[LB243 LB315 LB524]

The Committee on Health and Human Services met at 1:30 p.m. on Wednesday, February 6, 2013, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB315, LB524, LB243, and a licensing briefing. Senators present: Kathy Campbell, Chairperson; Bob Krist, Vice Chairperson; Tanya Cook; Sue Crawford; Mike Gloor; Sara Howard; and Dan Watermeier. Senators absent: None.

SENATOR CAMPBELL: Good afternoon and welcome to the Health and Human Services Committee public hearings for the afternoon. I'm Kathy Campbell and I serve District 25 which is east Lincoln and eastern Lancaster County. Before we have the other senators introduce themselves, I want to remind you of a couple of things. If you have a cell phone, please double-check that it's turned off or that it's on silent. There's nothing worse than listening to a ringing phone while you're testifying. If you are testifying today, you need to complete one of the orange sheets, print very legibly. And when you come forward bring the orange sheet with you and any handouts, and you can hand them to the clerk, Diane Johnson, over there and she and the pages will take care of them for you. If...we do use the light system in the Health Committee, although today it doesn't look like we have a packed house for the hearings. But you have five minutes on green...you have total five: four minutes on green; it'll go to yellow, you have one minute; and then it goes to red and I'll probably try to get your attention to finish out. When you come forward and sit down, please introduce yourself by saying, I'm Kathy Campbell, K-a-t-h-y. In other words, spell your name. That is for the transcribers who listen to the tape, and the orange sheet is for the clerk--two different sources here. The pages today are Kaitlyn and Deven so if you need some assistance, they'll be glad to help you. And we will start with introduction of senators. Senator to my far right, would you start, please?

SENATOR WATERMEIER: Dan Watermeier, District 1, which is southeast Nebraska.

SENATOR HOWARD: Sara Howard, District 9, midtown Omaha.

SENATOR COOK: I'm Tanya Cook, District 13, northeast Omaha and Douglas County.

SENATOR KRIST: Bob Krist, District 10, northwest Omaha and Douglas County.

MICHELLE CHAFFEE: I'm Michelle Chaffee, I serve as legal counsel to the committee.

SENATOR GLOOR: Mike Gloor, District 35, Grand Island.

SENATOR CRAWFORD: Sue Crawford, District 45, that's Bellevue, Offutt, eastern Sarpy County.

DIANE JOHNSON: And I'm Diane Johnson, the committee's clerk.

SENATOR CAMPBELL: Okay. Before we open our hearings this afternoon on the three bills, we have asked the Department of Health and Human Services' Division of Public Health to provide a briefing to some extent on licensing and credentialing and 407 and all those things. And, really, for the senators new to the committee, we generally have them come in once a year and just refresh our memory before we start on a long list of scope-of-practice bills so that you have a frame of reference. And Doctor, every year I ask this.

JOSEPH ACIERNO: Thank's fine.

SENATOR CAMPBELL: Acierno?

JOSEPH ACIERNO: Acierno, that's perfect. I go by Joe though normally.

SENATOR CAMPBELL: I got it right. Please come forward. Please come forward. Dr. Acierno usually comes to give us a handout, and while he is getting seated I will remind you that at any point you can certainly call Dr. Acierno or Dave Montgomery who is behind if you have questions about the 407 process and scope of practice and bills in front of it and they'll be glad to help you. So welcome, and please feel free to start right in.

JOSEPH ACIERNO: (Exhibit 1) Sure. Name...first name is Joseph, J-o-s-e-p-h, Acierno, A-c-i-e-r-n-o. I'm the deputy chief medical officer for the Division of Public Health. With me today I have Dave Montgomery. Many of you know him because of the 407 process, and that's what we're going to talk about a little bit. We have 15 minutes--and hopefully I won't make it more confusing to the new senators--and what's going on with that whole process because there was a change last year. I'll just open by saying I think the 407 process is a great process, and I think it's really a tool for all of you to use as you start evaluating practice issues. And the practice issues come in various forms from, I think I could be doing this, I think I should be licensed to do this, or an ongoing professional who thinks...profession who thinks, well, my profession should be allowed to do this. So that's kind of how it all kind of goes. And with the handout, I made sure it was--I call it middle-aged font for me so I can read this stuff anymore--but just a quick overview of what changed from where we were last year for the senators who have been involved with it. And many of you know the bill from last year; but we revised the criteria, and a proposal can now be favorably recommended without meeting each criterion. And that had always been a little bit of a sticking point. People had always complained, well boy, you know, on balance everything looked pretty good and then I failed on one criteria. So we looked at that, and I think there was agreement to move that forward. And the review time line was extended from 9 to 12 months--gives a little more breathing room to get

information in. And eligibility for the process was extended to include all professions regulated by the Division of Public Health, and we'll get into that a little bit more as we go on. An important factor: technical committees have more specific charge to require scientific evidence. The Technical Review Committee is kind of the first phase, and we'll get into that in a little bit. And what's been important is I think that that Technical Review Committee is to be used as a fact-finding body. Originally, before the law was changed last year, you could have adversarial folks sitting on that Technical Review Committee, so you already knew how votes or whatever could be lining up. We decided it was better to be an information-gathering body and to take out some of the bias. So as it's all being looked at, I kind of look at it as a little bit of a think tank--kind of looks at everything, brings information in, determines whether it meets...whether the proposal meets the criteria. So they have more leeway now for encouraging compromises and proposals. And the application process has been streamlined. I'll tell you, our folks do a very good job in getting all that information out to the folks because it is a cumbersome process. When you first say I want to go through the 407, there's a fair amount of information that we require in the department. So how does it begin? Well, a potential applicant can contact the department and say, here's what's going on, do I need to go through this process? So they consult with it, and it may be Mr. Montgomery or one of the other staff members, to determine whether they're eligible statutorily to go through the process. Describe what...and we describe the program to them and the responsibilities. And as you would know, some of this really begins when a constituent contacts one of you regarding a proposal for a new credential or change in scope of practice. And then referring to the department for consultation--and we do appreciate when that happens--to have the department called and say, hey, do I need to go through this process? And sometimes a bill will already be introduced, and then we can be contacted at that time. So before any consultation has occurred, you're kind of seeing it. So it's normally how it's going to begin. The application really is the foundation and the framework for the entire process. And I will tell you, the law is...and I'll just...and it's at 71-6221--I'm sure legal counsel always likes to hear citations to the law, so I thought I'd say that but that kind of lays out--and the subsequent sections of this process. And the application, again, there's various things in it, and it leads out through A through J some items, and it's fairly intensive. We want information from people ranging from the extent to which the change in the scope of practice might harm the public, to experience in other jurisdictions regulating that profession, the role and availability of third-party reimbursement for services. So we're looking at a whole host of things in the application process. So that application identifies the issues to be addressed, why action is needed, proposed solutions. The application may be for new credentialing; we'll get into that. This is where I think the process can get a little confusing, but...as far as what's for what here. But maybe for new credentialing, so we have two versions of that or change in scope of practice. Probably the thing you may hear most about is the change in scope of practice. Many times you'll have various professions who want to do some sort of procedure, let's say. And the application is for any profession currently regulated by the Division of Public Health or proposed to be regulated by them. That's a change from

where it was before and the law last year. Examples of that where we had no statutory authority was animal therapists or body artists. So we had no authority, so it would really be in your hands without any of that information to determine whether you want to proceed with a change in a scope or to, you know, go down a licensure path, a credentialing path. So now we have the Technical Committee is the first. They get appointed. The Board of Health appoints one of its members as the chair and recommends other appointees. And as you can see from the handout, the director of Public Health makes the other appointments. And it's usually not a very difficult process. And it says they must be neutral or objective to the issue, and we know that. We do send out questionnaires, so we know a little bit of the background of the folks who want to be on these committees, public members, and we ask them specific things that may show some sort of bias. And hopefully, we can elicit enough information from them that we know that they would be impartial as part of the whole process. So eventually they're appointed and then the Technical Committee goes into their work of considering the application. And I was talking to Mr. Montgomery earlier, the average time really to move through Technical Committee has been about six months. It just depends on getting people together. The scope of what we're looking at, some may be more intense than others depending on what's going on. So what the Technical Committee is trying to do is--and you can see the questions there--is the issue of sufficient importance for legislative action? If so, what action should be taken? So they analyze the proposal based on the statutory criteria we're going to be talking about in a minute here. And request...they receive information from applicants, opponents, others, so not only are people wanting to give them information, they could be asking for it. They may say, we want...can you go out and get information on X, Y, and Z; so maybe certain studies. If you say, this procedure, we can do it. Well, tell us what's going on in other places. So they kind of have some broad range of authority. And then they make findings and recommendation, holding a public hearing. And then they issue a report, so that's one of the reports you would end up seeing. You would see how the Technical Committee viewed the whole process. You're going to end up with, basically, three components of this. So first of all, you have the Technical Committee. I'd look...again, I look at them as more of an investigative body, and analyzes data and various information to determine whether...how it lines up with the criteria. The next page is where I think it gets kind of interesting because we're looking at three different sets. We'll call it criteria A. It's not laid out as such in the statute, but it's a good way to do it here. We're talking about credentialing of an unregulated health professional currently allowed to practice. Now I know that may seem kind of odd, but we'll use a recent example--the genetic counselors. They were able to do their work, they just weren't credentialed to do it. We have other people maybe who have wanted to go down that route, maybe it's dental assistants or something like that. They can practice, but they're not credentialed. So then the various criteria are reviewed and as you can see, number one...and I know some of this doesn't seem common sense as you kind of read some of these at times. But we try to boil them down to simple concepts like the first one, the first criteria. We're asking, is there a problem, and what's the impact on the public? And then as we look to

number two where we talk about regulation of the health profession doesn't impose significant new economic hardships. In other words, is the fix that they seek or what they seek worse than the alleged problem or deficit? So, I think that's the second one. The third one is, why does the state even need to be involved in this, in so many words? Why is it important for the state to regulate all of this? And then the fourth one is, is there a better solution? And that's part of everyone's analysis. You can hit on every...all those other criteria, but the fourth one might be they say, you know, here's a better way of doing it, we don't have to credential you or expand your scope of practice. Here we have this over...you know, this other issue that may solve the problem. So again, this is dealing with the folks who are out there practicing, but are not credentialed presently. We don't get a lot of those, I would say that's one of the smaller subsets. The second one we talk about is the criteria B. These are the ones that are just prohibited from practice, period. Probably...that's probably the smallest number; example of that could be lay midwives where they're just prohibited from practicing in this state, period, that type of work. Maybe they're licensed in another jurisdiction, but not in this state. And we go down really...if you look through the criteria, there's very...there's similar themes that go through all these. Is there a problem, and are we filling a void some way? In this case, we're looking at is there a void in the system that they're planning on filling? Where is the failure in the system that they would plug in and serve a need? And, again, is the fix worse than the problem? And I think the third criterion, creation of a separate regulated profession would benefit the health, safety, and welfare of the public, I think that's self explanatory. And the fourth, the public can't be protected by a more effective alternative. Again, is there a better way to do things? And then finally, the one that I think most people are familiar with. This is the change in scope of practice. This would be, you know, recent ones maybe like podiatry, optometrists, dental hygienists where we're getting into issues, can I do a specific act, you know? And we kind of go from there. Now there's more criteria here as you can see, and you don't have to meet all the criteria. And I think depending on the profession and what they're wanting to do, I think just logically there would be different weights applied to the various criteria. I think when you look at some of this depending on, let's say you go to criteria five, there's appropriate post-professional programs, competence assessment measures available to assure that the practitioner is competent to perform the new skill or service in a safe manner. I think that depends on the profession, what is available out there for, you know, post-professional training. Physicians would...may be looked at very different than what training is out there versus cosmetology--we'll just use that as an example. And so really everyone...you kind of go through all of that and eventually at the end of that process is really coming to a conclusion whether...how it all squares up with all those criteria. And eventually as we just keep going, now we have a technical...in every phase, these are all being looked at whether it's the Technical Review Committee, whether it's the Board of Health, or whether it's the director of Public Health is looking at the criteria that are applicable. But again, it all starts with the Technical Committee. Now we have the Board of Health. They're going to review the application as well, they're going to review those recommendations by the Technical Review Committee, and

they're going to discuss all those...each individual criterion and determine whether they meet it as well. And they make recommendations that are also going to have a report, and it may differ. It doesn't always square up that it's a three to nothing. When it's all done, it could be two to one, one to two; however you look at it. One may give a thumbs-up, the other two may give a thumbs-down. So then we have the Board of Health, and so they do their part of it. And then finally we have the director of Public Health issues the final report from his or her--it's been her perspective for the last many years--but...and so she goes through the exact same thing, reviews the recommendations, and really comes to--looking at all the evidence--a conclusion on her part. That report is then put together as well. I'm sure you all have seen Dr. Schaefer's reports over the years, the Technical Committee, and the Board of Health reports. Hopefully they've been readable, understandable, all that kind of stuff because sometimes when you're doing these, you just assume people understand all this stuff that's going into them. And if you ever have an issue with any of that, please don't hesitate to contact us. And so we look at, okay, we've put all these documents together and well, what's the point of all of it? Well, we're trying to focus on, you know, the clinical, technical parts of it and the public health and safety issues, and that's ultimately what we're concerned about, health and safety. That's what regulating people is about, I don't think...it's not about...we're not looking at who should have a professional advantage, that isn't our goal. Our goal is to determine safety issues. And we hope that all of this is evidence based and not political. When we say bring scientific evidence, we want them to bring scientific evidence to the table--why they're doing things or not. And it's there really to provide you with really a package that may be able to help you to make decisions as bills are moving forward. So you receive copies of all the reports, and other parties may also want to know what's going on and want to see the reports. And they usually arrive before a bill is introduced, if possible. So I'm sure you keep all these for many years because you never know when the same issues may come up. And sometimes the reports are going to come after bill introduction. But that's...I'm trying to give a quick snapshot of really that's the process. I think we have a great staff to carry it all out, and I'm really appreciative really of whether it's Board of Health members, whether it's professionals, or the public health or the public members of these boards who just do a fantastic job for us, and I hope...I really hope it's serving you well after going through the entire process.

SENATOR CAMPBELL: Dr. Acierno, for the record, would you state your title?

JOSEPH ACIERNO: Yes. I'm the deputy chief medical officer for the Division of Public Health.

