CLEMENTS: Good afternoon. Welcome to the Appropriations Committee. My name is Rob Clements. I'm from Elmwood, and represent Legislative District 2, which is Cass County and eastern Lancaster County. I serve as chair of this committee. We'll start off by having the members do self-introduction, starting with my far right.

PROKOP: Hi. Jason Prokop, Legislative District 27 in west Lincoln and Lancaster County.

M. CAVANAUGH: Machaela Cavanaugh, District 6; west central Omaha, Douglas County. Thank you.

LIPPINCOTT: Loren Lippincott, District 34.

DORN: Myron Dorn, District 30.

STROMMEN: Paul Strommen, District 47; nine counties, 10,500 square miles of western Nebraska.

CLEMENTS: Assisting the committee today is Cori Bierbaum, our committee clerk, and to my left is our fiscal analyst, Mikayla Findlay. And our pages today are Demet Gedik and Wesley Earhart, UNL students. If you're planning on testifying today, please fill out a green testifier sheet located in the back of the room, and hand it to the page when you come up to testify. Online position comments must have been submitted on the Legislature's website by 8 a.m. the day of the hearing to be included in the record. If you have submitted a comment online, we ask that you not testify in person today. If you will not be testifying, but want to go on record as having a position on a bill being heard today, there are yellow sign-in sheets at the entrance to my left. These sign-in sheets will become exhibits in the permanent record after today's hearing. To better facilitate today's hearing, I ask that you abide by the following procedures. Please silence your cell phones. Move to the front chairs to testify when your bill or agency is up. When hearing bills, the order of testimony will be introducer, proponents, opponents, neutral, and closing. When you come to testify, please state and spell your first and last name for the record before you testify. Be concise; we request that you'll limit your testimony to five minutes or less. 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 you need to wrap up your final thought and stop. Questions from the committee may follow. Written material may be distributed to the committee members as exhibits only while testimony is being offered; hand them to the page for distribution when you come up to testify. If you have written testimony but do not have 12 copies,

please let the page know so they can make copies for you. With that, we will begin today's hearing by opening a hearing on LB146 from Senator Ibach. Welcome.

TYLER MAHOOD: Good afternoon, Chairman Clements, and members of the Appropriations Committee. My name is Tyler Mahood, T-y-l-e-r M-a-h-o-o-d, and I am Senator Ibach's legislative aide. She sends her regrets that she cannot be here to open on LB146. LB146 is a simple bill, and it seeks to increase the provider reimbursement rates for dental services provided that are reimbursed by Medicaid by 12.5%, or approximately $7.8 million when combined general funds and federal funds. Knowing the budgetary constraints we are currently facing as a state, Senator Ibach knows this may be a hard sell to incorporate into this year's budget. However, she believes this is an important discussion to have to keep this issue under-- of-- under a reimbursement for dental providers and the lack of providers, primarily in rural areas, at the forefront of future budget deliberations. With that, I thank you for your time, and I would respectively ask that you defer any questions to those who are following me. And I will be waiving the close.

CLEMENTS: Yes, we will. Will you be here to close, did you say?

TYLER MAHOOD: No.

CLEMENTS: You will not. All right, thank you. Well, then, we welcome proponents for LB146. Please come forward. Good afternoon.

JESSICA MEESKE: Good afternoon. Dear members of the Appropriation(s) Committee, my name is Jessica Meeske; it's spelled J-e-s-s-i-c-a M-e-e-s-k-e. I'm the president of the Nebraska Dental Association, and I'm a practicing pediatric dentist in Hastings and Grand Island. I'm speaking in favor of the bill. First, I want to thank you for moving a similar bill last year through the body, where you ultimately and unanimously gave us 12.5% of the 25% rate increase we asked for. And my biggest fear wasn't in getting the bill passed last year; it was actually facing all of you this year and being able to-- being concerned that we hadn't moved the needle on access to care. But thankfully, I was wrong. Because of your July 1 rate increase decision, we've moved the needle a great deal in six months, and I'm going to tell you how. The total number of new dentists that signed up after the July 1 rate increase was 90. 90 is a big deal when we only have about 1,000 dentists in the state. The number of new children that were seen for a dental exam was about 10,000 kids, and the number of new adults was nearly 6,000. The number of children under three that we're seeing

for a new exam, that number rose greatly, and that's going to pay off big time when you consider how much earlier we're getting to these kids, getting to their parents, giving them information on how to prevent very severe early childhood cavities and expensive trips to the operating room to get their teeth fixed. The number of Nebraskans that had dental pain and went to hospital emergency rooms is down in the last six months by 500 visits. Think about the economics of this when you consider the average cost of one E.D. visit for dental-- not a traumatic injury like a baseball hitting a tooth, just a cavity, an abscess, infection. In one month, the cost savings to the state was $86,618. For that six months, July through December, it was $519,000, and for 12 months, if you were to annualize this cost savings, we saved the General Fund over $1 million. Furthermore, when a patient goes to the hospital E.D., they're not getting the root cause of their dental problem fixed, such as getting the tooth pulled. What they're getting is an antibiotic and a narcotic, and told to see a dentist, which they would have done if they were able to get into a dentist at a cost much closer to $150 for an office space visit. Furthermore, the ND-- the NDA and MLTC and the three managed care organizations were chosen by the ADA as one of six states in the country that is making a difference to become part of a pilot program to continue improving their dental Medicaid programs. And because of this partnership, we now have real-time data that we're sharing. So, instead of throwing money at, at the Medicaid program, now we have ADA's research arm saying, hey, if we pull a lever over here, like giving a rate increase, how is it going to impact care and access to care over here? And we now can do that more seamlessly. I want you to know we did thoughtfully consider various creative ways to invest dental Medicaid dollars, such as tagging on to the Prenatal Plus Program you passed last year. However, MLTC, the MCOs and the NDA, while were willing to work on these creative solutions, when I presented it to the collaborative group, we don't have the metrics yet and the billing codes to do that, but we're going to work on that next year and look at very specific projects. So, what I mean is this would be taking dental Medicaid dollars in the future and targeting it to those with the greatest need who would increase the cost, and how can we help them so we decrease Medicaid expenditures? Thank you for support-- your support and believing in Nebraska dentists to step up and make a difference in the lives of the underserved. We've been a good steward of these funds, and dental Medicaid is a sound investment in keeping people healthy and lowering the medical Medicaid costs for those with medical conditions exacerbated by poor oral health. Thank you, and I'd be happy to take any questions.

CLEMENTS: Are there questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here. It's so nice to see you again.

JESSICA MEESKE: Thank you.

M. CAVANAUGH: I miss seeing you in my old committee.

JESSICA MEESKE: I miss seeing you in your old committee, too.

M. CAVANAUGH: 90 dentists have signed up. I, I, I just highlight that because for six years, I have heard you come and testify specifically about pediatric Medicaid dentistry and what a struggle it is. So, in six months, we've increased by 90?

JESSICA MEESKE: That's right.

M. CAVANAUGH: That's, that's amazing. I, I just commend you for that effort. I know--

JESSICA MEESKE: Thank you. Because, you know, you know how bad I would have felt coming in asking for the money, and then I had nothing to show for it, or if the situation would have gotten worse. So, we're really starting to make strides, and we feel like if we can get people in for preventive dental visits, early detection of dental disease, you're going to pay a lot less than once it becomes a much bigger problem, and now I'm taking a child to the operating room because they have 20 bombed out teeth. Which I did four cases this morning before I came.

M. CAVANAUGH: Oh.

JESSICA MEESKE: So, it's, it's very common.

M. CAVANAUGH: So, the problem with the-- taking pediatric dentistry cases that are Medicaid-specific, those kids tend to have higher dental issues than a general population of kids, right? Is that accurate?

JESSICA MEESKE: A lot of times, yes.

M. CAVANAUGH: And so, in addition to the reimbursement rates for the dentists-- which has been, obviously, an obstacle, a barrier to entry for dentists-- are you seeing any improvement in the approvals for procedures for those-- that population of kids?

JESSICA MEESKE: Absolutely. So, one of the-- this is so exciting because I get to sit at the table at the national level and see what's

happening with dental Medicaid all across the country. I am so proud to sit before you and tell you Nebraska is the only state where our three managed care organizations work together collaboratively. If you were to go to Ohio, you'd have eight different companies all competing, not talking to each other, not sharing information. Our dental directors and our chief medical officers, the dental association and the Medicaid leadership, we get together monthly and we talk about what are the barriers to care, where are the problems, and so we're not having a lot of problems with procedures getting accepted; it's actually gotten much better. And if you can remember what happened with dental is dental used to be a carve-out Medicaid program. So, medical was separate, dental was separate. And then, what Mr. Bagley did when he was the director is he integrated medical and dental together. And why that's been helpful is where we're going to save you money-- it's not just on prevention and early detection of dental disease; it's when I help that mom who's pregnant that has periodontal gum disease, who can't get treated, who now is at risk of having a baby that is premature, low birth weight. To fix her dental problems is not expensive. For you to pay for a 24-week or a preemie baby, on the medical side, those hospital costs are going to be $400,000 to $750,000. So, if we can address the pregnant women's gum disease and get it under control before she goes into labor and has birth, we're going to hopefully save that baby from being premature and the additional costs to the state that it's-- that it would cost you.

M. CAVANAUGH: Well, thank you. I, for six years, have not heard-- I've heard a lot about the struggles, so hearing that things are on an upward swing is really nice, and I appreciate all your work in this area.

JESSICA MEESKE: Thank you. It's-- it is nice, because I've been in this arena, both in the policy space and, and practicing with-- on these kids for 25 years, and it is a very uphill battle to be able to make improvements. But we are now just making fantastic improvements, and we're being noticed nationally for what we're doing. So, thank you to you for the 12.5% increase you gave us last year. And we would like to just uplevel those fees to where dentists are not losing money, we get a critical mass that's participating, and we don't have these patients, particularly in your areas-- Ogallala, Sidney-- are traveling hours and hours to see a dentist. So.

CLEMENTS: Are there other questions? Seeing none. Thank you for your testimony.

JESSICA MEESKE: All right. Thank you.

CLEMENTS: Next proponent, LB146. Good afternoon.

JADE DOREMUS: Good afternoon. My name is Jade Doremus-- that is spelled J-a-d-e D-o-r-e-m-u-s-- and I am speaking in favor of the bill. As a mom, it has upset me that no dentist near me will take Medicaid. I have been trying to get my daughter into a dentist since she started getting teeth. WIC, which is another government program, wants children to see dentists at one years old to get cleanings. I was calling all surrounding areas from Hastings, Grand Island, Kearney to Geneva to get my daughter in to see a dentist. I called multiple times every year, and the answer every time I asked "Do you accept Medicaid?" and the answer was always no, or yes, but only in your-- in our county, which I did not live in. At the, at the time, my daughter did not have any troubles with her teeth, until now. She is almost five years old. She recently started to constantly cry in pain, stating "Mommy, my tooth can't get better." Yet once again, I got the same answer: "No." At the exact moment, I felt defeated as a parent. It took, it took having my daughter crying in pain and me crying on the phone for my daughter to be seen by a dentist. When the receptionist said "Yes, we could see her, but it will not guarantee for the dentist to take her on," in the split moment, I was relieved to have heard "yes," but worried that I would be back to square one of finding a routine dentist for my daughter. When I took my daughter to the specialist dentist in Hastings, Nebraska, she was terrified to have an X-ray done, or even have teeth-- her teeth looked at. On March 3, she had to go under general anesthesia to get her tooth capped; that was the initial plan. However, while she was under the anesthesia, I found out that her tooth was so decayed that it had to be removed at almost five years old. My heart sank, and I started crying again, feeling defeated and like a terrible mother. But it was the system of dentistry not accepting Medicaid that had failed my daughter, not me. Most or all of this could have been prevented if more dentists near Hastings, Nebraska accepted Medicaid. No parent or child should ever have to go through this, and it should not be a hassle for kids on Medicaid-- or really anyone on Medicaid-- to be seen by a dentist. Thank you.

CLEMENTS: Are there questions? Seeing none. Thank you for your testimony.

JADE DOREMUS: You're welcome.

CLEMENTS: Next proponent. Good afternoon.

HEIDI STARK: Good afternoon. My name is Heidi Stark; it's H-e-i-d-i S-t-a-r-k. I'm one of eight board-certified pediatric dentists with

Lincoln Pediatric Dentistry here in town. I started Lincoln Pediatric Dentistry 21 years ago. We have always taken care of children with Medicaid because we care for everyone, regardless of who they are and how they can pay. We call this compassion for all people. I'm testifying today in support of LB146. Our practice in 2024 saw 10,752 children on Medicaid; this made up 38% of our practice. We cannot increase the number of children that we see on Medicaid because of the rising costs of providing care to the patients. Since COVID in 2020, the expense of caring for these patients has increased 11% in running a dental practice year-over-year. When you figure that out, that equates to 20-- a 25% increase in expenses for dental practices in the last four years. The investment that you made last year, with a 12.5% increase in reimbursement, has encouraged dentists-- as Doctor Meeske said-- around the state to enroll in the program. So, it's working, but the reality is that the increase was not enough. In our practice last year-- this gives you, I think, a little bit better idea of what we're talking about here-- in our practice last year, we took 268 young children and kids with special health care needs to the hospital for dental treatment; they could not tolerate dental treatment in the office because they were too young or disabled. So, 213 of those cases were for children with Medicaid. The research says that the hospital cases cost the state $8,000 for the dental and medical bills. This equates to $1.7 million, and that would be the equivalent of just in our practice. Had most of those kids come to us and had access to care before they started getting cavities around 12 to 18 months of age, we could have potentially saved the state over $1.6 million. Preventative care for those same 213 kids to visit us twice last year would have only cost the state approximately $64,000. You all cannot deny that dental care is critical to all of our health and well-being. Imagine your kids and your grandkids not having access to dental care because no dentist will take their insurance. Imagine your kids and grandkids not getting braces because no orthodontist will take Medicaid. So, right now in Lincoln, for example, only one orthodontist takes Medicaid. Kids in our state are the future of this state. They are also our workforce. They are our greatest resource. With dental pain and facial anomalies caused by lack of dental care and access to it, children will be less educated, they certainly lack self-esteem, and the cycle of poverty will continue. I can tell you all of the facts, but the facts don't always tell you the truth. The truth is that investing in a 12.5% increase for dental Medicaid will be one of the wisest decisions that you make. I realize that you've got lots of hard budget decisions. In your own household, you budget to go to the dental-- to go to the dentist to avoid pain and greater expense later on. You know the consequences of avoiding dental care. The facts

explain it, and the reality of not passing LB146 means that we will all lose. The taxpayers will lose more money to paying for dental disease, and the patients-- especially children-- will suffer. Passing LB146 is critical for our state because it will do three things: it will increase access to care; it will reduce the cost to us as taxpayers and to the state; and it cares, obviously, for our most vulnerable people, especially children. Thank you so much for your time. I'm happy to ask-- answer any questions that you may have.

CLEMENTS: Any questions? Questions? Senator Prokop.

PROKOP: Thanks for being here today--

HEIDI STARK: Absolutely.

PROKOP: --and for the work that you do. Just a quick question. You mentioned-- I didn't jot it down fast enough, but you talked about the increased business costs that you had. Can you maybe expand upon that as to what that entails and what's driving that?

HEIDI STARK: I'd love to answer that question.

PROKOP: Yeah.

