[LB1017 LB1072 LB1078]

The Committee on Health and Human Services met at 1:30 p.m. on Wednesday, February 12, 2014, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB1072, LB1078, and LB1017. 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: (Recorder malfunction)...hearings of the Health and Human Services Committee. We are pleased to have you and that you're taking time from your schedule to testify today or to monitor the hearings. I'm Kathy Campbell and I represent District 25 and I chair the Health and Human Services Committee. I'm going to go over some procedures, and then we'll do some introductions. If you have cell phones, please turn them to silent, or turn them off. We also remind anyone who's using a tablet to also do that, so that we do not hear any sound. Handouts are not required, but if you have them, we would like 15 copies; and the pages will be glad to help you with those. If you're testifying today, please complete one of the orange sheets or bright tangerine or whatever color you wish to call it; print very legibly so that Brennen can read your handwriting. As you come forward, you can give that sheet to Brennen and any handout copies that you have, and the pages will distribute it for you. As you sit down, please identify yourselves and also spell your name; and, we would remind you, do not go too rapidly on the spelling. We do use the light system in the Health Committee. And it's...you'll start at five minutes, and it will be green for what you think is a very long time; and then it will go to yellow and you'll have one minute; and you have red and I'll be trying to get your attention. So with that, we'll do introductions. Senator, would you start for me.

SENATOR WATERMEIER: Dan Watermeier, Syracuse.

SENATOR HOWARD: Senator Howard; I represent District 9 in midtown Omaha.

MICHELLE CHAFFEE: I'm Michelle Chaffee; I serve as legal counsel.

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

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

BRENNEN MILLER: I'm Brennen Miller, I'm committee clerk.

SENATOR CAMPBELL: And our pages today, Emily and Stuart; they are both at the University of Nebraska-Lincoln. Emily's hometown is Sioux Falls, and a political science major. And Stuart is an English major, originally from Lincoln. So we're glad to have

them. Senator Krist and Senator Cook will be late; they both have bills in another committee, presenting. Everybody is presenting everywhere, so there's hardly anybody at the committee hearing them, but anyway...Senator Lathrop, always a pleasure to see you again in front of the committee. And so today we will start out with your bill. And if you'd identify yourself...

SENATOR LATHROP: I'd be happy to. Steve Lathrop, L-a-t-h-r-o-p; I'm the state senator from District 12 in Douglas County. I'm here today to introduce LB1072. And you'll recall last year I introduced a bill on prescription drug monitoring. The nature of the problem we talked about at some length last year. It is something that I have, in my professional life, had an opportunity to observe. And the importance of trying to get ahead of people before they become addicted to narcotic painkillers is a very, very significant issue. Getting to the solution has presented a significant challenge. I'm introducing today LB1072 as a second attempt at a bill to address how do we develop a prescription drug monitoring program. What I have learned in the last year is that the process of doing that is even more complex than what I ever imagined last year. And the difficulty is providing...or getting...bringing together the platform, which is, where are we going to...just what process is going to be in place? Are we going to use NeHII or some other tool? Who's going to report? Who's going to have access to that information? And a lot of those issues are issues that I think can be resolved. We've taken a stab at it with LB1072. And even as late as noon, when I was leaving the Chamber, I had people coming up to me telling me they had some concerns. So I appreciate that LB1072 may need some work in terms of ironing out concerns people have in terms of addressing the interrelationship between this bill and the future of NeHII, which I think Senator Howard is working on. And as we work through those, this will at some point be ready for the floor. But I think that work has to be done first. And again, it is a very significant problem. I think there are people getting hooked on these medications, and we need to do something. But getting to the place where we bring all the people together that need to be in the room and we iron out the relationship between this idea and NeHII are our challenges before we're ready for floor debate. [LB1072]

SENATOR CAMPBELL: Okay. Thank you, Senator Lathrop. Any questions that you have? I mentioned to Senator Lathrop that this morning Senator Haar (phonetic) and I were talking about perhaps putting in an interim study to bring all of the players together and talk about that platform, because at some point we really are going to have to take, with a figure of speech, our chips and put them someplace and say, "Okay, this is it," and make everyone who's working on electronic records and sharing come together and make some decisions. [LB1072]

SENATOR LATHROP: And I appreciate that. That may be ultimately the best we can hope for. I would suggest though that having an amendment that at least allows us to amend Senator Gwen Howard's work... [LB1072]

SENATOR CAMPBELL: Right. [LB1072]

SENATOR LATHROP: ...by allowing us to accept some funding for or spend money, if we can receive money, would be beneficial. And I don't think that needs to wait until after the interim study is done. So, hopefully, that is something we could, if we do not move LB1072, at least we could make an amendment to one of your prioritized bills and open the way for the receipt of money into Gwen Howard's bill. [LB1072]

SENATOR CAMPBELL: Okay. Any other comments? Thank you, Senator Lathrop. [LB1072]

SENATOR LATHROP: Good. [LB1072]

SENATOR CAMPBELL: And I know you're not going to stay. [LB1072]

SENATOR LATHROP: I would love to stick around. I love this committee and the work you do, but apparently we're shorthanded over in Judiciary, so I'd better... [LB1072]

SENATOR CAMPBELL: Go back. [LB1072]

SENATOR LATHROP: ...make my way over to my committee. [LB1072]

SENATOR CAMPBELL: Sounds like it. [LB1072]

SENATOR LATHROP: All right. [LB1072]

SENATOR CAMPBELL: Thank you. [LB1072]

SENATOR LATHROP: Thank you. [LB1072]

SENATOR CAMPBELL: (Exhibits 15 and 17) We should note for the record, we have received three letters: from the Nebraska Board of Medicine and Surgery, a support letter; and a support letter from the Cancer Action Network; and I have not opened the pharmacy...I'm assuming it is a support letter. Oh, you can put these back. We'll try to clarify that before the end of the hearing. We'll start out today with our first proponent for LB1072. Anyone here wishing to testify? [LB1072]

JASON KRUGER: Good afternoon. [LB1072]

SENATOR CAMPBELL: Good afternoon. [LB1072]

JASON KRUGER: It's Dr. Jason Kruger, J-a-s-o-n, last name K-r-u-g-e-r, speaking on

behalf of the Nebraska Medical Association and the Nebraska chapter of the American College of Emergency Physicians, in support of this bill. The medical association and the emergency physicians in this state have been fighting for years for an effective prescription drug monitoring program. As a practicing emergency physician here in Lincoln at St. Elizabeth and EMS medical director for Lincoln Fire and a number of agencies that surround Lincoln, this is a problem unfortunately that we see every day, with prescription drug abuse. It's a challenge because dishonesty is some part of this disease process, and having accurate information is important in effectively dealing with the problem. As a physician, we never...I never want to withhold pain medications from somebody with a truly painful condition. At the same time, abiding by our Hippocratic oath to do no harm, I do not want to pour gasoline on a fire and continue someone's addiction issues without recognizing it and being able to appropriately intervene and to try to get them help. The end process of this disease is death or permanent disability. This is important. More people are dying from prescription drug overdoses in this country now than are dying from car accidents. We have made huge inroads over the last 50 years in making cars safer, making highways safer, and doing everything we can to save lives on our highway systems. This is something that we are seeing more and seems to get worse every year. And we need an effective program so that we can address this, because this destroys lives and it destroys families. I think this bill strengthens our system by not allowing people to opt out; it ensures access to all prescribers and dispensers and helps to ensure that we're capturing all prescriptions. Just...with any bill that would move forward we'd just...speaking on behalf of the medical association, we do want to avoid any kind of "mandatory obligation" language, that we have to...we are required by law to check this every single time. As an ER doctor, if I've got somebody with an angulated forearm fracture, I'm pretty sure they're not faking it. I don't know that I need to log into the system every single time, by law. And, you know, as an EMS medical director, I use our state e-NARSIS system to check my run reports from my various agencies. And, being a doctor, I've got about 25 different log-ons and passwords for different things; and unfortunately I locked myself out this last weekend, and it took a couple of days to actually get ahold of somebody to get a new password and get that reset. I wouldn't want to be breaking the law if I accidently failed on my three password attempts for some system and was unable to check it for a weekend. I don't think my partners would want to cover my weekend shifts because I accidentally made a mistake. I think this bill ultimately, though, is extremely important. I think it saves money in our system. These people are kind of engaging the healthcare system in numerous ways. When they're hitting the emergency department with the worst headache of their life, I don't want to miss anything. I don't want to keep ordering CAT scans and MRIs on the same person and costing the system money and ultimately exposing them to excess radiation. And, ultimately, I think this bill is about saving lives. So thank you very much; I appreciate your time. And if you folks have any questions, I would be more than happy to answer them. [LB1072]

SENATOR CAMPBELL: Thank you, Dr. Kruger. Are there any questions? Senator

Gloor. [LB1072]

SENATOR GLOOR: Thank you, Senator Campbell. And thank you, Dr. Kruger, for your testimony and for your service to Lincoln and to emergency medicine, for that matter. Are there limits in the amount of controlled substances you can send a patient out of the emergency room with? [LB1072]

JASON KRUGER: There are some states that are kind of venturing into that right now, that are putting limits on the amounts of prescriptions you can send somebody home with. Currently there is no limit. I mean frankly as an ER doctor, it's pretty rare that I give somebody a prescription for more than 20 of anything. I think New York City had some issues where they were requiring their city hospitals to prescribe, like, a minimum of three days' worth of any type of pain medications. You know, unfortunately, if Christmas Eve lands on, like, a Thursday or something, and you can't get somebody into the orthopedist reasonably for a week, I don't know that that's a great solution. And frankly, I mean, the emergency physicians...like I said, most of us write for about 20 of something. A lot of these people when they're engaging multiple different family practitioners who are writing a month's worth of supplies and giving out 240 pills is where you really get the...have the issues. I don't think that's really the avenue to go down to fix this issue. [LB1072]

SENATOR GLOOR: Okay. Thank you. [LB1072]

JASON KRUGER: Sure. [LB1072]

SENATOR CAMPBELL: Other questions from the senators? Thank you, Doctor, for coming. [LB1072]

JASON KRUGER: I appreciate it. Thank you very much. [LB1072]

SENATOR CAMPBELL: Our next testifier in the proponent. Good afternoon. [LB1072]

DEB BASS: (Exhibit 1) Good afternoon. Good afternoon, Chairperson Campbell and members of the committee. My name is Deb Bass; for the record, that is spelled D-e-b B-a-s-s. I am the chief executive officer of the Nebraska Health Information Initiative, known as NeHII. And I first want to say that we support this legislation, and we are here to offer our help in furthering the effort to get a PDMP up and running in our state. Before I begin, I'd like to give you a brief background on NeHII. It is a nationally recognized system that allows healthcare providers to exchange healthcare records in a secure environment. NeHII is not a data warehouse. We do collect the records; we allow them to be exchanged. The best analogy is probably to roads: NeHII is the highway, better known as the exchange. We are not the trucking company nor the stores on the end of the highway. Patients are allowed to opt out of the system if they

choose. But less than 3 percent of the 2.7 million lives in our system have chosen to do so. NeHII has been actively engaged in trying to get a PDMP operational in Nebraska for some time. We worked with Senator Gwen Howard on LB237 in 2011. That law would have directed HHS and NeHII to create a PDMP. One problem was that there is a specific prohibition on the use of state funds to create one or to allow grant funds to flow through a state agency. This stands in the way of a PDMP because it makes it difficult to apply for a federal grant if they can't work with that state as a grantee. We believe that the best first step is to repeal that prohibition. Even with that language in place, however, we have begun the implementation. We are working with vendors to enhance the current system. We have done the following: We've included the retail prescription feeds from nine major pharmacy chains in the U.S. so that self-pay prescription data is included in the medication history information found in NeHII. We've offered a site license payment schedule to all the participating hospitals so that their employed and their contracted ED physicians can have access to NeHII at no cost. And we are exploring grant opportunities to enhance the current system. NeHII believes a PDMP is an important part of the state's health IT infrastructure that needs to be integrated with all of the state's other health IT projects. NeHII has been selected by CMS as one of six states for a pilot project to incorporate PDMP data into the HIE. That's why we have worked so hard on this project. There are a few challenges for us, as there would be for any entity trying to establish a PDMP. First, NeHII is voluntary. Patients do not have to participate. To work properly, the PDMP function needs to be mandatory, as drug seekers tend to opt out otherwise. With the future planned enhancement NeHII would be able to make all patient medication records available to providers. Second, with the customization outlined above, we need to be able to give stand-alone access to providers to the PDMP. As we know, not all healthcare providers want to use all of the services that NeHII has to offer. However, for those providers who do participate in NeHII, we believe strongly that it would be best to integrate all the projects. Providers would have access to the medication history portion of NeHII at no cost, and therefore the service would be available to all providers across the state. I listened to the other testimony and believe that the issues are resolvable for us if we work together to develop a solution. We don't want to put pharmacists and other providers to unnecessary work or added expense. We are in the business of avoiding duplication. We look forward to developing the technology solution that will help resolve some of the issues we've heard about today. Thank you. And I ask that you advance LB1072. And I would be very happy to answer any questions that you have. [LB1072]