SENATOR CAMPBELL: Thank you. I'd like to just make a couple of comments and then we'll go to questions. The bill that you see that was revised was introduced by Senator Gloor. This was a major effort of the Health Committee, and Senator Gloor did a great job shepherding it through the Legislature. But it certainly brought us up to date. And

while he has appeared before the committee before, I know that Don Wesely is in the audience. And I believe the original 407 process came under his time as the chair of the Health and Human Services Committee, and Mr. Wesely can tell us at some point what year that was. I can't remember. But for the senators and certainly for our new members, if you can just imagine trying to ferret out whether this scope of practice should, you know, whether they should be able to do it when another medical profession in many cases is saying, no, they should not. And for the senators, I'm sure Mr. Wesely could tell you horror stories about the number of bills that came before this committee, and there was no other review; the senators had to figure it out for themselves. And this is really an undergirding now of how we look at scope of practice and professionals in the field. And one last comment--last year we learned how far-reaching our scope is because we had a bill on bovine implants, which was a very interesting discussion for this committee and was on the floor of the Legislature. So with that, we'll open up to senators if you have questions or comments. Senator Gloor.

SENATOR GLOOR: Thank you, and it was nice of Senator Campbell to point that I carried LB834. Senator Wesely and I had conversations about whether it would continue to be the 407 process or the 834 process. And I said, 834 just doesn't roll off your tongue the way 407 does; it'll always be 407.

JOSEPH ACIERNO: Yeah, I think that number, 407, just is emblazoned in everyone's head, so there's no use going anywhere else with it.

SENATOR GLOOR: Yeah, yeah, it's like Xerox.

JOSEPH ACIERNO: It is. It's true. Tylenol, all those things, yeah.

SENATOR GLOOR: But doctor, now that we've had a chance to kind of work with this for the past six months, I'm guessing, how has it worked out? How have our changes worked out so far or is it time for maybe considering a little tweaking?

JOSEPH ACIERNO: I don't know about that, and I will have Dave chime in on that. But what I'm hearing is, I mean, we're moving things through technical committees at this point. And I think the feedback we're hearing is actually, I think, with the more latitude they've been given and I think it's been looked at as a more objective process at this point. And which I think is all good because that is really the goal of this is to be objective. But with that being said, I will ask Dave if he's hearing anything that, you know...

DAVID MONTGOMERY: I'm David Montgomery, M-o-n-t-g-o-m-e-r-y.

SENATOR GLOOR: I think, Dave, you're going to probably have to get up to the mike if you're going to...

DAVID MONTGOMERY: Sorry. Yes. We are anticipating five reviews this year, and we are three meetings into the first one. So I'm not sure I have an evidence base right now to say that things have drastically changed. I believe the tone of the discussion, though, has changed; and it has gone away from much of the adversarial content and comment that we previously saw and seems to be, as we'd hoped, more evidence based at this point. We'll know more when we finish the first review and, as I say, we have a very full plate this year of five of them. It's the second most we've ever done in one year, so it will be interesting.

JOSEPH ACIERNO: So in answer to your question...

SENATOR CAMPBELL: Mr. Montgomery, she brought a chair for you.

DAVID MONTGOMERY: Oh, thank you.

JOSEPH ACIERNO: ...it doesn't need to be tweaked quite yet. So it doesn't need to be tweaked, so at this point because we're still...it's kind of in its infancy of moving through under the new system.

SENATOR CAMPBELL: So we will be able to judge...I mean, with five reviews you're going to have a fairly good idea about the changes. Are any of those reviews...have bills in the Legislature, Mr. Montgomery?

DAVID MONTGOMERY: Two bills in the Legislature dealing with optometric scope of practice. We are doing one review that will cover the subject matter that's contained in those two pieces of legislation.

SENATOR CAMPBELL: And for the senators' benefit, the sponsor of the bill and the people who are representing had asked for a very late hearing. And I believe it is listed on the last day of our hearings. Most likely they'll give all the evidence in record but clearly say to us, we will wait until the final review comes out from the 407 process. So that's how it's structured. They're not trying to end run around the 407, but I think they're just trying to put everything on the record.

DAVID MONTGOMERY: That's actually a very typical procedure.

SENATOR CAMPBELL: Okay. So I don't want the senators to be concerned about that, but the reports are extremely helpful.

JOSEPH ACIERNO: That's good.

SENATOR CAMPBELL: Without...I mean, I can't even imagine trying to decide some of

these issues without them because they just really give you the kind of background you need to make a decision, and you use a lot of it when you go to the floor on an issue. Senator Krist.

SENATOR KRIST: I hope when we get done with this question and an exchange you don't consider me picking on you in particular. But this whole process brings to light an issue that I've seen in the last five years in the Legislature. The reason that we need the 407 and the reason that we need you is because we're not qualified to make some of the decisions that we're asked by the general public to make in this elected position. The information that we get gives us the basis for that information so it leads me to a follow-up question. And as a deputy director in the position that you are, why is it that it is so difficult to ask a member of the department or part of the executive branch to come talk to us and give us the real reason why or the background information? And I could cite examples with the Fire Marshal, with the director of the Department of Aeronautics, with any number of people in the Department of Health and Human Services. Why is it, it takes almost a subpoena to get people to come to talk to us? Are you being told you can't talk to us? Is the Governor telling you, you can't?

JOSEPH ACIERNO: It's hard for me to speak for the entire executive branch, and I actually don't feel comfortable doing that. I'm not being told I can't speak with you ever, so I mean, that's not the way that works. I think it depends on issue to issue, what we're being contacted about. That's the only way I can answer that.

SENATOR KRIST: You know I have a bill that's right now foremost in my mind and it's public safety and it's radon related. And I have been told the department has issues and I, frankly, have asked for input. So my point is just if this is a public forum that I'd like to make the statement...

JOSEPH ACIERNO: That's fine.

SENATOR KRIST: ...it would be much better if we were given the information that we're asking for or the advice that we need from professionals when we go about our day-to-day business as legislators than have to pull teeth to get there. And the 407 process, although it's a great process, is a formal process in place. Sometimes it's not formal feedback that we need as much as the information from professionals.

JOSEPH ACIERNO: Sure, and I understand that. And I know the bill you're talking about; and if you want to talk later on today, we could set up a time to talk about this specific bill.

SENATOR KRIST: Thank you.

SENATOR CAMPBELL: That would be very helpful, Dr. Acierno. Any other questions or

comments? Senator Crawford.

SENATOR CRAWFORD: So I assume that you review all of the bills that have been introduced. Do we get...some kind of...

JOSEPH ACIERNO: Not every bill that's introduced.

SENATOR CRAWFORD: No, no, no. Ones that you think might have a scope-of-practice change. Do we get some kind of report? I guess I haven't seen a report saying this bill, this bill are advisory scope-of-practice bills or how do we get that information?

JOSEPH ACIERNO: No, we don't routinely do that, send a report over that says this is covered under...we don't.

SENATOR CRAWFORD: Okay.

JOSEPH ACIERNO: It depends how you'd want to communicate that fact; ask, is this something that's being reviewed under the 407?

SENATOR CRAWFORD: Okay. Okay.

JOSEPH ACIERNO: Sure, we could let you know that; but no, we do not just pore through and then send out memos what's on the 407 and what is not.

SENATOR CAMPBELL: Before I take Senator Gloor, that's usually where the legal counsel comes in. As she reviews bills, she'll note if there is one and then check. I mean, we've had...certainly we've worked probably most closely with Mr. Montgomery in this effort, and we've never had any problem in terms of trying to ferret that information. But the legal counsel's going to catch that for us, Senator Crawford. Senator Gloor.

SENATOR GLOOR: Thank you, Senator Campbell. Dave, you said there were five bills...

DAVID MONTGOMERY: Yes.

SENATOR GLOOR: ...that are currently under review for scope of practice or 407, 2 optometric. Do you...

DAVID MONTGOMERY: That will be only one of the five reviews. There are two bills before you, but the review is somewhat of an omnibus.

SENATOR GLOOR: Oh, okay. What are the other four areas, do you remember right

offhand?

DAVID MONTGOMERY: We are currently reviewing a change in the practice status of advanced practice registered nurses. They have asked to remove the requirement that there be a collaborative agreement with a physician to allow them to practice. We're about to begin a review of acupuncture practice, and they are also asking to have removed the requirement that a patient coming to an acupuncturist first have been seen by a physician within the 90 days previous to that. They want to remove that requirement. We have the optometry one. We haven't received that application yet, so I'm not completely sure what all is in it. There are two more that I anticipate coming in, both in the area of dentistry. One is a revision of the requirements for anesthetics, anesthesia administration by dentists. Right now it does require a separate permit for a dentist to do this. The requirements of our law are no longer in sync with the national standards in the area of dental anesthesia, so this is primarily an effort to bring those into sync. But there are some issues involving what should and should not require a permit before anesthesia can be administered. The final one is near and dear to Senator Campbell's heart--coming from her dental task force--and I will be meeting with them Friday to get further details. But I understand they will have a proposal for credentialing dental assistants at possibly multiple levels and possibly changing some scope of practice issues with dental hygienists. So we have not received formal filings for the two dental ones yet, but I do anticipate that they'll be in this year. We would hope to finish all five of those by the next legislative session. That may be late March, but they still should be fitting into that general time frame.

SENATOR GLOOR: The dental anesthesia bill or bill, proposal, request, is that...I'm assuming that's not topical or an injectable but a general.

DAVID MONTGOMERY: Well, it involves general. It also involves the systemic...

SENATOR GLOOR: Yeah. Okay, that's the term.

DAVID MONTGOMERY: ...and ingestibles. It will make some changes in the requirements for anesthesia. Some...and again, I'm not at liberty to go into detail because they haven't formally filed it yet so I don't know the details. My understanding is that in some areas, practices that currently require an anesthesia permit might no longer require that permit. In other areas there might be things that are currently done as part of the general practice of dentistry that might now require a permit.

SENATOR GLOOR: That will be interesting.

SENATOR CAMPBELL: But only one area has a bill in the Legislature.

DAVID MONTGOMERY: Yes. The optometry bills are the only ones that we currently

have legislation for.

SENATOR CAMPBELL: And I think you're going to see, as time goes on, more and more that they're going to start with the 407 process rather than with a piece of legislation. Because there...I remember when I first came, there were several times in which a bill would be introduced and the Health Committee would say, we're not going to do anything until you go through, because we can request that. We can say, I'm sorry, we think this a 407 process, and we have done that. Okay. Any other questions? Thank you both for coming today and for the information.

DAVID MONTGOMERY AND JOSEPH ACIERNO: Thank you. Have a good afternoon.

SENATOR CAMPBELL: We appreciate that. We will open our hearings today with LB315, Senator Christensen's bill to redefine massage therapy and change licensure requirements. Good afternoon.

SENATOR CHRISTENSEN: Good afternoon. Thank you, Madam Chair and members of the Health and Human Services Committee. I'm Senator Mark Christensen, M-a-r-k C-h-r-i-s-t-e-n-s-e-n. I represent the 44th Legislative District, here to introduce LB315. LB315 amends Section 38-1706 and 38-1709 to clarify the definition of massage therapy along with the clarification of who is required to be licensed under the Massage Therapy Practice Act. This bill seeks to clarify the massage therapy definition in order to provide an indirect help with regulation and accountability of escort services addressed in LB314, the Escort Service Accountability and Permit Act. Currently escort services advertise nontherapeutic massage services to try and exempt themselves from the requirement of licensing under the Massage Therapy Practice Act. This not only skirts the law and confuses the public, but hurts the reputation of legitimate, licensed massage therapists and the industry as a whole. I want to thank you for your consideration of LB315. [LB315]

SENATOR CAMPBELL: Questions? Senator Gloor. [LB315]

SENATOR GLOOR: Thank you, Senator Campbell. Senator Christensen, I've just gotten a letter that kind of almost mirrors exactly what my question to you is. And that is, how does physical therapy stay clear of the bill or the language as drafted, because most physical therapists I know get involved in massage? Obviously, we're not talking about the same massage that you're trying to get to here, but it is...it would seem to me to be somewhat problematic. [LB315]

SENATOR CHRISTENSEN: Well, that would be under the exclusions in Sections 38-1706 or 38-1708. I forgot to bring them with me, but them are the statutes that have the exemptions for physical therapists and other groups that are exempt from this licensing. [LB315]

SENATOR GLOOR: Could you give me that...the sections? [LB315]

SENATOR CHRISTENSEN: Yes, 38-1706 and 38-1708. [LB315]

SENATOR KRIST: It's in the letter. [LB315]

SENATOR GLOOR: Yeah, I just saw that. Okay, thank you. [LB315]

SENATOR CAMPBELL: Any other questions for Senator Christensen? Will you be staying to close, Senator? [LB315]

SENATOR CHRISTENSEN: Yeah. [LB315]

SENATOR CAMPBELL: Okay, that would be great. Thank you. We will proceed to proponents for LB315, those who are in favor of it. Good afternoon. [LB315]

AL RISKOWSKI: (Exhibit 2) Good afternoon. My name is Al Riskowski, it's R-i-s-k-o-w-s-k-i, executive director of Nebraska Family Council, and I appreciate the opportunity to be here today. I serve on the Governor's task force in regard to human trafficking and the research component of it; I cochair that. We have been looking into the illegal trade that goes on. And in the sheet that I handed you--I'll refer to it in a moment--but on the back are a couple examples of how the escort services advertise. And I see a number of you looking at it; maybe I'll refer directly to it. In the Lincoln telephone directory, Omaha telephone directory, there are numerous ads under escort services. Some of them just refer to a Web site and the top portion is a copy of a Web site. I didn't put on all the pictures that were there, but if you'll notice they specifically state nontherapeutic massages are provided by them. Below is an actual ad out of the Lincoln telephone directory. It says Nebraska girls galore and, again, nontherapeutic massages. And so the intent of this bill is to make it very clear what is a...needs to be a licensed massage and an unlicensed massage and to try and close up that loophole that is in the licensing. In questioning with the individuals from massage therapists, they said actually quite a bit of the massages given are not therapeutic. And we had the indication from them that to drop that word "therapeutic" would not affect their services, and we certainly want to encourage the legal trade of massages--I would be in big trouble in my office if I did anything else--but go after and expose the illegal types of individuals. I might just mention, in 2005 I noticed the yellow page advertisements, and there were so many of them at that point. And I spoke with the Lincoln Police Chief at that time, Tom Casady, and he confirmed my assessment that most escort services are associated with prostitution. Since that time, we have done even more investigating and have been in contact with the Omaha FBI. Our problem here in Nebraska is Interstate 80, it goes from East Coast to West Coast. And so the escort services...some of these escort services actually advertise the same ad on the East Coast and on the West