HEIDI STARK: So, it's a little bit complicated, but you probably understand that when you're taking care of kids, you have to have a large staff because you can't walk away from the chair. So, in order to care for the kids with Medicaid, for example, who have most of the decay, you end up having to hire a lot of staff to manage those needs. And so, because of COVID and because-- I believe a third of the workforce left dentistry during COVID; a lot of the hygienists got very nervous, and they retired because they were afraid of coming back and getting sick. And then, just because of dental assistants finding other types of jobs and not having to deal with the masking, et cetera, there's been a huge work shortage. And I serve on a committee at the Southeast Community College to deal with that work shortage. But basically, everything became so inflated, not only from a manufacturing standpoint and from supplies but from a wage perspective, that all of us in private practice are in these wage wars, and so we had dental assistants jumping ship and going all over to different practices, basically almost holding hostage dental practices for increased wages that we just cannot afford. And so, that's typically where we're seeing the biggest challenge. Thankfully, that's slowing down somewhat because-- like, in our business, as Dr. Meeske notes, if you want to work with kids, you're all-in, so we have found the people that love to

take care of kids. But really, it's just an increase in all of the supplies that we order because of manufacturing, and the-- for sure, the increase in the wages that have been required to keep our people. And obviously, the cost of health care has gone up, and so therefore insurance for the people that we employ. We have 83 people in our practice, so obviously we want to have benefits for our employees; medical, dental insurance, all those types of things. So, it's just the cost of business is so great. And thankfully, I have eight pediatric dentists who are willing to see Medicaid, but most of my partners or colleagues throughout the state take very little, if any. Around the country, you talk to most of my friends and partners, they just-- it's too much of a risk. We got hit with RAC audits a number of years ago, which you-- some of you are probably aware of. And that's initially what drove people away from seeing Medicaid in the state of Nebraska. And then, once that passed over and-- RAC audits happened all over the country, and Dr. Meeske is really an expert in RAC audits. But then, one of our colleagues, Dr. Marty Killeen, who's here in Lincoln, he got audited and was treated like a criminal because of the documentation that they said he needed to provide. All of us in pediatric dentistry know that if a kid needs to go to the hospital, that means that they're so young and they have so much decay that it is very difficult to provide that in the office. And so, he was taking kids to the operating room who had significant amounts of decay. And a lot of them, as you know-- I think we have 50-some languages in the city of Lincoln, and so a lot of the kids that he was treating, because of the health department-- which is where he was working part time-- he would do the hospital cases. Anyways, the decay was so bad that he was doing stainless steel crowns. And so, Dr. Meeske was also in on that testimony. So, because of Dr. Killeen and his-- the way he was treated, a lot of pediatric dentists in Lincoln bolted because they're, like, I'm not going to sit through being treated like a criminal for taking care of kids the way that we're all trying to do, which is-- if you have a large cavity on a small baby tooth, you need to save that tooth so that you don't have an extraction. If you have an extraction of a baby molar, that's a problem because then the permanent teeth shift forward, and then that ruins the alignment and the potential is greater for kids to have-- need, you know, orthodontic needs. And in orth-- the orthodontics situation, and Senator Cavanaugh would remember this from last year-- when I got up to testify last year, there was pretty much everything had been said, but the one thing that was not mentioned is orthodontics. Orthodontics, as you all know-- we look around the room, we all pretty much have straight teeth; most of us have a really great education, or at least somewhat of an education. And a lot of that is-- we know from research it's because we have nice smiles and access to

dental care. So, that's a big thing for me. I'm not an orthodontist, but man, if you could increase reimbursement 12.5%, I can guarantee you-- I'm a very persuasive person. I can get some orthodontists in Lincoln to start taking a better look at getting kids in with Medicaid so that they can get braces, have a chance at having straight teeth, and then hopefully, moving on to get, you know, some type of college degree and be, you know, better for all of us, and contributing to the system instead of taking away from it.

PROKOP: Thank you.

HEIDI STARK: Yeah, you're welcome.

CLEMENTS: Other questions? Seeing none. Thank you, Dr. Stark.

HEIDI STARK: Thank you. Great to see you.

CLEMENTS: Next proponent. Good afternoon.

BEN REIMER: Good afternoon. Thanks for having me. My name is Ben Reimer. It's B-e-n, last name R-e-i-m-e-r. I'm a pediatric dentist in central Omaha and a graduate of UNMC College of Dentistry, and then did my pediatric training in Omaha, and I'm here to testify in favor of this bill. Just like Dr. Meeske did, I first just want to thank this committee and the-- last year's Legislature for passing the 12.5%, and I kind of want to just talk, talk about what that did as a young dentist, for me. Our practice is right across from Children's Hospital in Omaha, so we're very proud of that. We see kids from all throughout the city and surrounding suburbs, so a very diverse patient population. And my two partners there were a year and two years behind me in school, so all of us are under 35 years old practicing. We love what we do, we love seeing kids. But seeing the difference in reimbursement these last six months was a significant difference, and it allows us, being younger, dealing with things like student loans, deciding where we want to practice, deciding where we want to start our family-- is that in Nebraska, is that out of Nebraska? This really helps. And so, I'm looking at it as a way of-- yes, you know, Dr. Stark, Dr. Meeske talked about access to care. I echo everything they say there, but also keeping talented, smart people that train here to practice here. I think that's really valuable. And as I mentioned, it allows us to see more patients that do have Medicaid that are at high risk for dental disease; it allows us to talk to their parents and build good habits from the beginning, keep them from being sick, allow them to not miss as much school, to sleep better at night, to eat better. All things very important for growth and development, for learning, and obviously,

to be more successful as they grow. So, I look it as an opportunity to help break cycles of poverty, not just, you know, take care of kids and then see them out the door. So, that's been really special for our group, just being able to see these kids younger. We see a lot of kids at age one, and you'd be surprised at how many go to bed with a bottle of milk or sipping apple juice, and just the lack of awareness of what that can do to teeth. So, catching that ahead of time and preventing expensive surgeries or late-night emergency room visits is important. The other thing I wanted to talk about-- or, a couple more things is-- first of all, workforce. Dr. Stark just alluded to it, but I look at this opportunity to make Medicaid reimbursement closer to private insurer pay-- payers as a way for us to invest in our team. The workforce issue is real, and just being able to provide a better life for the people that work so hard for us taking care of kids is something really important to me. And so, you know, making Medicaid reimbursements higher and, and getting to that full 25% that we brought to the table last year will continue us to-- continue to allow us to invest in our people that really make our offices go. And just from my group, I couldn't do what I do without, without those people. And I think it will make dentistry a more appealing career choice again for young people and, and something that they can grow in and, and really enjoy taking care of people, but also providing for their families and children. And then lastly, I, I want to talk about just how proud I am to be a pediatric dentist in Nebraska. I was able to go to a leadership conference for the American Academy of Pediatric Dentistry in Chicago last fall and talk with dentists from around the country and hear stories of-- just, honestly, horrible situations with Medicaid. And I feel very lucky to practice in a state where, if we invest these dollars, the managed care organizations running dentistry are talking to each other. They come to our yearly Nebraska Society of Pediatric Dental [SIC] meetings and hear our feedback; they work together, you know, to, to listen to us, to, to get these kids what they need, so. We are really fortunate that if we invest these dollars, we have people working together and not against each other, and so I really believe that, that it will make a difference as we move forward. So, that's all I got. I appreciate you guys' time. Would love to answer any questions if anyone has any.

CLEMENTS: Are there questions? Seeing none. Thank you for your testimony. Next proponent.

SCOTT MORRISON: Oh, there he is.

CLEMENTS: Good afternoon.

SCOTT MORRISON: Good afternoon, Senator. Senator Clements and Senators of the Appropriations Committee, I am Doctor Scott Morrison, spelled S-c-o-t-t M-o-r-r-i-s-o-n. I'm a periodontist from Omaha, a past president of the Nebraska Dental Association, and current legislative chairperson for the Nebraska Dental Association. While we typically talk about Medicaid with Health and Human Services Senate Committee [SIC], I'm happy that today I can address the Appropriations Committee. I think it's common that many laypeople do not understand the link that exists between dental disease and overall health, and this includes associated costs. As a periodontist, I've seen this firsthand. Tooth decay is the most common chronic disease in both children and adults. In children, it's about five times more common than asthma. Nebraska children miss thousands of hours of school due to untreated tooth decay. From our Nebraska State Oral Health Surveillance Program, we know that, while we are making progress, rural children still have more cavities than urban children. And you can see in the smaller print the numbers that decay is associated with rural, urban, ethnic, and income levels in our state. When our kids suffer from untreated dental disease, they cannot pay attention at school or play with their friends. This spills over to adults as well. Many adults miss work because of dental disease and pain. We know that when adults are in better oral health, they are more likely to get promoted and have jobs. This equates to more persons eventually moving off Medicaid and other government social services programs, and ultimately paying taxes. Good oral health has a direct impact on our state's economy. All persons on Medicaid need to be able to access dental care. This is particularly true for those with chronic or severe medical conditions. If you have diabetes, you are for more-- far more at risk for periodontal gum disease and losing your teeth. And if you have cancer, you must treat all the infection in your mouth and gums before you are cleared for chemotherapy or radiation. Can you imagine having to wait for lifesaving cancer treatment because you cannot get in to see a dentist to treat your teeth and gums? If patients must be admitted to the hospital for dental treatment because their condition is becoming life-threatening, the average cost to treat is $42,000. Prevention of dental disease is better for people and for payers, such as Medicaid. Prevention of disease that is based in a clinic setting helps keep costs down. While many dentists accept Medicaid, they do not want to lose money or every-- on every Medicaid patient visit. A new dentist graduate who wants to stay in Nebraska, on average, has about $300,000 in educational debt. They're facing unprecedented stress to make their payments and start their young practices and families. New young dentists want to help care for the underserved, but reimbursement rates equivalent to less than 50% of usual and customary costs will make it

extremely difficult for new dentists to see Medicaid patients. A 12.5% increase will raise the Medicaid reimbursement rate to a percentage that gets closer to a break-even point, but still well below a level that results in any profit to the dentist. Nebraska dentists want to do the right thing and take care of members of society that are underserved. Please consider moving this bill forward. Thank you.

CLEMENTS: Are there questions? Senator Armendariz.

ARMENDARIZ: Thank you. Thank you for being here.

SCOTT MORRISON: Hi, Senator.

ARMENDARIZ: And I have a question not, not necessarily about Medicaid reimbursement, but-- in your leadership positions, are, are you seeing any information about private insurance coverage changing, shifting? And I'll, and I'll tell you, my company, my husband's company both stopped coverage, coverage at our dentist. We use two different insurance companies, and both of them no longer would support the dentist we were going to. So, I was wondering if the private insurance is also having some kind of an issue with coverage.

SCOTT MORRISON: So, I think the thing to recognize that-- for what we all accept or expect insurance to be, dental insurance is more of a, a dental benefit than it is an insurance. And so, we deal with that all the time. Yesterday, we just had a-- we testified in Banking, Commerce and Insurance about getting more of the patient's premium dollar into their mouth. And that becomes a concern, because when we see premiums, let's say, $100, and only $40 of that goes into the mouth, that's a concern. So, there is issue with private insurance. As I said, I call it-- some call it a, a dental benefit. I call it a dental gift card because you're limited to, you know, maybe $1,500 in the course of an annual, you know, yearly process.

ARMENDARIZ: Yeah, that get-- that's get-- gets me thinking about options. Thank you for your answer.

SCOTT MORRISON: Yeah. Thank you.

CLEMENTS: Other questions? Seeing none. Thank you for your testimony, Doctor.

SCOTT MORRISON: Thank you, Senator.

CLEMENTS: Next proponent. Good afternoon.

KENT ROGERT: Good afternoon, Senator Clements, members of the Appropriations Committee. My name is Kent Rogert, K-e-n-t R-o-g-e-r-t, and I'm here today to testify in support of LB146 on behalf of the Nebraska Dental Hygienists' Association. We thank Senator Ibach for her continuing-- continued efforts in trying to get more money into the dental Medicaid program. Just got a couple of points of data here for you. From 2016 to 2023, there was a 41% reduction in the number of dentists who enrolled as Medicaid providers. We have started to turn the corner on that, but "insufinch"-- insufficient provider reimbursement is the number one reason we hear when they make that decision. In 2008, this body-- trying to address the Medicaid provider shortage-- we passed a bill in Nebraska creating a public health authorized dentist-- a dental hygienist. These professionals are authorized to provide oral health services in community settings such as schools, childcare centers, long-term care facilities, without the supervision of a dentist. The addition of the public health dental hygienist to Nebraska's dental workforce model has proven to be instrumental in increasing oral health care for underserved populations. In 2022, 40 public health dental hygienists were actively utilizing these permits, and they conducted over 35,000 oral health screenings to provide services such as fluoride varnish and dental sealants, and they were provided in 85% in the counties-- of the counties in Nebraska. When patients cannot access dental care in a timely manner, as you've heard before, their oral health care conditions worsen, and they end up seeking care at emergency departments at hospitals. From 2009 to 2016-- it's a little old stat, but there were almost 8,000 emergency dental visits per year, and in 2012, the average cost of that visit was $712. By 2018, that-- each of those visits rose to a cost of $1,900, which amounts to over $15 million per year being spent on conditions that could have been prevented with oral care at the beginning, at much lower costs. So, this bill would provide much created-- much-needed stability to the mental-- Medicaid dental program. I'll answer any questions if I can.

CLEMENTS: Are there questions? Seeing none. Thank you for your testimony.

KENT ROGERT: Thank you.

CLEMENTS: Next proponent. Seeing none. Is there any opponents? Seeing none. Anyone here in the neutral capacity? Seeing none. We have online comments for the record: proponents, 48; opponents, 1; neutral, 0. That concludes the hearing for LB146. Next, we will open the hearing for LB54. Just a minute, please. Welcome, Senator Dorn. Good afternoon.

DORN: Good afternoon. Thank you. Good afternoon, Senator Clements, and members of the Appropriations Committee. My name is Myron Dorn, M-y-r-o-n D-o-r-n, and I represent District 30. I would like to introduce LB54 to you today. The bill attempts to raise the direct support provider rate by 11%; direct support staff who provide service to the developmentally disabled. The current average starting wages for private providers is $15.56 per hour. The starting wage at the Beatrice State Developmental Center is $20.54, plus differential rates for different shifts. I believe private providers should have parity in hiring wage rates, with the rate paid to providers for service at BSDC. When you consider the living wage for a single adult, no children should be $20, Nebraska providers are far below that rate. The fiscal note has estimated that in order to meet the 11% increase in salaries, the state funds would be around $25.3 million, and would bring in $28 million in additional federal funds. I know this is a significant ask during this budget cycle. In addition, the governor has been working on eliminating the state's DD waitlists for service. Granted, not all of those on the waitlist will accept services right now, but there will be many that do, and those individuals will almost all go-- be looking for services with private providers. The Legislature must ensure adequate and fair compensation to those providers. There are a few people behind me that can answer specific questions regarding services, wages, et cetera that would be happy to try to answer some questions that you may have. We also handed out a couple other handouts that-- on the handouts that came around or whatever, that shows some of the difference in cost and stuff for our developmental disabled, and what some of the living wages and that stuff might be, so. I will sure try to answer any questions, but like I said, I know there are people behind me that are very much more qualified than I am.

CLEMENTS: Questions? Seeing none. Will you stay to close?

DORN: Yeah, I'll be here to close, and then open, and then-- yeah. So. Thank you.

CLEMENTS: Thank you. We welcome proponents for LB54. Good afternoon.

ERNIE GOSS: Good afternoon, Senator Clements, chair of the committee and members of the committee. I'm Ernie Goss, E-r-n-i-e G-o-s-s. I'm here as rep-- discussing a study that I completed for Alana Schriver and NASP, and, and my colleague Monique Devilliers provided copies of the, of the executive summary of that study. The overall findings-- we, we completed the study, but in addition to doing the study, I'm also a parent of a, an individual who is a client or a member of-- who gets care from Mosaic, so I'm well aware of some of the, the potential

benefits of increasing the wages for the so-called-- or, direct support personnel. So, I'll talk about that, but I'll only talk about what we found in our study. It was concluded that Nebraska has a significant shortage of direct support providers to provide, to provide services to the state's individuals with intellectual and developmental disabilities. For Nebraska DSP-- direct support providers-- wages are 60-- about 67% of the state's hiring-- living wage, so quite a bit lower, and results in a shortage of 711 workers, or about 19%, so there's a need for 19% more workers. The lower Nebraska DSP wages have contributed to Nebraska's higher turnover rate, which of course results in training costs-- increase in training costs and personnel costs. And the turnover rate is at 50.2%; it's the 11th highest in the nation in Nebraska. And there are 2,400-- about 2,400 individuals on the waiting list for, for services provided by the individuals with developmental disabilities. And importantly, I think we talk about reducing turnover; that's very important-- of raising the wages to be competitive. It's certainly competitive with the Beatrice center, which it is not at this point in time, as brought up by senator before. An, an important benefit of increasing the wages, minim-- the wages for DSP personnel is that individuals are then-- parents, caregivers who are in the home, taking care of individuals-- are able to free up and go to work and pay taxes, state taxes, federal taxes, and so on. That's an important benefit that we calculated, my research team. And certainly in my case, my wife-- we're fortunate enough to-- that's not an issue for us, but my wife does have to stay home and take care of our, our-- when the-- when, for example, when there's a day off, and so on. So, we have that facility, but a lot of folks don't, so that means they're not able to work; they have to stay home with the, the child. And adults, in many cases; my, my daughter is an adult now. We found-- we calculated that for every dollar of increase in support from the state in terms of wages, it results in $1.40 for benefits calculated. The average annual wage for a home health and personnel, personnel-- personal care aides in Nebraska was 55% of the average for all occupations in the state. Nebraska ranked fifth among its neighbors in average wage for this occupation. Nebraska's wage, at $30,000, was exceeded by Wyoming's $38,000, Colorado's 34-- 35-- actually, $35,000, Iowa's $32,000 and South Dakota's $32,000. So, those are what we consider to be the neighbors of Nebraska, those states that share a border with Nebraska. The average wage for direct support providers-- DSP individuals-- was about $22,000, which was about 67% of Nebraska's living wage. So, that's-- again, that's very underpaying, in my judgment, these individuals. An estimated 1,724 parents are currently out of the workforce-- out of the workforce that would enter the workforce had the wages-- if the wages were sufficient to attract individuals and get the

waiting list down. So again, that's about 1,724 individuals. Now, certainly included in our benefits, the-- again, $1.40 for every $1.00 of state increases, but I have to say that is considering support from the federal government of about $54.4 million through Medicaid funding, so. And-- we're leaving-- or, Nebraska, I should say-- Nebraska is leaving on the table at this point in time. Now, this point in time is January of 2023, but-- 2023. Was about-- leaving on the table about $54.4 million of federal support, so. There is, there is some reason to, in my judgment and in the study's conclusion, to increase the funding for those individuals and certainly bring it up to support for the Beatrice Center as well, to compete with the Nebraska's facility as well. Thank you.