SENATOR CAMPBELL: Thank you, Ms. Bass. Questions from the senators? Senator Crawford. [LB1072]

SENATOR CRAWFORD: Thank you, Senator Campbell. And thank you for your testimony and your work. So what do you see as the biggest obstacle to providing that stand-alone capability? [LB1072]

DEB BASS: The...we're working on the technical solution. [LB1072]

SENATOR CRAWFORD: Okay. [LB1072]

DEB BASS: And that has to be addressed; and, of course, that takes funding. [LB1072]

SENATOR CRAWFORD: Funding. [LB1072]

DEB BASS: Um-hum. [LB1072]

SENATOR CRAWFORD: Okay. So the funding...the funding language component of the bill, do you think that addresses your need to...I mean, does that make it possible...if you receive those grants, does that address your need to get the funding to tackle that? [LB1072]

DEB BASS: Depends on the grant. That would be... [LB1072]

SENATOR CRAWFORD: Sure. I mean... [LB1072]

DEB BASS: ...a great first step. [LB1072]

SENATOR CRAWFORD: Okay, okay. I mean, you don't know how much you would get with the grants, but that language that's in the bill now, I think it would allow you to receive the money that if it's sufficient could be used to provide that capability. Is that true? [LB1072]

DEB BASS: Yes. [LB1072]

SENATOR CRAWFORD: Thank you. [LB1072]

SENATOR CAMPBELL: Any other questions? Senator Gloor. [LB1072]

SENATOR GLOOR: Thank you, Senator Campbell. And thank you, Deb, for your work on NeHII. I know it's been a life's...a lifelong love, almost. I'm trying to, in my own mind, to understand with the NeHII how reasonable it is that we can ever get everybody tied in the way we'd like to. You start with the larger groups, hospitals but then...so let's say, to address the ER problem we have, we've got all of the hospitals tied in. Won't drug seekers then go to urgent care centers and...I mean, how long are we going to be chasing after this if we don't figure out a way to implement NeHII everywhere at pretty much the same time? Because, you know, then we tie in the urgent care centers, then people will gravitate to physicians' practices; but then it will be the larger physicians' practices, and then they'll gravitate to the smaller, individual physician practices. Obviously every time we address the issue, I mean, maybe we lessen the problem. But

I'm trying to figure out to what extent and how many years might it take to do that. [LB1072]

SENATOR GLOOR: ... [LB1072]

DEB BASS: Drug seekers are a savvy group. So... [LB1072]

SENATOR GLOOR: Yeah. [LB1072]

DEB BASS: ...you know. And they do have a good communication challenge. I completely understand the question that you're raising. And yet, you know, to begin to address the challenge...our medication history feed comes from the Surescripts data. And we do have a good percentage of pharmacies and physicians that...providers that use the Surescripts information and use it for their prescribing. So again you look for a solution that best answers...and constantly looking. Technology is always...you're looking to improve what's in place and enhance it. You know as a technologist, our work is never done. That's...we're always looking to make it better. [LB1072]

SENATOR GLOOR: Maybe we should have one giant controlled-drug pharmacy in the state; everybody has to go there and have their pictures and fingerprints taken, and we do that for a year and clean up the state, and then we don't have to worry about it anymore. You think? Thank you. [LB1072]

DEB BASS: Thank you. [LB1072]

SENATOR GLOOR: That wasn't really a question; it was frustration. [LB1072]

SENATOR CAMPBELL: Any other questions? It seemed to me then there was a big "maybe" on her face. Thank you so much for your testimony. [LB1072]

DEB BASS: Thank you. [LB1072]

SENATOR CAMPBELL: Our next proponent? Okay. Those who wish to testify in opposition to LB1072? I don't think that's an opposition. Those who wish to testify in a neutral position. Good afternoon. [LB1072]

BRUCE RIEKER: (Exhibit 2) Good afternoon. My name is Bruce Rieker, B-r-u-c-e R-i-e-k-e-r, vice president of advocacy for the Nebraska Hospital Association. We're here testifying in a neutral capacity on this particular bill. We appreciate Senator Lathrop's efforts and everyone else that's been involved. And as Dr. Kruger already mentioned, it's a vitally important issue, and we think that it's time we get this solved. Dr. Kruger pretty much outlined the one reason or the reason that we are neutral, which would be in the fourth paragraph of the testimony that I've submitted to you, is that, in

the way the bill was originally drafted, it excluded inpatient care from...through the definition of a "dispenser" and these pharmaceuticals. However, there are many outpatient scenarios where the same situation may apply. And Dr. Kruger stated it very well with his emergency room work, and I don't think I need to go through that. But it's the same concern that we wanted to bring to light to the committee. And therefore we're in a neutral position and look forward to working on it. [LB1072]

SENATOR CAMPBELL: Excellent. Any further discussion or questions? Thank you, Mr. Rieker. [LB1072]

SENATOR GLOOR: Actually, quick question. [LB1072]

SENATOR CAMPBELL: Oh, sorry, Senator Gloor. [LB1072]

SENATOR GLOOR: Thank you, Senator Campbell. Bruce, just to make...I haven't had a chance to read the whole paragraph yet, but I understand the concern and the need for change in language. But if that were taken care of, is it safe to assume the association would be in favor of this? [LB1072]

BRUCE RIEKER: Very much so. [LB1072]

SENATOR GLOOR: Okay. [LB1072]

SENATOR CAMPBELL: Okay. Thank you, Mr. Rieker. Our next testifier in a neutral position. [LB1072]

JONI COVER: (Exhibit 3) Good afternoon, Senator Campbell, members of the committee. My name is Joni Cover; it's J-o-n-i C-o-v-e-r. And I'm the executive vice president of the Nebraska Pharmacists Association. And I appear today in a neutral capacity on LB1072. I have provided you with my comments, some of which go into the technical aspects of the amendment which you're also receiving that we have shared with Senator Lathrop's office, and so I won't bore you with the details. But I do want to say that I do appreciate Senator Lathrop and his staff and all the time they have spent working on this issue, because the pharmacists of Nebraska do support a prescription drug monitoring program. And we think it's very, very important that we somehow establish one. We can work out all the details and move forward. You know, I guess the good thing about being one of the last states to implement one is we have lots of experts all across the United States. And we have really looked to our chain pharmacies for expertise in what works well and what doesn't work well. And so you'll see some of those things in our amendment. But I do want to echo what Deb Bass said and also what Bruce Rieker has said, is that I think the state of Nebraska should really take a look at if this is a priority and, if it's a priority, making funding available to make this work. This really isn't part of my written comments, but we had a very real situation

happen in the last several months where we were notified by the State Patrol about folks flying in from Florida with prescriptions, knowing we don't have a monitoring system, going to different pharmacies, getting large amounts of narcotics, and then flying out of the state of Nebraska back to Florida. They know that they can come here and do this because we don't have any way to track them. And so, you know, if we set up a system, we need to be able to talk to other states so we can prevent this kind of thing from happening. But it's a real concern, and I believe that, again, since we have the expertise, I think you have a commitment on behalf of the healthcare providers to make this work. And so I would just hope that, you know, we could make it a priority in our state to come up with some creative ways to address it, and also some funding. So with that, I'd be happy to answer any questions. [LB1072]

SENATOR CAMPBELL: Thank you, Ms. Cover. Questions? Thanks for your testimony. [LB1072]

JONI COVER: Thank you very much. [LB1072]

SENATOR CAMPBELL: Our next testifier in a neutral position. Good afternoon. [LB1072]

MICHELLE MACK: (Exhibit 4) Hello. Good afternoon, Chairperson Campbell and members of the committee. My name is Michelle Mack, Michelle, M-i-c-h-e-l-l-e, Mack, M-a-c-k. I'm a senior manager of state government affairs for Express Scripts. Express Scripts is a pharmacy benefit manager that administers prescription drug benefits on behalf of our clients, employers, health plans, and unions for over 100 million Americans. We are headquartered in St. Louis, Missouri, and we provide integrated pharmacy benefit management services across the country. And we are...I'm here to provide testimony today in a neutral capacity for LB1072. Express Scripts, however, does have a few concerns with the bill, which I sent...we passed out for you. I won't go into detail of all the technical details, but one of the major issues that we do have is that as a pharmacy benefit manager that has mail-order pharmacies we ship our prescriptions. So we don't operate on a real-time basis, so we are asking for us to be able to batch our prescriptions every week so that we can send them to you in a batch, which we do in a few other states across the country. One of the other issues that I will bring up to you is relative to professional judgment. And I believe that one of the testifiers had discussed this previously. We just want to make sure that we don't always have to check, because if someone does need a drug, they do need to get it at the time. Or if the system possibly is down--your system or our system is down--we just want to make sure that the member or person gets their prescription medication. And also, I also see that it's a closed system, and we think that...other testifiers have come before. We just want to make sure that since Nebraska does border six states that everyone has access to the information which we believe is very important. Thank you for your consideration, and I welcome any questions that you may have. [LB1072]

SENATOR CAMPBELL: Questions? Seeing none, thank you very much. Our next testifier in a neutral position? Okay. And Senator Lathrop has waived closing. So we will close the hearing on LB1072 and move to the hearing on LB1078, Senator Nordquist's bill to change the Nebraska Telehealth Act, provide for the establishment of a patient relationship through videoconferencing, and require insurance coverage for telehealth services. Welcome, Senator Nordquist. [LB1072 LB1078]

SENATOR NORDQUIST: Thank you, Madam Chair, members of the committee. My name is Jeremy Nordquist, N-o-r-d-q-u-i-s-t; I represent District 7 which covers downtown and south Omaha. I'm here today to introduce LB1078 which is dealing with telehealth services. LB1078 would reduce the barriers to telehealth in Nebraska by requiring private insurers to reimburse for telehealth services that are already covered in in-person, face-to-face visits. It would add "telemonitoring" to the definition of "telehealth," allow for the use of "store-and-forward" and remote patient monitoring, allow for the establishment of a patient relationship via videoconferencing, and eliminate the 30-mile radius limitation that we currently have in place for Medicaid reimbursement for telehealth services. The purpose of LB1078 is to reduce disparities in access to care, enhance physician availability, improve quality of care, reduce health costs, and to create an innovative payment and service model design through the use of telehealth. To be clear, telehealth is not a separate medical specialty but rather a larger investment by healthcare institutions through information technology and the delivery of clinical care. For many people, especially in rural areas, access to in-person travel is very difficult for a wide variety of reasons including mobility limitations, major distance or time barriers, and transportation limitations--they don't drive, don't own a car, or have very limited other transit available. In fact, in the past two years the state has spent an average of about $4.7 million a year for Medicaid reimbursement for nonemergency transportation costs. These costs include vehicle operations, personnel service; miles of the trip, loaded and unloaded, standby time, or waiting time. There's no reason to transport medically frail patients an additional 30 miles when some of the same services could be offered conveniently in their home for a cheaper cost. Adding to the costs and travel time is the fact that many areas have a shortage of needed healthcare providers. Telehealth can alleviate these provider shortages by improving productivity of existing provider practices and incentivizing providers to practice in underserved areas. According to the Scientific American, about one in five Medicare patients--this is Medicare, but it certainly I think is reflected in all of our healthcare--return to the hospital within a month of being discharged. In order to improve the quality of healthcare, we have to start by helping people to look after themselves by means such as remote patient monitoring, which helps providers focus on prevention and avoid hospitalization. One argument that you may hear today against the private reimbursement for telehealth is that it will increase provider consultations and raise insurance premiums essentially raising costs. A 2013 case study done by The Commonwealth Fund analyzed data from large telehealth programs run by the Department of Veterans Affairs, Partners

HealthCare in Boston, and Centura Health based in Colorado. And that study showed that home monitoring programs can reduce costs and raise patient satisfaction by up to 85 percent. The VA's care coordination home telehealth program was implemented in 2003, focused on making the patient's home a primary care site whenever possible. And they have seen a 56 percent reduction in patients seeking hospital services for depression, a 20 percent reduction for diabetes, and a 40 percent decrease in hospitalization for other mental health issues. These savings were similar whether a patient had one health problem or multiple health problems, which demonstrates that these services are robust enough to handle complex medical cases. Additionally, the bill does not allow, just to be clear, does not allow for treatment to be covered that would not already be covered if provided by in-person or if the services are not deemed medically necessary. This is mandating telehealth parity rather than mandating any new services. Twenty states have taken action mandating coverage of telehealth-provided services under private health insurance, including our neighboring states of Colorado and Missouri and very large states that probably wouldn't be ideologically inclined to mandate insurance benefits, such as Texas, Oklahoma, and Montana. This past December Senator Gloor and Senator Wightman played a significant role in creating participation agreements for payment reform structures that support patient-centered medical homes. And, as you know, these medical homes are healthcare delivery models that use comprehensive, accessible, and continuous preventive care to improve health outcomes. Complementing telehealth delivery with these medical homes would truly foster what would be a modern and collaborative healthcare environment. More access to telehealth will allow more Nebraska families and communities to have access to the critical, lifesaving treatment that's often needed. As we reform our healthcare system and transition into managed-care models, telehealth is one way to align the incentives of stakeholders, including insurance companies, providers, and most importantly, patients towards improved clinical and health outcomes at lower costs. With that, I'd be happy to answer any questions. [LB1078]