Coast as well as right here in the state of Nebraska. The FBI has their Innocence Lost program that is in Omaha, and just last week I spoke with one of the FBI agents who I'm encouraging to write up a report to this Legislature which is due this July. But he related to me that within the last two years they have rescued from 10 to 20 minors out of the sex trade in the Omaha area--he wasn't sure of the exact number, he was going to look into that--but that also rescuing individuals who were 19 or older. It's very rare that any of those girls are staying there on their own, that they may have gotten involved initially on their own, but they're only staying there because of physical abuse or threats. And so it's a very kind of ugly area, and we just feel that this will give police one more way to evaluate the legitimate and illegitimate attempts in this area. So thank you for your time. [LB315]

SENATOR CAMPBELL: Thank you for your testimony. Questions? Senator Krist. [LB315]

SENATOR KRIST: Al, thanks for coming. You said, on their own. You mean voluntarily...initially they come voluntarily? [LB315]

AL RISKOWSKI: Yeah. Yes, a number of the girls...in speaking with the FBI, they confirmed that the average age that a girl will get involved with the sex trade is somewhere between 12 to 15. And then many of them can be girls who have run away, who are on the streets, etcetera. They get forced into the sex trade or perhaps for survival, but then they're soon sold or kept there against their will. [LB315]

SENATOR KRIST: I would encourage you to tap in also to the FBI and local law enforcement. They're starting to keep records on those, both male and female, that have ended up in YRTC and Geneva as a result of the sex trade. There's a valuable link there in terms of those that have come voluntarily or those that are staying there involuntarily or against their will and then the ramifications to the judicial or to the juvenile justice system, those that are incarcerated at both those facilities. And try to have him include that into the information back to the Legislature. [LB315]

AL RISKOWSKI: Thank you. [LB315]

SENATOR KRIST: Related topic, but I'd like to see that information for sure. Thank you very much. [LB315]

AL RISKOWSKI: Okay, thank you. [LB315]

SENATOR CAMPBELL: Senator Gloor. [LB315]

SENATOR GLOOR: Thank you, Senator Campbell. Thank you for your testimony. I'm trying to decide if this is an issue of verbiage and advertising or one of licensure. I

mean, if the term was not "massage" but "rub downs" or something, is that okay to use? I mean, if...I'm...again, I'm struggling trying to decide if we change verbiage, will somebody just...are we chasing after this problem and trying to stay ahead of a thesaurus or I'm... [LB315]

AL RISKOWSKI: Well, our intent is to clarify the legal massage therapist, and our hope is that this actually encourages and strengthens that service. It makes it very clear that if you're advertising for a massage for pay, that you need to be licensed. And so our hope is, again, to strengthen that profession. [LB315]

SENATOR GLOOR: But if I were to say in an ad that I was providing nontherapeutic rub downs, I could do that even if this bill passed because I'm not using the term "massage." [LB315]

AL RISKOWSKI: I would...I'm not sure if I can fully answer that. I don't know if the definition would extend to that. I know our intent is that the legal massage therapists advertise that way, and so many of the escort services advertise a parrot advertisement giving the impression as though in the Yellow Pages it's some sort of a massage when, in truth, it's not. [LB315]

SENATOR GLOOR: But a legitimate massage, a masseuse, isn't going to say nontherapeutic. They would say... [LB315]

AL RISKOWSKI: It's true, but the public does not have that full awareness. [LB315]

SENATOR GLOOR: So our concern is that the public doesn't understand that nontherapeutic means this isn't supposed to make you feel better in the ways that most massages are supposed to make you feel better. [LB315]

AL RISKOWSKI: Exactly, yes. And again, our...Senator, we had some long conversations with the massage therapists trying to best...how to best approach this because we don't want to harm the legal massage therapists and their occupation. We actually want to do the opposite, we want it to become more reputable and expose the illegal therapists. [LB315]

SENATOR GLOOR: Okay, that's helpful. Thank you. [LB315]

SENATOR CAMPBELL: Other questions or comments? Senator Krist. [LB315]

SENATOR KRIST: One follow-up just for the record and maybe, Senator, you'd like to cover it in your closing. I am aware, traveling to other states quite frequently, that local jurisdictions will not allow advertisements in the Yellow Pages that are for nontherapeutic massage, and it cuts down the advertising. They do that in South

Dakota. I know that there are some restrictions in how they advertise in other states. So if that's the intent is to keep us from seeing advertisements, then they restrict it by qualifying those advertisements in the Yellow Pages and the like. That doesn't keep us away from the Internet and all those other issues; but, if that's part of the issue...thank you. [LB315]

AL RISKOWSKI: Okay, thank you. [LB315]

SENATOR CAMPBELL: Any other questions or comments? Thank you very much for your testimony. [LB315]

AL RISKOWSKI: Thank you. [LB315]

SENATOR CAMPBELL: Our next proponent? Okay. Those who are opposing the bill who wish to testify? Any opponents to the bill? Okay. Those who wish to testify in a neutral position? Seeing no one, Senator Christensen, would you like to close on your bill? [LB315]

SENATOR CHRISTENSEN: Again, thank you for your time on this bill. I think the reason there's no opponents is because we did work with all interested parties in the last year and a half since we introduced...the last one or two years, trying to work through the language because last time when I was in here the massage therapy group come in, and we worked with them. It took us quite a while to get through the language, but it was a very beneficial deal to get to agreeable language and some that benefits both the...what we're after as well as protecting their business. So if there's other questions, I'd be glad to address it. I know Senator Krist mentioned something about stopping nontherapeutic massage ads, and that's sure something that I'd be willing to look at. But part of the reason, again, I think I stressed in the opening was cleaning up this language so it would match with LB314 on the Escort Services Act for human trafficking. So thank you. [LB315]

SENATOR CAMPBELL: Okay. Are there any other questions? Senator Gloor. [LB315]

SENATOR GLOOR: Thank you, Senator Campbell. Senator Christensen, have you had a chance to see this letter from the physical therapists yet that was handed out to us today? It's in opposition to your bill. [LB315]

SENATOR CHRISTENSEN: The physical therapists? [LB315]

SENATOR GLOOR: From the Physical Therapy Association. [LB315]

SENATOR CHRISTENSEN: Now if I understand correctly, they may not be added in this one section. And if we would add their name in there, we would take care of their

complaint. We worked with the massage industry, previously the physical therapists hadn't come in. And so maybe I have...my staff might have mentioned that to me. I'm a little handicapped, my LA is out because his mother is very sick. But anyway, I know how to tweak that, and I can get that to you. [LB315]

SENATOR GLOOR: Yeah, you're going to want a copy of the letter. I'm sure we can... [LB315]

SENATOR CAMPBELL: I think that the clerk is going to...Kaitlyn has a copy for you, Senator Christensen. [LB315]

SENATOR GLOOR: Yeah, that ought to help you. [LB315]

SENATOR CHRISTENSEN: Okay. Okay. [LB315]

SENATOR CAMPBELL: And we'll follow up with you... [LB315]

SENATOR CHRISTENSEN: All right. [LB315]

SENATOR CAMPBELL: ...when you've had a chance to talk to this person. Anything else? Thank you, Senator Gloor. All right. With that, we'll close the public hearing on LB315 and move to LB524 which is Senator Christensen's bill to adopt the Pharmacy Audit Integrity Act. Go right ahead, sir. (See also Exhibit 3.) [LB315]

SENATOR CHRISTENSEN: This one will be more fun. Senator Campbell, members of the Health and Human Services Committee, I'm Senator Mark Christensen, M-a-r-k C-h-r-i-s-t-e-n-s-e-n. I represent the Legislative District 44, here today to introduce LB524, Pharmacy Audit Integrity Act. LB524 was introduced on behalf of an independent pharmacy owner in my district. He shared with me a few issues that he is having with the pharmacy benefit managers or PBMs regarding audits and the maximum allowable cost pricing for drugs. LB524 does not address maximum allowable cost pricing, as I decided to tackle one problem at a time starting with the audit package. We may want to address maximum allowable cost pricing in an interim study this fall. The goal of LB524 is to put in place provisions that provide good business practices for PBMs to follow when conducting audits for pharmacy records. Nebraska Pharmacy Practice Act and the Nebraska Health and Human Services oversees the practice of pharmacy and standards to make sure pharmacists safely provide medications to their patients and within the parameters of the law. No PBM shall be allowed to supersede the legal process. Additionally, PBMs should not be allowed to use audits as profit centers at the expense of pharmacies and issues the plans they are supposed to represent. Most insurance companies work with PBMs to coordinate and manage their prescription drug benefit. For example, Blue Cross Blue Shield of Nebraska works with their PBM, Prime Therapeutics, to manage their retail drug plans

for their insurance business. PBMs are not regulated by any agency, not on a state level, not on a federal level, in Nebraska. Several states over the past few years have adopted laws regulating PBMs because of their continual questionable business practices. In fact, LB524 is mirrored after legislation that was passed in Minnesota just a year ago. Minnesota's legislation was negotiated and agreed to by the Minnesota Pharmacists Association working closely with the PBMs CareMark, Prime, and Medco--now Express Scripts. Those same entities should be willing to accept LB524 as introduced. There are several experts that will follow me to answer questions you may have and to share with you their personal experience with PBM audits. I encourage the committee to advance LB524. I'm going to give you a little history why I brought this bill. I've got a pharmacist in my district that...in a small town--1,000 people--and he's having a tough time competing because insurance companies have set up their own pharmacies on-line, and they have different reimbursement levels. They reimburse higher level if you use the Internet service they have and less to my local pharmacist, which is economically killing my pharmacist. There shouldn't be a double standard on a identical, same drug--two different levels. That's what I hope to address secondly. What I want this bill to do is provide the evidence behind it so I can more easily show the discrepancy that's going on. I've had people come up to me and be willing to try to go address the one pharmacy and try and get it taken care of. That's not my approach. My approach is I think everybody needs to be treated fairly. And if we audit this and take care of this, then we'll have the evidence to back the discrepancy in the reimbursements. And that's why I've asked for this step first because I know as a Legislature--we even basically got on that debate a little bit this morning---we're always looking for ways to help greater Nebraska economic develop or support businesses. But if we allow different levels in reimbursements, we're going to take more businesses out of my communities; they can't compete. Then that's going to force the hospitals to keep more drugs because there's none available from the local pharmacist, which most small hospitals do work with their local pharmacist. There's a lot of partnerships out there. And so again, that's another great paying job or two, three out of the community if this practice continues. And so that's why I'm trying to get into the base level with the audit--following what Minnesota has done for one--and see if we can get this practice stopped. I think if they have to be audited, they're going to stop the practice. But at the same time, I know I want to be able to take care of my local businesses. I don't ask them to be favored, but I ask them to be on the same level. And that's how...why I brought this, like I said, probably in a two-bill process--this one this year, the next one following next year--as a way of trying to handle the situation of different level of reimbursements. [LB524]

SENATOR CAMPBELL: Senator Gloor. [LB524]

SENATOR GLOOR: Thank you, Senator Campbell. And Senator Christensen, I apologize because I haven't had a chance to read the bill summary which is pretty detailed. But I'm asking a question that you don't have to answer, but hopefully it will tee

up for the folks that are going to follow you to maybe try and address my confusion. The price for drugs that my hospital paid, and I assume the same would be true for a pharmacy or a long-term care facility, is part of a group purchasing contract that we negotiated. And there are lots of different contracts or group plans that you can join to get the benefit of discounts for volume buying. But that's separate and distinct to me from pharmacy benefits managers who, to me, have always served more of a compliance role of checking for the accuracy and use of generics and substitutes as well as getting the pricing that you're expected to get. The two are different to me, completely different. And pharmacy benefits managers can't one way or another, to my way of thinking, disadvantage a pharmacy or disadvantage a hospital given the role they play within the insurance industry. And, again, that's where I'm coming from and maybe I can be educated on why I look at these as two separate and distinct issues. [LB524]

SENATOR CHRISTENSEN: And that could be that I have it wrong, too, but at the same time, I think there is some very good information that could come there that I think will be interesting. And I'll listen to the testimony of those pros and cons and maybe I'll find out you're right and I'm wrong and that I'll have another approach to go at this another year. But... [LB524]

SENATOR GLOOR: Well, I'm certainly empathetic to the plight of small pharmacies or even large pharmacies in larger towns trying to compete against major group-purchasing contracts with on-line suppliers and whatnot. But again, I'm not...again, the pharmacy benefit manager piece may not help the industry with that issue. But again, I've been away from this for a while so I'm asking the question hopefully and I can get an answer and we can go from there. [LB524]

SENATOR CHRISTENSEN: Okay. [LB524]

SENATOR GLOOR: Thank you. [LB524]

SENATOR CAMPBELL: Senator Crawford. [LB524]

SENATOR CRAWFORD: Thank you, Senator Campbell. Was the language for this bill pulled from some model act or statute in another state? [LB524]

SENATOR CHRISTENSEN: Well, it's very similar to, I believe, it's the Minnesota one. Yes, the Minnesota legislation passed a year ago... [LB524]

SENATOR CRAWFORD: Okay. [LB524]

SENATOR CHRISTENSEN: ...in which the PBMs Caremark, Prime, Medco now Express Scripts all approved last year. [LB524]

SENATOR CAMPBELL: Senator, based on that last statement that you made, have you made contact with any of those in Nebraska? [LB524]

SENATOR CHRISTENSEN: Several of them have said they've been going to come in, in opposition. I've just turned...my response has been if your companies have negotiated this and agreed to it in Minnesota, why would you oppose it here? [LB524]

SENATOR CAMPBELL: Okay. And we may hear some of that, too, in the testimony. Any other questions from the senators? Senators like Senator Gloor really need to delve into this. [LB524]

SENATOR CHRISTENSEN: Yup. [LB524]

SENATOR CAMPBELL: ...okay, because you made me aware of the second problem when you and I talked. [LB524]

SENATOR CHRISTENSEN: Uh-huh. [LB524]

SENATOR CAMPBELL: And I understand that you're going to split this issue, so we probably need to become much more informed and read thoroughly through all this. So thank you very much. Any other questions? Will you be staying, Senator? [LB524]