CLEMENTS: All right. Are there questions? Seeing none. Thank you for your testimony.

ERNIE GOSS: Thank you for allowing me to testify.

CLEMENTS: Next proponent.

ALANA SCHRIVER: Good afternoon, Chairman Clements, and members of the Appropriations Committee. I'm Alana Schriver, A-l-a-n-a S-c-h-r-i-v-e-r, and I'm the executive director of the Nebraska Association of Service Providers, which is a statewide association for those home- and community-based providers supporting individuals with intellectual and developmental disabilities, which we partner with the state to provide those services at a fraction of the cost of the Beatrice State Development Center. So, thanks for the opportunity this afternoon to speak on behalf of the thousands of Nebraskans we support and employ. As Senator Dorn mentioned-- I believe he gave you a copy of the chart that compares our current average hiring wage of $15.56 to both Beatrice State Development Center and the living wage. It's interesting, just last night I saw a study that the average salary needed to be happy in Nebraska is actually now $95,550, which is a little bit lower than what Dr. Goss just reported, where we're sitting about $30,000 for our staff. And DHHS will usually say, well, if you compare our wages to the rest of the nation, we fall in the middle. But we're not competing with staff-- people aren't moving to New York City to become direct support professionals-- we're competing with those businesses just down the street. So, I could give you a million examples of our job coaches who are helping those individuals with disabilities get jobs in their community. They'll go to Menards, help someone fill out a job application. The person they're supporting is now going to make $3 more an hour than them at Menards, so the job coach ends up filling out a job application at the same time, and we

lose them down the street to the gas station or wherever. So, we're competing within Nebraska, in our highly competitive job market here, not necessarily where we fall on the national scale, although I'll get to how quickly that is changing as well. We've actually become number one in the country in turnover since Dr. Goss' study last year; we went from 11th to number one, so, not really something we want to be number one at in the nation. With Nebraska's minimum wage going up to $15 an hour next year, really, our goal with this bill is to try to maintain the national standard for this job, which is 150% of the minimum wage, which isn't still going to be the living wage, but at least would help us be a little bit more competitive. And then, of course, that gets tied to the consumer price index, and our rates have no guaranteed rate increase annually; we don't get a COLA, we don't get CPI, we don't get anything like that. So, we have to come back year after year after year, like a broken record, just trying to stay fiscally solvent. Senator Clements, you used language yourself this summer in the special session in LB3 about state contracts needing to be tied to CPI. We're state contractors, we agree that that would be helpful, and help maybe break this cycle of, of us coming back every single year, which would be great. And with the governor's plan to eliminate the waitlist in mind, a lot of that relies heavily on what we call intermittent supports. So, that's helping someone be at their most independent, whether that's in their own apartment or supporting the family with supportive family living. But intermittent supports are the hardest to staff. Typically, those families want weekends or evenings, so it's hard to staff those in the first place; the hours aren't reliable because maybe the family doesn't need you that evening or that weekend, so we can't guarantee full-time hours for those employees. Also, to do those in-home services, we have to do something called electronic visit verification, which-- Nebraska DHHS has now chosen to go way above the federal requirement, and we are no longer allowed to make manual corrections to those electronic visit verifications, or those visits will not be paid. So, typically, what you do, you get to the house, you use the phone app to clock in, it captures the GPS, and then when you're done, you clock out. We all agree this is great; you should be clocking in and out, you should be capturing GPS. We also know that tech doesn't always work. GPS doesn't always work in Nebraska; you can't get to my parents farm with GPS. And now, if the GPS-- or you just have human error, some of these staff are clocking in six seven times a day, that visit will no longer be paid. So, we're losing revenue under what the services the governor would hope to have us do more of. Other states are experiencing similar budget shortfalls. I've given you a list on the back of my hand out of what other states are having to do to address the realities of costs going up. Nebraska DHHS

did a study themselves, recommending that provider rates get tied to CPI, although they don't parade that study out too often. And I also just included some data from a national survey on our crisis of care. This is not unique to Nebraska; we're just-- our unemployment rates exasperate the problem here. So, like Senator Dorn said, we know this is a big ask, we know you guys have a budget shortfall to deal with. But I just want to remind you that these are actually services the state's legally obligated to provide. It's not like nursing homes or things like that. If home- and community-based providers close, the state does have to offer these services at the state institution, which is exponentially more expensive than working with us in the community. So, thank you for your time.

CLEMENTS: Are there questions? Senator Spivey.

SPIVEY: Thank you, Chair, and thank you so much for being here. And I appreciate the explanation that this is, like, still mandated in statute, and so I think that clarity was helpful. And the only other comment that I just wanted to add on the record is that you mentioned that, like, $95,000 is what you need to be happy in Nebraska, and we only make $12,000 about here. So, just on the record--

ALANA SCHRIVER: I don't make it, either.

SPIVEY: -- I just wanted to put that in the universe.

ALANA SCHRIVER: I don't make it either, but we're, we're-- we'll put our smiles on.

SPIVEY: Thank you.

CLEMENTS: Other questions? Seeing none. Thank you for your testimony. Next proponent, please. Good afternoon.

MATT KASIK: Good afternoon. Chairman Clements and members of the Appropriations Committee, thank you for the opportunity to testify today. I also want to expend-- extend my appreciation to Senator Dorn for im-- for introducing this important bill. My name is Matt Kasik, M-a-t-t K-a-s-i-k, and, and I serve as the CEO of Apace; we are formerly Region V Services. We are Nebraska's largest provider of services for individuals with intellectual and developmental disabilities. Apace is a political subdivision, meaning we have no profit motive. Any surplus we have is reinvested to improve the quality of supports for the 720 individuals that we serve across southeast Nebraska. Apace is over halfway through our current fiscal year, and we are operating at a 6% deficit. Reimbursement rates for our services

have not matched our increasing costs. For example, our insurance costs-- including employee health benefits, property liability, and worker's compensation-- have increased by $1.3 million compared to last year, which is a 56.5% increase. The workforce behind these services is at the heart of our mission. 86% of our expenses go directly to wages, benefits, and payments to those providing direct care. In the past five years, we have invested heavily in our workforce to ensure a high quality of care. Between 2019 and 2024, wages and benefit costs have increased by 26.2%. Our direct support professionals who make up 91% of our workforce have seen average wages grow from $13.56 to $18.22 per hour, which is a 34.36% increase during that time. Temporary ARPA funds have been a lifesaver for our inter-- industry by supplementing wages. For example, in 2024, federal ARPA added an average of $1.08 per hour to each of our DSP's wages. However, ARPA funding is ending, and these wages will decline unless rates are permanently adjusted. LB54's 11% rate increase is crucial to sustaining competitive pay and ensuring high-quality services. Apace also faces direct competition from our state-run Beatrice State Developmental Center, where employees start at $21.79 per hour, with-- which includes shift differentials. At Apace, our starting wages are $15.31 per hour. This disparity makes hiring and retaining skilled staff increasingly difficult, especially if state employee wages were to increase. LB54 is an investment in Nebraska's most vulnerable citizens and the workforce that supports them. Without it, organizations like Apace will struggle to keep up with the rising costs, retain staff, and maintain quality services. I urge your support to ensure stability and quality in developmental disability services. Thank you, and I welcome any questions.

CLEMENTS: Are there questions? Seeing none. Thank you for your testimony. Next proponent. Good afternoon.

PATRICK HAYES: Good afternoon, Chairman Clements, and other distinguished members of the committee. My name is Patrick Hayes; that is P-a-t-r-i-c-k H-a-y-e-s. I am the chief financial officer of Elite Disability Services of Nebraska. I would like to start by expressing my sincerest gratitude for granting us this audience to speak with you on behalf of the people that we are privileged enough to support and employ. I am here to ask for your support in addressing the crisis of care for some of the most vulnerable citizens of our communities. The remedy for this crisis begins with the people in this room who hold the power of the purse. That power would be shown in your passage of LB54, and all the conspicuous opportunities that would follow in helping to create a livable wage for our community of direct support professionals who have selflessly dedicated their professional lives to the service of others. These are people who consistently give more than they

consume, and adapt rather than complain. We stand on the precipice of the elimination of the waitlist for DD waiver services for over 2,000 Nebraskans, with no staff to serve them. This is part and parcel of the wages that can be offered to the direct support professionals due to the current reimbursement rates. In a study conducted by ANCOR, the median wage for a DSP is actually around $14.50 an hour. This has led to a turnover rate of nearly 44% and vacancy rates of more than 20%. Our DSPs are required to be champions of quality of care and innovation during the day, and at night, kiss their families goodbye once again on their way to their second job because $14.50 an hour is not sufficient to pay the rent where prices range from $1,050 to $1,615 to purchase groceries, pay child care, and keep a vehicle in good repair in a place where the potholes are more like portals to another dimension. We understand that while we as human beings may be resistant to change, our economy is not, and there is no vaccination that can make us immune to the effects of inflation. The preservation of the status quo is not our reality; the reality we face is that change is necessary. It is necessary because investing in everyday Nebraskans who have devoted themselves to making a positive and lasting difference in the lives of others has never been more worthwhile. The return on that investment is evidenced by the fact that consumer spending is the largest driver of our economy. We are asking for your support in the passage of LB54 because collectively, you can take actions that push back against this crisis of care, and specifically, for our direct support professionals who make 66.9% of the Nebraska living wage standard. They do this while working tirelessly to be attentive to the needs of others, administer necessary medications, provide safety to our loved ones, manage their finances, foster independence wherever possible, teach daily living skills, and a multitude of other tasks that require detailed documentation as evidence that they are meeting the expectations of their chosen profession. All of this while working to provide a better quality of life for others who could only realize that life through the services that our agencies provide. This bill is not just about the wages we can afford to pay and remain sustainable. This bill is about the people who will be affected by the change you have the power to generate, and those of us gifted with the responsibility to carry it out. We need the power of your voice, because when the whole world is silent, even one voice becomes powerful. We ask that you be our voice. Thank you again for your time and consideration. You are wholeheartedly appreciated. I'm available for any questions you may have.

CLEMENTS: Are there questions? Seeing none. Thank you for your testimony.

PATRICK HAYES: Thank you, Chairman.

CLEMENTS: Next proponent. Good afternoon.

MATT NORMAN: Good afternoon. Good afternoon, Chairman Clements, and members of this committee. Thank you for taking the time to listen to my concerns. My name is Matt Norman, M-a-t-t N-o-r-m-a-n. I am the CEO and co-owner of Independent Horizons, an agency providing day, vocational, and residential services to individuals with developmental disabilities. I'm here to support increased funding for individuals on the developmental disability waiver. I have been in this field for 30 years, and I've seen the quality of services for people with intellectual disabilities go up and down. I am deeply concerned about developmental disability's funding this year, and the quality of those services. I am currently serving this population in an administrative role in my company, although I have had experience as a DSP staff. It is a hard job. DSPs working for my company help find-- help people find jobs, provide meaningful activities, engage with the community, help people with volunteer positions, and assist those people achieve their own goals. If you are not in this field, you may not understand the full extent of the care provided in this field. DSPs may have to be a CNA, assisting people with disabilities with using the restroom or cleaning them up after they've had an accident, giving showers, and providing medical assistance and administering medications to those people that cannot provide that care themselves. DSPs are advocates because a lot of the people we serve in our-- live in a society that is not designed to help them. DSPs act as counselors to people that we serve, helping them when they are upset; they may not have the effective ways of dealing with their frustrations. They may have to put themselves in danger from an individual so frustrated they've lost all control of their own behaviors, and are unsafe. They, as staff, may have to put themselves in between the individual and a police officer, with that police officer not able to understand that the individual causing a problem will not comply because of an intellectual disability. DSPs consistently work holidays because the people we serve may not have families that are engaged with them. It is one of the hardest jobs that you can have. I bring up these challenges to show the difficult work in this field. It is a job with high turnover, increased mental health issues for those employees, high, high call-outs from burned-out workers, extremely long shifts, and on top of all of that, low pay. My company attempts to provide a living wage, but this is impossible with current funding rights-- rates. In fact, I, as a business owner, have taken three pay cuts in the past two years due to the challenges of managing a disability agency which is underfunded. As health, health insurance, liability insurance, rent, and every other aspect of business increases, the funding for developmental disability

services does not keep up, which is unsustainable. Another issue related to underfunded developmental disability services is the quality of the workforce. While I am very proud of the work my employees do, low funding means there is a smaller, less-equipped pool of potential DSPs to hire from, and the staff that are working are-- and are qualified may be burnt out from covering too many shifts. In my 30 years in this field, I have seen funding dip at times, and I remember that that-- as that funding dips, there is an increase in abuse and neglect. People in the disability demographic are at a higher risk of being abused, neglected, and sexually exploited, and in fact, they are four times more likely to be sexually abused than the general population. Without proper funding, we can't hire proper staff, we can't hire staff for that oversight, and the proper services are extremely difficult to provide. If you have any questions, I'd be happy to answer them.

CLEMENTS: Are there questions? Seeing none. Thank you for your testimony. Next proponent. Seeing none. Are there any opponents? Seeing none. Anyone here in the neutral capacity? Seeing none. We have comments for the record: proponents, 14; opponents, 0; neutral, 0. That concludes the hearing for LB54. Next, we will go to LB55. Senator Dorn.

DORN: Thank you for hearing all the testimony on LB54, there, and stuff. It-- I think it, it kind of laid out what some of the costs are, and what some of the issues are in the developmental disability people that we have, so thank you very much.

CLEMENTS: Oh--

DORN: Next-- and I think they have it shifted--

CLEMENTS: I'm sorry. I meant to give you a chance to close.

DORN: OK.

CLEMENTS: Is that your closing?

DORN: That was my closing, kind of right there. Yeah, that's good enough.

CLEMENTS: OK. Now, LB54 is closed.

DORN: OK. Yeah.

CLEMENTS: I'm sorry about that.

DORN: No, no. No problems. Because it--

CLEMENTS: All right.

DORN: We-- well, we run into each other today. I mean, we run into each other bill-- all these bills here together and stuff today, so. But I thank you for having them all on the same day. This works out good for some of these testifiers to be here and, and be a part of this. So.

CLEMENTS: Very good. Now, we'll open the hearing for LB55.

DORN: You bet.

CLEMENTS: Senator Dorn.