SENATOR CAMPBELL: Questions? Senator Krist. [LB1078]

SENATOR KRIST: Senator Nordquist, it seems to me, searching through the database here, that we've talked about these pass-through kind of services and the insurance problems with a primary physician referring to a psychologist or a psychiatrist or a therapist and then how that second or third provider of care is going to get paid through this system. Does this bill...or let me ask it a different way. And I know Senator Gloor would probably...there to. Can you tell me, does this bill answer that question? Do we require the insurance company to acknowledge the fact that there would be a secondary, tertiary...? [LB1078]

SENATOR NORDQUIST: I can't say that that's defined in the bill, but... [LB1078]

SENATOR KRIST: Okay. [LB1078]

SENATOR NORDQUIST: ...I would think that the...if the service is provided, whatever level it's provided at, that that is where...if that service is reimbursed at an in-person visit, it would have to be reimbursed, then, at a...through a telehealth arrangement. But I don't know if I'm... [LB1078]

SENATOR KRIST: Yes, you... [LB1078]

SENATOR NORDQUIST: ...understanding the question. [LB1078]

SENATOR KRIST: ...you've answered. [LB1078]

SENATOR NORDQUIST: Oh. [LB1078]

SENATOR KRIST: Senator, can you talk to that for me, Senator Gloor, please? [LB1078]

SENATOR CAMPBELL: Senator Gloor. [LB1078]

SENATOR GLOOR: Thank you, Senator Campbell. I don't know. (Laughter) But it's a good question. [LB1078]

SENATOR CAMPBELL: Moving on. [LB1078]

SENATOR GLOOR: I mean, the scenario that we have to guard against is that I walk into a provider someplace who looks in my ear, because I've had an earache, and says... [LB1078]

SENATOR NORDQUIST: Right. [LB1078]

SENATOR GLOOR: ...you know, I'm not sure what I'm seeing here; let me get ahold of an ENT. And so they call up an ENT, who we hook up, and through digital...the wonders of digital telemedicine... [LB1078]

SENATOR NORDQUIST: Right. [LB1078]

SENATOR GLOOR: ...looks and says, I've never seen this before. Boy, Mr. Gloor, you sure have an interesting...let's get a subspecialist that I know that looks at these things at the university of wherever. [LB1078]

SENATOR NORDQUIST: Right. [LB1078]

SENATOR GLOOR: And they look at it. Do we generate three bills? Can't get involved

in fee splitting; that's... [LB1078]

SENATOR NORDQUIST: I know. [LB1078]

SENATOR GLOOR: ...illegal... [LB1078]

SENATOR NORDQUIST: Right. [LB1078]

SENATOR GLOOR: ...at least by definition. [LB1078]

SENATOR NORDQUIST: Okay. [LB1078]

SENATOR GLOOR: So I think that is one of the questions that...I'm still not sure as I read... [LB1078]

SENATOR NORDQUIST: Right. [LB1078]

SENATOR GLOOR: ...through here. I'm guessing that in the final analysis the insurers will say, no, we're not paying three times under every circumstance... [LB1078]

SENATOR NORDQUIST: Right. Right. [LB1078]

SENATOR GLOOR: ...but sometimes it's appropriate. And so my guess is insurers will be up here at some point in time during it, and we can ask them. [LB1078]

SENATOR NORDQUIST: Yeah, I would... [LB1078]

SENATOR GLOOR: But it's a good question. [LB1078]

SENATOR NORDQUIST: Right. If it were a referral in person, it would definitely be paid for, but... [LB1078]

SENATOR GLOOR: You bet, hop in the car and drive... [LB1078]

SENATOR NORDQUIST: Right. Right. [LB1078]

SENATOR GLOOR: Hop in the car and drive. We're trying to avoid that. But we still have... [LB1078]

SENATOR NORDQUIST: Right. [LB1078]

SENATOR GLOOR: ...we still have the issue of the payment system... [LB1078]

SENATOR NORDQUIST: I appreciate that concern. Yeah. [LB1078]

SENATOR GLOOR: ...that may not allow it. [LB1078]

SENATOR NORDQUIST: All right. [LB1078]

SENATOR CAMPBELL: Senator Krist, you wanted to follow up? [LB1078]

SENATOR KRIST: Thank you for reminding...that's exactly a... [LB1078]

SENATOR NORDQUIST: Yeah. Yeah. [LB1078]

SENATOR KRIST: ...scenario we heard a couple years ago. And that is, a doctor needs to... [LB1078]

SENATOR NORDQUIST: Right. [LB1078]

SENATOR KRIST: ...confer, and it would be absolutely legal if you got back in your car and went 300 miles in a different direction to get that service... [LB1078]

SENATOR NORDQUIST: Right. Right. [LB1078]

SENATOR KRIST: ...but not so much so if you stay in the same office and do whatever. So that I think is...I completely support what you're doing. I support telehealth. [LB1078]

SENATOR NORDQUIST: Yeah. There will be someone coming up after me who has worked on this in other states and might have a good idea on that, so... [LB1078]

SENATOR KRIST: Oh, sure. [LB1078]

SENATOR NORDQUIST: Yeah, so... [LB1078]

SENATOR KRIST: Shrug it off on someone else. I'm kidding. (Laughter) Thank you, Senator Nordquist. [LB1078]

SENATOR NORDQUIST: Thank you. Any other questions? [LB1078]

SENATOR CAMPBELL: We'll always have to hope the people behind us... [LB1078]

SENATOR NORDQUIST: That's right. That's right. [LB1078]

SENATOR CAMPBELL: ...have got the answers, don't we? Other questions for Senator Nordquist? Will you be staying to close? [LB1078]

SENATOR NORDQUIST: Yeah, absolutely. [LB1078]

SENATOR CAMPBELL: Thank you. [LB1078]

SENATOR NORDQUIST: Thank you. [LB1078]

SENATOR CAMPBELL: Our first proponent. Our first proponent. [LB1078]

SENATOR KRIST: There's a reluctance to be first. [LB1078]

SENATOR CAMPBELL: You certainly can come forward. Just have a seat in the front, sort of save yourselves some time. While we're getting set up, we have several letters that we need to put into the record. But I think we'll go ahead and take the testimony and then come back to the letters. Go right ahead, sir. [LB1078]

JAMES SUMMERFELT: (Exhibit 5) Thank you, Senator Campbell. Thank you for the opportunity, Senator Campbell and committee. My name is James Summerfelt, J-a-m-e-s S-u-m-m-e-r-f-e-l-t. I'm president and CEO of the Visiting Nurse Association, testifying in support of LB1078, supporting telehealth and telemonitoring services for Nebraska's aging population in a fiscally responsible manner. I've handed out my written testimony, also a study that has looked at results and the propensity of keeping people out of the hospital and as well as a map of Nebraska with existing coverage of home health agencies that do cover telemonitoring. In my testimony--and I won't read it--but I go over the need for chronic care management with an aging population, and which we do have in Nebraska. It's been documented many times, as far as the aging population. The cause of death: number 1 leading cause of death being heart disease. Telemonitoring: which, actually, the VNA has been doing it for over ten years. And we have lots of statistics that support the efficacy of telemonitoring people's weight, blood pressure, pulse oximetry, asking them symptomal questions that they can answer yes and no about their extremities swelling or shortness of breath. So we got into this ten years ago because of a shortage of nurses and needing to reduce our expenses to meet the reduction of reimbursement for home care. We were successful in doing that, taking what was averaging about 30 face-to-face visits for a nurse down to--for per patient--down to about 15. And we also were able to have one nurse monitoring 200 patients on a daily basis, instead of one nurse visiting a patient maybe three times a week and only seeing maybe three to five patients. So you can do the math and figure out that this is much better use of a staff person's time, which reduces the costs. And then we were able to follow up and look at rehospitalization, because that is now also outcomes being so important in keeping people out of expensive levels of care, keeping them at home, where they want to be, where they aren't going to catch something else, and it's a higher quality of life. And again, our results have demonstrated that close to 9 percent better chances of keeping somebody at home than being back in the hospital.

I'm trying to do this by memory and not just read you the testimony as well. But...so you can read that. And I went over the fiscal...and just doing the...the telemonitors themselves cost about $4,000 to $5,000 apiece. They last, and we can speak from experience, 5 to 7 years apiece. So the cost per monitoring patient is dollars; it's $4.50 roughly. Now, that doesn't eliminate home visitation totally, but it makes the home visits more appropriate. And in the rural areas, it again very much so, you can appreciate, instead of spending an hour driving to a patient's house and an hour driving back, minimally sometimes, and the time spent with the patient, maybe, you know, that three visits a day is even exaggerating productivity. So it's much more effective in keeping in contact with your patients. You can telephone the doctor and adjust medications. You can monitor people's diets. If they're gaining weight or their pulse oximetry is lowered, you can ask them how much bag of chips have they been eating or ham or something that has caused them to retain weight. So you can help their diet management too. So medication management, diet management, activity. And then our case study of our 93-year-old client who was referred to us for home care, had been frequently hospitalized for congestive heart failure. We've had her on service--and this is just one of many--but we've had her on service for two years now and avoided all of her hospitalizations. And again, just ballpark figure, a three-day hospitalization for congestive heart failure is going to run, roughly, about $20,000. So for the cost of telemonitoring, you know...and as I said, we've been doing this for ten years, all on the expense of the VNA. And other home care agencies that do get into this are paying for it out of their own pocket and not getting any reimbursement from commercial insurances, Medicare, or Medicaid. Other states have figured out a way to help reimburse and offset some of the costs of this. So again, I urge you to look further into the advantages of telemonitoring and telehealth, and support LB1078. [LB1078]

SENATOR CAMPBELL: That's correct. [LB1078]

JAMES SUMMERFELT: Thank you. [LB1078]

SENATOR CAMPBELL: Questions? Senator Gloor. [LB1078]

SENATOR GLOOR: Thank you, Senator Campbell. And, Mr. Summerfelt, thank you for the testimony. VNA has a long and storied history of providing quality care. [LB1078]

JAMES SUMMERFELT: Thank you. [LR1078]

SENATOR GLOOR: And so the question I'm going to ask you, I hope you understand is because I know you're quality operators and your staff are quality. But what I'm trying to get comfortable with, and I always have tried to get comfortable with, with telemedicine, isn't the...isn't all the good things that can be done with it, it's the "scooter store" scenario. It's the fact that nobody would argue that putting elderly or disabled people on scooters and having insurance, Medicare, Medicaid, pay for those scooters to help them

get around and give them some mobility is a good thing, except then the Justice Department gets involved in an investigation because everybody is on scooters. And a whole industry has developed, with scooter stores in malls and advertising on TV. And then all of a sudden, we snap back the other way, and people go to jail because they've been jobbing the system. And scooter stores in...don't exist anymore. And we end up with a problem that we have to then reconcile by going back to the way things used to be. That would be a shame to happen in telemedicine, because it's got such great potential. But how do we protect ourselves from me walking in with my ear problem and a practitioner saying, I know a practitioner who can look at this. And that practitioner takes a look at it and refers to their partner who happens to be in the office someplace else who's a subspecialist and they take a look at it. And pretty soon, because of one or two disreputable practitioners who run every patient through two or three people who are part of the same business operation, we end up with multiple bills being generated because of the wonders of telemedicine that should do good things, provides an opportunity for a bad operator to job the system. How do we protect ourselves? How do we measure outcomes so that we know that second referral, that third referral after the second referral, is appropriate and resulted in improvement in the patient's overall health status? [LR1078]

JAMES SUMMERFELT: Yeah. Well, I wish we could as an industry demonstrate that everybody is as good as the VNA is. And we know from the reports of Dade County and other places that that's not the fact. And I think we do the best we can through state licensure and Medicare and Medicaid certification, that we have surveyors that come in and actually review patient charts and see that the care that is being provided is appropriate, medically necessary. Insurance companies, believe me, don't just roll over and pay claims just because you submit a claim. They do an extensive medical review. Even in hospice, after people have died, they're still questioning whether or not they should have been on hospice. Just another whole story that (laugh), you know...so I would just say that the insurance industry and the adjudication of claims is very tight. We have to rely on that, as well as their licensure and certification, that we do away with...as much as we possibly can screen out the fraud and abuse in the system. I don't know if that answers your question or not. [LB1078]