SENATOR CHRISTENSEN: Yes. [LB524]

SENATOR CAMPBELL: Okay, excellent. Thank you. All right, we will take proponents for LB524, those who are in favor. Good afternoon. [LB524]

SCOTT LOUDERBACK: Good afternoon, Senators. My name is Scott Louderback, S-c-o-t-t L-o-u-d-e-r-b-a-c-k. If you don't mind, I'm going to kind of thumb through this bill as we go along, as I made some notes. [LB524]

SENATOR CAMPBELL: Okay, you're fine. [LB524]

SCOTT LOUDERBACK: Yeah. As a supporter of this bill, one thing that I really like about it is that it's going to bring uniformity to the PBM industry where you won't have one PBM doing one thing with their audit practice and another one doing another thing. That will really help us as pharmacy owners, and I would imagine also the chain corporations. Starting with the 14-day initial on-site audit notice, that's really key. As a pharmacy owner, you know, I might be on vacation or have some staff out. And to be able to have adequate notice for an audit is very important, as sometimes it can take anywhere from 80 to 200 hours, depending on the size of the audit, to prepare for it. So I really like that as part of the bill. Another thing that I like is them providing us with

information prior to the audits. We have a chance to review some of the things they'll be coming in looking for. I believe in the bill it says they'll provide a prescription number and a date range. That way we have time to kind of see what the medication is, what some of the questions they might be asking us. And also part of the bill is that there will be no audits the first five business days of the month. That's so important in the medical world, especially in the pharmacy side of it. Our busiest days are the first five days of any given month, and then every Monday thereafter. So helping us, again, with staffing and patient care, not taking our focus off, really what we went into the profession to do. Again, having adequate time to prepare is very beneficial. Any recoupment that shouldn't be deducted against future remittances until the appeal process has completed is a big one for cash flow for our business. So often a audit may hit and the finding might be that the pharmacy has been overpaid and prior to the appeal process the amount is deducted from our remittance, meaning our next cycle of funds that are due to us. And so having the ability to appeal and have that ended and then I guess settle up either via an underpayment or overpayment is big for us as far as small business owners and having the cash and the opportunity to make that payment. Information that's not required to be on a prescription written according to federal and state law: one of the problems and frustrations that we have is some of the PBMs are requiring, for instance, if you would get a cream or a lotion prescribed to you, they want to know why are you getting it prescribed? Do we know what body parts you're applying it to? And how much are you going to use? Another example would be insulin where a physician may put a diabetic on a sliding scale of insulin not knowing exactly how much they need depending on their exercise, what they've eaten for the day. And so if we don't meet their requirements on those prescriptions from an audit standpoint, they'll want to possibly take that back from us, including the dispensing fee. So those kind of things when you're filling a prescription are very hard to do, to call the doctor up and say, look, you know, how big of an area are they going to use with this or how much insulin do you think they're going to need to take on the top end? So I like that part of the bill that talks about things that aren't required to be written on a prescription to have it valid. It's kind of unknown on an auditing agency for me on if they're getting paid on commission. Certainly if that is the case, that would be a practice that in my opinion should be frowned upon. Nobody should be paid to try to find something wrong with our business. Case in point, the instance that I just gave you whether a person is applying a cream too much or they believe they're using an eye drop too often, then to try to ding us for that as fraudulent filling and then take the money back that was paid to us is wrong. So I think getting rid of a commission is an important part of this bill. Also in case of errors that don't harm patients; for instance requirements now, if the prescription is written, electronically prescribed, or phoned in, we need to let the insurance company upon billing know, you know, what type of prescription it was or, again, maybe it's a days' supply issue where mistakes happen, unfortunately. You know, we do every effort not to, but let's say they were prescribed a drug one a day and the patient, you know, received 30 of them and the technician accidently put 31 or 28 for whatever reason something like that happened as a mistake. That's an honorable thing, and the PBM will

try to recoup the entire amount of the prescription, including the dispensing fee, when honestly it was just, you know, a minor mistake that could easily be fixed with a reversal and a retransmittal of the claim. And also a history with the patient on how often they refilled it. So that's kind of a frustration that's rare, but does happen. Other than that, that was the main things that I wanted to address in this bill. I'd be happy to, at some point, talk with Senator Gloor--is that how you pronounce it, Gloor... [LB524]

SENATOR GLOOR: Yeah. [LB524]

SCOTT LOUDERBACK: ...about your questions on the next level on what a PBM actually does do, and I think there's a lot of education that particularly pharmacy owners across the state and even the nation could give you on exactly what they're seeing as far as the practice of the prescription benefits managers. Just touching on a few of them, a big law that I think everybody would like to see passed, the bill introduced, and I think some states have, is PBM transparency. As it was alluded to earlier, a PBM has a contract with me, then they have a contract with the end payer, whether it be the state of Nebraska, UnitedHealthcare, the Neighborhood Pharmacy. So the amount that I'm getting reimbursed is one contractual price, the amount the end payer would get reimbursed is totally different. And so as an end payer you never really know what that spread is. You know, how much money is the actual PBM making? And they do that in several manners via rebates or differential pricing, and so there's a lot of education, I think, could be given just in that practice alone. The other thing that's really hurting small business in Nebraska, particularly pharmacies, and one of, you know, a personal problem that I see is that the state of Nebraska employees have to use mail-order pharmacy in order to get the deep discount on their copays for their prescription benefits. So that mail order is located out of state. The prescriptions are then mailed. And, quite frankly, they don't even follow the letter of pharmacy law because when we get inspected, they check the temperature of our pharmacy--not only room temperature but also in the refrigerator. And when prescriptions are being mailed, we know that if they...in the middle of the summer in a truck someplace the temperature could get well over 150 degrees and somebody's prescription in this mail truck, when on the bottle it explicitly states store under 81 degrees. And so the unfairness of mail-order pharmacy and what it's doing to us as local businesses and even chain companies is just not good. There's so many jobs... [LB524]

SENATOR CAMPBELL: Mr. Louderback, we probably need to go to questions if the senators have questions. [LB524]

SCOTT LOUDERBACK: Okay. [LB524]

SENATOR COOK: Yes. I have a question. [LB524]

SENATOR CAMPBELL: We're going to start with Senator Cook, and then we can come

back if you missed...if we missed anything for you. Senator Cook. [LB524]

SENATOR COOK: All right. Thank you, Madam Chair. And you did not say it at the beginning, identify yourself. I'm making an assumption that you are a pharmacist. [LB524]

SCOTT LOUDERBACK: Oh, I'm sorry. Yeah, I'm a pharmacist and the owner of Lincoln Neighborhood Pharmacy here in Lincoln. [LB524]

SENATOR COOK: Thank you. [LB524]

SENATOR CAMPBELL: Senator Gloor. [LB524]

SENATOR GLOOR: And thank you for helping clarify some things, Mr. Louderback. How many PBMs do you have contracts or signed agreements with? Do you know right offhand? [LB524]

SCOTT LOUDERBACK: Oh, you know, it's interesting. You know, there's probably upwards of maybe 40 different PBMs, but then there's so many different groups within those PBMs that the contracts even go deeper than just with the particular pharmacy benefits manager. Within them, there are different levels and tiers of contracting that are done. [LB524]

SENATOR GLOOR: When you use the term "audit"--I'm assuming that means you've got a lot of contracts or a lot of agreements--when you say "audit," those audits aren't necessarily somebody walking into your clinic. Are some of those conducted on-line or over the phone? [LB524]

SCOTT LOUDERBACK: Yeah. I see a lot more audits that are done via a FedEx where they deliver the list of materials they're requesting for different prescriptions. Then we send it in, and then we'll deal with somebody over the phone typically. Me personally, I haven't seen an on-site audit in a long time; but speaking with my colleagues, one just particular today, they have one going on in their particular store. So... [LB524]

SENATOR GLOOR: So it does happen at least some places. So what I'm trying to get to is, you know, how often are audits done? I mean if you have a ten-hour day, are you spending one hour a day, one hour every other day, half your days, dealing with the different audits that come down from PBMs? That's what I'm trying to get a handle on. [LB524]

SCOTT LOUDERBACK: Yeah. You can't put a daily figure on how much you spend on audit time because audits will usually come as a bundle at different times of the year that are somewhat unknown. So the larger the audit, obviously, the larger amount of

time you have to spend in it. So if you would get an audit of perhaps 100 different prescriptions, you know you're talking of probably spending around 40 to 80 hours depending on what they're looking for. You'll have to find all the prescriptions, make copies of the front and back, and so forth to satisfy the requirements for the audit. [LB524]

SENATOR GLOOR: Do you happen to have a copy of the...is that what you have in front of you is a copy of the law or the proposed bill? [LB524]

SCOTT LOUDERBACK: Yes. [LB524]

SENATOR GLOOR: Could you flip to page 5, Section 7, paragraph (3,) it's actually line 15 if you go to page 5. I don't understand what 15 through 18 says, but I think it's important. Can you help me? "A finding of overpayment or underpayment shall be based on the actual overpayment or underpayment and not a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs." [LB524]

SCOTT LOUDERBACK: I can't speak to that... [LB524]

SENATOR GLOOR: Okay. [LB524]

SCOTT LOUDERBACK: ...because I have not had that as part of an audit that I have received. [LB524]

SENATOR GLOOR: Okay. Thank you. [LB524]

SCOTT LOUDERBACK: Yep. [LB524]

SENATOR CAMPBELL: Perhaps someone coming behind you will know that. [LB524]

SCOTT LOUDERBACK: Right, right. Thank you for your time. [LB524]

SENATOR CAMPBELL: Uh-huh. Thank you for the information. Our next proponent? Welcome. [LB524]

VINCE JORN: (Exhibit 4) Thank you. Thanks. My name is Vince Jorn, I'm a pharmacist, I'm the director of pharmacy for Kohll's Pharmacies in Omaha. We operate eight pharmacies in Nebraska, Omaha, Nebraska, and one in southwest... [LB524]

SENATOR CAMPBELL: Mr. Jorn, I'm sorry to interrupt you. We do need you to spell your name. [LB524]

VINCE JORN: Oh, Vince, V-i-n-c-e, Jorn, J-o-r-n. [LB524]

SENATOR CAMPBELL: Thank you. You go right ahead. [LB524]

VINCE JORN: Thanks. To answer your question--I'm going to start that real quick--is that they can...the auditor can extrapolate the findings so if they came in and audited 100 prescriptions and they found 15 percent of them to be invalid and recoup 15 percent and say that total amount was $15,000 and you'd billed them $1 million, they could come and say, we're going to come and take $150,000 from you because we're going to assume that 15 percent of the rest of your business was also wrong. So I can answer some of the questions, but I...the questions you asked. I have reviewed thousands of claims and done hundreds of audits because of our corporation in the time I've been there. So just to give you an idea of...I think this bill is a step in the right direction to limit some practices. It's a big...I think for our company and I think for a lot of pharmacies, it's a burden on us...time expenditure. And it's also a little bit unfair in my view as there's no regulations they can really do. PBMs can for all intents and purposes do what they want and they decide at the end of the day. But to give you an idea of...so for 2013, our company we have so far this year had three desk audits. And a desk audit is what I consider...they send us a listing of usually 30 or 40 prescriptions and then we have to find the original prescription, the hard copy which is a printout, the patient's signature and send that...make copies of all that and send that all in. That extends over a two-year period. And when a pharmacy is filling 50,000 prescriptions, and these are in bundles of 100, and then you have 50,000 signatures, that is not an easy process to find all those prescriptions. It takes time. We also get an on-site audit, which you asked about, and I have been subject to I believe four of them overall. Those are usually over 100 prescriptions and an auditor comes into your pharmacy and gives you a list of prescriptions, again, ranging usually it's about a two-year period and you have many thousands, tens of thousands of prescriptions to go find and bring back to this auditor to look over. And the last type of audit that we receive is like a fax audit which is you get a list. It could be one...usually it's one, but I've seen up to five, and they'll just ask you for your records. Those are a little easier to handle. I mean, I'm not a proponent of any of it, but they're a little easier, you know, because they're usually more recent so they're usually on top and it doesn't take as much time. As Mr. Louderback stated, I spend a lot of time, 40, 50, 60, 100 hours to complete one of these audits. I've put some specific examples of things that our bill does address. And I just...I think this is a step towards--I'd like to even see it go further--but this at least puts some limitations on it. I put some specific examples of PBM audits and also the auditors' response. On the last page you can see the determination. In the first example, the prescription read two tables three times daily, one at bedtime, and as needed. The auditor determined that the end "as needed" was not a sufficient direction, so they decided to take additional money back from the pharmacy. In my opinion the auditor--this is an auditor, not a pharmacist--who's deciding what the doctor's directions meant and what money recoupments that should be made. Of course, we've talked about we don't...the

pharmacies don't really know whether or not the PBMs are getting money. We assume that the auditors are receiving money from what they find wrong. In my second example, this is...the directions led us to dispense what would have been a 30-day supply. The auditor said that the patient should have only received a 25-day supply, because if you read deep into your contract--most of you probably assume that your prescription allows you for a 30-day supply when you go into the pharmacy. Actually, if you can receive a 25-day supply, the pharmacy is not allowed to give you 30. If you were aware of that page, any of you would not like that at all. And actually most of our pharmacists and most pharmacists, myself included, I'm our expert on it, did not know that until an audit three years ago. And my third example, there was a drug that was available as a brand name. The generic...it went off patent. The brand-name manufacturer sued the generic company to remove the generic from the marketplace so only the brand name became available again. The auditor decided that we should have dispensed generic even though there was no generic in the marketplace, recouped over $13,000 from us, and then we had to fight it tooth and nail, show them, get records from multiple vendors showing them that there was none. How are we supposed to dispense a generic when there wasn't one on the marketplace? A rare example, but just to show you how they really have...can do whatever they want. And my last example--and this is also in the bill--the prescription read 60 units daily. This was just a clerical error in the days' supply. We dispensed 20 for a two-day supply, should have been a 30-day supply. The pharmacy was paid correctly, the patient paid the right copay, the pharmacy filled it at the correct interval, there was absolutely zero impact on the amount of money that exchanged hands, the quality of care, nothing was impacted at all, except for the days' supply that was submitted. The PBM in this instance also chose to recoup money. And that's in the bill, that if the auditing mistake takes place but has no financial impact, they shouldn't be able to recoup at any rate. I'm trying to go fast so I don't go over my time limit. [LB524]

