in another cost level.

TYLER JUILFS: I, I do think-- I've worked with the Department of Health and Human Services here in Nebraska, and, you know, I, I think they do a great job. I think they're very qualified, so.

RIEPE: Well--

TYLER JUILFS: I, I-- yeah. I think they do a great job. So forming it out is always, to your point, interesting to me.

RIEPE: Thank you.

HARDIN: You brush on this a little bit earlier at the beginning of Senator Riepe's question, but turnaround time for Medicaid, I'm sure it varies. And as you were indicating, state to state, things change, but do you have kind of a sense as an average if you had to guess as to how long it takes for a, a turnaround time with Medicaid?

TYLER JUILFS: I could-- let me get back to you on that.

HARDIN: OK.

TYLER JUILFS: Yep.

HARDIN: All right.

TYLER JUILFS: Gre-- it's a great question. When things go smoothly, it's, it's fine, no issues, but.

HARDIN: Whatever that is.

TYLER JUILFS: Yeah. When you get the hiccup-- I, I can get back to you.

HARDIN: Senator Quick.

QUICK: Yeah. Thank you, Chairman. Have you ever had to face-- I know we heard about clawbacks. Have you ever had an issue with that or had to deal with anything like that?

TYLER JUILFS: Yeah. That denial process, sometimes they go ahead and, and pay you. And then you go through their appeals process or their reconsideration process. And, you know, it's, it's a long, long process. Sometimes you're paid, sometimes you're not paid.

QUICK: OK. But there's-- you haven't had a-- where they've come back and you've-- they've been paid the money and then now they're saying, we're going to take it back because you didn't fill something out right or--

TYLER JUILFS: Yeah. We're going through that right now.

QUICK: Oh, you're going to that right now?

TYLER JUILFS: Yeah.

QUICK: OK.

TYLER JUILFS: Yeah.

QUICK: All right.

TYLER JUILFS: Yes. So it's a long process. I think so-- very-- as far as the claims go, we've-- in that case, we've been paid and we're going through reconsideration. Reconsideration, you have X amount of days-- I want to say 60-- and then they have X amount of days to, to return. And then you go through the appeal. If you lose there, you go through the appeal and there's more days and more days, so.

QUICK: OK.

TYLER JUILFS: Yeah.

QUICK: All right. Thank you.

TYLER JUILFS: It's not 24 hours.

QUICK: Yeah. Yeah.

TYLER JUILFS: Yeah.

QUICK: All right. Thank you.

HARDIN: Thank you.

TYLER JUILFS: Yeah. Thank you.

HARDIN: Proponents, LB832.

JALENE CARPENTER: Good afternoon.

HARDIN: Hi, Ms. Carpenter.

JALENE CARPENTER: Hello, Chairman Hardin and members of the Health and Human Services Committee. My name is Jalene Carpenter, J-a-l-e-n-e C-a-r-p-e-n-t-e-r. I'm the president and CEO of Nebraska Health Care Association. Today, I am representing our 386 nonprofit and proprietary skilled nursing and assisted living community members in support of LB832. Thank you to Senator Hansen for introducing this legislation. I'm going to try to hopefully give some context and answer questions that have come up. To Senator-- I'm trying to think of who it was-- Fredrickson about the methodology and the complexity,

so the current methodology, there are 25 different levels of care. A resident's level of care can change monthly, and they're able to capture that if there is a change of condition for that resident. We have found in other states that that complexity is incredibly difficult when transitioning from the one payer of the state to three individual payers. When it comes down to cash flow and timeliness of payment, there was a recent cast report-- cost report data published by American Health Care Association for Nebraska facilities ending 9, 2025. And it showed that Nebraska nursing facilities currently have 25 days cash on hand. They bill in a 30-day cycle. So putting any sort of strain on their cash flow would be completely disastrous. Also, when you look at the nation, nationwide, nursing homes have an average of 71 days cash on hand. I'll be quite candid: the managed care organizations are paid in ad-- advance. So they're paid in advance per month, per me-- per member. And then-- essentially, they have three ways to make money. They have-- they can deny care. They can deny prior authorizations, deny claims, or they can reduce provider payment and simply pay us less than what we were paying-- being paid by the state. When an individual resides in a nursing facility, their care is managed. Quite literally, they are incentivized for being as healthy as possible for as long as possible. Positive healthy outcomes is the business that we are in. It is only in the financial interest of a facility to have a resident as healthy for as long as possible. I would like to thank Senator Hansen for introducing this legislation. Oh, I will add: Iowa had 47 closures in the last five years. I would echo Senator Hansen's disappointment that, at the last minute, that we were not able to come together and have a collaborative decision on this bill. I will tell you that we strive to act in good faith and our-- honor our commitments. So it is disappointing the department appears to oppose this bill because of-- we were unwilling to come to some negotiation on some other specific language. I appreciate the committee and will answer any questions.