SENATOR GLOOR: No, it's, I mean, I do understand. And if we had a small number of quality providers who were...and, you know, some of what's happening in healthcare is we're starting to see a roll-up in provider organization and provider groups there's a reduction in the fractionalization; that certainly can help some. But there were all the appropriate screens and checks supposedly in place when it came to people who were being authorized to get scooters. [LB1078]

JAMES SUMMERFELT: Yeah. [LB1078]

SENATOR GLOOR: Yet we still ended up having that problem. And don't

misunderstand me, this has nothing to do with anything other than I would like telehealth to have every chance to be successful. But I worry about people who inevitably figure out ways to take advantage of the situation and ways that we might be able to have legislation that tightens things up so we don't have to worry about taking steps back when we think we're taking steps forward. [LB1078]

JAMES SUMMERFELT: Well, I think the movement that we're in the middle of, this whole change of the Accountable Care Organizations that are being formed and outcomes being, you know, value-based purchasing so you're getting paid for the results, not for the activity; so getting away from fee-for service. So, you know, I think...and that's where using telehealth will get us better outcomes. It will help to save money, keeping people in their homes, where we're not paying for the bricks and mortar. So...but it is a whole cultural shift, if you will, from fee-for-service to fee-for-outcomes. You know, "no outcomes, no income"... [LB1078]

SENATOR GLOOR: Yeah. [LB1078]

JAMES SUMMERFELT: ...is the catch phrase. [LB1078]

SENATOR GLOOR: Yeah. Well, certainly the stars are starting to line up a lot better to help us in that, I agree. [LB1078]

JAMES SUMMERFELT: We just need to keep moving and being innovative and using technology, either...you know, previous bill that was heard here as far as electronic health records. And if...and we're...it's the United States. We're the most innovative country in the world so we can figure this out. But we were innovative to be able to use automobiles or else we'd still be riding horseback. So I think we need to use the technology that's at our fingertips, with smart phones and all the technology that we have, so... [LB1078]

SENATOR GLOOR: True. But if we could make a justification that people needed to be in Cadillacs for health reasons everybody would be driving a Cadillac. Sometimes I worry about that... [LB1078]

JAMES SUMMERFELT: (Laugh) Sure. Yeah. [LB1078]

SENATOR GLOOR: ...part of it. Thank you. I appreciate your effort to try and reassure me. Thank you. [LB1078]

JAMES SUMMERFELT: Thank you. [LB1078]

SENATOR CAMPBELL: Any other questions? I do have one question. You mentioned that some other states have worked that out. Is there any particular state that you might

have looked at in their law and in terms of reimbursement or the issues that you think would be helpful for us to look at? [LB1078]

JAMES SUMMERFELT: I can get you those. As Senator Nordquist said there's like 20 states I think that already have the mechanism set up. [LB1078]

SENATOR CAMPBELL: Okay. [LB1078]

JAMES SUMMERFELT: I've been aware of Missouri for the longest time, in doing more of a waiver program for telehealth; but more recently it's paying for the initial setup of getting people started and not necessarily again the way that this is worded as far as paying the same as it would be for a visit. I do worry a little bit just as Senator Gloor said, as far as people wanting to be reimbursed the same for a face-to-face as a telehealth visit. And I don't think that necessarily is the answer, because it would lead to abuse of the system. [LB1078]

SENATOR CAMPBELL: Senator Krist. [LB1078]

SENATOR KRIST: You just used the word "waiver." Is that a CMS state plan waiver that allows them to do what they're doing in Missouri? [LB1078]

JAMES SUMMERFELT: I believe so, yeah. [LB1078]

SENATOR KRIST: Interesting. [LB1078]

SENATOR CAMPBELL: Any other questions? [LB1078]

JAMES SUMMERFELT: All right. [LB1078]

SENATOR CAMPBELL: Thank you very much... [LB1078]

JAMES SUMMERFELT: Thank you very much. [LB1078]

SENATOR CAMPBELL: ...for your testimony. Our next proponent. Good afternoon. [LB1078]

DALE GIBBS: (Exhibit 6) Hello. Senator Campbell and members of the committee, thank you. My name is Dale Gibbs, D-a-l-e G-i-b-b-s. I am the director of telehealth services for CHI Nebraska and also a past chair of the Nebraska Statewide Telehealth Network. CHI Nebraska consists of Good Samaritan Hospital in Kearney, Saint Francis Medical Center in Grand Island, St. Mary's Hospital in Nebraska City, St. Elizabeth Hospital in Lincoln, and Nebraska Heart Hospital also in Lincoln. CHI Nebraska has been a leader in telehealth services since Good Samaritan Hospital began their

program in 1995. In the almost 18 years since, every hospital and public health department in Nebraska has telehealth services available. Nebraska is the only state in the Union that I'm aware of where there is one telehealth system for the whole state. All hospitals, all public health departments are inside a closed system. It's a secure system. Because Nebraska is a large state with areas where few people live and do not have easy access to healthcare, telehealth can bring it to them. Without it, some people would have to travel up to three hours one way to see specialists or in many cases not seek care until it's absolutely needed or too late. When that happens, any healthcare worker can tell you, that's when the cost is its most expensive. Telehealth is not only a green technology since it saves so many miles, but it also allows us to spend less money keeping people well than what we spend when they're sick. Telehealth has a positive and huge future as healthcare changes to keep people healthy and out of hospitals. CHI Nebraska is committed to continue expanding our telehealth program, and we want to be collaborative with all payers towards that goal. We feel LB1078 will allow more access to early care because people who have difficulty traveling to see specialists will not have to worry if their insurance will cover a telehealth visit. Additionally, getting rid of the current Medicaid 30-mile rule will no longer require Medicaid patients to rely on friends, family, or the state for transportation to healthcare. By allowing asynchronous services in telemonitoring, LB1078 will help provide early diagnosis for a variety of diseases, which may keep patients home while being treated. This kind of technology lends itself to dermatology especially well. Paying for telemonitoring will provide incentives to see patients in their homes more often, assisting them in recuperation from procedures and/or hospitalization and keeping people healthy rather than seeing them only when they're sick. Technologies like telehealth allow us to expand access to care. And we expect it to be one of the most potent means to that end. By ensuring that providers and healthcare facilities can be reimbursed for their services, this bill will make a lasting positive impact on Nebraskans' health in the future. [LB1078]

SENATOR CAMPBELL: Thank you, Mr. Gibbs. Questions? Senator Krist. [LB1078]

SENATOR KRIST: Can you talk to my question earlier about the fee splitting and the potential of not being paid for follow-on services? [LB1078]

DALE GIBBS: I think that's going to be an issue. I think if we follow the same route as if it was a face-to-face visit, I think we would be okay. The question becomes...of hooking up with a specialist in let's say Omaha and the patient is in Callaway, Nebraska, in the physician's office connected...they're already going to get billed for that physician office in Callaway. But then how do you bill for that specialist in there too? That...I think that's going to be an issue that we're going to have to address. [LB1078]

SENATOR KRIST: At what level? [LB1078]

DALE GIBBS: Pardon me? [LB1078]

SENATOR KRIST: At what level? Is this a federal...is it CMS, or is it...? [LB1078]

DALE GIBBS: Eventually it's going to have to be at CMS, yeah. [LB1078]

SENATOR KRIST: Okay... [LB1078]

DALE GIBBS: Yeah. [LB1078]

SENATOR KRIST: ...which, again, would require a state plan to... [LB1078]

DALE GIBBS: Yeah. [LB1078]

SENATOR KRIST: ...change and...okay,... [LB1078]

DALE GIBBS: Yeah. [LB1078]

SENATOR KRIST: ...great. Thank you. [LB1078]

SENATOR CAMPBELL: Any other questions? I'll ask the same question of you, sir. Do you know of another state that you think is handling this fairly well--getting at Senator Krist's question and Senator Gloor's questioning--that we should look at? [LB1078]

DALE GIBBS: The one that comes to my mind immediately would be California. They recently passed a law that addressed telehealth for the whole state too. [LB1078]

SENATOR CAMPBELL: Okay. Senator Gloor. [LB1078]

SENATOR GLOOR: Thank you, Senator Campbell. Dale, I wasn't going to ask a question because I've been asking too many, but Senator Campbell's comment got me thinking. You know, you have to have counterparts throughout CHI, I would guess. Do you get together regularly with other regions or states and whatnot? [LB1078]

DALE GIBBS: Um-hum. [LB1078]

SENATOR GLOOR: Is this all coming to sort of a point at the same time in different states, or is each...is Kentucky different than North Dakota, Minnesota? [LB1078]

DALE GIBBS: Yeah. [LB1078]

SENATOR GLOOR: I mean, how is this beginning to shake out and what are some of the innovative ways things are looking at this within the CHI corporation? [LB1078]

DALE GIBBS: It seems like telehealth is on the cusp of really taking off nationwide. We've been working at it a long time. And within CHI, which is a national organization, the Franciscan system in Tacoma, Washington; a little bit of Centura in Colorado; of course, Nebraska; the Mercy system in Iowa; and in eastern Kentucky, the St. Joseph system, all do telehealth. And in North Dakota also, with the critical access hospitals up there they have a fabulous telepharmacy program they put together. Every state seems to be looking at different ways of doing it or the larger hospitals within those states are beginning their own telehealth system and then expanding it out. Montana has had two telehealth systems for many, many years, but they don't connect the two. Those two systems all come out of Billings, Montana, with two rival hospitals. But in Nebraska we've been very collaborative. All of the hospitals in Nebraska have gotten together to create the Nebraska statewide telehealth network because everyone believes it's the way we need to help treat patients who can't get access to care. So Nebraska has been very collaborative. And I'm pretty sure it's going to continue being collaborative. So we have been leaders in telehealth for many years. And I think that we can still be the leaders, too, in the future to come because telehealth is so extensive within healthcare already in Nebraska. [LB1078]

SENATOR GLOOR: Well, I would be remiss if I didn't say that Good Samaritan was sort of the nucleus for all that though. They've...they really in the state of Nebraska took the bull by the horns and were way out there for a long period of time investing a lot of money. And that's worth mentioning, because I'm always looking for opportunities to say good things about my friends in Kearney. [LB1078]

DALE GIBBS: Thank you. And I have to say, too, that it's a little-known fact, but telehealth actually started at University of Nebraska Medical Center back in the '50s with a site in Norfolk. And it was basically a big television camera and a big monitor at each end, and it was live TV from between two points. But that's where it started. So Nebraska has... [LB1078]

SENATOR GLOOR: That was before my time. (Laughter) [LB1078]

DALE GIBBS: Not mine. [LB1078]

SENATOR GLOOR: Thank you. [LB1078]

SENATOR CAMPBELL: We try to get those little advertisements in whenever we can. [LB1078]

DALE GIBBS: Yeah. [LB1078]

SENATOR CAMPBELL: Senator Crawford. [LB1078]

SENATOR CRAWFORD: Thank you, Senator Campbell. And thank you, Dale, for being here and for your great work in Kearney and with other CHI systems across the state. What I've heard here today...we've asked some questions about if somebody does something from a telehealth perspective that's the same as what would happen if you drove to their office and received that care, then it makes a lot of sense to reimburse it at the same rate. Then the other issue that I guess we may be talking about is something where it's a step back from that, maybe monitoring or a consultation, but it isn't maybe quite the same as the visit. And what raised my mind about that was the earlier written testimony that said right now a nurse can do 3 to 5 visits, and they could do 150 if it was monitoring. And so I wonder if you have seen any examples of a different pay scale for this...that, again, you want to be careful you're not paying less for something that would be the equivalent of something in the office, but yet there is some things in telehealth that are really important that are monitoring. Have you seen any examples of a different reimbursement or a different system for this kind of monitoring which seems so central to the economic value and prevention value of telehealth? [LB1078]

DALE GIBBS: Well, I can't think of anything specifically, but kind of along what you're asking there and what Senator Krist asked too, I'm thinking the possibility of a patient walking into Callaway, Nebraska, seeing a provider there and then that provider saying, you need to see a UNMC specialist; let's call them up right now. I don't think that's probably going to happen because that's going to be a scheduling nightmare. That specialist will not be open at that time more than likely. So there's going to have to be a separate schedule with that UNMC specialist, which might be the next day, next week, whatever. The net (phonetic) would take care of that billing issue, because I really do think it's going to be a scheduling nightmare to be able to just...I mean, you can pick up the phone and call somebody, but you're going to wait quite a bit sometimes too. And I think it's going to be even more difficult on video then too. [LB1078]

SENATOR CAMPBELL: Senator Krist. [LB1078]