DORN: Good morn-- good afternoon, Senator Clements, and members of the Appropriation(s) Committee. My name is Myron Dorn, M-y-r-o-n D-o-r-n, and I represent District 30, which is all of Gage County and the southeast corner of Lancaster County. I am introducing today LB55. In 2023, the federal Center(s) for Medicare and Medicaid Services changed a rule allowing licensed mental health practitioners to be credentialed and reimbursed by Medicare. Medicare in the federal health insurance program for people-- is the federal health insurance program for people 65 or older and younger people with disabilities. The change was made to expand the behavioral health provider workforce for this population. Before this change, those licensed mental health practitioners and licensed independent mental health practitioners were reimbursed by Nebraska Medicaid as if they were serving dual eligible clients that are low-income, older Nebraskans in need of behavioral health services, and qualify for both Medicare and Medicaid. These providers are the "backborn" of our behavioral health system of care. The CMS rule change should have been a godsend, expanding our health care workforce, particularly in rural parts of Nebraska. But an unintended consequence of this change resulted in a dramatic impact on licensed mental health providers because the difference between a notorious low Medicare rate and a higher Medicaid rate was significant. For over 15 years, Medicaid was paid-- has paid for this dual population, but when the Medicare change was made, Nebraska Medicaid decided to no longer reimburse at the higher Medicaid rate. That decision has had significant impact on providers, who now must make decisions on whether they can continue to serve dual-eligible Nebraskans because of the dramatic rate cut they must take. As providers last year attempted to negotiate with Nebraska Medicaid, they were told it would cost the state an estimated $1.5 million. I introduced LB55 to add these dollars to the state Medicaid budget so that these providers who do not practice in hospitals can

continue to serve these vulnerable Nebraskans trying to get better. The bill says $1.5 million for cost, though the one-point-- the $17 million carve-out in Nebraska-- the bill taps $1.5 million to fund this costs through the $17 million state carve-out in the Hospital Quality Assurance and Access Assessment Fund, although I believe there are several other funds that could be used to allow these providers to continue to provide service, including the Medicaid (Managed Care) Excess Profit Fund. Part of what that hospital quality assurance, that has not been approved. If there's one thing I learned from being up here, and Senator Wayne, you want to get on the front end of these things to try and, I call it, corner the funds instead of-- or towards the tail-end. Realize very much that that-- don't know if or when that will be approved, if those types of funds or that funding would be available or not. As we had discussion, as we went through the process of trying to determine where or how to maybe come up with some additional funds, this was one area we ended up dwelling on or whatever, and that was why we brought the bill this way, to tap into those funds. Fully understand that if there aren't no funds there, it will not be funded as part of this bill or whatever, but also, at the same time, that is one option that we just want to make sure we put out there and stuff, so. Other than that, I will be happy to try to answer questions, and there-- again, there will be more people behind me that are also very knowledgeable about this.

CLEMENTS: Are there questions? Senator Spivey.

SPIVEY: Thank you, Chair, and thank you, Senator Dorn. Do you know why Medicaid said that they would not approve that $1.5 million, or, like, what the context was of that conversation?

DORN: I think we'll ask Annette.

SPIVEY: OK.

DORN: She is very knowledgeable in that one, there.

SPIVEY: I will save that question.

DORN: I have a general idea, but if we want to get the proper answer, I think we'll have some other people answer that question for you.

SPIVEY: OK. I will definitely save it.

DORN: And she has that on her radar now, so she knows that-- to answer your question. Yeah.

SPIVEY: OK. Thank you, Senator.

CLEMENTS: Senator Cavanaugh.

M. CAVANAUGH: Thank you. I just wanted to comment. I really hope former Senator Wayne was watching you praise his techniques of negotiation.

SPIVEY: I'm going to text him.

CLEMENTS: It, it looks to me like the way the bill is written is using the hospital quality assessment fund.

DORN: Yes. That's another option that we, we have out there maybe and stuff, so. Several of those who will be visiting with you are visiting more about maybe where we can access some funds.

CLEMENTS: All right.

DORN: Yeah.

CLEMENTS: Any other question? Seeing none. We'll recognize you to close later.

DORN: I'll, I'll, I'll try and hold my closing short. Thank you.

CLEMENTS: First proponent, please. LB55. Good afternoon.

JON DAY: Good afternoon. Good afternoon, members of the Appropriations Committee. I'm Jon Day, J-o-n D-a-y. I'm the executive director of Blue Valley Behavioral Health, Nebraska's largest outpatient behavioral health provider. We provide a variety of mental health and substance abuse treatment to over 6,000 adults and youth to 16 mostly-rural counties in southeast Nebraska. I'm here today seeking your support for LB55 that will place $1.5 million from the Hospital Quality Assurance and Access Assessment Fund to Medicaid-eligible participants who have both Medicare and Medicaid. These funds would help resolve the dramatic rate reduction that was unintentionally provided by recent changes in Medicare. In 2024, Medicare increased access to behavioral health counseling for their members by credentialing more master-level counselors. However, this decision had an unintentional impact on a subset of Medicare participants who have both Medicare and Medicaid, otherwise known as dual-eligible. The primary demographics of this population are those over the age of 65 and have low-income. Prior to 2024, when a dual-eligible individual saw a non-credentialed Medicare provider for counseling, the billing for this service bypassed Medicare and was instead reimbursed 100% by Medicaid. However, in 2024, when

these new master-level counselors were mandated to be credentialed by Medicare, Medicare now had to be billed first, with Medicaid being the secondary payer. The problem created by this new process involves Medicare reimbursing behavioral providers at, at approximately half the rate compared to Medicaid. In other words, compared to the previous year, master-level counselors statewide who were treating dual-eligible clients are now receiving half the reimbursement for this exact same service for the exact same people. Since this, since this has occurred, master-level counselors throughout Nebraska have to choose between two losing options: either stop seeing dual-eligible clients, or continue to see them and experience a tremendous financial loss due to decreased rate reimbursement. In practicality, this would mean hundreds of individuals throughout Nebraska losing access to services, or providers losing tens to hundreds of thousands of dollars. In addition, this will be a problem-- this will-- with-- problem will only increase as a higher number of baby boomers continue to grow older. At BVBH alone-- Blue Valley Behavior [SIC] Health-- we see approximately 200 dual-eligible clients annually, and we're on pace to lose approximately $200,000 this year. Last July, we started having therapists spread out appointments for these clients, which has slowed that projected loss, but has also resulted with over 100 new dual-eligible clients placed on waitlists, on waitlists and not being seen. This same scenario is duplicated throughout all of Nebraska, affecting all those involved, clients and providers alike. So, who are these individuals who are now having their access to behavioral health treatment denied or severely restricted? It's a widower who is dealing with depression to the death of a long-term spouse; it's an individual who's been trying to find better ways coping and dealing with lifelong trauma, and has avoided hospitalization up until now due to treatment; and it's an individual who's legally blind and trying to square up anxiety that interferes with the daily living. This is just a small example of the numerous examples of people who have been receiving outpatient counseling, many with behavioral health issues that both you and I can easily experience. This is counseling that should be easily accessible, where progress can continue to occur, and not be denied by an unintentional yet solvable problem. In addition, providers should not have to choose between experiencing financial loss or providing treatment from a population that should have equal access to it. LB55 provides the most effective, simplest, and highest-impact solution to this problem. The funding for this bill is not only available, but more importantly, it takes a lose-lose scenario and replaces it with a win-win outcome where your constituents are able to receive services, and providers can offer treatment. Problems do not always have reasonable solutions, but when they do, such as this one does, it becomes imperative that we act on

them. Please support LB55, and prioritize keeping behavioral counseling accessible to those who have both Medicare and Medicaid, who are primarily over the age of 65 and being low-income.

CLEMENTS: Thank you. Are there questions? Seeing none. Thank you for your testimony.

JON DAY: You bet. Thank you.

CLEMENTS: Next proponent. Good afternoon.

CHASE FRANCL: Good afternoon, Chairman Clements, members of the Appropriations Committee. It's good to see you this afternoon. My name is Chase Francl, C-h-a-s-e F-r-a-n-c-l. I serve as the president and CEO for Mid-Plains Center for Behavioral Health Care Services, headquartered in Grand Island. Mid-Plains Center has served our communities for more than 50 years. We provide an array of services that includes outpatient and home-based counseling, medication management, community support, as well as crisis stabilization and detox services. I'm testifying today on behalf of my agency and of NABHO in strong support of LB55, which would rectify the payment gap in therapy services provided to dual-eligible populations. As the committee has already heard about the causes and background of this problem-- thank you, Jon-- I would like to use my time to provide a bit more context to our efforts at remedying the situation, and to more fully highlight the fallout that we've already seen occur. From my agency's perspective, we understood that the potential risk we took on by continuing to serve the dual-eligible population this year. Our early projections showed that we stood to lose between $80,000 to $100,000 this year in that program alone, but we believed that the right thing for our community was to continue providing services, as long as there was still hope for the payment problem to be solved. As longtime members of NABHO, we've enjoyed a long history of good-faith partnership with the state, and we are confident that we hold in common a shared desire to see this service made right for clients that we have a responsibility to serve together. We saw evidence of this partnership when the new requirements were unexpectedly issued last January. Like us, DHHS and Nebraska Medicaid recognized the problems this would cause to our system, so they granted a six-month stay to allow time to better understand the consequences and find a solution that would mitigate the negative impacts. Even into late June, we had reason to be optimistic that a solution-- such as a state plan amendment that would allow Medicaid to pay the difference-- might still come together. Much to our disappointment, the state declined to file a state plan amendment, expressing their belief that it would set a precedent that would compel

Medicaid to likewise fill all other payment gaps between Medicare and Medicaid rates across the board, a position that the state was understandably wanting to avoid. As the year continued and local counseling agencies around us began to experience the rate reductions, as expected, many had to make the difficult decision to stop serving dual-eligible clients, and in turn, our numbers have continued to grow. Our latest projections now show that our loss this year alone will climb to between $120,000 and $140,000 by the end of June if nothing changes. Throughout this time of uncertainty, we've continued to hold out hope that a common-sense solution would present itself, and I'm grateful that that's what was offered by this bill. LB55 utilizes targeted funds to effectively provide a targeted solution to a targeted problem. Outpatient therapy offers arguably the highest impact for the lowest cost in the entire behavioral health system, yet, as you've heard, to the agencies such as ours that are operating at break-even or negative margins, the current rates are dealing an unsustainable blow. At Mid-Plains Center, just over 10% of the 2,200 clients we serve annually in our outpatient clinic fit this dual-eligible population, but they also represent 21% of our total therapy services; to walk away from serving them means removing 250 clients from our services with nowhere left to refer them. Our mission as a nonprofit continues to be to meet the needs of our communities as they exist and evolve, and it's our hope that the decision of this committee will allow us the opportunity to continue doing just that. As it is now, the federal legislation that was intended to open more doors for the treatment of this population has barred them shut instead. While Nebraska didn't create this problem, it is the responsibility of our leaders to adapt to solve it. Without LB55 or another source of funding, this is not-- there is not another path remaining that allows agencies like ours to continue serving thousands of Nebraskans across the state, which is why I'm asking for your support for this bill today. I want to thank you for your time, for your consideration. Would be happy to try to answer any additional questions to the best of my ability. Thank you.

CLEMENTS: Are there ques-- Senator Lippincott.

LIPPINCOTT: What do you see as your biggest need right now? Is it services or facilities?

CHASE FRANCL: So, our agency happens to have both. We're in the process of expanding our crisis stabilization and detox unit so we can handle the opioid epidemic that we know is partially here, and, and is probably still coming, so we certainly have a facility need. However, this challenge in particular around services is, is really devastating. We've held out hope that, that there was going to be a solution. I can

tell you, looking ahead, as we begin to budget for next year, we're not going to be able to do this again without, without an adjustment to this rate. Our, our agency operates on about $6 million; we spend that money to-- this year, it'll look like losing close to $200,000, and that's just not a sustainable, sustainable way to move forward.

CLEMENTS: Yep, go ahead.

LIPPINCOTT: Additionally, how-- your personnel. Do you have vacancies? Do you have a need for more people to come work for you folks?

CHASE FRANCL: Mm-hmm. We do. We experience waitlists, as is pretty common. Honestly, things have gotten a little bit better here over the last six months; it's felt like the job market has, has started to thaw; we've been able to add some more. But as we kind of project some growth in some areas we'd like to press into, we can see the opportunity to add between 40 to 50 additional spots over the next three years, as we move towards sort of a, a CCBHC-type model for our agency to provide more well-rounded care to, to Nebraskans, particularly in our, our Grand Island area.

CLEMENTS: Senator Armendariz.

ARMENDARIZ: Thank you. Thank you for being here. Just one question. What is the difference in the gap between Medicare/Medicaid patient and a Medicare/non-Medicaid patient, reimbursementwise?

CHASE FRANCL: I'm sorry. Can you ask that one more time?

ARMENDARIZ: You have a patient that's on Medicare--

CHASE FRANCL: Mm-hmm.

ARMENDARIZ: --but not Medicaid.

CHASE FRANCL: Mm-hmm.

ARMENDARIZ: And you have a patient that's on Medicare and Medicaid.

CHASE FRANCL: Right.

ARMENDARIZ: What's the payment reimbursement [INAUDIBLE]?

CHASE FRANCL: So, so since this change, an individual who is on Medicare, we are now able to bill for. So, that same rate is there, whether they have just Medicare or they have Medicare and Medicaid. The difference with this legislation is we have contracts with our

behavioral health regions that previously, if someone was a Medicare client, we could have billed-- we weren't able to bill on them, and we were able to tap into our region contract, which is commensurate with Medicaid rates. And so, we kind of took a, a double hit on folks we're serving with only Medicare insurance, as well as those that are dual-eligible. Both those rates effectively got halved for us in this year.

ARMENDARIZ: So, would this bill take care of your Medicaid patients on Medicare, but not your Medicare patients not on Medicaid?

CHASE FRANCL: It would-- I believe it would take care of, of the dual-eligible, the Medicare and Medicaid patients. I actually-- I'm, I'm not clear if it would handle the Medicare-only patients as well. It's a good question.

ARMENDARIZ: OK.

CHASE FRANCL: I should probably know that, but I don't.

ARMENDARIZ: Thanks.

CLEMENTS: Yes, I was curious about that as well. All right. Any other questions? Seeing none. Thank you for your testimony.

CHASE FRANCL: Thank you very much.

CLEMENTS: Next proponents. Good afternoon.

ANNETTE DUBAS: Good afternoon, Chairman Clements, and members of the Health-- not Health-- Appropriations Committee. Excuse me. My name is Annette Dubas, A-n-n-e-t-t-e D-u-b-a-s, and I'm the executive director for the Nebraska Association of Behavioral Health Organizations. So, Jon and Chase did a really good job of telling you the impact coming from the providers' perspective, as well as the clients that they serve. And we supported this change in bringing these additional providers into the workforce, because that was a way to expand workforce, which in turn was going to build capacity. Unfortunately, the unintended consequence was the difference between the Medicare rate and the Medicaid rate was substantial. And I think with the handouts that Jon Day gave you, there's an example of the difference between, between those rates that will walk you through that. So, when we realized that well over a year ago, we reached out to Medicaid. And I want to give kudos to Medicaid, they were, they were great. We sat down, they recognized this as a problem. In fact, they gave us that six-months extension, let's see if we can figure out a way to make this

work. We turned over every stone we could possibly find to see if there was a way that we could make this work, from them just going ahead and making up the difference. We reached out to CMS. We kind of got some mixed answers from CMS. At one point they told us, you know, the state could do a state plan amendment. Every time we came back to the state saying, "Can we do this? Can we do this?" And so, they, they took everything we brought back to them under advisement. So, again, we want to let them know that we're very appreciative of that. But at the end of the day, their reason was-- I, I guess I'll let them explain their reason, but their decision was that they just were not going to be able to find a way to help us make up this difference. So, we have continued to try to figure out how, how do we make up the difference in this rate; brought this idea to Senator Dorn to use the hospital, hospital funds. But in preparing for today's hearing-- an email that I inadvertently overlooked, so I have not shared this information with Medicaid, so it will probably be new to them-- an FAQ that I just handed out to you with the highlight-- highlighted area. Our understanding says that Medicaid should be able to make up the difference between what Medicare doesn't pay. And so, we are hoping in some way, shape, or form that we can get the difference made up between the Medicaid and the Medicare rate to keep these providers whole, because we're talking about a population is-- that is the most vulnerable of vulnerable populations. They're typically elderly and, you know, the poorest of the poor, so-to-speak. So, while it's not a large number in the grand scheme of things, it's a very critical population, these are very critical services. And while my members are health care providers, they are also businesspeople as well, and at some point in time, they're going to be forced to make a business decision, and we don't want to have to put them in that position. So, we were really hoping, you know, between what the CMS FAQ says, that, you know, Medicaid should be able to make up this difference, or if there's other funding mechanisms that we can use that we can find a way to keep these providers whole, keep these services in place, and keep these individuals in the care that they need, that we'll be able to do that. And I'd be happy to try to answer any other questions you may have.

CLEMENTS: Senator Armendariz.