SENATOR CAMPBELL: You're doing just swell. [LB524]

VINCE JORN: And I'd be happy to answer any questions. [LB524]

SENATOR CAMPBELL: Questions from the senators? And you indicated you were a pharmacist in Omaha. [LB524]

VINCE JORN: Yes, a licensed pharmacist in the state of Nebraska, and I review all the audits that come for our company. [LB524]

SENATOR CAMPBELL: Okay. Questions from the senators on this? So that's your sole job for the company? [LB524]

VINCE JORN: No. [LB524]

SENATOR CAMPBELL: I was going to say, I don't think so. [LB524]

VINCE JORN: It's one of my side jobs. I'd like to be doing something else as most...you know, but when it comes up there's so much at stake. You can have a million...we have an on-site audit...so four weeks ago we received a letter...three to four weeks ago we received a letter that said in three weeks somebody's going to come and they're going to look over prescriptions ranging over this two-year time period. So, you know, now that's something that I'm going to have to...and that, you know, that's something that I'll deal with that will take a lot of time. But that will be...there will probably be over $1 million at stake. And in these instances, you either lose or you don't lose; there is no upside. You spend...you're definitely going to be out your time, all your time, and your best-case scenario is you get to keep the money that you have. Your worst-case scenario is you lose your time and your money. [LB524]

SENATOR CAMPBELL: Questions? Senator Howard. [LB524]

SENATOR HOWARD: Thank you for your testimony. Wouldn't a worst-case scenario be that you made an error in your prescription and a patient was harmed? [LB524]

VINCE JORN: Yeah, from the auditing standpoint. But an error in your prescription isn't, in my...you know, that isn't something that you find in an audit. You know, if you have a problem in your prescription, hopefully you found it before that. They're looking for billing issues, not patient care issues in my perspective. [LB524]

SENATOR HOWARD: Thank you. [LB524]

SENATOR CAMPBELL: Are they supposed to be looking for patient care perspectives? [LB524]

VINCE JORN: I think the...I mean, my opinion--and, again, it's not...you can't see what their role is--but I mean all of our opinion is it's a financial gain that--I don't know what other purpose this serves--is for the PBM to get payments back. And in my view if the goal was to find a pharmacy that was fraudulently billing, you're saying you're not giving people prescriptions, you're giving them too many prescriptions, you're lying--I can definitely see that--you know, take the money away from the pharmacies, close them down. But when you're dispensing prescriptions and you're looking for a clerical mistake to recoup money, that's a different issue to me. [LB524]

SENATOR CAMPBELL: Any other questions? [LB524]

VINCE JORN: I'd also be happy to answer questions about the PBM, the issues that you discussed earlier. [LB524]

SENATOR CAMPBELL: Senator Gloor, did you have any follow-up? [LB524]

SENATOR GLOOR: No. Your answer was kind of what I was afraid it meant. [LB524]

SENATOR CAMPBELL: Yeah. [LB524]

SENATOR GLOOR: But, thank you. Appreciate it. [LB524]

SENATOR CAMPBELL: Thank you very much. Our next proponent? [LB524]

DEVEN MARKLEY: Could I have your orange sheet? [LB524]

JONI COVER: Oh, sorry, this is my first time doing this. We know that's not true. [LB524]

SENATOR CAMPBELL: Can't get away with that, Ms. Cover. Sorry. [LB524]

JONI COVER: (Exhibits 5, 6, 7) Sorry about that. Senator Campbell, members of the Health and Human Services Committee, my name is Joni Cover, J-o-n-i C-o-v-e-r. I'm the executive vice president of the Nebraska Pharmacists Association, and I appear today in support of LB524. And I would like to thank Senator Christensen for introducing this legislation. The provisions of LB524 require pharmacy benefit managers or PBMs who handle prescription claims to implement fair and reasonable business practices when auditing pharmacies. Over the past few years, audit practices of PBMs have become more demanding, often invalidating legal prescriptions and taking back money for prescription drugs and dispensing fees because of policies that are irrelevant to the legal dispensing of medications to patients. Most often the focus of audits are high-dollar prescriptions so we're not talking the $4 generics, we're talking the $100, $200, $1,000 types of prescriptions. PBMs are very complicated entities to understand, which I'm guessing you understand that there's a lot of different facets of the PBM business. So Senator Christensen was right when he said that, you know, there's other things we need to address, and he started with the basic audit provision. PBMs contract with pharmacies, of which most provisions are nonnegotiable and often not clear, and then add additional layers of rules in their provider manuals, which are often changed with little or no notice to the pharmacy. If PBMs--this is a question that I've sort of had in my tenure at the NPA--if PBMs have rules in place that pharmacists are supposed to follow--so, you know, you can't dispense a drug any way other than a written prescription, that's an example--then why do the PBMs allow the pharmacy claims to be processed and the patients to get their medications only to later say, no, that claim should have been denied, and take the money back from the pharmacy? The patient still got their medications, but the pharmacies are now out of their money and there usually isn't any patient harm. PBMs should not be allowed to impose nonnegotiable rules that are above and beyond state legal requirements for dispensing medications.

And the provisions in LB524 add protections to the pharmacy practice for proper notice, which is important, when the audits can take place during the month, the recoupment and appeals procedures, and then what an auditable claim is, and how exactly the auditors are to be paid in their audit process. LB524 mirrors legislation that was agreed upon by PBMs and pharmacists and passed in Minnesota, I believe last August or last fall sometime. One particular provision of LB524 that I am hopeful that the insurance industry would support is that any money that's recouped by the PBM has to be paid back to the plan sponsor since they are the ones who are actually hiring the PBM to work on their behalf. The plan sponsor is actually paying the bill for the insurance drug proposal. I have provided you a packet of information about pharmacy benefits managers--there's a lot of information there--and it was compiled by our National Community Pharmacists Association. They've done a lot of work in lots of other states and on a federal level. And it also includes various states' laws. There have been several states in the last few years that have implemented some sort of PBM rules, laws, regulations, and so I just put that in just as a summary so you could see what other states are doing because I'm guessing we'll be having this discussion again at some time in the future if Senator Christensen decides to go forward with his proposals. And I've also sent or provided you with some letters of support from Eric Hamik who is a pharmacist in Kearney and then the National Association of Chain Drug Stores, neither of whom could be here today. And I appreciate the opportunity to testify today. If you have any questions or there's further discussion that we need to have with the committee, I'm happy to participate in that discussion. Thank you very much. [LB524]

SENATOR CAMPBELL: Thank you, Ms. Cover. Is there questions from the senators? Senator Gloor. [LB524]

SENATOR GLOOR: Thank you, Senator Campbell. And thank you for your testimony and the handouts especially, Joni. Is the plan sponsor...a plan sponsor could be an insurer or a plan sponsor could be an employer, self-insured. [LB524]

JONI COVER: Right. If it's an ERISA plan, it's an employer. If it's...yeah, whoever works...the insurer is the plan sponsor. [LB524]

SENATOR GLOOR: Okay. Here's...I mean, let me play out a scenario, and explain to me how this might work. That is, you're having trouble with a pharmacy benefit manager because you run and own a pharmacy. And you're having a problem with a pharmacy benefit manager. You say, I'm not signing a contract with you. [LB524]

JONI COVER: Uh-huh. [LB524]

SENATOR GLOOR: What are the ramifications of not signing the contract with a poor operator? [LB524]

JONI COVER: If you would decide not to sign a contract with a particular PBM, then you will not be able to process any business through that PBM, that's plain and simple. So a lot of times it won't just specifically apply to one certain plan, it will apply to all of the business that expands across their PBM business. I don't know if that makes any sense. [LB524]

SENATOR GLOOR: No. [LB524]

JONI COVER: So if Caremark--I'll use them for example because that was the first one that came into my mind--if Caremark is a PBM for let's say the University of Nebraska and the state of Nebraska and Joni's manufacturing company, and I'm having problems with the provisions in the contract with Joni's manufacturing company and I say, I'm not interested in that particular...signing that particular provision, typically what happens is Caremark will say, okay, that's fine. Then not only will you not be able to participate in the dispensing of prescriptions for Joni's manufacturing company, but because we cover plans for the University of Nebraska and state employees, you are not able to participate in any of those contracts. That's typically what happens. Not always but, you know, that's the more common thing that happens. [LB524]

SENATOR GLOOR: And that...I mean, I would expect that ramification. But it sounded like there were lots and lots and lots of PBMs. And, I mean, I'm thinking... [LB524]

JONI COVER: Yeah, some of them are big, some of them are nationwide, some of them are more regional. [LB524]

SENATOR GLOOR: But we don't have lots and lots and lots of health insurers in this state. [LB524]

JONI COVER: No, we don't. [LB524]

SENATOR GLOOR: So I'm guessing each health insurer has their own PBM. [LB524]

JONI COVER: Or somebody that they work with. [LB524]

SENATOR GLOOR: Yeah, so let's assume we have seven major health insurers in some way, shape, or form, including Medicare and Medicaid, by the way. [LB524]

JONI COVER: Uh-huh. [LB524]

SENATOR GLOOR: That would tell me that there are, in that case, there are seven PBMs. [LB524]

JONI COVER: Right. [LB524]

SENATOR GLOOR: Not lots and lots of PBMs, although there are the ERISA plans that are out there, and I understand that could add on a considerable amount more. [LB524]

JONI COVER: Right. Right. As you know, with insurance that we have exceptions, and I'm assuming that this would also go under those exceptions where if it's a Medicare federal law type...you know, if it falls under federal law, if it falls under self funded or ERISA I don't think these would apply. So they would only be applicable to any insurer who is working with a PBM that is under the state insurance provisions in Nebraska. I believe that's how it would work, but I'm not 100 percent sure about that. I'd have to find out...I'd probably have to find that out for you. [LB524]

SENATOR GLOOR: Well, and my line of questioning fits into this category and that is, if there're bad operators--and it seems like your association can serve as a focal point for these are bad operators--we're just not signing contracts with them, then they go out of business. I mean, that's the way the market is supposed to operate. I'm not saying that that's the right approach here, but if you've got people who provide bad service and you don't sign a contract with them and enough people buck up and do that, then there's some self cleaning up within an industry or a segment of business and you don't come to the Legislature saying, take care of this for us because we can't take care of it ourselves. [LB524]

JONI COVER: Right. Right. I would say a couple things to that. We have to be really very careful of antitrust laws because we can run ourselves aground of antitrust laws by saying these are bad contracts. Typically the Pharmacists Association does not get in the middle of contracting; that is a business decision. And some pharmacies in our state take all of the contracts whether they're good or bad, and that's a business decision they make. But I think that there's a perception there that the contracts are negotiable, so if I have a problem with somebody I'm going to be able to negotiate the terms that are unreasonable to me, and that just really isn't the case. So I would say that if there were a group of pharmacies in a region or even the Pharmacists Association said, we do not like the apple--I should probably not say the word "apple"--the orange PBM, yes, we can run afoul of antitrust laws so we don't usually go there. That's just not something that we do. You have to be very careful about that. And I do know that there have been some states that have...some state associations who have found themselves in the middle of discussions about antitrust. You know, absolutely not intentional, it just...it was sort of a, well hey, I heard this. Hey, I heard this. And then they ended up in the middle of a lawsuit. So we're not interested in that, but...at all. [LB524]

SENATOR GLOOR: I'm sure. Well, and I'm not naive enough to think that there aren't employers who contract with PBMs and don't care about anything other than results. I mean, I understand that results are probably what's driving PBMs and so you've got employers or insurance plans who are part of the problem also. But I'm just trying to

understand why the market isn't cleaning up bad operators, is my question. [LB524]

JONI COVER: That's a really good question, and you would think at this point in time that PBMs have been in business long enough that some of that cleanup would have taken place by now, and it really isn't. It isn't. And I know that on a federal level some of our national pharmacy organizations are working to try to clean it up, but they're just...it's just we're not seeming to make any headway. Part of the problem is insurance companies follow state insurance laws or federal insurance laws. PBMs aren't regulated by anybody, so who goes after them? You know, how do you stop the bad business practices unless you take them to court? And that does happen. [LB524]

SENATOR GLOOR: Good point. [LB524]

JONI COVER: You know, there are some hurdles we have there too. Again, this is a very, very complicated business to understand. And, you know, if you have more questions, I'd be happy to answer them. I will tell you that I have to say kudos to Prime Therapeutics, and that is at least when they do an audit of a pharmacy in Nebraska they provide information to the pharmacy about who the auditor is going to be and when they're going to show up and it's on their letterhead and there's a phone number and a name. That's pretty good because that usually doesn't happen. So I'm throwing a kudos out to our friends at Prime Therapeutics. So... [LB524]

SENATOR CAMPBELL: Several years ago under LR42 when we were all working on the budget, you know, trying to figure out how to make cuts in that budget, this committee spent some time talking about the whole issue of Medicaid Integrity. [LB524]

JONI COVER: Uh-huh. [LB524]

SENATOR CAMPBELL: Does this legislation impact that at all? [LB524]

JONI COVER: I would say that it would probably go side by side with it, I would say. I mean it doesn't specifically spell out anything with Medicaid, and so we do have Medicaid audits that happen. You know, that's a good question. I'd have to look into that because I don't really know. [LB524]

SENATOR CAMPBELL: I suppose the question would come as to whether those Medicaid audits are being done under the Medicaid Integrity portion... [LB524]

JONI COVER: Uh-huh. Right. [LB524]

SENATOR CAMPBELL: ...not on a PBM, but we don't know, right? [LB524]

JONI COVER: Right. [LB524]

SENATOR CAMPBELL: That's what you're saying? [LB524]

JONI COVER: Right, that's what I'm saying. [LB524]

SENATOR CAMPBELL: Okay. That's probably something that we probably need to look into because on Section...on page 3, Section 5, Ms. Cover, is where it talks about "unless otherwise prohibited by federal requirements or regulations, any entity conducting a pharmacy audit shall follow." So I don't know...you know, remember your...you said, I don't know whether this affects all the federal? We probably need to check. [LB524]

JONI COVER: Right. But it probably would not impact Medicaid or Medicare, excuse me. [LB524]

SENATOR CAMPBELL: Yeah, not... [LB524]

JONI COVER: But there is potential that it could be with Medicaid. [LB524]

SENATOR CAMPBELL: I'm sure, because we have a state plan. [LB524]