SENATOR KRIST: I agree. And I think that that may be a work-around, if you will, in terms of scheduling. And now you come back to the same office you were in in Callaway, and now you're scheduled to see somebody else and that office is facilitating that process. I'm going to wait to address this question to Mr. Rieker when he comes up here because I think he's loaded and ready to come up. But I've seen the emergency room and the intensive-care bills from my mother, who passed. And that doctor that was on that TV screen was never in that room yet he handled all of her care through the nurses that were around her bed. So if we can do that we certainly should be able to schedule and work through the billing options that are there. [LB1078]

DALE GIBBS: Yeah. [LB1078]

SENATOR KRIST: So I agree with you, I think it's going to be a scheduling nightmare unless you're in the same facility and you have a dedicated staff...I mean, sorry, the same network and you have a dedicated staff standing by, to be on call. [LB1078]

DALE GIBBS: Yeah well, no one is going to pay anybody to be standing by. [LB1078]

SENATOR KRIST: That's not going to happen. Yeah, exactly. That defeats the purpose, right? [LB1078]

DALE GIBBS: Yeah, exactly. [LB1078]

SENATOR KRIST: Thank you so much. [LB1078]

SENATOR CAMPBELL: Any other questions? Thank you very much, Mr. Gibbs. [LB1078]

DALE GIBBS: Thank you. [LB1078]

SENATOR CAMPBELL: Our next proponent. Good afternoon again. [LB1078]

BRUCE RIEKER: (Exhibit 7) Good afternoon. Again it's my pleasure to be before the committee. My name is Bruce Rieker, B-r-u-c-e R-i-e-k-e-r. I'm the vice president of advocacy for the Nebraska Hospital Association, here testifying in support of LB1078. In my capacity here I am also entering or submitting a letter of support from Nebraska Appleseed that the page is distributing as well. The testimony that's being distributed to you pretty much extols the virtues of the telehealth network for...many of which have already been outlined. One area that I'd like to bring to your attention that's not in the testimony, that may be something that, for those of you interested in prison or corrections reform, county budgets, things like that, is that when you look at the cost of transporting a patient or a prisoner, inmate, whatever it may be, a patient and it takes two or three individuals to transfer those particular patients, there is a sizable cost to either the state or the county. And as we look at this, there could be sizable savings to those political subdivisions in providing this care. I'll also submit to you I don't have the facts with me, but I would be happy to run these down, have started to look at our neighbor to the south, Kansas. Along those lines, when Senator Brownback came back and became governor one of his promises was to reduce the prison population and recidivism. And by doing that, they did it...have already achieved a substantial reduction in recidivism by providing behavioral health services to those who most need it. So if this is an avenue through telehealth that we can reduce some of our costs to the public and the state, I think that I can share with you to take a look at that. Senator Gloor, you asked about some of the potential abuses. I'd like to talk about that for a little bit. You know, when I was going to come up and testify, I was just going to say this is another

proposal that...its time has come, that we need to forge ahead in telehealth and provide these services. I appreciate your question about the fraud and the abuse that could take place. Nebraska significantly lags behind many parts of the country, it's already been established. And we appreciate the Legislature's support of this last year of appropriating money for the MMIS system which will help us track some of the things going on in the Medicaid program. But this bill is much more expansive than just the Medicaid program. I've talked with some of you about making sure that the MMIS program can handle that. In your LR22 efforts, with you in this committee and the Banking, Commerce Committee, the meetings that we've participated in...can't remember where the gentleman was from but he referenced a thing called an all-payer claims database. And it's time that our state look at that. We recognize that we need to protect the proprietary information but we also need to track what's going on. And we cannot reduce the overutilization, the fraud and abuse or whatever it is, if we do not have the technology to track that. With that...building those systems, we would be able to find where there is a propensity on the part of providers to be overbilling or multiple billing, and we could find trends and those sorts of things. If you just take the Medicaid program, we spend $700 million per year of state money and about $1 billion of federal money. And now if the critics are right and we have 30 percent waste in the program. We're blowing, wasting, half a billion dollars a year that we should be fixing or should be utilizing to our greater ability than we are. So with the all-payer claims database incorporating the private payers, Medicare, Medicaid, obviously we're going to have to work with CMS to make that happen. I think that we can put the protections in place to build a system that shares the information and helps us monitor the things that are going on. So I've talked until the yellow light came on. And I know that Senator Krist has a question for me. I tried to anticipate exactly what it was going to be. But that concludes my testimony, and now I'll entertain questions. [LB1078]

SENATOR CAMPBELL: Thank you, Mr. Rieker. Your question. [LB1078]

SENATOR KRIST: Surprise. [LB1078]

BRUCE RIEKER: Yeah. [LB1078]

SENATOR KRIST: It comes to mind recently in our family experiences that the physician...actually three specialists who were on the screen in the intensive-care never really saw my mother, but they treated her through the hands of the nurses around, which is, I think, another extension of telehealth in terms of the application within the institution. How do you bill for that within the hospital, and is that a model that we can use to carry forward so that that same process is there for on-site doctor's offices and other visits? [LB1078]

BRUCE RIEKER: Well, I can't speak to every hospital's particular situation. And it's somewhat different for Medicaid and Medicare, the public payers. But in many times it

may be a contractual relationship, not fee splitting or anything like that, but a contractual relationship with affiliated providers. It could be something that's negotiated with the commercial payer, such as a United or a Blue Cross or things like that. But in the private sector, a lot of those things are negotiated. I don't have...I'm not privy to the exact information about how each one is handled. But as more and more systems and networks are being built, such as...Senator Gloor referred to the CHI system, and we have other networks that are being built here in Nebraska and others that are present such as Banner Health out of Arizona. They do some of that through some of the hospitals that they manage here in Nebraska as well. So each one of them has a different model, but it's...on the private side, they have a little bit more flexibility to negotiate those things than how it works through the public payers. [LB1078]

SENATOR KRIST: Thank you. [LB1078]

SENATOR CAMPBELL: Any other questions? Thank you. [LB1078]

BRUCE RIEKER: You're welcome. [LB1078]

SENATOR CAMPBELL: Our next proponent. Good afternoon. [LB1078]

KIM ROBAK: (Exhibit 8) Good afternoon. Senator Campbell and members of the committee, my name is Kim Robak, R-o-b-a-k. I'm here today on behalf of COPIC; COPIC is the Colorado Physicians Insurance Company. We are not a health insurer but we're a malpractice insurer, so we represent hospitals and doctors. We operate only in the states of Colorado and Nebraska. We're a physician-led, physician-directed insurance company that was created years ago when because of the high cost of malpractice insurance a number of insurance companies refused to provide insurance for physicians or hospitals. And so COPIC was created by a group of doctors in Colorado, and then came to Nebraska when Nebraska had a similar problem a number of years ago when one of the malpractice...the main malpractice carrier left the state. I wanted to testify in support of the bill on behalf of COPIC because COPIC believes it's appropriate to expand the services of telehealth beyond Medicaid at this point in time. The original Telehealth Act was passed in 1999 back when I was actually part of the Nelson administration. And the comments that you are asking right now about how are we going to pay for it, are we going to fee-split, who's going to actually do this, were questions that were asked then. So 15 years later we're still asking the same questions. And it seems to me that if we move in this direction, perhaps the insurance industry and the physicians can get together and figure out how to solve those problems. It is the appropriate step to take, particularly in light of healthcare reform and particularly in light of all the technology changes that have taken place in the last 15 years. One of the reasons that Nebraska has this one single-based technology system that was mentioned earlier is because of the Nebraska Information Technology Commission. And it pulled together all of the concepts of pulling the communities together and the

hospitals together to have this one network for telehealth. One of the things I did pass out to you however is a proposed amendment, and I have talked to Senator Nordquist's office. Because of the way this is drafted and because of the way that Bill Drafters Office opened up the Practice Act, we would propose an amendment to the bill. The bill opens up the Practice Act for physicians, physician's assistants, nurse practitioners, and pharmacists and allows them the ability to do teleprescribing. Unfortunately or fortunately, whatever the case is, it's been implied that physicians have the ability to perform telehealth. It's not actually written in the Practice Act anywhere. So by only saying that physicians and the other healthcare practitioners have the right to do or the ability to do teleprescribing, you could infer that that's the only thing they can do, that they don't have the ability to tele... [LB1078]

SENATOR KRIST: Treat. [LB1078]

KIM ROBAK: ...treat. Treat, thank you, diagnose, etcetera. So what we're doing is we're allowing each of those sections that are being opened to have the ability to perform telehealth as defined in the act. You will also note in the first section that we...interestingly, the Practice Act does allow physicians from other states to treat patients in Nebraska. And so what we do say if that does occur then Nebraska law would apply. So we would add that language as well. So we offer those amendments, and I'd be happy to answer any questions. [LB1078]

SENATOR CAMPBELL: Senator Krist. [LB1078]

SENATOR KRIST: Thank you. Your perspective, particularly the historical perspective, is really very valuable. But more than that my comment is, you suggested that we could come together and solve the problem; that would be the insurance industry and the doctors. From my experience just lately in this committee, that if you don't bring people to the table forcibly, you're not sometimes going to get an answer to a question. So that's key I think in your testimony. We have to have them come to the table and solve that part of the problem because I think it will come back to haunt us. And that, I think, from the testimony I've heard, has to be a CMS-level issue in order for us to do what we need to do because obviously we don't want to take this out of General Funds for the rest of our history. So...and you're welcome to comment, if... [LB1078]

KIM ROBAK: The other thing I would comment on is, the question was asked whether or not...what you would pay for, what insurance companies would pay for. And it seems to me that insurance companies often ask you to precertify or preapprove anything that you do. So it seemed to me that you could ask...an insurance company could simply ask that if you're going to use telehealth in any way that you'd have to preapprove it. And that would solve the problem of whether or not you extended or did certain types of procedures that were not appropriate. [LB1078]

SENATOR KRIST: Thank you. [LB1078]

SENATOR CAMPBELL: Any other questions? Thank you, Ms. Robak. [LB1078]

KIM ROBAK: Thank you. [LB1078]

SENATOR CAMPBELL: Our next proponent. Good afternoon. [LB1078]

DIANE DERICKS: (Exhibit 9) Good afternoon. My name is Diane Dericks, D-i-a-n-e D-e-r-i-c-k-s. I am an RN, director of a home health for Good Samaritan Society in Hastings, Grand Island, all the way to the Kansas border. And I did hand out my testimony but I'm going to start a little bit by clarifying what we talk about when we're talking about, in home health, "telemonitoring." There's all this..."telehealth" is a big, huge bundle word for different services. Telehealth, from the hospital or the doctor perspective, they're talking about on-line conferencing and so forth. Telemonitoring that the VNA talked about and that I'm talking about is actual telemonitoring that are units that we put into a patient's home. And they take their weight, they take their vital signs, O2 saturations. It also asks them questions. We could preprogram questions with education attached to it or we could pre-program very simple questions like with a congestive heart failure patient: Did you have to sleep in your recliner last night? Which means they're getting "fluid-ed" in their lungs. Are your ankles more swollen? Different things. And they answer yes or no. That information comes to the computer in our office that we monitor every single day. So the case of the VNA nurse watching 200 patients a day, my nurse that monitors our telehealth, she is able to if somebody does their vitals at 9:00, we can pull that up within seconds. And so right in our office we look at that information and we can tell, is their weight up 3 pounds from yesterday. With a congestive heart failure patient if their weight is up 3 pounds from yesterday they're headed for trouble; they're getting "fluid-ed," they're going to end up back in the hospital. Further on in my testimony I talk a little bit about rehospitalization of patients. A congestive heart failure patient going back into the hospital because nobody is monitoring that fluid and they end up within a day, two days, they're up 5 pounds, they're up 8 pounds, they're in the ER. And then they end up in ICU. A visit for ICU for a day can be several thousand dollars, depending on how critical that patient is. So for somebody ending up back in hospital by not having these vitals monitored, by not having that weight monitored can cost thousands of dollars a day to Medicare, Medicaid, private insurances, and so forth, and out of the hospital's pockets if they don't end up paid for those services. So that's our perspective of the telehealth. And I got totally derailed from my testimony, so I'll apologize for that. But just listening to the conversations going on I thought some clarification was a good thing. So I'll kind of get back on track on that. But the...my point of this whole testimony is to tell you that telehealth in the telemonitoring form that we do, can save thousands of dollars to Medicare, Medicaid, private insurances. We not only have seen that firsthand but there are several studies that show that information. And I did attach some statistics and a

couple studies that talk to telehealth and how it does decrease the cost of rehospitalization. Our agency alone, I can tell you that our numbers for rehospitalization for home health are far below the state and national average because we make it a practice to use telehealth on our patients. Our telehealth monitors cost us about $5.80 a day to operate per patient. If I send a nurse on a half-hour visit, or, you know, excuse me, a visit that's a half hour away, I'm paying them an hour of drive time, I'm paying them mileage, and I'm paying them for that hour visit. That costs about $75; that cost gets passed on. And that's probably a low estimate, but I was trying to be nice with my numbers. (Laugh) But that cost is passed on to insurances. That cost is passed on in one way or another. Small home health agencies aren't able to survive and provide those cares to those long-distance areas if they can't control those costs. And through using telehealth, I can take a congestive heart failure patient that may...they get out of the hospital, they're going to need a nurse there three or four days that first week if they were very, very ill. Instead of sending somebody 30 minutes, an hour away to do that visit seven days a week, we're looking at their vitals and their weight on the computer and monitoring and controlling what's going on with their illness and helping them without it getting to that crisis point and without that cost of a nurse going there every single day. So...and I will say, you know, on the rehospitalization part, 75 percent of rehospitalizations are avoidable if we have things like telehealth in place. So I'm not going to go on farther. I'll let you read my testimony; I did have more information in there. So I did kind of get derailed in the beginning. But any questions or...and I... [LB1078]