ARMENDARIZ: Thank you. Thank you. As I-- I, I apologize for walking through this, and I know we tried it earlier today too, and I want to make sure I have it correct. So, Medicare now has expanded their coverage of-- and, and had these masters-level practitioners accredited.

ANNETTE DUBAS: Yes.

ARMENDARIZ: So now, they can get Medicare payments.

ANNETTE DUBAS: They brought this additional workforce into being credentialed so they are-- Medicare, then, now is the payer of-- the first payer. Yes.

ARMENDARIZ: OK. So now, Medicare is the first payer to these newly-accredited masters-level professionals.

ANNETTE DUBAS: Yes. Yes.

ARMENDARIZ: And this bill will help them promote them seeing those Medicaid patients?

ANNETTE DUBAS: They'll continue to see these same-- the, the patients aren't going to change. They'll still bell-- they will still bill Medicare first, but then they will be able to come in-- right now, Medicaid will pay a small-- like, a co-pay. But instead, Medicaid would now come in and pay the difference up to the rate--

ARMENDARIZ: The gap.

ANNETTE DUBAS: --that they had been paid.

ARMENDARIZ: To where they were paying for Medicaid--

ANNETTE DUBAS: Yes. Yes. Taking them back to their original rate of being paid 100% by Medicaid.

ARMENDARIZ: Got that. And then we keep those licensed professionals wanting to see them--

ANNETTE DUBAS: Correct.

ARMENDARIZ: --they're, they're made whole.

ANNETTE DUBAS: Correct.

ARMENDARIZ: What about the other Medicare?

ANNETTE DUBAS: This doesn't have anything to do with straight Medicare clients.

ARMENDARIZ: I'm just wondering what, what encourages them to keep seeing them now, if they're getting the reduced rate for them.

ANNETTE DUBAS: Well-- I guess I can't answer that specifically. I don't know what the percentage of straight Medicare patients are versus the, versus the dual-eligible. So, I, I can't--

ARMENDARIZ: OK. That's the question that came to mind as I listened to testimony.

ANNETTE DUBAS: Yes, and-- I'll check with, with our testifiers and see if we can answer that question for you better.

ARMENDARIZ: OK. Thank you.

CLEMENTS: All right. Would you review what this highlighted paragraph is saying?

ANNETTE DUBAS: Yes. So, this is the FAQ from CMS website. And the question is, is a state required to pay primary for an item or service provided to a full benefit, dually eligible individual enrolled in original Medicare? So, the, the response that we have highlighted on this is "If [a] provider or supplier is enrolled in Medicare and provides an item or service covered by Medicare and Medicaid to a full-benefit dually eligible individual, then the provider or supplier should bill Original Medicare as the primary payer as Medicaid is generally the pair of last resort for items and services provided to full-benefit dually eligible individuals. If a balance remains after Medicare has paid the provider [...] or Medicare has denied a payment for a substantive [...] reason, the provider or supplier can submit the claim to the state for payment of the balance, up to the maximum Medicaid payment amount established." So, that's our interpretation; that, that Medicaid can come up and pay that difference.

CLEMENTS: Is that a CMS answer to a question?

ANNETTE DUBAS: That's-- this is the CMS FAQ, yes.

CLEMENTS: All right. Senator Armendariz?

ARMENDARIZ: Thank you. That provokes one more question. This, to me, sounds like it would be a savings.

ANNETTE DUBAS: It would be, because previously, before these--

ARMENDARIZ: To the state.

ANNETTE DUBAS: To the state. Previously-- so, if an LMHP was seeing a dual-eligible client, Medicaid was paying 100%. Then, when they were

able to become credentialed by Medicare, Medicare was the first payer. So, this would be not additional dollars; this would be-- actually, they'd be paying about half of what they had been paying.

ARMENDARIZ: All right. So, why do we have a fiscal note?

ANNETTE DUBAS: I mean, there would be a cost. There still would be a cost.

ARMENDARIZ: Additional to what we were already paying?

ANNETTE DUBAS: No.

ARMENDARIZ: We can go through this [INAUDIBLE]--

ANNETTE DUBAS: Yeah. My, my, my opinion is it wouldn't be additional money because these were monies you were already spending. You were paying 100% previously.

ARMENDARIZ: And it'd be less, now.

ANNETTE DUBAS: Now, you would only be paying about 50%.

ARMENDARIZ: Correct.

ANNETTE DUBAS: And that's where we-- you know, we got the 1.5 in conversations. You know--

ARMENDARIZ: We'll work on that.

ANNETTE DUBAS: Yeah. We will. We'll be happy to work with you.

CLEMENTS: Other questions? Seeing none. Thank you for your testimony.

ANNETTE DUBAS: Thank you.

CLEMENTS: Next proponent. Seeing none. Is there an opponent? Good afternoon.

DREW GONSHOROWSKI: Good afternoon. Happy to be back. Good afternoon, Chairman Clements, and members of the Appropriations 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 director of the Division of Medicaid and Long-Term Care in the Department of Health and Human Services. I'm here to testify in opposition to LB55. DHHS has always enrolled licensed independent mental health practitioners and marriage and family therapists as providers in the Nebraska Medicaid program, but Medicare has not

historically done so. To minimize the impact on patients, the department previously created a bypass policy that allowed LIMHPs and MFTs to bill Medicaid directly. Effective January 1, 2024, Medicare changed its policy and expanded provider enrollment to include LIMHPs and MFTs. Because Medicaid is required to be the payer of last resort, the bypass was eliminated, requiring LIMHPs and MFTs to enroll with and bill Medicare first when the patient is dually enrolled in the two programs. These changes bring the LIMHPs and MFTs into parity with our clinical psychologists and licensed clinical social workers, which still pays quite well. In fact, Nes-- Nebraska Medicaid's behavioral health rates are already 2.6 times higher than the national average, and the current Medicare rates are higher than 44 other states' Medicaid rates. LB55 would revert the payment process for the LIMHPs-- LIMHPs and MFTs back to how it existed under the bypass, and would also reverse the way the Nebraska Medicaid program has always paid for the other behavioral health providers. The department's opposition to this bill comes down to maintaining parity across all our services and provider types. When considering if the department should set a precedent by making special accommodations for one provider group, the Nebraska Medicaid program must evaluate that need in its full context. Making exceptions to our coordination of benefits policy will open the door to many provider groups that would love similar accommodations. The department has a responsibility to manage the entirety of the Medicaid budget, not just this portion of the program. DHHS recognizes that these changes have a significant impact on some organizations that may have built their billing structure or budget based on the previous bypass process. However, we can not justify its continuation or potential expansion given the inequity of payments and processes it would create. We respectfully request that the committee not advance the bill to the-- to General File. Thank you for your time. I would be happy to answer any questions on this bill.

CLEMENTS: Are there questions? Senator Armendariz?

ARMENDARIZ: Thank you for coming, and I am so glad you are the next one up because you're going to tell me.

DREW GONSHOROWSKI: And thank you. And I'll do my best to answer any questions, too.

ARMENDARIZ: I understand your position on it. You, you see that the feds came in and they're going to cover them across the board now, that you can step back and they're, they're supported financially, and Medicaid can just remove themselves from it. So, instead of the reduction in expense that seems that this bill would be doing, you

would just like to let them go with Medicare across the board, whether they're Medicaid eligible or not. Tell me why there's a fiscal note on this, if it's a savings to Medicaid--

DREW GONSHOROWSKI: Ultimate--

ARMENDARIZ: --aside from that argument.

DREW GONSHOROWSKI: Ultimately, the bring-- in 2024, we're, we're sort of-- we're sort of discussing the, the fact that across all our providers and services, we have this coordination of benefits policy. Ultimately, what that means is that-- let's say-- let's take an example specific to this. You, you would have Medicare usually pay 80% of, you know, a master's-level therapist. So, let's say right around $100 bucks, so, Medicare pays $80. Under our continue-- our-- under our, our, our current policy, that $20 co-pay, Medicaid would make them whole to the Medicare rates. That's, that's how it works across all of our services and providers. Ultimately, that, that sort of is very different under-- when our rates are nearly twice as high as the Medicare rates for, for these specific therapists, and that's how it had been previously. Under current policy, we're paying up to the Medicare rate. If we reverted that policy again, that-- that's your additional cost in the, in the fiscal note. In addition to that, this piece of legislation extends to all behavioral health providers in our reading of the legislation, which has an even additional cost. That's why it's higher than the, the 1.5 that, that is-- that's outlined in the bill. So, it wouldn't just be the marriage/family-- marriage and family therapists and the LIMHPs; it would actually extend to all behavioral health providers.

ARMENDARIZ: So, you're saying that previously, you were paying up to Medicare rates?

DREW GONSHOROWSKI: So previously, we were paying a Medicaid rate for a pop-- for, for a service that wasn't provided by Medicare. And when it was--

ARMENDARIZ: OK. And it was higher than the Medicare rate.

DREW GONSHOROWSKI: Yeah, it was twice as high.

ARMENDARIZ: Twice as high.

DREW GONSHOROWSKI: Yes.

ARMENDARIZ: So now, you would just be the payer of last resort, which would shrink that way down.

DREW GONSHOROWSKI: Yeah. Which would pay it to the co-pay, yeah.

ARMENDARIZ: But there's still an additional cost.

DREW GONSHOROWSKI: There is an additional cost because our current policy is paying up to the Medicare rate. So, the cost of this-- so, as it stands right now, that, that is our current policy. This changes our current policy, and, and effectively, instead of paying that extra $20, we're, we're on the hook now for another $100.

ARMENDARIZ: OK.

CLEMENTS: Senator Spivey?

SPIVEY: Thank you, Chair. Thank you for being here again. It's nice to see you. And I think I'm kind of struggling a little bit with that as well. One of the questions-- and as you heard from the testifiers-- is that there's an issue with parity on pay, and so that, that is not actually being matched. And so, I, I don't think I'm tracking with you around what you're saying for the current policy and reimbursement rate versus what the providers are actually saying they're getting reimbursed, and why this is necessary. So, if you can maybe provide some clarity to that?

DREW GONSHOROWSKI: Yeah, for sure. And I really appreciate the question. Ultimately, January 1, 2024, Medicare started covering these services. Traditionally, there was a-- Medicaid was filling-- previously in Nebraska, Medicaid filled this gap at a much higher rate.

SPIVEY: OK.

DREW GONSHOROWSKI: When, when Medicare stepped in and became the first payer, my understanding is Medicaid stepped back and incorporated this service into its coordination of benefit policy, which is the same for--

SPIVEY: Can I ask you a question?

DREW GONSHOROWSKI: Yeah, go ahead.

SPIVEY: So then, that's where people that are dually-- can be dually enrolled.

DREW GONSHOROWSKI: Correct. That, that would be for people that are, that are dually enrolled.

SPIVEY: But so, for folks that are eligible that just have Medicaid, they're still at-- and necessarily not pay parity then, correct? Since Medicare has a higher rate and is the first payer.

DREW GONSHOROWSKI: So, Medicare has a lower rate. So, I-- OK. OK, so, let me try to under-- let me try to explain it. So, Medicare's rate is about half of what Medicaid's rate was for this service--

SPIVEY: OK.

DREW GONSHOROWSKI: --previously. And Medicare's rate is actually at that level for someone that would have a Side D [SIC] as well. So, if they are just someone that is Medicare-eligible-- so their income would be above that eligibility threshold-- and they got services, they would be getting-- the, the provider would be getting half of what Medicaid paid previously.

SPIVEY: OK.

DREW GONSHOROWSKI: So, dually eligible would be someone that is income-eligible for, for Medicaid and also over the age of 65. And that is what the-- this legislation is trying to address, that population specifically. Medicaid is-- we can't touch sort of what is going on on, on that Medicare side, if it-- if they are only Medicare-eligible, if they-- if their income is above the threshold.

SPIVEY: OK.

DREW GONSHOROWSKI: Does that help?

SPIVEY: Yeah. That's helpful. Thank you.

CLEMENTS: Other questions? So, the state's policy now is to pay the 20% of the Medicare co-pay?

DREW GONSHOROWSKI: Yes, that, that is the policy, and that's the--

CLEMENTS: Medicaid-- Nebraska Medicaid pays the 20%?

DREW GONSHOROWSKI: Yeah, that, that is correct, and that is the policy off-- across all of our-- all of our services--

CLEMENTS: All right.

DREW GONSHOROWSKI: --as the payer of last resort. Yes.

CLEMENTS: And did you hear about this CMS question?

DREW GONSHOROWSKI: I, I would, I would have to look at that and take it back to my team. It's not something I-- I'm aware of.

CLEMENTS: All right. I'd be interested in your comments about this, if we can get you a copy of it. Any other questions? Seeing none. Thank you for your testimony. Are there other opponents?

DREW GONSHOROWSKI: Thank you.

CLEMENTS: Seeing none. Anyone here in the neutral position? Seeing none. We have comments for the record: proponents, 21; opponents, 0; neutral, 0. Senator Dorn, you may close.

DORN: You bet. Thank you. I, I, I think-- I, I, I think-- Jon, you gave this handout, didn't you, what listed the rates? I, I think everybody got that. He was the first person talking that listed the Medicare rate in there, 93-something, and the Medicaid rate at 187, and explains what has happened to the thing or whatever. I also would be very much remiss if I didn't say a little-- I don't know, maybe Annette left already-- is she in the back? Annette Dubas-- former state Senator Annette Dubas has announced that she is retiring at the end of this year. And she has been a very, very vital part to all of these types of, I call it, legislative activities. Very, very knowledgeable, and we really thank her for all she's done. I just wanted to mention that when she was here and stuff today. I don't know if you'll be back to testify this year or not, but I wanted to make sure that we, we got the words in to thank you very much, so. Yeah, I-- thank you for some of those questions. I think those were some very, very good questions and stuff, so we get a little bit of explanation more on this. And I guess if there's other questions that I can maybe answer, fine. If not, we'll go on to the next one and stuff, so. And Senator Armendariz, those-- yeah. So-- it-- many of these things, the one-- another thing I've learned in being up here in six, seven years, many of these things are so, I call it, involved that it's not just a black-and-white thing always; it's so many other things that become a part of it. And they have-- I know Senator Clements, too, it, it is-- it takes a while to learn some of those things, and, I call it, the intricacies of all those things, so. Thank you for some of those questions.

CLEMENTS: Very good. That will conclude LB55. We will next open a hearing for LB57. Senator Dorn.

DORN: Yes.

CLEMENTS: Just wait-- wait just a minute, here.

DORN: OK. We'll let someone move up here, too.

PROKOP: Just, just spin around in your chair to reset, right? Yeah, just do a circle.

CLEMENTS: Please begin.

DORN: Good afternoon, Chairman Clements, and fellow members of the Appropriations Committee. My name is Senator Myron Dorn, M-y-r-o-n D-o-r-n, representing District 30, here to reduce-- introduce LB57. LB57 would appropriate funds for the Medicaid waiver assisted living facility service under Program 348. In 2021, the Department of Health and Human Services contracted with a third party to carry out a rate study of Medicaid waiver services by conducting a detailed cost analysis and rate comparison with other states. LB57 would appropriate the funding necessary to increase the Medicaid waiver assisted living rate to the level recommended in the study-- study's preliminary report, which identified a significant gap between the current payment for these services and the actual cost of care. Current daily rates are $62.73 for rural facilities, and $73.91 for urban facilities. The DHH [SIC] study recommended parity between rural and urban facilities' rates, as the study found no difference in the cost of care, regardless of where the facility was located. Based on speaking with assisted living providers in my district and other parts of the state, it is important that Nebraskans, especially those who rely on Medicaid, are able to access assisted living services when they need assistance but don't require 24-hour nursing care. LB57 would apply the department's own study recommendations to provide parity between the two separate rates. The specific rates within the bill are the recommendation rate of $78.45, plus an additional amount to include an inflationary adjustment, since the cost data for the rate study well u-- was-- were utilizing 2021 data. Therefore, the rate proposed within LB57 for fiscal year '25-'26 is $88.24, and for fiscal year '26-'27 is $91.78. We all know this is nowhere near the actual cost of an assisted living facility to provide care, especially as the study was based on 2021 cost report data. But at the very least, LB57 moves us closer to the actual cost, and helps alleviate the financial burden placed on assisted living facilities who provide the essential care to their clients. I would like to make a comment on the fiscal note. The fiscal office and DHHS included the Medicaid rate for multiple occupancies, which DHHS only rarely approves. Typically, this is only approved when

a husband and wife both qualified for Medicaid waiver assisted living and share a room. It is reasonable, but perhaps we should have specified that we are only asking to raise the single occupancy rate to $88.24 for both rural and urban assisted living facilities for fiscal year '26, and $91.78 for fiscal year '27. This could shift the fiscal assessment, and our office will be following up. Following me will be Jalene, Jalene Carpenter, representing the Nebraska Assisted Living Association, and several providers who will share their perspectives, and available to respond to any questions also. Thank you.