HARDIN: Questions? How many homes does Iowa have? They closed 47 in five years.

JALENE CARPENTER: I would have to get that number for you.

HARDIN: Hopefully they didn't ha-- they had more than 47.

JALENE CARPENTER: I think they had more than 47.

HARDIN: OK. That's a lot.

JALENE CARPENTER: Yes.

HARDIN: All right.

JALENE CARPENTER: It is.

HARDIN: There are no other questions. Thank you. Proponents, LB832. Opponents, LB832. Welcome.

DREW GONSHOROWSKI: Hey. Thanks for having me. It's nice to be back. Good chair-- good morning, Chairman Hardin 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 LB832. All of us are, are aware of the challenges facing the nursing home and home care industry as well as all industries serving aging and disabled populations across Nebraska. We need to do everything we can to ensure our families and neighbors have access to the care they need and at the highest quality. In our current system, nursing home care is paid differently than every other aspect of a member's care. The disjointed payment from two different sources, managed care organizations and state fee-for-service, leads to barriers in the continuity and coordination of care. We are actively engaged with providers and patients on these issues in hopes that we can make thoughtful changes to improve the lives of Nebraskans. LB832 as written would remove some of the flexibility the Medicaid program has to address changing trends and beneficiary needs through our contracts with the MCOs. The traditional long-term care model is no longer sustainable, and I worry that clinging to the status quo will only perpe-- perpetuate the problem. We need to be innovative to meet these challenges, and moving long-term care into managed care has shown promise in other states. Looking at the broad landscape of long-term care services, we cannot afford to take any tool off the table. I am confident that, with the engagement of stakeholders and the legislator, we can make changes to meet the needs of our fellow Nebraskans. Thank you for your time. I'd be happy to answer of the que-- any questions on this bill.

HARDIN: Thank you. You made one statement which was "the traditional long-term care model is no longer sustainable." It seems like there's more to share about that from your perspective. What does that mean?

DREW GONSHOROWSKI: So, so ultimately, I think that-- and I think that this is across the country-- and, and I also just want to lead off by saying that I have toured long-term care facilities in the state and I've met with, with some of the previous testifiers today, and I, I am always just heartened by the amount of care that they take in terms of caring for the members that they serve and caring for the aging population here in Nebraska. It really truly is just a, a great-- and I, and I, and I think back to the specific interactions. I-- if you would have told me that I was going to be shown pride around an HVAC sy-- HVAC system and that level of detail all the way down to the granular level in terms of the pride that-- and the quality that our long-term care facilities across the state provide, I would have been-- I, I was shocked having seen other facilities in other states. I also will say that benchmarking to Iowa, I've learned very quickly as, as an honorary Nebraskan it's not always the best place to start. But, but I do think there are sort of broad issues in long-term care space, and I think ultimately it, it goes down to the individual. It's a question of where that individual wants to spend out their days. And the system has an act-- should have an active conversation around where they want to be and also what is mes-- medically necessary for them. In, in many states, that conversation includes, I think, a more vigorous conversation around home-- home-based care. Nebraska ranks in the bottom quartile in terms of the percentage of LTSS users, or long-term services and supports. Actually having home- and community-based services, I think we are seventh, seventh lowest in terms that percentage. And, and just, just to highlight that, it's-- you know, ultimately, we've all had people that have, you know, had to interface either with long-term care in, in some aspect. And so many people-- we want to ensure that we have that conversation where it's-- you know, if they want to age in their home and we can provide those supports, that, that is ultimately the goal. Or if they want to be in a long-term care facility when, when their need rises or their preference rises, we want to be able to have that full, transparent, and open communication.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Director, for being here and for your, your testimony. I can certainly appreciate some of your comments. I'm, I'm kind of balancing that with some of what we heard from some of the proponents of the bills and specifically as it relates to, you know, the, the complex nature of, of, of payments in, in the-- in these facilities. And I guess I'm kinda curious to hear your perspective on what, what do you feel is-- do you feel it's

realistic to switch under the MCO umbrella without interrupting reimbursement?