SENATOR CAMPBELL: Great job covering a lot. Thank you. [LB1078]

DIANE DERICKS: You're welcome. [LB1078]

SENATOR CAMPBELL: Questions from the senators? Senator Crawford. [LB1078]

SENATOR CRAWFORD: Thank you, Senator Campbell. And thank you. That's very helpful to see that comparison on the $75 and the $5.83. And as I understand it right now a lot of that work you're doing is not reimbursed at all. So you're... [LB1078]

DIANE DERICKS: No. [LB1078]

SENATOR CRAWFORD: ...not even getting...you're not getting $5.83 for the... [LB1078]

DIANE DERICKS: No. [LB1078]

SENATOR CRAWFORD: ...for that monitoring. You're not getting anything for the monitoring. [LB1078]

DIANE DERICKS: We lease...our telehealths cost us about $175 a month per unit. And

that is all completely out of our pocket. [LB1078]

SENATOR CRAWFORD: Okay. [LB1078]

DIANE DERICKS: And it's not because, oh, we're wonderful and we want to do that. I mean, it's the right thing to do. And we know it provides better care for our patients. [LB1078]

SENATOR CRAWFORD: Now, have you heard from any other professional peers or other home health organizations if anyone else or any other state or any innovation in terms of developing reimbursement schedules for this kind of monitoring work? [LB1078]

DIANE DERICKS: I know Minnesota...Good Samaritan Society is a national nonprofit chain, so we have home healths throughout the country. Minnesota and it's either South Dakota or North Dakota has just started paying for the... [LB1078]

SENATOR CRAWFORD: For this. [LB1078]

DIANE DERICKS: ...telemonitoring... [LB1078]

SENATOR CRAWFORD: Okay. Thank you. [LB1078]

DIANE DERICKS: ...so, yeah. [LB1078]

SENATOR CRAWFORD: Thank you. [LB1078]

DIANE DERICKS: You're welcome. [LB1078]

SENATOR CAMPBELL: Any other questions? Thank you very much... [LB1078]

DIANE DERICKS: You're welcome. [LB1078]

SENATOR CAMPBELL: ...for coming today. [LB1078]

DIANE DERICKS: Thank you. [LB1078]

SENATOR CAMPBELL: Our next proponent. Good afternoon again. [LB1078]

JONI COVER: Good afternoon again. Senator Campbell, members of the committee, my name is Joni Cover, J-o-n-i C-o-v-e-r, and I am here on behalf of the Nebraska Pharmacists Association to testify in support of LB1078. And I'd like to thank Senator Nordquist for introducing this legislation and also including pharmacists in this provision

for being able to recognize that we can provide cognitive services and do it through the telehealth system. The legislation, which we think is important, requires fair payment for that service, which really lends itself very nicely to Senator Howard's bill which will be heard next week before Banking, which is LB858. I won't do a commercial on that bill, I'll talk to you all about that later. But pharmacists manage patient diseases through drug therapy and especially with the chronic diseases or multiple medications, being able to communicate with them through this technology is very important. A couple of things I want to point out. Our Pharmacy Practice Act already recognizes telepharmacy. We don't have remote dispensing, but we do allow some of our hospitals in more rural areas to contract with other hospitals to provide some pharmacy/cognitive services. So that's a plus for us. One thing I think is interesting to note is that community pharmacy is not a part of the Nebraska telehealth network. So I'd like to somehow work with Senator Nordquist's office and all of you to figure out how we can work that all in because as we know medicine is moving more and more into technology. And pharmacies have really been very into technology for a long time. And if we can somehow marry the two that would be ideal. So we just want to say thank you for including us in this bill and are happy to help support, do whatever we need to do to move it forward. So thank you very much, and I'd be happy to answer any questions. [LB1078]

SENATOR CAMPBELL: Any questions? Thank you very much. [LB1078]

JONI COVER: Thank you. [LB1078]

SENATOR CAMPBELL: Our next proponent. [LB1078]

JASON KRUGER: Senator Campbell and members of the Health and Human Services Committee, my name is Jason Kruger, J-a-s-o-n K-r-u-g-e-r. I'm testifying today on behalf of the Nebraska Medical Association in support of LB1078. Healthcare reform has been generating new approaches to care delivery and reflects the need to contain costs while improving access to care quality to assist with provider shortages across our state and to take care of our growing sicker and aging population. These approaches are all built on the foundation that puts patients at the center of their medical care and focuses on keeping them healthier. One example of this involving importance to healthcare is through the use of telemedicine and telehealth. These services are proven to bring value through the ability to provide remote visits with patients and enhancing the care provided in rural areas of the state, immediate access to healthcare professionals, and real-time access to health data and health monitoring capabilities. The advantages of using telemedicine include: decreased travel time and lower job absenteeism for patients who reside in rural communities; earlier disease intervention and fewer unnecessary interventional procedures through increased access to specialists; decreased average length of stay in hospitals; decreased out-migration of primary care services by expanding the availability of services locally; enhancing the status of local critical access hospitals and local primary care practitioners; enhanced

clinical support and improved confidence in clinical judgment for local practitioners; increased referral opportunities for specialists; opportunities to enhance and supplement services provided at existing outreach specialty clinics; increased opportunities to attract the most medically challenging cases; screening opportunities for preventive care; and the opportunity to consult with other professionals internationally. One of the most commonly cited reasons for the use of telemedicine technologies are the associated cost benefit. Obviously by treating patients remotely both physicians and patients can be spared the extra expense of the cost of travel including fuel and time off. Telemedicine brings minimal or unavailable levels of care to access...to remote and rural areas of the state giving patients in these areas access to necessary specialists and better overall care again is one of the cornerstones of telemedicine. There's a number of services currently being offered via telemedicine. Currently some of the key services include mental and behavioral health, dermatology, emergency and teletrauma services, family advocacy, internal medicine and specialty care, infectious disease, pre- and postsurgical assessment, neonatology, OB/GYN, orthopedics, ENT, pediatrics, radiology, rehabilitation therapy, disease management for chronic diseases such as diabetes, CHF, arthritis education, deaf (phonetic) consults, wound care, and dietary consults. The Nebraska Medical Association supports LB1078, which would foster further harmonization through the integration and coordination of accessible healthcare via telehealth and telemonitoring to rural Nebraskans via physician-led, team-based levels of care. Thank you very much, and I'd entertain any questions. [LB1078]

SENATOR CAMPBELL: Thank you, Dr. Kruger. Questions? Thank you for once again... [LB1078]

JASON KRUGER: Thank you. [LB1078]

SENATOR CAMPBELL: ...testifying. Our next proponent. Good afternoon. [LB1078]

MILLICENT PALMER: (Exhibit 10) Good afternoon, Senator Campbell, members of the Health and Human Services Committee, colleagues, and guests. I'm Dr. Millicent Palmer, an ophthalmologist on the faculty of Creighton University and University of Arizona and section chief of eye care at the Nebraska-Western Iowa Health Care System. [LB1078]

SENATOR CAMPBELL: Doctor, would you spell your name for the transcribers... [LB1078]

MILLICENT PALMER: Yes. [LB1078]

SENATOR CAMPBELL: ...that listen? [LB1078]

MILLICENT PALMER: First name, Millicent, M-i-l-l-i-c-e-n-t; Palmer, P-a-l-m-e-r. Sorry. [LB1078]

SENATOR CAMPBELL: Thank you. [LB1078]

MILLICENT PALMER: Today I'm speaking to you as president of the Nebraska Academy of Eye Physicians and Surgeons, in support of LB1078. I would like to formally commend Senators Nordquist, Dubas, Campbell, and McGill for introducing this bill. The rising cost of healthcare, increasing demands, and provider shortages are forcing policymakers to look at alternatives in healthcare delivery. The American Telemedicine Association reports that so far this year alone 28 state legislatures have introduced over 50 legislative proposals to improve patient access to care using telehealth; Iowa, Mississippi, Wisconsin, Ohio, and Washington state are just a few. The proposed LB1078 cannot be timelier. Telemedicine has been in development for over four years now. It has evolved from experimental research and demonstration grants to mainstream healthcare delivery. Our own Nebraska statewide telehealth network is a testament to this, as well as other networks such as the CHI network. There is now a collection of peer-reviewed research that has evaluated the cost-effectiveness of telemedicine. These studies indicate that telemedicine services improve access; save the patient, providers, and payers money; and enhance quality of care. Utilization of telemedicine applications as you've heard before may include primary care settings; hospitals, such as intensive care units; schools; home monitoring of chronic conditions; emergency rooms; nursing homes; and correctional facilities. Glenn Fosdick, president and CEO of the Nebraska Medical Center, has recently acknowledged the potential role of telemedicine in the coordination of patient care across the newly formed regional provider network of hospitals that extends from Omaha to Scottsbluff. Not surprisingly, I have a special interest in development of teleophthalmology and currently working on a project plan to develop a teleophthalmology network within our state to better serve citizens in rural, underserved areas of Nebraska such as Norfolk, North Platte, and Hastings. This would greatly improve timely access to primary and/or subspecialty care and reduce the burden of travel and duplication of services. Teleophthalmology services would be in conjunction with the well-established Nebraska statewide telehealth network and the University of Nebraska Department of Ophthalmology. Teleophthalmology is well suited to utilize advances in digital, still, and video imaging technologies and patient information systems for real-time or store-and-forward electronic consultations. The development of teleophthalmology would also greatly enhance opportunities for collaboration between ophthalmologists, optometrists, and primary care physicians. Clinical applications for teleophthalmology may include access to eye specialists for rural or remote areas; urgent care evaluations; ocular disease screening, diagnosis, monitoring, and management--in particular, chronic diseases such as diabetes, macular degeneration, and glaucoma, all of which are potentially sight-threatening conditions; the sharing and linking of diverse medical resources; visual rehabilitation of the low-vision patient...are just some of the examples. This legislation will allow for the

expansion of existing and the development of new telehealth applications such as teleophthalmology for the citizens across our state and support their sustainability. Let's take telemedicine in the state of Nebraska to the next level. Thank you for your attention. [LB1078]

SENATOR CAMPBELL: Thank you, Doctor. [LB1078]

MILLICENT PALMER: And I'll entertain some questions. [LB1078]

SENATOR CAMPBELL: Questions? Appreciated your comments very much. Senator Cook. [LB1078]

SENATOR COOK: Thank you, Madam Chair. And thank you, Dr. Palmer, for your testimony and for your service to the state of Nebraska. You're focusing on a project related to teleophthalmology. Are you aware among your colleagues whether they're in Arizona or back in New York or...who are working on other kinds of telemedicine initiatives in specialty areas? [LB1078]

MILLICENT PALMER: Yes. Arizona has a diabetic screening. California does diabetic eye disease screening. There are some that also...Pennsylvania is now doing some urgent care evaluations using telemedicine. [LB1078]

SENATOR COOK: All right. Thank you very much. [LB1078]

SENATOR CAMPBELL: Any other questions? Thank you, Doctor. Our next proponent? Those who would like to testify in opposition to the bill. Good afternoon. [LB1078]