JONI COVER: So I'd have to check, I don't know. I don't know the answer, but I'll find out for you and get back to you. [LB524]

SENATOR CAMPBELL: That would be great because we probably need to be at least more knowledgeable about that. Any other questions for Ms. Cover? Senator Crawford. [LB524]

SENATOR CRAWFORD: So the...some of the handouts that you provided talked about the concern about conflict of interest. I don't see that that's in this audit statute yet. Is that true or do you see things in the audit statute that we have here that also address that issue of conflict of interest? [LB524]

JONI COVER: No, I don't think there's anything in LB524 that deals with conflict of interest. Again, that's another sort of layer in...an example of conflict of interest would be Caremark and CVS Pharmacy. There's been questions about their...whether it's a conflict for a PBM to own a pharmacy business, and that's being discussed on a federal level in courts so that's where that would arise. I don't see that language in LB524 though. [LB524]

SENATOR CAMPBELL: Any other questions? [LB524]

JONI COVER: I forgot to also tell you that I gave you a map of the...I always provide the

Health Committee a map--and I thought this would be a good time since we're talking about pharmacies--of the pharmacies and pharmacists that are located in Nebraska... [LB524]

SENATOR CAMPBELL: Okay. [LB524]

JONI COVER: ...just, you know, for your reading pleasure. [LB524]

SENATOR CAMPBELL: And numbers. [LB524]

JONI COVER: And numbers. [LB524]

SENATOR CAMPBELL: And numbers. [LB524]

JONI COVER: Thank you very much. [LB524]

SENATOR CAMPBELL: Thank you, Ms. Cover. Other proponents to the bill? Anyone else? Those who are opposed to LB524? Good afternoon. [LB524]

COLEEN NIELSEN: Good afternoon, Chairman Campbell and members of the Health and Human Services Committee. I apologize for my voice and all the paraphernalia that I brought up here, but I hope I can make it through without coughing. In any event, my name is Coleen Nielsen, C-o-l-e-e-n N-i-e-l-s-e-n, and I am the registered lobbyist for Express Scripts and I am testifying in opposition to LB524. I want to give a little bit of background about how this process came down. You know, as a pharmacy benefit manager there are different roles that they play. But with this particular bill, LB524, they're generally acting under a contract with either a health plan or an employer who is self insured to go in and audit--per contract--to audit for that health plan or that employer, the pharmacy and how the benefits are paid and whether there have been overpayments. It's just a typical business practice that occurs with taxes or any other business that is audited for their accounting system. The prescriptions that you give to your pharmacist end up being the claim. So when they talk about having to gather all these prescriptions, once that's negotiated and dispensed, the prescription is...becomes the claim. And so they talk about gathering this together, but that's the evidence to show that the claim has been paid. I guess I come...I sit here before you and I'm a little bit confused about what we're trying to do here with this legislation because I've been...and I want to tell you that I am not team A for Express Scripts. And currently my expert is testifying in North Dakota on a different measure and wanted to be here very badly because I can't testify to the details in this bill or what some of the pharmacists have described to you. But what I can tell you is, is that over the last year or so Express Scripts--formerly Medco--has been working with the Pharmacists Association with regard to audits and have put on educational seminars and webinars and worked together with them to help try to sort out any problems that they may be having with

these audits. And never once did they complain or tell them there was a problem. And suddenly, suddenly on the last day of this legislative session, we see this audit bill. My understanding is it didn't come from the Pharmacy Association, although they testified in support of this bill now. But when this bill came in, the first thing that we did, we talked to the clients and we talked with Prime Therapeutics and we offered to Senator Christensen to negotiate this bill. And we brought him a marked-up copy, and I also gave the Pharmacists Association a copy of some changes that...and we were ready to come to the table. And we were not asked to come to the table. We were ignored with those demands. And it is the first time that I have heard the statement that Minnesota passed it and those pharmacists...these PBMs agreed to it and so you should agree to this one. I'd never heard that before. And I have approached Senator Christensen, and I've approached the Pharmacy Association and said, we wish to negotiate because there are details...this is pretty complex, there are details here. But the most...so, we're ready to come to the table. And I can bring in my expert next week. He's ready to come. But more importantly, when I heard Senator Christensen's introduction, this is what's confusing to me. I understand that he thinks that this...that he wants to use this first piece to move on to fair pricing amongst PBMs and how those contracts are negotiated or perhaps transparency or whatever he's moving toward. I understand that. But this bill...this audit bill has nothing to do with that. This is a situation where PBMs, as a third-party administrator, go into pharmacies and audit their claims. That's what this does, and it regulates it. And I think we can come to an agreement on portions of this bill. What he's describing in his introduction is, is that he feels he can get information about pricing through these audits and then can move on to this next step. But that information will not be available to him. So we are confused about where this is headed but, again, we'd come to the table on LB524. We just haven't even had a chance to talk to them about what their concerns would be and why they must specifically have these provisions because some of the language...and, I'm sorry, my time is up but I'll just finish. Some of the language that was suggested by my people were clarifications and standard language that have been passed in other states so it would be consistent. So with that, I'll answer any questions. [LB524]

SENATOR CAMPBELL: Questions? Senator Gloor. [LB524]

SENATOR GLOOR: Thank you, Senator Campbell. Ms. Nielsen, is...do the PBMs have a national association? [LB524]

COLEEN NIELSEN: Yes, they do. [LB524]

SENATOR GLOOR: Does this get talked about, do you know, within that national association? I mean, I'm back to the issue of sometimes all it takes is a few bad players... [LB524]

COLEEN NIELSEN: Uh-huh. [LB524]

SENATOR GLOOR: ...and everybody has to pay the penalty for that. I mean, I'm just curious. I'm back to the market cleaning itself up when there are folks who...I have personal experience with Medco. That's who we contracted with... [LB524]

COLEEN NIELSEN: Uh-huh. [LB524]

SENATOR GLOOR: ...for my ERISA plan, and as best I could tell from local pharmacies--and this goes back not a long while, but a little while--Medco wasn't problematic to deal with. So, you know, I'm listening to these stories, and I don't doubt the stories are factual, I'm just saying, I'm thinking, how many bad players...is everybody a bad player now in this day and age? Is the pressure on PBMs to deliver such that everybody has started to take an impossible line with pharmacies and whatnot? And that's why I wonder about the national association is trying to take a look at this and clean themselves up or divorce themselves from some of the bad players that are out there. [LB524]

COLEEN NIELSEN: I think this is a topic of conversation, and I would only be speaking anecdotally to say this, that when I talked with my contact within Express Scripts they said that oftentimes what happens is--and there may be bad actors out there; but I believe Express Scripts and Prime Therapeutics and many of the others to be professional organizations who try to work through these things--but they often...but apparently, CMS has...hires people that aren't necessarily as trained in terms of auditing, and that there have been experiences reported to the PBMs--and it...and people thought it was the PBMs or whatever, so I'm speaking...it was just something that was told to me very quickly, so I don't know if that's true or whatever--but I think that they are trying to address this issue. And so part of the reason that they agree to these bills is for that very reason. So we're ready to come to the table. [LB524]

SENATOR GLOOR: Okay. [LB524]

SENATOR CAMPBELL: Okay. Other questions? Ms. Nielsen, I asked a question earlier of Ms. Cover and I know we will check on it, but I just thought maybe you'd know. Do any of the company or the company you work with, do they have a contract with the state on Medicaid? [LB524]

COLEEN NIELSEN: No, Express Scripts does not. [LB524]

SENATOR CAMPBELL: Would any of them? [LB524]

COLEEN NIELSEN: Well, you know what? I'm not sure of that, but I don't believe. [LB524]

SENATOR CAMPBELL: Okay. Well, when your expert...when you're talking to your expert... [LB524]

COLEEN NIELSEN: Yes. [LB524]

SENATOR CAMPBELL: ...I think we...that's something we need, as a committee, to know and track down. [LB524]

COLEEN NIELSEN: Okay. All right. [LB524]

SENATOR CAMPBELL: Okay. Any other questions? Thank you very much. [LB524]

COLEEN NIELSEN: Thank you. [LB524]

DON WESELY: Senator Campbell, members of the Health and Human Services Committee, for the record my name is Don Wesely, W-e-s-e-l-y, representing Blue Cross Blue Shield and who does contract with Prime Therapeutics which was mentioned as having done a nice job working with some of the pharmacies. And back to your point, Senator Gloor, in every profession there are those who do a good job and maybe some who don't do as good a job as they would like to. We're following and offering again to also work with the pharmacists in trying to find the answers to the questions they've raised today. It's very important to have these PBMs. They do help us save money. And we're all looking to try and save money in the healthcare system, and so I think it's an important process. But if there are problems that are resulting, obviously we should try and address those. And again, today also this was the first time that we'd heard that this language came from Minnesota. We weren't aware of that, and it's recently been passed. So we, too, have experts we can bring in that would be available. And I think with the leadership of the committee, we'd be willing to sit down and see what we can come up with that would work in Nebraska. [LB524]

SENATOR CAMPBELL: Okay. Madam clerk, did Mister...did you spell your name, Mr. Wesely? [LB524]

DON WESELY: Yes. [LB524]

SENATOR CAMPBELL: Oh, sorry. I was busy writing all this stuff down, and I missed it. Do you know the answer to my question, whether you represent any Medicaid? [LB524]

DON WESELY: I am not aware of that, so we will find out. [LB524]

SENATOR CAMPBELL: Because we're trying to figure out, I think, if...how this might affect what we put into place on Medicaid Integrity. [LB524]

DON WESELY: Well, it's an important question. [LB524]

SENATOR CAMPBELL: Yeah, it is. [LB524]

DON WESELY: You bet. [LB524]

SENATOR CAMPBELL: Exactly. Any questions? Yes, Senator Crawford. [LB524]

SENATOR CRAWFORD: Thank you. And thank you for your testimony. Could you give an example of a provision in the act that you would find problematic in terms of your work, your work with Prime Therapeutics? [LB524]

DON WESELY: Well, I think some of the provisions...I think the notice provisions are something that may or may not be workable. And I think it, you know, the number of days and amount of notice might be something we'd take a look at. The pricing issues that I think Senator Gloor mentioned were kind of confusing, and I think we'd have to clarify some of that. But I think we're all willing, again, to take a look at this and see what's agreeable and what isn't. [LB524]

SENATOR CRAWFORD: So your concern is that it would get passed without your input... [LB524]

DON WESELY: Yeah, we have not had a chance to walk through this. [LB524]

SENATOR CRAWFORD: ...not...just clarifying, not the general idea of rules for PBMs in general? [LB524]

DON WESELY: No, I think some reasonable oversight is sensible. [LB524]

SENATOR CAMPBELL: Any other questions? Thank you, Senator Wesely. [LB524]

DON WESELY: Okay, thank you. [LB524]

SENATOR CAMPBELL: Any other opponents that wish to testify on LB524? Those in a neutral position? I know that Senator Christensen had to leave to introduce another bill. So we will close the public hearing on LB524, and we will move to Senator Howard's bill. If you are leaving, please leave quietly and take all conversations in the hall. Thank you. Senator Howard. Senator Howard's bill, LB243, to redefine nurse practitioner practice. [LB524]

SENATOR HOWARD: Good afternoon, Chairwoman Campbell and members of the committee. I am Senator Sara Howard, H-o-w-a-r-d, and I represent District 9. I am introducing LB243 on behalf of the Nurse Practitioners of Nebraska to provide clarity in

their Practice Act with relation to nurse practitioner specialties. The bill simply adds the word "acute" to the Practice Act and may be a good fit for the consent calendar. There are over 1,000 nurse practitioners licensed in the state of Nebraska. The American Academy of Nurse Practitioners identifies nurse practitioners who practice in ambulatory, acute, and long-term care as primary- or specialty-care providers who provide services according to their practice specialty. This is a very nice, long sentence. Practitioners who specialize in adult, neonatal, or pediatric care may practice with populations who are critically ill and require acute care. Under the current Practice Act, the scope of practice for nurse practitioners is diagnosis, treatment, and management of individuals with common health problems and chronic conditions and is not descriptive or inclusive of those nurse practitioners who are practicing in acute care. The addition of the word "acute" updates the Nurse Practitioner Practice Act to be inclusive of all nurse practitioner specialties. Thank you for your time and attention to LB243. I wanted to be brief partially because it is a brief issue ideally; it's one word. This reflects some of the educational changes. A lot of...in the field, a lot of nurse practitioners are being trained as acute-care practitioners and are practicing in acute settings already. This just really covers that. And they are going through a 407 process now. Do you have any questions for me? [LB243]

SENATOR CAMPBELL: Senator Howard, since you brought it up, with the 407 is the word "acute" a part of that 407 process? [LB243]

SENATOR HOWARD: You know, not to my knowledge, but I'm hoping somebody behind me will be able to answer that question. [LB243]

SENATOR CAMPBELL: Okay. Thank you. Any other questions from the senators? Senator Howard, you're free to return. [LB243]

SENATOR HOWARD: Thank you. [LB243]

SENATOR CAMPBELL: With that, we will take testimony of those who favor the bill. Good afternoon. [LB243]