CLEMENTS: Are there questions? Senator Spivey?

SPIVEY: Thank you, Chair. And thank you again, Senator Dorn. You have brought, like, a multiple kind of bills around, like, Medicaid and-- which I think is important. Like, I work in this space, so I, I really appreciate that. Is there, like, a reason-- have-- like, have you noticed, and as you're working with partners, that they're saying, here are ways that we can really start to address some of the things that they're seeing? Or, like, what was kind of the intention around this catalog of the bills that you brought?

DORN: I hope I understood the question right. I, I, I have always been, I call it, bringing bills for these type of rates and these type of assessments. I think-- I was going to use this in my closing, but I'll mention it now. When the dental people were here-- particularly Jessica with the state dental association-- I think she showed some numbers that when we are what I call proactive, and we are out ahead of the curve and we do some of these, I call it, preventive type services, it shows that in one year, what they basically saved or whatever, many of these things here that I've been bringing today or similar type situations-- yes, we, we, we as a state don't always fund them fully, and yet later on, we know we're going to have costs, we're going to have higher costs. And if we can do preventive on the one hand and fund it at those levels, what will we save, or what will we now decrease in costs for the state in future years? Sometimes-- and as I've been up here over the years that-- we'll-- we're hear quite often the comment, "Why are our costs so high out here? Why are our costs in certain areas so high?" If you really wanted to dwell into it and look, you could go and look back and go 10 years ago or 15 years ago, they didn't implement this part of the program that that would have saved us a bunch of funding. We-- you know, there's quite often-- they're-- the dental people, there, when they went to the hospital. Many of these other things are the same thing here. If we don't take care of these patients, right? Don't have the right provider rates, these patients will end up, then, maybe in the hospital. Now that just becomes another

whole cost for us that is a higher rate, and yet we pay that because that is the steps that are involved in it. And yet, if we could really do a really good job as a state, we would fund many of these things, I call it, more on the front end, and save ourselves costs. But that's--

SPIVEY: Yeah.

DORN: --unfortunately-- and especially in a town-- time like this, where we have a budget deficit, those types of funds are very, very hard to come by.

SPIVEY: Yeah, I appreciate that, and I think-- like, I see on the maternal health side, if you invest in, like, the health of the mom and baby, then there's not the pre-term births, or NICU stays and all of that. So, I really appreciate you lifting that up, and kind of, like, the intention behind it an-- it makes a lot of sense, and I just appreciate it. So, thank you.

DORN: Thank you.

CLEMENTS: Other questions? Seeing none. We'll welcome the first proponent.

DORN: I'll be around for the close.

CLEMENTS: Oh, OK.

JALENE CARPENTER: Good afternoon, Chairman Clements, and members of the Appropriations Committee. My name is Jalene Carpenter, J-a-l-e-n-e C-a-r-p-e-n-t-e-r, and I am the president and CEO of Nebraska Healthcare Association. I'm here today on behalf of our 230 nonprofit and proprietary assisted living community members to testify in support of LB57. Thank you to Senator Dorn for introducing this important legislation. He did a fantastic job of telling you exactly what the bill does, and so I would like to start to address why the bill is important to, to be taken up now. Your handout will be coming around, but there is a graph where, starting on the left, is what is called the caregiver support ratio. And these are family members who could potentially care for an aging person in their home. In 2020, there were roughly six family members for every aging individual. By 2040, there will only be three. On the right hand side of the graph are Nebraskans age 75 and older. As you can see, that number is increasing exponentially. The need for access to multiple levels of care now and in the future will be critical to address our aging population. So, we're back at-- we are talking about assisted living Medicaid waiver, and I would like to define both of those, starting with "What is an

assisted living?" An assisted living is a vibrant community where individuals can receive shelter and food, personal care assisted services; they have activities and housekeeping; they are given medication assistance, transportation, et cetera. An assisted living is not a nursing home, and cannot provide ongoing medical care by a licensed nurse. Medicaid waiver. I think this is an important distinction to make, because not all Medicaid is the same. So, Medicaid waiver is only available to an individual who is aged or disabled, determined medically necessary by the state of Nebraska, and have exhausted all of their financial resources down to $4,000 or less. These are hardworking Nebraskans who supported their families; they paid their taxes, they contributed to their communities, they truly believed that they planned for their future and that they had resources financially to pay for their care. Unfortunately, many are outliving their financial resources. In our current system, very few assisted livings will accept Medicaid waiver due to the woefully inadequate rate. This pushes individuals into more costly and higher level of nursing home care. The graph paints a very clear picture. We as a state, need to ensure that as Nebraskans age, that we have available levels of care-- assisted living and nursing facility care-- available at the right time for that individual, whether that individual has financial resources or not. There's many providers behind me that are going to give you examples of why it's critical and who they serve, but I would ask for your support of LB57, and I would be happy to answer any questions.

CLEMENTS: Are there-- excuse me. Are there questions? I had a question about the, the rate study that was discussed. Was that comparing to national rates?

JALENE CARPENTER: No, that was a study done by a third party that the state of Nebraska issued, and it took data from Nebraska assisted living facilities specifically.

CLEMENTS: OK. Of costs?

JALENE CARPENTER: Of costs, yes.

CLEMENTS: Costs of care?

JALENE CARPENTER: Yes.

CLEMENTS: All right. Thank you. Thank you for your testimony. Next proponent. Welcome.

MARV FRITZ: Good afternoon. Thank you, Senator Clements, and the, and the Appropriations Committee. And thank you to Senator Dorn for introducing this. My name is Marv Fritz, M-a-r-v F-r-i-t-z. My wife Dee and I-- my wife Dee and myself operate a rural assisted living facility in O'Neill, Nebraska. I, I left you an expanded testimony because it's a lot more than three- or five-minute story. I have our analysis from our 24 facility-- or, our '24 cost from our 24-year-- on our facility, and also the 2019 numbers that the DHS [SIC] used. Everybody keeps saying 221, but it was really 219. Shows our-- and also showed our payment waiver rates clear back to 2011. We fell behind every other medical service in reimbursement because we started with a low rate and everybody got the same percentage rate every year, so our $50 rate with a 2% raise every year, compared to even urban or a nursing home at 10 or-- $10 higher than ours, all of a sudden keeps stretching out. So, we're a long way behind. They've had-- I, I guess DHS [SIC] would never rebase that. They rebase nursing homes all the time, but for whatever reason, they tell us that you won't let us, let us rebase that one. I'm not sure, so hopefully you can at least tell them to do that much. Because we have to compete for the same workforce. I mean, once, once these guys had the money to do what they needed to do-- which they needed, absolutely. Then, we have to hire the same people that they do, and what happens is we hire them, and then they go to work for those facilities because they pay rates that we can't match, and we have to start over with young kids again. And we're kind of-- we're kind of at a crossroads, I think. This is, like, year number four I've been here. But we're now get-- I have-- I decided to take in independent living people into my AL because-- and I get $1.50 a day less for those than I get for waiver people. Next year, at the same kind of rates, I will actually get more money out of independent living than I'll get out of my Medicaid waiver people, which means no care versus all kinds of care. That just isn't going to fly. And what's happened? The insurance companies have gotten out of the long-term care business. So, we had for years about 60% of our people on, on insurance, along with the rest at about 20% private, and the other 20% were Medicaid waiver; we're down to 36% of the people on insurance now the last few years, and then our Medicaid waiver's up by about the same amount. So, this difference in wages for-- just for ours, we have, we have nine residents right now, we take $176,000 hit. Donation, I guess I call it, to the state of Nebraska for, for taking care of the Medicaid waiver people versus what we charge the same, same kind of care and the same kind of rates to, to the private people. Obviously, the private people have to make up most of that difference, otherwise we go out of business and we don't care for anybody. But there is a limit to what we can do. We've sent-- and I've, I've said this in prior years. I mean, we can, we can take care

of people a lot higher care than we used to 20 years ago. The average, the average cost to the state of Nebraska for each person that we've sent to the rest home or to the nursing home in the last three years has been about $250 a day, and you were paying us $91 a day for the same care. We can't take care of them for-- they, they have a higher level of care; understand they have way higher cost. So anyway, we did-- we, we can do it for part of that, but we can't do it for a third of it. And I, I just think overall, assisted living care could be the cheapest thing in the state if, if we would develop a program, more people would take it, we would-- more people would do it and, and it could save the state some money. The rest of it, you have some numbers in front of you of how that could work, so. Anybody has any questions, I'd be happy to answer them, and I appreciate your time.

CLEMENTS: Are there questions? I was wondering what your Medicaid population percentage is currently.

MARV FRITZ: Excuse me?

CLEMENTS: What is your percentage of Medicaid residents?

MARV FRITZ: About 20%. It runs-- it's ran from 20-- from 17% to 23% through the years. It-- the other thing that happens that I forgot to mention was the-- once the Medicaid-- and as far as taking care of people, we can take care of them that have a-- you know, we run a 95% to 98% survey we-- which-- survey, we sent to the parents or to the residents and the family each year. We run 95% to 98% excellent care for the last 23 years. And if-- you know, if we wasn't taking care of them, we wouldn't have that kind of a care level, so-- or, that kind of appreciation for our care. Oh.

CLEMENTS: Well, very good. Seeing no other questions, thank you for your testimony.

MARV FRITZ: Thank you.

CLEMENTS: Next proponent. Good afternoon.

ELDONNA RAYBURN: Good afternoon. Good afternoon, Chairman Clements, and Senator Dorn for introducing the bill, and Appropriations Committee members. My name is Eldonna Rayburn, E-l-d-o-n-n-a R-a-y-b-u-r-n. I am the executive director of The Lexington Assisted Living at 5550 Pioneers Boulevard, right here in Lincoln. I have been at The Lexington for eight years, and have spent a total of 25 years in the senior health care experience. We are very blessed in our community to have a lot of options in assisted living, and The Lexington, from its very

beginning, had a mission of serving individuals with limited and low incomes. We are the largest assisted living with the largest Medicaid waiver population. We are a 98-apartment building with a licensure of up to 104 people, and currently, we have 80% of our residents on the Medicaid waiver program. So, that is-- right now, with our current occupancy, that is 73 people that we serve every month on the waiver program. Even though Lincoln is blessed with many assisted living providers, not every provider has or does takes Medicaid waiver. We do not have any private pay minimums; you can move in on day one to The Lexington with Medicaid waiver approved. I also wanted to say that there are a number of things that are important in order for us to provide that many people on the waiver program. Number one is we were getting regular increases in the reimbursement rate. However, it's been since the middle of 2023 since we received our last increase. So, we made it through that year, but 2024 was extremely challenging for us. We are experiencing a number of increases in our expenses, and that would be our insurance, across the board, went up 30%; wages, since 2020, have gone up for a variety of reasons, mainly due to COVID and the shortage of workers, and the increased use on agency. So, the reimbursement is a, an extremely important part of that formula in order to provide the services. It's also very important that-- in a large facility such as ours that we maintain occupancy and run a very streamlined business, which we feel like we do. However, with market inflation impacting our food, we were over budget in food for the first time last year in a very long time. So, I am here in support of LB57 to move this along, to reimburse for the services that we still receive a very discounted rate, as opposed to our private pay rate. We want to continue to serve former teachers, nurses, veterans, business professionals, et cetera that don't have $5,000 plus a month to receive the care that they need in an assisted living facility. Thank you very much.

CLEMENTS: Are there questions? Seeing none. Thank you for your testimony.

ELDONNA RAYBURN: Thank you.

CLEMENTS: Next proponent. Good afternoon.

LISA NIELSEN: Good afternoon, Senator Clements, and Appropriations Committee. I'd like to also thank Senator Dorn for introducing LB57 and being committed to being a con-- an advocate for long-term care. We appreciate his support. I'm here in-- today as a proponent of LB57. My name is Lisa Nielsen, L-i-s-a N-i-e-l-s-e-n. I'm the current co-chair for the Nebraska Health Care Association Reimbursement Committee. I'm

also the managing partner in three assisted independent living facilities in Nebraska. They're located in Ord, Gothenburg, and Doniphan, and our Medicaid occupancy in those buildings range from 10% to 53%, depending on the location of those buildings. In 2019, assisted living started seeing higher than normal inflation, just like everyone else did with COVID. The cost of labor, insurance, food, and all other services became so much higher, and Medicaid income versus cost per day to do business became upside down. The average losses that we're experience in our buildings varies based on the number of beds, facility occupancy, and debt. Each situation is different, but for our buildings, the Medicaid loss per day averages $35 per bed. In a year, that's over $12,000 for a resident that we're losing, and that's significant; up to $150,000 a year. And, as you're probably aware, assisted living facilities are not required to participate in Medicaid waiver. For the first time, rural facilities like ours have started to limit the number of people that we will admit as Medicaid recipients. In addition to the financial burden of Medicaid, we're seeing much higher level of care as those people are moving in a little bit later in life. They often have very little family support because children are all moving away from the rural communities and going to the cities, so we really become their family, and we're doing, we're doing a lot for them. And then, in addition to the, the rate and the increased level of care, there's a greater regulatory oversight for assisted living Medicaid than there's been in the past. Recently, the state contracted with Liberty Health to come in and do an annual survey of assisted living facilities that accept Medicaid. We already are surveyed by the state; we already have state regulations, so it's another layer of regulations in addition to a caseworker that comes every month to see those residents. And reporting requirements, whenever somebody falls, whenever there's an incident, whenever they go to the hospital, medication change. There's just-- like, there's a list of things that we have to notify their caseworker if something happens, and that's become more onerous on the administration. And in a small facility, you have an administrator that's wearing many hats. It's becoming harder and harder to provide that care. And my home's in Kearney; I travel between the facilities that I help manage. And thinking about my testimony today, I wanted to just find out what the local area assisted living facilities-- you know, how many Medicaid beds, how many Medicaid people those were accepted in the-- in Kearney, and there are 425 licensed beds in Kearney. And in talking with the administrators, about 20% of those beds are available for Medicaid, so that's 80 beds-- approximately 80 beds in an area that's going to serve 8,000 people that are over the age of 65. And the "silver tsunami" is coming, it's here, and I, I just don't know who is going to care for

these people. Rural facilities like ours are closing because we can't compete with wages and the benefits of a larger community. We wish to continue to provide quality environments for residents who must rely on Medicaid benefits. However, the magnitude of the daily cost cannot continue to be absorbed. LB57 will be a significant step in allowing us to provide services to those with limited resources, in a quality living environment. And I'm happy to answer any questions. Thank you for your time.

CLEMENTS: Are there questions? Senator Cavanaugh.

LISA NIELSEN: Sure.

M. CAVANAUGH: Very important one. Have you trademarked "silver tsunami?"

LISA NIELSEN: No. I've heard it before.

M. CAVANAUGH: Oh, I have never-- I have never heard it before, and my dad is--

LISA NIELSEN: It's a, it's a-- I think it's a fact.

M. CAVANAUGH: My dad is not actually, like, a derogatory term of use of it, but he is a boomer.

LISA NIELSEN: It is.

M. CAVANAUGH: So, I'm going to say that to him now. Thank you for your testimony, and for being here today.

LISA NIELSEN: Thank you.

CLEMENTS: I think I resemble that remark. [LAUGHTER] Other questions? Seeing none. Thank you for your testimony.

LISA NIELSEN: Thank you.

CLEMENTS: Next proponent. Good afternoon.