DREW GONSHOROWSKI: So, so that is-- that's a great question, Senator. And I think, I think the theme of-- my view, my view on this is ultimately that Nebraska is unique in terms of the care. And, and really happy to hear that my team that manages this-- which is a very small handful team-- manages this complex program that-- for the, for the NFs is, is roughly $450 million and, and broadly in the system is $750 million a year. The, the point here too is that it is a conversation around what the best approach could be and a careful, open, transparent conversation around, you know, what is the actual needs of our members. I-- I'm confident that, as we've worked with our, our long-term care partners in terms of our current situation, if the path in terms of-- and all we're asking here is to be able to consider a carve-in of long-term care over the next two years. It isn't about specific timings. It's about just having the conversation of what's best for Nebraskans. And I'm confident if that is the best approach, if we arrive on that, we're able to usher a process through here unique to any other state. I, I think that there is some examples of positive transitions to long-term care. I, I talk often with, with folks experienced in Tennessee. I also think that there is confe-- confounding factors in states that often aren't just within the system and you have to think holistically. I know Kansas was doing, at least my understanding, was doing some sort of update-- large update to their eligibility system along with [INAUDIBLE] care. You have to be careful about those details because, at the end of the day, not being careful about these details negatively impact our most vulnerable citizens.

FREDRICKSON: Sure. I, I guess my, my concern primarily lies in-- you know, obviously, this is a area where we already struggle to have access to care, availability of care especially in rural parts of the state, you know. And, and we're hearing from experts in the field who are sort of in the trenches the, the possibe-- possible detrimental impacts that delays in reimbursement or payments can, can have. And so it, it, it feels like a bit of a gamble.

DREW GONSHOROWSKI: Yeah. And, and in terms of the MCO situation in the state, I-- I'd have to get the exact number, but, but I believe that 95% of our payments happened within ten days for managed care as it stands currently. And we do have the contractual devices to point them to say, OK, this is your timeliness requirement for a certain percentage of, of the services. And if they don't hit that, there is

very clear contractual actions and also monetary penalties that we could apply in those spaces. So we can hold them accountable. And what is I think genuinely unique to Nebraska in terms of how we interface with our managed care programs-- we have three managed care plans in the state. And those three managed care plans, it is very rare for all, all managed care plans in any state to sit together and try to work out a solution. And that is the expectation in Nebraska. I can talk to my peers across the country and they will just not even-- they'll be like, I have 15 meetings with MCO plans this week, because each one comes in with their own interests. And these plans will sit together, they will openly disagree, and they are more transparent than what I would have expected over the past year in that process.

FREDRICKSON: OK. Thank you.

HARDIN: Senator Riepe.

RIEPE: I guess what I would like to have is some assurance that-- to take on the added cost of having managed care manage this and-- that I would want to see an offset in state employees that match dollar for dollar. Because if-- you can't have two people doing the same thing. If I don't know who's managing it now, maybe it-- that's obviously within your division.

DREW GONSHOROWSKI: Mm-hmm.

RIEPE: But if you're gonna throw on another, pick a number. If managed care makes-- the three of them collectively make $50,000 a year, then I wanna see $50,000 a year specifically out of your division of employees that are now, quote, unquote, now doing that same service.

DREW GONSHOROWSKI: No, and, I, I understand that, Senator. And I al-- and I also--

RIEPE: Can you guarantee me that?

DREW GONSHOROWSKI: I-- I'll, I'll also add that, as it stands currently, there is staff that is working on long-term care. And, and, and I will say that they do a great job, but they, but they do wear multiple hats. So they, so they-- that is also an issue here too in terms of the continuation of-- or, the continuity of care, right, is that the resources that the state does not have in terms of case management, in terms of continuity of care that, that could also be

brought in, in other different payer models. I, I would also add that I-- I'm always open to talking about how we can guarantee efficiencies and find efficiencies when we move to different cases.

RIEPE: I'd like to move beyond talk on this-- and I've worked with managed cares a lot-- care organizations a lot, and part of their role and everybody's role in health care has to be continuity of care. If you don't have that, your system will fall apart. So I-- I'm, I'm a skeptic on it in terms of-- first of all, I think it's a different set of knowledge skills about acute care, managed care, which is what the managed care organizations do, and what long-term geriatric care is. It's a whole different deal. But-- again, thank you, Chairman. Thank you. I appreciate you being here.

DREW GONSHOROWSKI: Yeah. Thank you.

HARDIN: Senator Quick.