KATHERINE A. HOEBELHEINRICH: (Exhibits 8, 9, 10, 11, 12, 13, 14) Good afternoon. I'm Kathy Hoebelheinrich, H-o-e-b-e-l-h-e-i-n-r-i-c-h, and I'm here on behalf of Nebraska Nurse Practitioners. I'm the executive secretary. I have handed you written testimony from six other entities: Dr. Juliann Sebastian, who is speaking as a private individual; I have written testimony from Creighton University, Clarkson College, the Nebraska Board of Nursing; and three practicing nurse practitioners, Terrie Spohn, S-p-o-h-n, Julie Sundermeier, S-u-n-d-e-r-m-e-i-e-r, Cathy Phillips. If you'll bear with me, I'll try not and repeat any of those things that doctor or that Senator Howard just stated. Our membership in Nebraska Nurse Practitioners represents nearly 50 percent of the 1,100 nurse practitioners in the state. NNP advocates on behalf of issues that impact nurse

practitioners in the state; we're asking for your support of LB243. Our proposal is a modification of the language in the Nurse Practitioner Practice Act that would represent the current practice of nurse practitioners in the provision of acute care. I wish to emphasize that this is a change in descriptive language with no real or implied change in the current scope of practice for nurse practitioners. The current statute, 38-2315, reads "Nurse practitioner practice means health promotion, health supervision, illness prevention and diagnosis, treatment, and management of common health problems and chronic conditions." And as Senator Howard mentioned, we're suggesting adding the words "acute and" to precede "chronic conditions" on the basis of the following three points: Current definition was written in the mid-1980s and was appropriate to the practice of nurse practitioners as it was actualized at that time. It was a relatively new advanced role, there was a small number of nurses educated as nurse practitioners, and the vision for their utilization in primary-care was comparatively narrow by today's standards. Over the past 30 years, the descriptors "common health problems" and "chronic conditions" have fallen short of the actual expansion of the role and utilization of nurse practitioners in healthcare. Nurse practitioners currently provide services in acute care settings like hospitals and emergency departments. The depth and focus of their responsibilities in those settings is acute care. Nurse practitioners also manage acute episodic or time-limited exacerbations of illness or other conditions in the typical course of their work in multiple other healthcare settings. Acute and chronic care services frequently overlap one another. And a simple example of that would be the individual presenting with flu symptoms and a history of tobacco abuse, chronic lung disease, hypertension. That person would be managed much differently because of those chronic entities as opposed to the 20-year-old college student that had no other comorbidities and was coming with the same symptoms. The proposed acute care descriptor in the statute also would be consistent with the definition of the professional role of the NP offered by the American Association of Nurse Practitioners, and I won't repeat that here. Again, Senator Howard has spoken to that. Historically--and I want to go back a bit--in 1984, LB724 authorized the practice of the first nurse practitioners in the state. Testimony was offered before the Committee on Public Health and Welfare on behalf of 35 nurses in the state who were educated as nurse practitioners at the time. The role of the nurse practitioner was described as follows: "education in specialties for management of clients with uncomplicated problems and for general health maintenance...nurse practitioners would be utilized in industry, schools, college or university health settings, private physicians' offices, community health clinics such as well baby clinics, health maintenance clinics, older adult services such as senior citizen centers, hot meal sites, wellness centers, independent living settings and nursing homes." And I want you to pause for a moment, and the person that spoke those words was likely sitting in a chair like this or perhaps in this room speaking to a group like this. A lot has happened in 30 years, and definitely there's more than 35 of us. And these were 35 individuals who had been educated, but at that time did not have practice privileges in the state. Not only have the numbers grown exponentially, but education and certification have kept pace with the evolution of the role. And much of the written

testimony that I've provided you comes from the colleges that speaks to that. In summary, LB243 would update and modify the Nurse Practitioner Practice Act with the addition of a definition of acute care to the functions and scope of the nurse practitioner. This change is intended to be inclusive of all specialties, practice settings, and patient populations. It represents uniformity with the definition of the professional role of nurse practitioners by our national parent organization reflects current practice. It is not a change in the scope of practice. That concludes my remarks. I do want to thank you for allowing me to be here. I also want to, on behalf of our organization, acknowledge our appreciation for your service to the citizens of this state. I'm happy to respond to further questions, and I can also address your questions regarding the 407 review. [LB243]

SENATOR CAMPBELL: Okay, good. We'll start...why don't we go ahead and start with the response on the 407 question. [LB243]

KATHERINE A. HOEBELHEINRICH: Okay. Please, ask again. [LB243]

SENATOR CAMPBELL: Well, you are... [LB243]

KATHERINE A. HOEBELHEINRICH: Is whether or not this particular...the addition of this word "acute"--the answer to that is...and I am chairing that process. The...it actually became glaring apparent to us in that review--and I do wish to commend Senator Gloor and you, Senator Campbell. It's an academic and it's a rigorous process, but I just can't emphasize how useful it's been--but it became apparent to us as we started looking at the statutes and doing our research, this was a gaping hole in our own Practice Act. And we've been functioning in this role, but the language isn't there to support that. So the answer to that...the simple answer is, no. This is...it came about apparent, but it really is not related to the 407 or will have any bearing on that process as that unfolds. [LB243]

SENATOR CAMPBELL: So have you submitted your application for the 407... [LB243]

KATHERINE A. HOEBELHEINRICH: Yes. [LB243]

SENATOR CAMPBELL: ...already? [LB243]

KATHERINE A. HOEBELHEINRICH: Yes. [LB243]

SENATOR CAMPBELL: So nowhere in that application does it refer to this issue? [LB243]

KATHERINE A. HOEBELHEINRICH: No, not at all. We chose to keep that as a separate issue. [LB243]

SENATOR CAMPBELL: Okay. Okay. Because that would be an important question, I think. Senator Gloor did you want to follow up with any questions on the 407? [LB243]

SENATOR GLOOR: No, I'm fine. Thank you. [LB243]

SENATOR CAMPBELL: Any other questions? Senator Crawford. [LB243]

SENATOR CRAWFORD: So can you clarify why you don't consider it a scope of practice change? [LB243]

KATHERINE A. HOEBELHEINRICH: Because nurse practitioners have been and are functioning in these roles. They're educated as acute care nurse practitioners, there's several education tracks. And two of my colleagues behind me will explain for those that are functioning in primary-care roles, how that acute and chronic overlaps so there's acute care functions. For example, myself as a clinician, my clinical practice area is diabetes. By definition, if I respond to someone with an acute hypoglycemic event or low blood sugar, that would require an acute...I would be managing an acute episode, although the majority of my work is chronic disease. [LB243]

SENATOR CRAWFORD: So if the...just so I understand how this all flows together, if the 407 process is already started... [LB243]

KATHERINE A. HOEBELHEINRICH: Yes. [LB243]

SENATOR CRAWFORD: ...it's going through asking about the independent practice question without this word in the statute, is that right? So would we have to go back through and assess...I mean, do we have to redo any of the 407 process if we make this change... [LB243]

KATHERINE A. HOEBELHEINRICH: No. [LB243]

SENATOR CRAWFORD: ...or do you think they are considering that fact that that is part of what you are doing already in practice in that 407 process? [LB243]

KATHERINE A. HOEBELHEINRICH: It is not addressed in the application. The application focuses solely...the basis of the application is that we're requesting removal of the integrated practice agreement with physicians. And we've been asked to describe our practice, but at no point in the application have we addressed the fact that the word "acute" does not appear in the Practice Act. [LB243]

SENATOR CRAWFORD: But in the descriptions of your process, it would include discussions of acute care that you are providing already? [LB243]

KATHERINE A. HOEBELHEINRICH: Yes. Yes. [LB243]

SENATOR CRAWFORD: Thank you. [LB243]

SENATOR CAMPBELL: (Exhibit 20) We are reviewing a letter that we received in a neutral position from the Nebraska Medical Association. [LB243]

KATHERINE A. HOEBELHEINRICH: Yes. [LB243]

SENATOR CAMPBELL: And just so that...have you seen that? You probably have not, it's... [LB243]

KATHERINE A. HOEBELHEINRICH: I have not. I was aware that they were coming in neutral, yes. [LB243]

SENATOR CAMPBELL: They indicate that this neutral position is based on the current statute and scope, and I think what they're trying to say in the letter that should the 407 process change that then the last paragraph says, thus LB243 underscores the importance of the current statutory requirement for integrated practice between NPs and physicians. Without those integrated practice agreements the NMA would be opposed to LB243. And that's why we're asking some questions here, and we'll try to clarify that. And I hope...and I'm probably going to...Hoebelheinrich, am I saying that right? [LB243]

KATHERINE A. HOEBELHEINRICH: Yes, it is. Thank you. [LB243]

SENATOR CAMPBELL: I think what we will normally do by protocol, we'll probably just run the bill and all the testimony for the 407 folks to take a look at, just to make sure that we're not running afoul of anything there. But I wanted you to know of this letter and what it said. [LB243]

KATHERINE A. HOEBELHEINRICH: Thank you, and I will tell you that I was not aware that that was their position. They had...the word we had is that they were weighing in neutral. [LB243]

SENATOR CAMPBELL: Okay. [LB243]

KATHERINE A. HOEBELHEINRICH: So definitely I can't comment. We need to ask more questions. [LB243]

SENATOR CAMPBELL: Right. Oh, no, I understand that. I just wanted you to be aware, and they are weighing in neutral as it now stands, as the statute now stands. [LB243]

KATHERINE A. HOEBELHEINRICH: Yes. [LB243]

SENATOR CAMPBELL: Okay. Any other questions? Thank you for your testimony. [LB243]

KATHERINE A. HOEBELHEINRICH: Thank you. [LB243]

SENATOR CAMPBELL: You know, it's probably a good reminder. I just double-checked on this this morning. If you give us letters, it will show in the legislative record, but none of those will show in the committee statement--I knew I got that right--because there's been a lot of questions about that and there were a lot of questions. And the reason I checked this is because the Revenue Committee in hearing today hearing all of this, there were a number of people that thought if they just submitted a letter it would show in the committee statement. You must testify in order to have it be in the committee statement, but it will be in the record. Yes. [LB243]

SENATOR CRAWFORD: Signed? On the sheet? Is it... [LB243]

SENATOR CAMPBELL: You have to testify. You must testify. Okay? So if you get constituents who ask you, well, when the committee statement comes out, why is my association not listed? It's not listed because you didn't testify in person. Okay? Our next testifier in favor of the bill? Sorry for that small procedural...good afternoon. [LB243]

LaDONNA HART: (Exhibit 15) Good afternoon, Senator Campbell, members of the Health and Human Services Committee. My name is LaDonna Hart, spelled L-a-D-o-n-n-a H-a-r-t. I am here today in support of LB243 and, of course, I thank you for the opportunity to be able to testify. I am a nurse practitioner. I have a master's degree in the science of nursing, graduating from the University of Nebraska Medical Center. I have my credentialing or my certification as a family nurse practitioner. I've been in practice for nearly 15 years, and I thought I'd tell you just a little bit about my practice experience. I started providing care in an ob-gyn practice, and I did that for about eight years. And then I had a wonderful opportunity to do family practice for five years. And then in the last year and a half, I rejoined my previous employer back in a setting of women's health. I also, over the last six years, have worked in urgent-care facility, and I work about one to two days a week. And I see about...between about 15 and 25 patients a day. So as I was writing this testimony I was thinking about, well, what does your practice really look like if you had to look backwards? And, of course, I know what it looks like when I'm doing it. And I recalled that my clinical practices looked...you know, I saw individuals across the life span, babies to our very elderly patients with acute illnesses such as influenza, pneumonia, RSV, acute sports injuries, acute gastroenteritis, some of those being time limited. And also some of those being an acute exacerbation of a chronic illness. And those were seen in both my full-time job within the setting of women's health and also in my urgent-care facility. I performed

several preoperative evaluations for surgical interventions. I referred two women to colleagues for surgery. I should mention that I work for seven physician colleagues and I have two women's health nurse practitioners that I work with, one of those physicians being a family practice doctor within our clinic. I treated several young women for acute pelvic pain, pain that had been less than maybe 24 to 48 hours, and also treated acute abdominal pain. And, let's see, I also referred one young woman for a hospital admission for an acute pyelonephritis, which is a severe kidney infection in which she needed hospitalization. I performed many health promotion activities, health prevention screenings including pap smears, family planning services, smoking cessation, counseling on cardiovascular and diabetes behavior modification. I performed many gynecological procedures, including endometrial biopsies, the insertion of subdermal contraceptive implants, IUDs. And I do colposcopy, which is the diagnostic treatment and evaluation for cervical disease in women. I ordered and interpreted all the laboratory tests that were necessary to treat any of these conditions if they were needed. And I ordered any pharmacologic and nonpharmacologic treatments that were needed as well as chicken soup for some of those conditions if that's all they needed; and, of course, provided any teaching and counseling for those conditions. Also I mentor and precept other nurse practitioner students in women's health and family nurse practitioner tracks and, as a matter of fact, this week I provided a first-year resident physician from Lincoln LMES...instructed her in IUD placement and in the art of colposcopy. On any given day my education, training, certification, have prepared me to fulfill the definition for primary care to include the provision of care at first contact for an undifferentiated condition, the ongoing management of acute and chronic conditions, health promotion, and coordination of patient care as defined by the American Academy of Nurse Practitioners. LB243 updates the Nurse Practice Act to currently reflect our national standards for licensure, accreditation, and education without changing my scope of practice...our scope of practice. Madam Chair, I don't have anything else. Members of the committee, I thank you for letting me give testimony. I do recognize that my last...nearly last sentence says LB234. It is LB243, it was a little late. My phone number is right though. So I'll be happy to answer any questions. [LB243]

SENATOR CAMPBELL: Are there any questions? Senator Crawford. [LB243]

SENATOR CRAWFORD: Thank you, Senator Campbell. I wonder if you would explain to us what makes a condition acute. So you're listing some of the things you've done... [LB243]

LaDONNA HART: Right. [LB243]

SENATOR CRAWFORD: ...you know, over the past few days and some of them you define as acute. Just for the record, what is...what makes a condition acute? [LB243]

LaDONNA HART: Acute is to...can be interpreted in two different ways. One is just

simply that the illness has been present for a certain period of time, at which point if that condition remains it becomes a chronic condition. A cold is an acute condition, time limited, most people will get better without intervention. And then if that cough were to continue for say, six weeks, that becomes a chronic cough. If we have acute back pain and injury within 24 to 48 hours, that is an acute back pain. If it lasts greater than perhaps two weeks, it becomes a chronic health condition. Then we have the issue of acuity: how critically ill is this patient? And so I deal with both acute, time-limited illnesses, and I deal with acute illness. An example, my young woman that had the very severe kidney infection would...could be life threatening if not treated and actually did need to be hospitalized. So that...does that help with your question? [LB243]

SENATOR CRAWFORD: All right. So one part of the...something may be acute because it's time limited... [LB243]

LaDONNA HART: Right or time and disease, right. [LB243]

SENATOR CRAWFORD: Or it's acute because of the severity. [LB243]

LaDONNA HART: Right. And an acute exacerbation of a chronic condition is a patient underlying asthma or a coronary...sorry, obstructive pulmonary disease, chronic obstructive pulmonary disease, catches cold or has a very bad exacerbation of their chronic condition in which they can't breathe. So their chronic condition is generally stable, they have an incident or an insult such as a virus or an allergy that triggers that condition to become acute again. We treat the acute to get them back to their baseline. [LB243]

SENATOR CRAWFORD: So they have a chronic condition and some kind of spike... [LB243]

LaDONNA HART: Right. [LB243]