KIERSTIN REED: Good afternoon, Chairman Clements, and members of the Appropriations Committee. My name is Kierstin Reed-- that's K-i-e-r-s-t-i-n R-e-e-d-- and I serve as the CEO for LeadingAge Nebraska, which represents governmental, nonprofit, and locally-owned providers of aging services. Together, our members serve over 5,000 Nebraska seniors in a variety of settings. We would like to thank Senator Dorn for bringing this bill forward. This bill aims to increase

the Medicaid reimbursement rates for those assisted living facilities in Nebraska. This has not occurred since January of 2022. It also intends to standardize the rate between urban and rural settings. Assisted living providers play a critical role in the state's health care continuum by providing supportive services and care to individuals that are either aged, have illness, or physical disabilities. These facilities offer a housing alternative for those who may not be able to stay in their home, and assistance with their activities of daily living. They also provide safety and security for these older adults. Nebraska has been facing a significant challenge in maintaining these vital assisted living services. Since 2017, more than 33 assisted living facilities in Nebraska have closed. This has a lot to do with inadequate funding and services through the Medicaid waiver program. In our rural areas, it forces people to travel greater distances in order to access essential care. The proposed increase in Medicaid reimbursement rates is essential in order to provide stability in these services. As you have heard, the current rates fail to cover the additional costs of care, and providing these services-- the providers of these services are left with making a difficult decision to not provide services to people on the Medicaid waiver, because they simply cannot afford to. We are asking for reimbursements to be adjusted to more accurately reflect the cost of service, not to cover the cost of service. This will allow providers to continue to provide these essential services to those in need. The projected rate of-- by 2030 is that the number of people over the age of 65 is going to reach-- double by more than near the-- nearly 30%, becoming the largest demographic population in Nebraska. The demographic shift underscores the importance of enhancing these services and making sure that assisted living providers are able to meet the needs of this growing population. I urge the committee to advance this bill, and to support assisted living services in our state. Thank you for the opportunity to testify today, and I'm happy to answer any questions you may have.

CLEMENTS: Are there questions? Senator Prokop.

PROKOP: Thank you. And, and feel free-- realizing maybe I should have asked this to one of the earlier testifiers-- but you mentioned just the closures and the amount of travel that people have to do, or, or where they have to go to get to facilities. Has there ever been a study done as to, I guess I would call where a resident would have to move from their home base-- I mean, I guess their hometown-- to a facility, to be able to have the kind of services and level of care under this? It-- you know, how far away they have to get in order to access services from, I guess, their hometown? Has there anything ever been done like that? Because I'm, I'm just thinking of the dynamics of--

the, the impact this has on taking them away from their family members that might be in that hometown, and then those folks that then have to move with them too, and the economic impacts that has to their hometown. I'm trying to connect a lot of dots, and I-- also, I guess I wanted to say "silver tsunami," too, and get on the record--

KIERSTIN REED: Silver tsunami. Yeah, we all want to say that.

PROKOP: --of that, the transcript. So, yeah. Yeah.

KIERSTIN REED: I'm glad we were able to bring that word to you.

PROKOP: Yes.

KIERSTIN REED: It's been a popular phrase in our world.

PROKOP: Yeah.

KIERSTIN REED: I-- I'm sure there have been studies. What I-- I can't quote them today. What I can tell you is that, you know, when someone moves into an assisted living facility, obviously, they're going to try to find the place closest to home, right? So, they're going to go to that place. And when that place-- so, with assisted living, they only need to provide 30 days of notice. So, if that person says "I can no longer pay the bill and I need to go on Medicaid," and they've already got their fair share of Medicaid, they may say, "I'm sorry, we can't provide service." And so, they may need to go elsewhere. And these kind-- or, you know, your level of care is beyond what we're able to do. These things happen, and then people move from one place to the next place to the next place. And that has definitely been studied. So, the effects of moving from an assisted living to and the next assisted living, or even to skilled nursing, that has devastating impacts on people's health and people's lives. You know, there's also-- I was at one of our communities visiting, and there was a young woman there who was there supporting her grandma for the celebration that they were having, and she said the, the place that my-- or, he couldn't-- my dad couldn't get in-- or, my grandpa couldn't get in here; he had to go to the next facility down the road, and so now I have to come over here and I have to get her, and now I have to take her to go visit him. This is what happens in the smaller communities: they're traveling to take grandma to go visit her husband.

PROKOP: Yeah. And it's down the road 60 miles, or--

KIERSTIN REED: Yeah.

PROKOP: --100 miles, or--

KIERSTIN REED: Yeah.

PROKOP: --200 miles. Yeah. Thank you.

KIERSTIN REED: Yeah.

CLEMENTS: Other questions? Seeing none. Thank you for your testimony. Are there additional proponents? Good afternoon.

HANNAH GRAHAM: Good afternoon. My name is Hannah Graham, H-a-n-n-a-h G-r-a-h-a-m. I am the administrator of Parkview Lodge Assisted Living in Rushville, Nebraska, and have been invited here today by LeadingAge Nebraska. Today, I have the honor of speaking to you all as an advocate for LB57, which proposes an increase in funding appropriations to Medicaid in order to support the services our residents rely on every day. Parkview Lodge is a nonprofit facility operating as an entity of our local municipal government. Our facility is located in Nebraska's 43rd District, and houses 26 of the district's 170 licensed assisted living beds. The immensity and rural nature of the district presents distinct challenges to service providers in the region, while also imparting a unique importance to our presence in the eldercare industry. When a facility is forced to close, the displacement of residents is always inconvenient. On our end of the state, it can be catastrophic, as an alternative placement can be hours away. Providing competitive reimbursement ensures that facilities continue their ability to serve in the face of challenging economic times. Approval, approval of LB57 would aid in mitigating one major challenge my colleagues and I face: that of pay source availability and adequacy for lower-income adults. Many Nebraskans rely on Medicaid funding to subsidize their stay in an assisted living, without which their health and safety may be vastly compromised. Ensuring that adequate funding is available, facilities will be incentivized to take in the individuals that need these services without the fear of financial instability, keeping more beds full, and in turn, supporting an industry that has faced substantial hardship in recent years. Costs continue to increase. As wages go up, so do groceries, utilities, and other supplies. Providers rely on the revenue from resident rent, including Medicaid, to continue, to continue operations. Unlike many facilities, Parkview Lodge does not limit our Medicaid beds, and on average, 30% of our residents rely on Medicaid AD waiver to remain in our facility. Moreover, adequate Medicaid appropriations support the elder care industry and Nebraska's economy. These funds are not only ensuring that our elders are cared for, but the funding allows for opportunity,

especially across our state's rural spaces where jobs can be few and far between. Parkview Lodge, for example, is one of the largest employers in our community. We offer positions across multiple disciplines and levels of experience, and these roles allow for more people to build their future in rural Nebraska. I thank you all for listening to me today as I vocalize the needs of our state's elderly, and I hope that you consider bringing this bill forward and continuing its progress. And I'm open to any questions you may have.

CLEMENTS: Are there questions? How many hours away from home are you?

HANNAH GRAHAM: About six-and-a-half.

M. CAVANAUGH: Oh, wow.

HANNAH GRAHAM: Yeah.

CLEMENTS: Do you have any more comments? Driving that far, you get more time.

HANNAH GRAHAM: No, it's been very fun. Been a-- been an exciting trip. All of Rushville is abuzz. My residents are waiting patiently for me to return home with stories of the big city and a reenactment, you know. So.

CLEMENTS: Are you seeing increased requests for Medicaid beds?

HANNAH GRAHAM: As time goes on, yes. When I-- and I entered the industry fresh out of college, so I've been swimming around in it for almost ten years. And in that short window of time, there's been a shift from having a little higher rate of private pay application to seeing more and more Medicaid coming across and seeking rooms. Especially, as I mentioned, on our end of the state, beds are so limited. And then, you narrow down beyond that to who will accept Medicaid. It, it becomes a real challenge for people. We've brought in people from great distance that are seeking a bed that will accept Medicaid.

CLEMENTS: Senator Dorn said current rate for rural is $62.73. Is, is that your rate?

HANNAH GRAHAM: Mm-hmm.

CLEMENTS: And what would your average private pay rate be?

HANNAH GRAHAM: So, we are really unusual on that note. I will say that, that Parkview Lodge is used to living off of table scraps. Wildly conservative. We can really make-- part near make wine out of water out there. It is what we're doing because our private pay floats right at equivalence to Medicaid, if not a little below that. We have recently brought it to meet exactly what state Medicaid rate is. That was met with a lot of angry faces, as those westerners are resilient and very conservative themselves. They don't want to be overbilled or overcharged for anything. So, so we make ends meet, but it has not been easy. As I sit before you, I am the administrator, but I also work in the kitchen and I scrub carpets and I wax the floor, and I contract-- you know, anything that needs done, I do the hiring, I do the firing; I do all the payroll by hand. It wasn't until the last couple of years that I hired a service to figure my payroll taxes and submit them for me. I mean, everything has been an in-house job. My team is wildly committed.

CLEMENTS: Has statewide minimum wage affected your payroll?

HANNAH GRAHAM: That is an incredible hurdle for us. That little bit of leap that we had this year has not been entirely felt, but as we close in on that $15 mark, we will have a lot of hardship. The majority of my employees are working at or below $15 an hour, so that will be huge. Our licensed folks, of course, we'll need to bump them to accommodate bringing our minimum wage to $15, and so the trickle effect goes. That's one of those things that I'm constantly bracing for. Right now, we're planning to do quarterly increases so that we can gauge and respond proactively to that cost.

CLEMENTS: Other questions? Other comments?

HANNAH GRAHAM: Just thank you so much for having me. And if any of you want to, come out to Rushville. Spend the day with us.

CLEMENTS: All right. Thank you for your testimony.

HANNAH GRAHAM: Thank you.

CLEMENTS: Next proponent. Seeing none. Are there any opponents? Seeing none. Anyone here in the neutral capacity? Senator Dorn, come-- you may close.

DORN: Well-- oh, thank you very much. Thanks for the committee for sitting through three bills from one senator in one afternoon, so. I don't ever remember doing that, so. But thank you very much. Thanks for your attentiveness. And this last bill, there was a rate study-- part

of what we had in Appropriations, we'd had the discussion through the years, and, and DHHS was-- we were kind of, I call it, looking at what the rate study was going to be. The rate study has been done, and this bill here, this was brought based on the, the recommendations of that rate study, so that's maybe why the fiscal note seems a little bit, I call it, bigger than sometimes what we think it should be, but-- thank you very much.

CLEMENTS: Wait a minute.

DORN: OK.

CLEMENTS: Are there questions? I have a question. Could you spell "tsunami?"

DORN: I like that.

CLEMENTS: Seeing--

DORN: Just a minute. I'll have that looked at on this.

CLEMENTS: Seeing none. We have comments for the hearing record. T-s-u-n-a-m-i. Proponents, 55; opponents, 0; neutral, 0. That concludes LB57. We will now move to LB188, open the hearing. Welcome, Senator Dover.

DOVER: Thank you, Chairman Clements, and good afternoon, committee members. For the record, my name is Robert Dover, R-o-b-e-r-t D-o-v-e-r, and I represent District 19. LB188 would appropriate funds for the Medicaid nursing facility services under Program 3848 [SIC]. The request for fiscal year 2025-- '25-'26 reflects a 3% increase from last year's appropriation. Also included is an additional 3% increase for fiscal year '26-'27. This equates to a total increase in '25-'26 of a little over $13 million; 5-- 50-- $5.7 million would come from general funds and $7.3 (million) would come from federal funds. For '26-'27, it would be a total increase of $14 million, with $6.3 million coming from general funds and $7.9 million from federal. Just like our own household budgets, nursing facilities have experienced cost increases. The skilled nursing facility in my district are reported a significant increases in food, medical supplies, personal protective equipment, and the services necessary to operate a 24-hour residential facility. These costs, coupled with the need to increase wages to address staffing challenges as well as unfunded federal mandates, are crippling facilities not only in my district but across the state. You'll hear from a few of them this afternoon. Failing to provide an-- any increase in the appropriations only further exacerbates a critical

situation in our skilled nursing facilities and widens the gap between the cost of care and the Medicaid reimbursement, particularly in our rural communities. There will be testimony following my introduction to provide more detailed information. Thank you. I just want to say that I just think it's important that we take care of the rural communities, make sure that there's-- that they have all the-- I really believe that government should take care of public safety and public health number two, and transportation et cetera after that. But I really think that, that public health is critical for our rural communities, and people shouldn't have to move out of their community away from family members to go to a facility where they can get that proper health care. Thank you.

CLEMENTS: Are there questions? Seeing none, will you stay to close?

DOVER: Yes.

CLEMENTS: OK. We welcome the first proponent for LB188. Good afternoon.

JAY COLBURN: Good afternoon, Senators. My name is Jay Colburn, J-a-y C-o-l-b-u-r-n, and I'm from York General, where I serve as the vice president of long-term care services, also the administrator of our nursing facility, and I have been a nursing facility administrator in the state of Nebraska since 2001. I also serve on the Nebraska Nursing Facility Association board. So, a couple bullet points-- and I'll try and keep it brief-- so far in '25, we've had two facilities announced that they are closing and-- more nursing facilities, and there's another one brewing that I just learned about today, but no official announcement. So, facilities continue to close in Nebraska. Of those of us remaining, several if not a majority of us are, are marginal financially. If you go to the kind of personal closures for me in my career, my first facility closed-- not while I was there, but it has closed since I was there. That was Tilden; I'm in York, so my neighbor Utica closed, my neighbor to the south Exeter closed. Aurora tried to close; they were lucky they had some local business folks who've been and, and propped them back up, and built a nice new facility. And I really think the, the big canary-in-the-coal-mine moment for Nebraska was when, when we lost Valentine and created that care desert out west. So, we've already kind of covered that the country is aging; Nebraska is aging faster than the country on average, and rural is aging more quickly than urban areas. So, Nebraska will need more skilled nursing facilities in the future, but we continue to see the closures. Just looking at some of the demographics, we were provided some specifics that I was looking at-- so in 2020, we had 42,000-ish Nebraskans over 85; in '25, we had about 44,000, so that was a change of 1,000 in 5

years. If you go out to 2040-- in 15 years-- we're estimated to have just under 80,000 folks over 85, so we have a need coming up quickly but we're, we're swinging in the opposite direction, so. We've already talked about the budget at the state being very tight. We've already visited a lot about all of the inflationary pressures we're seeing with food supplies, health insurance, energy costs, labor costs, so I won't belabor that, but I will just remind everyone that our residents live with us 24/7, and we have to cover everything for them and care for them. Additionally, we have minimum wage along with nursing facility state and federal regulations that really limit us on how much we can trim from our budgets and remain compliant while taking good care of our residents and maintaining a safe work environment for our staff. So, a 3% increase will not offset everything that we'll see for increased costs this year, but it would be helpful and much, much appreciated. If I could switch to the hospital side real quickly as my organization has a hospital as well-- what we see in the hospital is sometimes we can't transition patients to an appropriate level of care, and beds become unavailable for those in need. So, in rural Nebraska, that can mean a long, long drive to find a hospital bed. Or, if you operate a critical-access hospital, it sometimes can mean that you have someone that really needs to be able to go to a bed in an urban environment for a higher level of care-- like coming over to Lincoln or Omaha from York's hospital-- and we're not able to get a bed because they can't clear their beds, because there's not enough nursing facility beds or not enough staffed beds. So, again, we're losing total SNF beds, and the beds remaining are not fully staffed at many buildings. Sad to say, this type of thing plays out even in my own organization where we really communicate well, we try to work well together and share what, what we have available for resources to take care of our community, and that's happened within the last month in our little town of York, so. Thank you for your time, and thank you all for your service to the state.

CLEMENTS: Senator Dorn.

DORN: Thank you, Senator Clements, and thank you for being here. You talked in-- or-- in the first part of the presentation about some of the nursing homes, skilled nursing homes that have closed. What-- give us several reasons why. Too much-- too high of a Medicaid patient numbers, or staffing, or what, what, what do you see, or what do you-- what does your organization hear?

JAY COLBURN: Yeah. A lot of it does come down to the cost of staffing has really risen very quickly in the last 4 or 5 years. So, I recently had a medication aide asking me for another raise, she didn't feel like

she was being compensated fairly, and I had figured out that in the past four years, her wage had gone up 35%, 36%. And so, we're seeing a lot of-- a lot of staffing costs that are driving that. That's my number one: staff and benefits. And then, Medicaid increases; you can go back historically and you can see kind of how those matched up with how costs changed. We, we did see a good increase in '22, sorry. And that was much appreciated, and that helped-- that, that did help a lot, but if, if you look back historically, I think we kind of had a lot of catching up to do. And unfortunately, we're, we're trying to maintain our costs reasonable, but we have requirements we have to meet.

DORN: It-- it's not because you're, I call it, only half-full. I mean, there's still demand out there for, I call it, beds.

JAY COLBURN: There is a strong demand for beds. Right now, our facility, we are not full, and we have a household closed for renovation but it's because we see the need for memory support care, and we've seen a lot of skilled nursing facilities exit skilled-- exit memory support care because it's a tough population to care for; takes a little more staff, takes special training, and can be tougher, tougher to run overall from the regulatory side. But yeah, we have, we have a hallway closed, but we need to--

DORN: Thank you.