ERIC DUNNING: (Exhibit 11) Good afternoon, Senator. Good afternoon, Chairperson Campbell and members of the committee. My name is Eric Dunning; for the record that's spelled E-r-i-c D-u-n-n-i-n-g. I'm a registered lobbyist and the director of government affairs for Blue Cross Blue Shield of Nebraska, here to testify in opposition to LB1078. Blue Cross Blue Shield is a Nebraska domestic mutual benefit company. We are a not-for-profit entity. This year we're celebrating 75 years of service to our 720,000 Nebraska members served by 1,100 Nebraska-based employees. We were founded to serve our members and we don't have shareholders and we continue to operate under those principles today. But I want to start by saying that we generally support the provisions of LB1078 that broaden the ability of healthcare providers to provide services to our members. Blue Cross Blue Shield currently provides such coverage to our members in response to the development of telemedicine over the years. We believe it's a good idea to reconsider any current legal restrictions that might limit our ability to cover services sought by our members. However much we support reconsideration of restrictions in this area however we oppose the part of the bill that mandates coverage. As I mentioned earlier, we've covered these services under conditions that we've

developed that we believe make sense for our members. As we do with all policies these conditions are reviewed to ensure that our members continue to have access to quality healthcare services by the appropriate level of provider. Underlying all of this is our concern that our members receive services comparable to those available on a face-to-face basis. Among the issues we are looking at as we are evaluating developing coverage in this area is coordination between telehealth providers and primary care providers. Continuity of care is important to a member's treatment and the ability to provide any medical history from the telehealth provider to the primary care physician will be important to us. Additionally, we're looking at whether the means of communication used in the telehealth procedure are sufficient to provide the best treatment for our members. Ultimately, we know our members want to obtain convenient, reasonably priced medical services and we're looking for those opportunities as well. Last, we're concerned about the imposition of mandates generally. Flexibility in plan design is essential in order to keep healthcare costs under control. Mandates that dictate plan design hinder creative solutions to the affordability and accessibility of healthcare. And I might add they make it difficult for us to contractually deal with issues that may be posed by such entities as a scooter store situation. Passage of the Affordable Care Act yielded a number of new requirements that consumers purchase coverage in various areas. If consumers are required to buy a broader coverage in this area, it's a mandate for our members as they seek to buy coverage for their employees, themselves, and their families. If a mandate remains in the bill, then we'd like to take a closer look at some of the specific services we would be required to provide. In particular, we'd want to look at provisions of the bill that repeal the exclusion of telephone, electronic-mail message, or facsimile transmission from the definition of "telehealth consultation" and their absence from the definition found in the mandate that's applicable to private payers. These exclusions are found in several other states, and we would believe that it would be important to review whether it makes sense for our members to keep those exclusions from the bill. However much we support the effort to broaden the availability of this treatment for our members, we oppose the portion of the bill that would require our members to purchase coverage that may or may not make sense for them. We'd ask that you not advance LB1078 with the mandate. [LB1078]

SENATOR CAMPBELL: Mr. Dunning, two questions. First, have you had an opportunity to talk to Senator Nordquist about the items that you're concerned...? [LB1078]

ERIC DUNNING: We have talked with the senator in particular about the...our concerns about the mandate. [LB1078]

SENATOR CAMPBELL: Okay. [LB1078]

ERIC DUNNING: And then we've had some conversations in that area, yes. [LB1078]

SENATOR CAMPBELL: And are you the person that brought the letter from Coventry with you, or...? [LB1078]

ERIC DUNNING: No, ma'am. That came up at the same time as I did, but I didn't bring it. I believe... [LB1078]

SENATOR CAMPBELL: Okay. [LB1078]

ERIC DUNNING: ...their registered lobbyist did. [LB1078]

SENATOR CAMPBELL: We just wanted to make sure if you brought that letter. I like to know that for the record. Senator Gloor. [LB1078]

SENATOR GLOOR: Thank you, Senator Campbell. Thank you, Mr. Dunning. Two sentences I'd like to read back to you and maybe you can put a little meat on the bone. "Blue Cross Blue Shield has covered these services"--telemedicine--"under conditions that we have developed that we believe make sense for our members." And the other sentence was, "Among the issues we are looking at as we evaluate developing coverage in this area is coordination between telehealth providers and primary care providers." [LB1078]

ERIC DUNNING: Right. [LB1078]

SENATOR GLOOR: Could you give me... [LB1078]

ERIC DUNNING: Well, it...the... [LB1078]

SENATOR GLOOR: ...a little more explanation of what it is that you developed that makes sense for your members... [LB1078]

ERIC DUNNING: Okay. [LB1078]

SENATOR GLOOR: ...and what your relationship-building is with primary care. [LB1078]

ERIC DUNNING: Currently, our policy provides coverage for telehealth services where there's visual contact, face to face, with our...between our member and the provider. We are looking for interactive, real-time communication. We want the patient to be present and able to participate to the extent possible. And we're also looking to make sure that this is medically appropriate and that we have BlueCard-participating providers on either end of those. [LB1078]

SENATOR GLOOR: And the piece that says, "coordination between telehealth

providers and primary care providers"... [LB1078]

ERIC DUNNING: One of the things that we're looking at is we're...telehealth is an evolving area and it's evolving very quickly. And as we're seeing these proposals come to us we're looking at whether or not this telehealth service has a link back to the primary care physician. And sometimes, you know, some of the proposals we've seen may not have those services available and that causes us some concern. [LB1078]

SENATOR GLOOR: What I was hoping you'd say...and so I'll say it because I'm sure it's where you were headed... [LB1078]

ERIC DUNNING: I'm sure it is, sir. (Laughter) [LB1078]

SENATOR GLOOR: ...is that if it furthered a relationship between the patient's medical home that there...that, in fact, may in and of itself be a good argument for the way reimbursement might look at telehealth, since that physician group or that medical home is probably incentivized to take a look at some of the outcomes and be a little more discerning in terms of what gets used and how it gets used. But... [LB1078]

ERIC DUNNING: And I'd...yes, I would say that, sir. [LB1078]

SENATOR GLOOR: (Laugh) Okay, thank you. [LB1078]

SENATOR CAMPBELL: A wise man. Any other questions? Senator Krist. [LB1078]

SENATOR KRIST: I read in the fiscal note--and this came from our Department of Insurance--that there...that he had some undetermined cost, based upon the mandates that would be set forwarded. So I recognize that what you're saying is consistent with what our Insurance Department director is saying as well. But I guess my...I'm sorry...I guess my question, more appropriately phrased, would be, you're in the business for your customers, your clients, your...the people that you serve. And what I heard you say, I think, was you'd rather have "Blue" on both sides of the phone, so to speak. And you don't, I guess, I'll infer this, so I'm not...don't take this as attack, I just want to confirm, you would hope not to participate if potentially the primary care provider would have a non-Blue person on the other side of the phone. [LB1078]

ERIC DUNNING: Well, and when I say Blue, I mean the healthcare provider, our contracted providers for us. Do you see...? [LB1078]

SENATOR KRIST: Within your insurance company? [LB1078]

ERIC DUNNING: Within our insurance company. But we contract with a great number of... [LB1078]

SENATOR KRIST: Yeah. [LB1078]

ERIC DUNNING: ...physicians and hospitals across the state. [LB1078]

SENATOR KRIST: And I guess where I'm going with that is, do you have the scope where you can provide those kind of services to...I mean, I...we're seeing more, I mean, I'm seeing more and more specialists fall away from Alegent, fall away from different organizations and go into private practice and not be associated with...and having experience with the government system and TRICARE and those kind of things, providers not participating in some of those programs. So what I worry about, to coin a phrase from Senator Gloor, is that we have "have" and "have-nots" within the system, because there might be a specialty that might be required. And although I don't suggest that that would be a mandate, I would suggest only that that might be a consideration. I have Blue Cross Blue Shield, and I would hope that at some point if I need a specialty that's not represented within the provider network that we can go outside of that network. Could you talk to that a little bit with me? [LB1078]

ERIC DUNNING: Well, you know, I'd begin by pointing out that we have a very broad network in this state, and we have arrangements with providers all across America through our BlueCard program. So I don't necessarily see that as an issue as much. And I'll say this is our current policy. We are always looking though at how telehealth is developing... [LB1078]

SENATOR KRIST: Okay. [LB1078]

ERIC DUNNING: ...and so... [LB1078]

SENATOR KRIST: All right. Thank you. [LB1078]

SENATOR CAMPBELL: Other questions? Thank you, Mr. Dunning. [LB1078]

ERIC DUNNING: Thank you, ma'am. [LB1078]

SENATOR CAMPBELL: Our next opponent. [LB1078]

RON SEDLACEK: Good afternoon, Madam Chair and members of the Health and Human Services Committee. My name is Ron Sedlacek, R-o-n S-e-d-l-a-c-e-k, and I am here on behalf of the Nebraska Chamber of Commerce and Industry. For those who have...are serving on the Banking Committee or have served on the Banking, Commerce and Insurance Committee in the past it should be no surprise that the State Chamber would come in on legislation that would be considered a mandate of insurance benefits. And I speak specifically of Section 7 of the bill itself. Telehealth and

its advantages we...of the program and utilization, we don't have any problem with at all and would see that as an advance. However, it's the mandate itself. When we take a look at the insurance market today, particularly we speak to the employer-provided insurance, the vast majority now, the vast majority would not be affected by this bill. It would not affect their insurance at all because this mandate would not apply. And that's because they are ERISA-based programs. This cannot touch an ERISA-based program. And more and more employers are migrating to those programs because they have less mandates. They're...they have the minimum essential benefits that are either in ACA or as prescribed by the federal government under ERISA. So what are we speaking to? We're speaking to programs, particularly those provided by smaller employers, by trade associations perhaps. And we have over 60 statewide trade associations. Fewer and fewer now are actually engaged in group health insurance. So those are dropping on the wayside, but those that remain...an additional mandate just affects the affordability and the availability then for small employers to provide this product to employees. And that's a concern. We also have over 90 local chambers of commerce as members, some of them which still provide those programs. So we're coming in from the point of view essentially of the consumer where our businesses are consumers of the product. And we're concerned about the price and to make it available and to continue the viability of employer-based insurance. So has there never been a well-intentioned mandate? I think every mandate has always been well-intentioned. But to enact one mandate and then another and another, then the precedent is such that that bothers us. Again though the problem is that we're really talking about fewer and fewer people that are being affected by this legislation. As I say, the vast majority are on ERISA plans, not on group plans that are being covered here. So we're left with those small group plans and then individuals...so are self-employed. And right now the self-employed are going through a lot of pain, quite a few of them. We're hearing from them. And the effect of insurance in trying to remain covered and to...and making decisions on how to be covered and the whole issue of deductibles and so forth, and copayments. So this just puts added pressure on the self-employed as well. Finally I'm not sure I understand the fiscal note. And I may be obtuse in this regard and probably am, but the fiscal note is saying that...it implies that the state of Nebraska is going to pick up all the charge. If you've read the fiscal note it says that...I think the Department of Insurance is incorrect in that regard. I'm not sure but I believe that this would...maybe for state plans all the charge because it's over and above the essential-benefit level. But it seems to me for employer-based, association-type plans, I would not think the state of Nebraska is going to be picking up that cost. I would think it would be the employers who would be eventually. And that's all my testimony. I'd be happy to answer any questions. [LB1078]

SENATOR CAMPBELL: Questions? In some cases this might be more cost effective than making the employee travel 300 miles to see a specialist; the example that was used at the beginning. It could be a very cost-effective way, rather than moving people. [LB1078]

RON SEDLACEK: It could be. I mean, I can't dispute that. In some cases it would be probably. And in other cases it wouldn't. And out of network, the amount of utilization, the number involved here, the very issues that this committee...the members of this committee were asking the proponents of the legislation, same questions we have. So yes in some cases, yeah. And it could be the majority of cases, I don't know. But again it's essentially because it's a mandate and that's our concern. Now, Senator Nordquist and the insurers could, if they could work out accommodations on this in this particular area, we wouldn't stand in the way of that. [LB1078]

SENATOR CAMPBELL: Thank you for clarifying that. [LB1078]

RON SEDLACEK: But at any rate, let's see what happens in that regard first. [LB1078]

SENATOR CAMPBELL: Thank you. [LB1078]

RON SEDLACEK: Okay. [LB1078]

SENATOR CAMPBELL: Our next opponent? Those who would like to provide neutral testimony. Good afternoon. [LB1078]

MANDI CONSTANTINE: Good afternoon. [LB1078]

SENATOR CAMPBELL: Go right ahead. [LB1078]