QUICK: Yeah. Thank you, Chair. And maybe my question isn't so much about the MCO, but you made a comment about maybe transitioning-- transition to more in-home care. So my question is more like-- so, like, this is so-- like the A&D waiver we're reducing the number of hours. That really doesn't promote in-home care if we're gonna cut the number of hours that people can receive in their home. And some of those people might end up in a facility. You know, if they're re-- if they're on a ventilator or if they are on a feeding tube and things like that. So-- you know, I'm ju-- I don't know if you want to comment on that or--

DREW GONSHOROWSKI: Yeah. And, and-- so my, my comment is, is around sort of where, where someone would decide to age in place. And, and it's building a system, and I think that there's opportunity to innovate in this space to ensure that, that someone that is, you know, considering moving into a nursing facility or staying in their home as they age. I, I think that there's opportunity to add services or think about what the service array looks like in that space to support them staying in the home. Obviously, acknowledging that is a con-- a, a constant conversation around safety and well-being. But, but that was sort of the nature of my comment, where, where I think there is really opportunity to work collaboratively around everyone-- with everyone providing care in this space to, to figure out some, some better solutions or more solutions.

QUICK: All right. Thank you.

HARDIN: Senator Ballard.

BALLARD: Thank you, Chair. Thank you for being here, Director. You used terms in your testimony such as coordination, continuity of care, flexibility. Can you kind of give real-life examples on what this transition-- what kind of flexibility would it provide the department? What continu-- is there a cost savings to, to this?

DREW GONSHOROWSKI: So I, I think it's, it's a, it's a reality that if someone is able to age in home longer there are savings associated with the cost of aging in home or, or on a, on a PM payment basis are, are cheaper. That often means that you have to have coordination around them. Best example I can think off of-- off the top of my head currently is sort of the conversation around med, med adherence. If you've ever been sort of tapped in as, as either an impromptu or a-- or, or a sort of de facto caregiver with an aging family member, you know, it's all about that sort of coordination, talking to the pharmacist, you know, giving a call, ensuring that they take the drugs on a specific day. I'm just trying to give a very simple example where-- when med adherence falls off, someone doesn't stay on the, the specific drug they need, you know, they're more likely to sort of decline and then fall into-- or, or have to move into a, a higher attention setting.

BALLARD: OK. And the transition to MCOs would, would help with that.

DREW GONSHOROWSKI: I, I mean, I think the question currently is-- I think that's a great question to ask. And that's, that's sort of where we are, is, actually considering all options. You know, actually having that conversation. Is, is the transition to MCO the best? Is staying with the status quo the best? Is there other pathways that, that could also be the best? I-- my, my personal opinion-- and, and I think the view of the division is that this is the time to have those actual conversations. And why we're coming in in opposition is specifically because it's cutting a large portion of that conversation right out. It's just saying we're not gonna talk about that.

BALLARD: OK. Thank you.

FREDRICKSON: Thank you, Senator Ballard. Any questions? Any remaining questions? Seeing none. Thank you for being here. Next opponent to LB832. Welcome.

ROBERT M. BELL: Hello, Vice Chairman Fredrickson and members of the Health and Human Services Committee. My name is Robert M. Bell, spelled R-o-b-e-r-t, middle initial M, B-e-l-l. And today, I am the-- acting as the executive director and registered lobbyist for the Nebraska Association of Medicaid Health Plans, or the association, whose members include the three current managed care organizations providing Medicaid coverage services under our contract with the Department of Health and Human Services, Molina Healthcare, and Nebraska Total Care, and UnitedHealthcare of the Midlands. The association is appearing today in respectful opposition to LB832. As you've already heard, LB832 seeks to bar the Department of Health and Human Services from adding long-term services and supports to the Medicaid managed care program until July 1, 2030. First, I, I would like to state my appreciation to Senator Hansen and to the members of the Nebraska Health Care Association for listening to the concerns of the individual members of our association and for the extensi-- extensive discussions that have occurred to date and perhaps will occur in the future. However, the association at this point must oppose any attempts to reinstate a moratorium on adding managed long-term care services and support to the Medicare program in Nebraska. Experience in other states-- which has been talked about-- in which Nebraska managed care organizations have sister health plans operating has shown that implementation of Medica-- Medicaid managed care for long-term care services and supports will provide enhanced, fully integrated coordination of care for individuals in need of long-term care services, help Nebraska control costs, and provide budgetary stability and provide superior consumer experiences by providing resources for home- and community-based services. Notably, 25 other states of a variety of sizes and political persuasions have successfully transitioned to managed care for long-term care services and support under the oversight of the various Medicaid agencies of those states and have achieved the goals of better care at lower cost and stronger fis-- fiscal predictability as well as improve customer satisfaction, all of which are to be expected if individuals are provided managed home- and community-based services alongside a residential care option. LB832 would restrict the state from moving towards this successful model until July 1, 2030. Previously, a moratorium existed from 2019 until 2023. In the two and a half years since the previous moratorium lifted, the state has not instituted managed long-term care services. And the association believes that it would be a mistake to prohibit the state from being able to move forward with this model before 2030 if the Department of Health and Human Services believes it is prudent and in the best interests of