SENATOR CRAWFORD: ...makes it considered acute... [LB243]

LaDONNA HART: Acute exacerbation of a chronic condition. [LB243]

SENATOR CRAWFORD: ...or it's something that's only a short time, so it wouldn't be chronic. [LB243]

LaDONNA HART: Right. [LB243]

SENATOR CRAWFORD: The other...I'm trying to remember. It was chronic...you're adding the word "acute" and then the other word is... [LB243]

LaDONNA HART: Common health problems? Yes. [LB243]

SENATOR CRAWFORD: Common health, yes. So a cold is not a common health problem? [LB243]

LaDONNA HART: A cold is a common health problem. [LB243]

SENATOR CRAWFORD: Okay. Okay. [LB243]

LaDONNA HART: No problem. So might we enter...so 50 percent of people have coronary artery disease. Might we consider that also a common health problem, although it could be much more acute? Right? [LB243]

SENATOR CRAWFORD: Okay. [LB243]

LaDONNA HART: So there...I think the point is that there is a huge overlap between these that we, you know, treat. And we're already in practice doing these things based on our education, our credentialing. Our training is within that scope of the national standards; that we continue to do those is simply updating the language in our act that was written at a time when nurse practitioner practice looked very different...appropriate for the time, but has expanded through our more in-depth training. The national standards across the United States have all encompassed a different role for nurse practitioners. And this language just reflects our doing those things. [LB243]

SENATOR CRAWFORD: So is there a standard nurse definition of how severe something is when it's...to make it acute on the severity scale? So one is the time-limited scale and one is severity. [LB243]

LaDONNA HART: Well, I don't know the answer to that. I don't know if there's...how do I determine if this is an acute cold based on someone with pneumonia that needs a different treatment? I think that comes down to our clinical experience, our education. Is it...certainly, we would know that once that pneumonia was diagnosed that that would be more of an acuity issue than the acute cold. So viral syndromes can be very severe, so I think it would come down to what the final diagnosis was. Of course, remember that we have the provision to see those undetermined...indeterminant diagnoses. If I find that someone is much more acute...and I, personally, where I am in my practice, cannot...I even refer, as I did with the young woman with the acute kidney infection. [LB243]

SENATOR CRAWFORD: Is there any standard above acute? [LB243]

LaDONNA HART: I don't think that there is any standard above acute. [LB243]

SENATOR CRAWFORD: Okay. So it covers a pretty big range then. [LB243]

LaDONNA HART: I don't know. I might leave that to my nurse practitioner (inaudible.) [LB243]

SENATOR CRAWFORD: All right. Thank you. [LB243]

SENATOR CAMPBELL: Other questions? Thank you very much. [LB243]

LaDONNA HART: Thank you. [LB243]

SENATOR CAMPBELL: All right. Our next proponent? [LB243]

LAZARO SPINDOLA: (Exhibit 16) Good afternoon, Senator Campbell and all the members of the Health and Human Services Committee. For the record, thank you for receiving me today. My name is Lazaro Spindola, that's L-a-z-a-r-o S-p-i-n-d-o-l-a. Even though I am the director of the Latino-American Commission, I come today as a private citizen--and I'm off the clock right now--and also as a former physician for 20 years and as a former public health officer for 10 more years. I am here today to testify in support of LB243, which introduces the term "acute" in a line that reads..."treatment and management of common health problems and acute and chronic conditions." I had some confusion too, Senator Crawford, with that term "common health problems." An acute condition usually means a rapid onset, rapid diagnosis and treatment, and a fast resolution. I was a trauma surgeon. I know what acute is; but, on the other hand, very few people were trained to do what I could do. Usually other physicians had to call me because of the degree of the severity of the acuteness. Now, a chronic condition is usually the opposite: a slow onset, many times a slow diagnosis, long-term treatment which is usually lifelong. Chronic conditions usually mean--and this is what I see as important--that the medical provider and the patient establish a very long relationship that many times is lifelong. And this last situation is what brings me here. The difference between acute and chronic seems to be very clear cut, but a condition being chronic does not preclude it from having acute manifestations. For example, asthma is a chronic condition; but a patient suffering from it may have an acute asthma attack. The same can be said for diabetes, migraine, chronic heart disease or most of the other chronic conditions. We now have a situation where the provider who knows the most about the patient's condition--that could be the nurse practitioner, the provider who has been treating this condition for years,--the provider who knows the patient as a person whether it be culturally speaking, whether it be the particular idiosyncrasies of that patient, whether the behaviors of that patient accepts is being precluded from treating is acute phase because of the way that the law is written. For me, that makes no sense. I cannot, for the life of me, understand how this is the best way to guarantee the quality of care that the patient deserves. Besides, this is going to increase the cost because the more medical providers you bring in to treat a patient, the more expensive the cost

becomes. It increases cost, it leaves out a large amount of information that ranges from medical to cultural issues that will need to be freshly gathered by the new provider who will be seeing this patient, places a barrier on communication, and slows the overall treatment for the patient. I, therefore, urge the committee members to move this bill to General File and for consideration by the Legislature as a whole. I will be happy to answer any questions. [LB243]

SENATOR CAMPBELL: Thank you, Doctor. Are there questions? Seeing no questions, thanks for your testimony. [LB243]

LAZARO SPINDOLA: Thank you. [LB243]

SENATOR CAMPBELL: Our next proponent? Good afternoon. [LB243]

KRISTI EGGERS: (Exhibit 17) Good afternoon. Good afternoon, my name is Kristi Eggers, K-r-i-s-t-i E-g-g-e-r-s, and I am a family nurse practitioner in Sutton, Nebraska. I'm here today to voice my support of LB243. I have been in Sutton, which is a rural Nebraska community, for the last seven and a half years providing care to all ages in that community. I was specifically hired and brought to Sutton to meet the needs of the rural population. I began work in a hospital-owned rural health clinic in 2005. Since that time I have worked with several part-time physicians, four other nurse practitioners, and a physician assistant. Recently I have transitioned into a private practice setting within the same community that employs a part-time physician, full-time physician assistant, full-time mental health practitioner, and myself. I want to take a minute to share my perspective of the healthcare needs in the rural area and the types of conditions that I see and treat on a daily basis. I see an average of 18 scheduled patients per day in addition to walk-in emergencies. The community depends on the clinic for immediate treatment of a variety of injuries and illnesses; these range from minor to life threatening. In our community there is no hospital. I'm often the first contact for someone in need. I routinely repair lacerations and provide fracture care. It is not uncommon for a patient to present to the clinic with chest pain or symptoms of a stroke. I provide the initial evaluation and treatment in these circumstances. I often have to provide stabilization so that they can be transported by our volunteer EMS squad to the next emergency facility. I collaborate and work with several area hospitals when an admission is required or further evaluation is needed for both chronic and acute illnesses that come through my door. I provide in-home services and on-site care at our local nursing home for elderly who are having difficulty getting out. These patients seek care for a variety of conditions. The most common conditions that I see in this population are acute respiratory conditions, gastroenteritis, viral syndromes, injuries, and pain. I also treat these same home-bound patients for chronic diseases such as diabetes, hypertension, chronic lung disease, coronary artery disease, obesity, arthritis, psychiatric, and terminal illness. I complete minor procedures such as skin biopsies, cryosurgery, incision and drainage, wound care, and I make referrals to appropriate

specialties as needed. I have been the initial contact for a variety of patients with a...with many diverse needs. I just want to share some recent examples of the types of patients that I've seen: a 56-year-old female having a heart attack or a myocardial infarction, a 76-year-old male with symptoms of a stroke, a teenager who was thinking about suicide, a male in his mid-50s with abdominal pain that was found to be a kidney stone, a 37-year-old female with pneumonia, a 4-year-old baby with RSV, a 66-year-old male with diabetes-related hypoglycemia, a 17-year-old with a fractured hand, a 64-year-old female with a pulmonary embolism or a blood clot in her lung, and a 4 year old with a laceration to his head. This is not an inclusive list of everything that I have seen, but it is quite reflective of encounters that we see in rural Nebraska. I have treated this same group of patients that I've just told you about over the last year for chronic diseases that include coronary artery disease, hypertension, hyperlipidemia, vascular disease, atrial fib, peptic ulcers, chronic kidneys, rheumatoid arthritis, and depression. Patients of this same-mentioned group have been seen for health promotion and prevention with physical exams, immunizations, we have completed Welcome to Medicare physicals, sports clearance physicals, preoperative clearance, driver's license exams. It's important for me to express to you that we manage both the acute and chronic illness in order to best treat our patients. I order and interpret a wide variety of diagnostic studies both in the clinic and off site. I prescribe medications and monitor their response. I provide dietary and exercise education, drug and alcohol screenings, smoking cessation, weight management counseling, and vaccine recommendations. I provide health maintenance updates and health promotion guidelines to my patients on a regular basis. And my red light is on. [LB243]

SENATOR CAMPBELL: Go ahead and finish out. [LB243]

KRISTI EGGERS: I am very proud of the services that I can give in Sutton. Many patients and community leaders have expressed over the years their gratitude for the services that we have. I'm able to provide evidence-based, comprehensive care to many that would not have access to healthcare at all. For these reasons, I'm in support of LB243. The update in wording would not change my scope of practice nor the outcome for my patients, but instead would more accurately reflect what I am trained and expected to do in a rural family practice clinic on any given day. I appreciate the opportunity to testify today. [LB243]

SENATOR CAMPBELL: Are there any questions from the senators? Seeing none, thank you very much for your thorough testimony. Our next testifier favoring LB243. [LB243]

DON WESELY: (Exhibit 18) Senator Campbell, members of the Health and Human Services Committee, for the record my name is Don Wesely, W-e-s-e-l-y, representing the Nebraska Nurses Association. I am passing around a letter to the committee from Douglass Haas who is a member of NNA and a registered nurse. Let me try to give you

the context of this--and you were asking about acute care versus chronic care, and I think you got good examples of that, Senator Crawford--but another would be if you had a truck driver's license and then it turned out that somehow in the statute we forgot to allow them to drive a trip less than 100 and they were only allowed to be a truck driver if the trip was more than 100 miles. That's kind of what this is. It's like, how did this happen? And you can blame me; most likely it was my fault since I was chair of this committee for 20 years. I should have caught this at some point, and obviously the 407 process helped illuminate the fact that somehow that language wasn't in there. Everybody has assumed it's there, everybody has been, you know, assuming that that sort of care has been under the practice of a nurse practitioner. So it's just an oversight. Back to the 407 review, I think the docs are just basically giving you a shot across the bow saying, when this comes up next year just remember, we're not going to like it. So that's accepted that they're not going to like that. We are going to like it, and we'll have the discussion next year; but this shouldn't be part of that and it should be adopted. In fact, I was going to suggest you might even think about having an E clause because this thing ought to be in the statute. It should have been in there whenever, you know, 20 years ago it should have been, 30 years ago it should have been in there. And so this isn't an issue. Once it's in there, then when we come back next year and debate over the independent and integrated practice issue, you know, that's how it should be discussed, their concern. So... [LB243]

SENATOR CAMPBELL: Questions for Senator Wesely? Thank you very much for coming. [LB243]

DEBORAH BJORMAN: (Exhibit 19) Good afternoon, Madam Chair... [LB243]

SENATOR CAMPBELL: Good afternoon. [LB243]

DEBORAH BJORMAN: ...committee members. My name is Deborah Bjorman, D-e-b-o-r-a-h B-j-o-r-m-a-n, and I am representing the Nebraska Neonatal Nurse Practitioners Association. I'm also a certified, licensed, neonatal nurse practitioner here in Nebraska. We are in support of LB243 because adding the word "acute" to define the care a neonatal nurse practitioner provides is the very word that already defines the majority of our practice. Just so you know, that's pretty much what we do. I have a definition in there, Senator Crawford, from Mosby's Medical Dictionary . It basically...just to reiterate, that acute care is usually given in a hospital by specialized personnel using complex and sophisticated equipment and materials, and it may involve intensive or emergency care. Often this is short time, just kind of what you heard, and then chronic care is usually considered long term. As neonatal nurse practitioners, the majority of our practice as clinicians is based in a hospital setting caring for the acutely ill neonate in a neonatal intensive care unit. Our primary patient base are those born prematurely with acute issues related to their premature birth, which include but are not limited to respiratory conditions, cardiac conditions, feeding immaturity, things along that line. The

medical problems managed by the neonatal nurse practitioner are--on a daily basis--are acute or short-term problems. Each day is new, and each day brings the ability for our patient population to present with a new medical issue. It is imperative that a primary skill for a neonatal nurse practitioner is the ability to manage an acute medical condition. Many of the acute medical problems presented in our patient population are life threatening; however, are normally medically manageable and are medically managed by neonatal nurse practitioners on a daily basis. To deny support for this bill is simply denying acknowledgement and ability of our highly educated and trained group of healthcare professionals in the state of Nebraska. And just to reiterate, like I said and it's just like what the senator just said before, we do this on a daily basis. This is our job. We provide acute care. Chronic care is not part of our job. We do a minor bit of that, but the majority of it is responding and reacting to what presents. So we are just asking that the wording of the bill correlate with what we already do. So... [LB243]

SENATOR CAMPBELL: Questions? Thank you very much for your testimony. [LB243]

DEBORAH BJORMAN: Thank you. [LB243]

SENATOR CAMPBELL: Our next proponent? Okay. Those in the hearing room who wish to testify in opposition to the bill? Those who want to testify in a neutral position? Seeing no one, Senator Howard, would you like to close on your bill? [LB243]

SENATOR HOWARD: I'll be brief because I know I'm the one thing standing between us and the end of the day, but I will say that nurse practitioners fill a really critical gap in the healthcare infrastructure in the state of Nebraska. I see it firsthand in my clinic that I work at. And so they're already practicing in acute settings, they're already practicing acute care. This addition just better describes the work that they're already doing as well as the sort of evolution of their educational structure since the 1980s. But I'm excited and happy to defer to the committee's expertise to ensure that this doesn't step on any toes in regards to the 407 process, and I really appreciate your consideration for this bill. So thank you so much, and have a great day. [LB243]

SENATOR CAMPBELL: Any questions for Senator Howard? Thank you very much. [LB243]

SENATOR HOWARD: Thank you. [LB243]

SENATOR CAMPBELL: That concludes our hearing on LB243 and our hearings for the day, so thank you very much for coming. (See also Exhibits 20, 21) [LB243]