JAY COLBURN: --get-- we'll get that back open in about two months, so.

CLEMENTS: Other questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thanks for being here. When did the facility in Valentine close?

JALENE CARPENTER: We can get you the date.

M. CAVANAUGH: OK. I'm just wondering if it was in the last couple of years.

JALENE CARPENTER: Yeah. 2020 I think--

M. CAVANAUGH: In 2020, OK.

JALENE CARPENTER: Right, right [INAUDIBLE]. Right around.

M. CAVANAUGH: So, I'm just reiterating what she's saying for the record. So, right before the pandemic, the Valentine facility closed in 2020. I asked because my aunt and uncle live in Hooker County, and the

Mullen facility closed after that. And so, that's-- I know having both of those in that area is pretty heartbreaking for those communities, so. Thank you for being here.

JAY COLBURN: No, thanks, thanks for getting that squared away on how it should be. I-- when I first moved to Nebraska, I lived in Brunswick, and whenever we went out west, we'd take the northern route. And Valentine is its own animal. Very unique, and-- yeah, sorry I'm blushing so much. It's just-- it's upsetting.

M. CAVANAUGH: Yeah, it is. Thank you.

JAY COLBURN: So.

CLEMENTS: Other questions? Seeing none. Thank you for your testimony. Next proponent for LB188. Good afternoon.

KATE REINERS: Good afternoon, everyone. Thank you for the time to speak to you today. My name is Kate Reiners, K-a-t-e R-e-i-n-e-r-s, and I'm asking for your support today of LB57 and LB188. For the last 17 years, I have served as the administrator of the village-owned Elwood Care Center assisted living and rehabilitation. I've watched members of our community pay privately for their care for many years, using up all of their savings, having to sell their homes, sometimes farmland, and then have to utilize Medicaid as their payer source. These are hard-working, community-minded individuals who never planned on utilizing Medicaid. Elwood is in the heart of rural south central Nebraska, Gosper County, and we have watched our neighbors to the north, south, east, and west close their doors, turn seniors away, and force elderly spouses, family members, and friends drive miles out of their way to stay connected to their loved one. The current funding is not sufficient. It costs us $300 per day to care for a senior. Our average Medicaid rate reimbursement last year was $205 a day. Half of the seniors we serve utilize Medicaid as their payment source; Medicaid reimbursed us $241,000 less than what it cost us to provide that care. How is the shortfall made up? We raised our private-pay resident rates by 20%. They are paying for the shortfall in government funding. The care centers in that position decreased $173,000 because of last year's operations; our revenues decreased 2.6%, and our expenses increased 5.6%. This business plan is not sustainable. The Elwood Care Center has been serving our aging population for over 50 years. We provide excellent care. We've repeatedly had deficiency-free annual state inspection results. Quality care is extremely important to us, and we have very high standards. We are the largest employer in the village of Elwood, with 62 employees generating $2.9 million in annual wages. We

find it a complete privilege to serve our aging population and provide great employment opportunities to our community members. But we must have your support to continue this. The inability for us to pay current staffing costs, keep up with, with the increases in minimum wage, incur constant increased costs in food, medicine, and supplies, and the shortfall in Medicaid funding will lead Nebraska to another nursing facility closure. It will happen. Another small town's economic health diseased, fewer job opportunities, fewer families, fewer choices on where to be cared for at the end of life, and another dried up rural community. Please prioritize Nebraska seniors and the care they deserve here in our great state of Nebraska, and their local communities where they are known and loved. Thank you for your time.

CLEMENTS: Are there questions? Seeing none. Thank you for your testimony.

KATE REINERS: Thank you.

CLEMENTS: Next proponent.

KIERSTIN REED: Hello again.

CLEMENTS: Hello. Welcome.

KIERSTIN REED: Senator Clements, members of the Appropriations Committee, for the record, my name is Kierstin Reed-- that is K-i-e-r-s-t-i-n R-e-e-d-- and I service the CEO for LeadingAge Nebraska. We represent governmental, nonprofit, and locally-owned providers of aging services. I, I think we've kind of made our point on, on the nursing home-- on the issue. I really want to go back, because I feel like I've been in front of this committee and, and Health and Human Services on numerous different funding issues this year, and it truly is because we have a crisis all across the board in aging services. So, we have our home- and community-based services, which is also part of-- the assisted living is part of that Medicaid waiver program, and then we have our nursing home services. And unfortunately, both are in desperate need. So, we did increase those rates for nursing home services, and I think we're always just trying to play catch-up. So, by the time we do get rate increases appropriated to those areas, it's based on dated information; it's based on information that was three years old, and we're still not funding those rates completely. So, that's why you see us back here year after year asking for more money. But I, I think the big concern is that we do have such closer-- closures in our aging services population, especially with the facility-based services. And our nursing homes--

we've lost 17% of Nebraska's nursing homes since 2017. That's a lot, and many, many, many of them are in our rural areas. So, you know, we really want to do our best to protect these, these nursing homes. We know that there is a budget shortfall in Nebraska; we know that you have a very hard job ahead of you to figure out how you're going to do this. The people that are aging in our state are, are that silver tsunami. They are coming at us like a herd of elephants. We don't have enough people to care for folks, and I-- we-- I-- it stresses us out every day. It's what keeps us up at night, is trying to figure out who is going to care for these folks. You know, if you have a business and someone is not paying you what the cost of your goods or services are, you're going to stop selling them the goods and services, you're going to go sell them to someone else. And someone earlier said that, you know, the-- it's the people who are paying privately who are the ones who are footing the bill, because we have to keep raising those rates. Well, guess who's going to be on Medicaid next? They are, because we just keep robbing Peter to pay Paul. We've got to figure out how we can adjust this and make sure that we've continually got increases coming in to get to covering the cost of these services. So, with that, I'll, I'll end there, and I'm happy to answer any questions that you may have.

CLEMENTS: Are there questions? Seeing none. Thank you for your testimony. Next proponent, LB188. Good afternoon.

MATT ROSS: Good afternoon. Thank you. My name is Matt Ross, M-a-t-t R-o-s-s. I'm the vice president of Rural Health Development. Our company manages small nonprofit rural nursing homes in 12 communities across Nebraska, and we provide consulting, consulting services to several others. We have been serving residents in Nebraska for 30-- 35 years. Thank you for the opportunity to give testimony here today so that I can share some of the challenges we see in rural Nebraska homes. A lot of this will probably sound familiar to what others have testified against. Hopefully by the end, we can kind of summarize back at what I think is the key point of all this. As you're aware, our state's had-- has seen a tremendous number of facility closures over the past five or six years. It has become increasingly difficult for small rural facilities to achieve a positive bottom line, and oftentimes, these nursing homes are exhausting their reserves to make up for the shortfall. Many of these homes have been forced to close, and others are in danger of a similar fate. In the past, it may have been census challenges that seemed the most pressing, but now what we see often as more problematic is finding and retaining enough qualified staff as our own facility employees. Many, many homes have become reliant on pool nursing agency members to maintain enough staff to care

for our residents. These agency staff come at a "heffy"-- hefty premium, so the cost of labor in many nursing homes has increased dramatically. Labor isn't the only expense that has grown. As you can imagine from experiences in your own life, the cost of food, supplies, and other necessities of care have increased at a pace we have not seen in quite a while. Our small town boards are having to make the difficult decisions to raise their private-pay room rates at percentages beyond what we are used to seeing. While Medicaid rates have historically been well below the rates facilities need to charge their private-pay residents, the gap will now begin to widen further if Medicaid funding fails to account for the increased cost of care in Nebraska nursing homes. The low-cost Medicaid rates often have nursing homes considering how many Medicaid residents they can afford to serve. The main concern that I wish to voiced to you today is that of availability of services for our elders. With so many nursing homes in Nebraska closing-- several more announced already this year-- access to local care is in jeopardy. Elders find themselves traveling out of their communities and away from their loved ones to receive care at facilities miles away from their homes. I believe a priority for our state should be to minimize this where we can. To ensure that, we need thriving nursing homes in our Nebraska communities. I'd like to thank you for your consideration as you deal with the challenging task of allocating resources for the care of all Nebraskans, and be happy to answer any questions you may have.

CLEMENTS: Senator Dorn?

DORN: Yeah, thank you, Senator [INAUDIBLE]. Thank you for being here. What-- what's going to happen some day when we have more people than what we have rooms?

MATT ROSS: That's the problem. I, I--

DORN: But, but, where will they go? Or what, what's going to happen? I mean--

MATT ROSS: That's what we're worried about. I mean, I, I think we see-- we've been talking about it today-- we see all the elders coming and that population expanding, and at the same time seeing nursing home closures, and, and I just think that's going to be problematic. I mean, obviously there's thoughts of, you know, caring for people in different points of the continuum, but that's a challenge all the way up through the whole line. You know, independent, assisted, home care, there's challenges all throughout that. But I, I am worried that the facilities, you know, in the past, you know, five or six years will be

closing that will be needed in five or ten years. And those communities won't have those folks, and, you know, people will just be forced to travel great distances, especially the rural. That-- that's who we help, you know, the rural communities, so we see facilities that they're the only nursing home in the county. And there's probably counties that just have none. I mean, you know, we've been talking about some of these closures that create these huge deserts of care, and it, it just seems that they just keep-- buildings just keep closing down. I mean, it doesn't take very long where you hear about another one.

DORN: Thank you.

MATT ROSS: Yeah.

CLEMENTS: Other questions? What percent of capacity do you see them, with their beds?

MATT ROSS: That's a good question. I-- you know, I think it does vary by facility. You know, most maybe are around 50, but-- or 80%. But what-- what's somewhat misleading about that is you do have some buildings who have-- technically, they have licensed bed numbers that are fairly high, but as they've tried to convert some of these tiny semi-private rooms to private, they may not really have the availability for, for that full number. You know, if, if, if-- how it's transitioned to really care for people is to put some single-occupancy people in a lot of these rooms. Sometimes, those bed numbers feel a little inflated. So, you kind of almost have to ask, you know, what is your licensed bed number? But then really, what's really your capacity? Because those numbers can be different.

CLEMENTS: I see.

MATT ROSS: Yeah.

CLEMENTS: Very good.

MATT ROSS: So.

CLEMENTS: All right. Thank you for your testimony.

MATT ROSS: You bet.

CLEMENTS: Next proponent.

JALENE CARPENTER: Good afternoon.

CLEMENTS: Welcome back.

JALENE CARPENTER: I think I'm your last one today. My name is Jalene Carpenter, J-a-l-e-n-e C-a-r-p-e-n-t-e-r, and I am the president and CEO of Nebraska Health Care Association. Thank you, Chairman Clements, and members of the Appropriation(s), and thank you to Senator Dover for introducing this legislation. I'm here today on behalf of our 170 nonprofit and proprietary skilled nursing facility members, and I had a whole page of written testimony, but based upon conversation and questions and the fact that it feels a bit like Groundhog's [SIC] Day because, you know, we've heard that it doesn't cover cost of care several times, so I think I'll just try to hit on the important, the important components of some of the questions that we have heard. I want to start by recognizing that Nebraska is, is incredibly unique. 61% of our nursing homes are not-for-profit or governmental. Nationally, that number is significantly less, so only 39% of our members are-- or, 39% of our facilities are for-profit, whereas 70% of providers in the nation are for-profit. So, we have a, an ecosystem right now of very benevolent providers who are trying to make this work, and there will be a handout that comes out that shows what our increases have been, and how they have not come up with the cost of care. I want to recognize that this Appropriations Committee has given dollars to increase reimbursement rates, and they have, and we've tried other creative solutions to do that as well. The problem is, is we never quite catch up, and so there's just this constant gap. And so therefore, we're back again asking for additional increases. There have been closures, and I am going to send out the-- in the handout that's coming around, it will show the closures that have happened: 16 in the last 4 years. There are care deserts that exist in the state of Nebraska. Valentine closed in 2021, just to answer that particular question. But I want to really address the reason for the closures. I know there have been conversations around what is called a certificate of need law that is here in the state of Nebraska, and how somehow that is resulting in closures of facilities. It is not. Certificate of need is actually intended to protect rural providers by ensuring that there is a need in the community. I would like to really stress the reason we have had closures is because we don't have an adequate system to allow rural facilities to remain open. When you have a facility who has 28 residents and they're in a town that is under 300 people, it is very difficult and very costly to continue to have that nursing home remain open. If we're serious about keeping facilities open, we would appreciate a 3% increase because that's reasonable, but if we truly want to address the issue upstream, it is to reconcile to cost; to say that we recognize that we think communities that are of rural nature

should remain open, and that those seniors should not have to travel. We need to look at a process where we reconcile to cost. I can't articulate enough our CON laws are not what is causing closure-- they're meant to actually protect quality and, and rural communities-- it's the fact that we don't have a system to support rural facilities. I think with that, I will try to answer any questions that, that we may have on that particular topic, or if there's questions around where the closures have occurred, and/or around anything else I said. Thank you.

CLEMENTS: Senator Armendariz.

ARMENDARIZ: Thank you. Thank you for being here today.

JALENE CARPENTER: Yes.

ARMENDARIZ: Can you give us an update on the assessment that we passed last year?

JALENE CARPENTER: Yes. So, we did increase our provider assessment; that allows facilities to pull down additional federal dollars. We-- we're just within the first quarter. We've been waiting for the department to give us the net impact on what that accomplished when it came to rates. It does increase the overall amount of Medicaid dollars that flow into the system. It is clearly not addressing the needs that we wanted it to, to have facilities be able to remain open. I can also tell you there was a lot of reservation from our membership to go in and increase that, based upon what's happening at the federal level where the provider assessment in particular is at top of the list when it comes to what federal Medicaid funding can be cut. From our national affiliate, when they look at the risk of federal Medicaid funds that potentially have the risk of no longer being funded, they-- you know, they've worked with the administration who said "we're not touching Medicaid. We're only looking at waste, fraud, and abuse," and there are several articles I can send you where there are Republicans on the federal level who see provider tax as abuse. And so, there are proposals to reduce that or eliminate it completely. Does that answer your question?

ARMENDARIZ: Yes. Thank you.

CLEMENTS: Other questions? Seeing none. Thank you for your testimony.

JALENE CARPENTER: Thank you. Oh, I forgot. May I have the priv-- apologies. Kate forgot one thing.

CLEMENTS: Oh. Go ahead.

JALENE CARPENTER: So-- Kate, I apol-- these are-- the gentleman on her left is a resident of hers, and the woman on the right is a-- the spouse of that resident who drives 80 miles every day to come to see her husband. And Kate wanted to show the photo, and she didn't, and I told her that I would do so.

KATE REINERS: Thank you, Jalene.

JALENE CARPENTER: You're welcome.

CLEMENTS: OK. Thank you for your testimony. Next proponent. Seeing none. Any opponents? Seeing none. Anyone in a neutral capacity? Seeing none. Senator Dover.

DOVER: I'll just end briefly saying that I, I think again, public safety, public health are what we should be doing here in state government, and I think that-- in rural communities, I think that the people that grew up there, have families there-- I have-- my grandmother was in Madison in a nursing home, and she got-- she, you know, was there for probably-- actually, nine years; she was 94 to-- lived to 102. [INAUDIBLE] I mean, I think, too, there's a certain thing that-- excuse me-- when we move them out of a, a nursing home that they're with all their friends they grew up with all their lives, and they, they know everybody in the community, I think there's a natural health benefit to that. I think when we take them out and put them in a place where they don't know anybody, I think they can go down quickly. And I think, I think we owe it-- owe them the right to, to live out the rest of our lives in the town they grew up in. Thank you.

CLEMENTS: Are there questions? Seeing none--

SPIVEY: Chair, I just have a--

CLEMENTS: Oh, excuse me. Senator Spivey.

SPIVEY: I just-- thank you, Chair. I just had a quick comment that I think what you're seeing in rural Nebraska also is in urban areas. Just nursing home closing, transportation is an issue, so I do think that there is synergy across our state in all of our different natural areas. So, I just wanted to uplift that, because I know in, like, District 13, we have the same issue, so. Just wanted to name that there's lots of synergies, and I think this type of legislation, to your point, is important. So.

DOVER: Great. Thank you, Senator Spivey.

CLEMENTS: All right. Seeing no further questions. Thank you, Senator Dover.

DOVER: Thank you.

CLEMENTS: We have comments for the record: proponents, 46; opponents, 2; neutral, 1. That concludes LB188, and that concludes our hearings for today.