Nebraskans. And I think the director already talked about this, but one final point I would like to make is that, should the, the state decide to move forward with managed long-term care services and supports, it will not occur in a vacuum or without notice or without the opportunity for feedback from stakeholders. There would have to be a significant ramp up in preparation for moving to managed care, which will include stakeholder input on the design as well as other preparatory activities. Additionally, approval from the Cent-- federal Center of Medicare and Medicaid Services would be required and completed before managed care can be implemented. For these reasons, the Association of Medicaid Health Plans respectfully opposes the passage of LB832. I appreciate the opportunity to testify. Thank you. And I'm sorry. When I have my readers on, I can't see the lights.

FREDRICKSON: You are OK. Thank you for your testimony. Any questions from the committee? Senator Ballard.

BALLARD: I won't let Rob-- Mr. Bell off that easy. It's good to see you in this committee. You, you talked about controlling costs. Can you expand on that? What, what is-- what can MCOs do that current payment systems cannot?

ROBERT M. BELL: That's a great question. You know, we, we talk about managed care, right? And we talk about managed care in a lot of different spaces in, in health, whether or not it's on the commercial side or, or the public pay side. And, you know, managed care is important because it saves money. I, I, I share an example from my own life where our dentist went off of managed care and decided he would only accept private-- he would only accept payment from the consumer. And my, my wife had been going to this dentist since she was a little girl, since she was-- first had teeth, right? This was a couple years ago. And I called her up, and she told me, we believe in managed care, which-- it's not-- a con-- you know, that's not a normal conversation between a husband and wife. But she happened to work for Ameritas and for Physicians Mutual Insurance, which, you know, work on managed care for dentals-- on the dental side. And we do that because we know that the services that we're going to get and that-- where everybody's joining are, are-- provide savings to those people that are part of that group, right? So over here, I think what we're seeing in other states on managed care is that there's this opportunity for these individuals who are already receiving medical services from the MCOs, right, or payment related to that, is that, that continuity of care can be expanded and, and, and we can look at

home- and community-based services. And that's been the experience on other states. And so that percentage flips a little bit of what amount of long-term care support and services is going to residential care versus home- and community-based services, is, is my understanding from the research I've seen from, from other states.

BALLARD: OK. I appreciate that. One more question if-- so we, we, we heard from proponents about denials of claims, about clean claims. Can you walk me through-- do you know what-- are 50% of those claims clean? Are-- I know that's a tough question.

ROBERT M. BELL: Yeah. The-- it is. And I, I think the director-- and I don't know. But I, I would say that, you know, there are prompt pay provisions currently in the contracts with the MCOs. And I, I think the director already talked about, you know, they have to meet certain benchmarks. And if they don't, there are penalties. And, and that's very common in, in managed care across all types of health care, right? If, if a payer doesn't meet those benchmarks and they are-- they have penalties that occur, so. Yeah. But I don't know how many times, like, a, a claim is denied. When I wake up at 4:00 in the morning and think about things, I, I don't think about the good things that happen to me. I only think about bad things that happen to me. And I, I think that might be the experience too of, of health care providers. They don't think about all of the claims that were approved. They think about the ones that are denied. And, and probably rightfully so, right, because they think there, there was obviously a disagreement at some point. And the ability to walk through that disagreement's going to take some time. And as you heard from the people that provide these services, you know, oftentimes, they win on those appeals, but not always, so.

BALLARD: Thank you. Appreciate it.

ROBERT M. BELL: You're welcome.

HARDIN: Other questions? Thank you.

ROBERT M. BELL: You're welcome. Stay warm.

HARDIN: Anyone else in opposition? LB832. Those in the neutral. LB832. Senator Hansen. We had online 38-- you win-- proponents, 0 opponents, 0 in the neutral.

HANSEN: 38? You're sure?

HARDIN: 38 is what it says.

HANSEN: I have 43.

HARDIN: 43. I have 38.

HANSEN: Thanks for-- what's that? Oh, OK. It was a lot.

HARDIN: It was a bunch.

HANSEN: Appreciate everyone listening to the conversation here. And I do appreciate the department and the MCOs both communicating to me beforehand about their opposition even though it was, like I mentioned before, a little disappointing that there couldn't be some kind of resolution beforehand. But I will be in further discussions with both entities and everybody here on the board about what we can do with this bill and answer questions at the best that I can why we kind of continue some of those discussions, so. Are there any questions for me?

HARDIN: Any questions? Seeing none.

HANSEN: That's easy. That's-- OK. All right. Thank you, Chair.

HARDIN: You bet. This concludes L-- LB832.