MANDI CONSTANTINE: (Exhibit 12) Thank you. Madam Chair and members of the Health and Human Services Committee, I am Mandi Constantine, M-a-n-d-i C-o-n-s-t-a-n-t-i-n-e, the executive director of telehealth for the Nebraska Medical Center in Omaha. I'd like to thank you for inviting me here today to present some facts regarding the use and outcomes of telemedicine and share where other states are headed in an effort to update the capacity to deliver services via telemedicine. I am here today at the request of Senator Campbell to testify in a neutral position. The rapid evolution of telehealth technology and the need to address provider shortages, reduce ER visits, allow in-state providers to remain competitive, and make significant strides toward equality in care distribution and healthier-quality outcomes have moved other states to update their telehealth legislation. In 2013, more than 30 states and the District of Columbia introduced telehealth legislation, and 18 of those bills were passed into law. And 30 states have introduced over 50 telehealth bills this session. Expansion of telehealth services to include remote patient monitoring, or RPM, has been approved in 14 states including neighboring states of Colorado, Kansas, and South Dakota. And to answer one of your questions earlier, I would look to Colorado as a model program for RPM. Research on RPM has demonstrated proven quality outcomes, reducing ER visits, and cost savings at both the national and state level. The VA did a study of over 32,000 veterans enrolled in RPM. The results demonstrated a 25 percent reduction in

bed-days and 19 percent reduction in hospital admissions. And overall, their telehealth program costs the VA system 8 times less than their home-based primary care service and 48 times less than traditional nursing home care. In Colorado, a study of over 200 patients enrolled in our RPM program resulted in a 62 percent reduction in 30-day rehospitalizations, a 6.3 percent reduction in hospitalization rates for telehealth patients, compared to 18 percent for patients receiving traditional home care, and a decrease in ER visits, from 283 in the year preceding the study to 21. In Kansas outcomes for a small group of patients of 25 in a one-year pilot resulted in no healthcare costs, because there were no readmissions, no transfers to nursing homes, and no ED visits, at a cost savings of over $1 million. You've already got my testimony. I don't think that I need to go over a lot of the things that are in here. Many have already been covered by speakers before me. But to answer some of your other questions that you asked earlier, RPM, remote patient monitoring, in Colorado and Kansas are model programs. Many states around the country are modeling their programs on Colorado. Colorado reimburses about $9.60 a day for every day that a patient is monitored on their program. Kansas reimburses about $6.30 a day. Some states that have remote patient monitoring also reimburse for installation of equipment, some don't. Tele-ED subscription...you referred to that earlier, Senator Krist. Avera in South Dakota, the Avera health system, has a very substantial tele-ED program, and it is by subscription. You pay on a contract for that service. Banner Health I think also has one that comes up into south Nebraska into a few of their facilities. It's an incredible program I would say. The American Telemedicine Association within the past eight months has put out about ten best practice standards for state Medicaid programs on telehealth, specifically focused on things like managed care, stroke, remote patient monitoring, and store-and-forward. They're small documents--no document is bigger, I think, than 15 pages--but they list states that have model programs and data to back those programs up. So those are really great documents that I would suggest if you have not looked at those documents, that you have someone pull those for you. United and WellPoint insurers did programs the past two years in over six states that included telemedicine for people who were in insured within their insurance programs, and they plan on expanding those programs out nationwide. At this time I will be happy to answer any other questions that you might have. [LB1078]

SENATOR CAMPBELL: Dr. Constantine, I appreciate your coming. I had heard that you had done some research, and I thought it would be helpful if we heard it. So I appreciate you coming, particularly talking about the Colorado program. [LB1078]

MANDI CONSTANTINE: Thank you. [LB1078]

SENATOR CAMPBELL: Do you have a question, Senator Krist? [LB1078]

SENATOR KRIST: Yes. When you said there was reimbursement available in Colorado and other states, how are they paying for that? Are they using a CMS plan, a state

waiver plan that puts it in place? [LB1078]

MANDI CONSTANTINE: Some use that, some pay out of their state Medicaid program, some pay out of their department of aging services. So it varies according to state. [LB1078]

SENATOR KRIST: Okay. [LB1078]

MANDI CONSTANTINE: There is an inch-and-a-half booklet that's put out once a quarter by the Center for Connected Health Policy. I get it every quarter that it comes out. And it talks about every state's policy, pending legislation, and how they handle their programs. [LB1078]

SENATOR KRIST: You know, I would like to ask you, and I know you have a full-time job (laughter), but if you could boil that down for us and say, if I were going to solve this problem this is what I would suggest you look at. I'd love to see that, because... [LB1078]

MANDI CONSTANTINE: Okay. [LB1078]

SENATOR KRIST: ...inch and a half of here and an inch and a half there, I get confused. But you seem to be an expert in the field and if you can tell me that the first step is to do a state plan that goes to CMS, second...and follow me through a concept, that's where I think we need to go. I don't think there's any doubt, even the people who have testified in opposition, we believe telehealth is a wave that we need to get onto this with our board and surf it because it's going in the future. But how do we get there? That's the nuts and bolts. So thank you for coming. [LB1078]

MANDI CONSTANTINE: Thank you. [LB1078]

SENATOR CAMPBELL: I just happened to glance down in your testimony on the second page. For my colleagues it's the paragraph that starts, "As of 2012." And in there you talk about a physician in Omaha who was given access on his iPad... [LB1078]

MANDI CONSTANTINE: Yes, ma'am. [LB1078]

SENATOR CAMPBELL: ...and...to receive images on stroke patients from physicians in rural Nebraska. Boy, we have talked about that in LR22, about having that. And I can't believe Senator Howard doesn't have her iPad on there. (Laughter) See? And Senator Crawford has...usually has one, and Senator Watermeier is usually taking notes on his iPhone or his phone. And so it's amazing to see that kind of technology. I want to go back to the concerns that were expressed. And I certainly do understand the

Department of Insurance and Mr. Dunning and Mr. Sedlacek coming forward because we have to think about that. Are there any states that have dealt with this insurance mandate question and, I mean, is there someplace that we can look for some data on that? [LB1078]

MANDI CONSTANTINE: Yes, ma'am, I can get you some of that data. There are actually, I think in my testimony I say here 20 states that have...I think Arizona's legislation comes into effect January of 2015; that would be the 21st state. And there are 11 states in this session that have parity laws on the docket. [LB1078]

SENATOR CAMPBELL: Okay. [LB1078]

MANDI CONSTANTINE: The American Telemedicine Association, I'm a member of the that; I've been a member for ten years. Prior to this I worked in Alaska, and I built telemedicine programs there. So I could also get information from there. [LB1078]

SENATOR CAMPBELL: Okay. That would be helpful for us. Senator Gloor. [LB1078]

SENATOR GLOOR: Thank you, Senator Campbell. Sorry I missed your testimony, but I'm reading through it and getting caught up real fast here. And so I'm going to ask you if you know if you take a look at the states that have begun to roll this out, what the preponderance of managed care might be in those same states. In other words it would seem to me that if reimbursements are more in a fixed...more in a managed basis, whether you're capitated or large HMO populations that I could see where it provides its own degree of restraint. I mean, if provider groups are only going to get paid so much money, how they spend it puts the onus on them to be discerning on how they use telehealth and use it in ways that maximize being able to provide patient care rather than--I've got to use the word because it's the only one that comes to mind--"churning" that might drive a lot more reimbursement. I mean, that's the predicament. We're trying to figure out ways to use it appropriately and avoid overutilization that drives up expenses and costs. I don't know. But I would love to see a map that overlays managed care penetration with states that have, in fact, expanded telehealth. I'd be surprised if there wasn't some correlation. [LB1078]

MANDI CONSTANTINE: I could look in that state Medicaid best practice the ATA just put out in January and see if they have that information in there, sir. [LB1078]

SENATOR GLOOR: It would be worth knowing. It really would be. [LB1078]

SENATOR CAMPBELL: Thank you. Any other questions? Dr. Constantine, we may be having you come and visit with some...at our LR22--LR422 now--conference, because I think it would be helpful for them to see some of your research. [LB1078]

MANDI CONSTANTINE: Thank you. Thank you for your time. [LB1078]

SENATOR CAMPBELL: (Exhibits 20, 21, 22, 23) Thank you for coming. Anyone else who wishes to testify in a neutral position? Okay, Senator Nordquist, I assume. While he is making his way up here we have a support letter from the Nebraska Optometric Association, from the Board of Pharmacy, and then we have a letter in opposition to Aetna. We'll make sure that's separate, and Mr. Dunning did not bring that. And then, Senator Nordquist, I left this for last. Did you receive a letter from the Department of Insurance? [LB1078]

SENATOR NORDQUIST: No. [LB1078]

SENATOR CAMPBELL: Have you seen this letter? [LB1078]

SENATOR NORDQUIST: I haven't seen it, no. [LB1078]

SENATOR CAMPBELL: Okay, we'll make sure that the clerk gets your office... [LB1078]

SENATOR NORDQUIST: All right. Okay. [LB1078]

SENATOR CAMPBELL: The Department of Insurance is raising some questions, and most likely you're going to want to visit with them about it. [LB1078]

SENATOR NORDQUIST: All right. Will do. I do not want to overstay my welcome here; I know you have a number of other bills to get to. But just a few comments. I certainly understand the position of the opponents and appreciate Blue Cross and the State Chamber letting me know of that opposition prior to the hearing. You know, I'm of the mind-set that if we're going to get to the capacity that we need in a telehealth system, we're going to need all the payers at the table. That's why the mandate is included. We have...as Dr. Constantine said, 20 states so far have enacted a private insurance parity. And, just, if you look at the last few years, there were three that passed in 2012, five that passed in 2013. So in the last two years eight states have come on board with a private insurance requirement or mandate for telehealth coverage. So it is something that is gaining traction around the country. As far as the multiple payment issue, I think certainly we need to...we should probably look at those five states that passed last year what they...because I'm sure they all wrestled with the same issue. But also, I'm not familiar and I should be, with how Medicaid is doing it right now because we are reimbursing for services outside of 30 miles. So what restrictions do we have in place in our Medicaid system for those people...for those services provided outside 30 miles as far as having multiple procedures, payments by multiple providers? And then I think Dr. Constantine did a great job talking about models to look at for remote patient monitoring. I, really, my interest really piqued in this probably about four years ago when I was at an NCSL meeting, and they had--it was in Washington I think--but they

had...Avera from my home state of South Dakota came in and did a...talked about their pilot program that has now led to the changes in their state law there for remote patient monitoring. And it was a very successful cost-saving pilot program for Medicaid to reimburse for remote patient monitoring. And then finally, I don't know if the Department of Insurance fiscal note or their letter addresses what they said in the fiscal note. We did get correspondence back from the American Telemedicine Association about their concern about whether or not this would be remote patient monitoring and...or whether or not this would be additional to the essential health benefits. Sorry, I got a little confused there. And the American Telemedicine Association said that this is clearly not an additional service to...at least their understanding of federal law and federal regulations, this is not an additional service being provided. It's not adding to the essential health benefits. It is a delivery for those services and therefore would not constitute any additional expansion of those services, and therefore the state would not be on the hook for any of that. So that is at least their understanding of the federal laws and regulations. [LB1078]

SENATOR CAMPBELL: Questions for Senator Nordquist? Senator Nordquist, you might...the reason I was asking legal counsel...committee members, do you remember last year we talked about this with Senator McGill's bill, wasn't it and children's mental health about getting rid of the 30-mile... [LB1078]

SENATOR CAMPBELL: ..... [LB1078]

SENATOR COOK: Yes. [LB1078]

SENATOR CAMPBELL: ...for the...I'm correct? [LB1078]

SENATOR COOK: Yes, that's where we talked about it. [LB1078]

SENATOR CAMPBELL: So you might want to visit with Senator McGill, because... [LB1078]

SENATOR NORDQUIST: Right. [LB1078]

SENATOR CAMPBELL: ...she had done some research on that issue. [LB1078]

SENATOR NORDQUIST: Right. Okay. Will do. [LB1078]

SENATOR CAMPBELL: Okay? [LB1078]

SENATOR NORDQUIST: Thank you. [LB1078]

SENATOR CAMPBELL: Thank you. And that closes today's hearing on LB1078. And if

you are leaving, please leave quietly. And we will move to LB1017 which is Senator Krist's bill to change and transfer pharmacy, prescription, and drug provisions and is the companion bill...isn't this sort of the other bill to Senator Gloor's bill? Okay. [LB1078 LB1017]

SENATOR KRIST: I don't have to read that in my introduction now. [LB1017]

SENATOR COOK: Yes. [LB1017]

SENATOR CAMPBELL: And now you're done, and that's it. Okay, Senator Krist, go right ahead. [LB1017]

SENATOR KRIST: Good afternoon, Senator Campbell and fellow members of the Health and Human Services Committee. For the record, my name is Bob Krist, B-o-b K-r-i-s-t. I represent the 10th Legislative District, northwest Omaha along with north-central portions of Douglas County, including Bennington. I appear before you today in introduction and support of LB1017, a bill introduced on behalf of the Nebraska Pharmacists Association to change and update the pharmacy practice laws. LB869, which was introduced by Senator Gloor and advanced to General File by this committee, was the first part of the update process; LB1017 is the second half. LB1017 creates a Prescription Drug Safety Act. The purpose of this act is to put in place statutory provisions for healthcare providers to follow with regard to prescribing, dispensing, labeling, storage, and recordkeeping of noncontrolled--noncontrolled--legend prescription drugs. The idea is to mirror in essence the Uniform Controlled Substances Act and create a set of statutes that all healthcare providers must follow when providing noncontrolled prescription medications to patients. LB1017 updates and harmonizes many sections of the Pharmacy Practice Act. The bill makes important changes to pharmacy practice provisions, such as compounding, hospital pharmacy practice, pharmacy technician ratios, and eliminates many outdated provisions. Others to follow will provide you with many more details. There was supposed to have been a item-by-item...did you get that, the section-by-section breakdown? That section-by-section... [LB1017]

SENATOR CAMPBELL: I think in the bill summary. [LB1017]

SENATOR GLOOR: Bill summary. [LB1017]

SENATOR KRIST: Bill summary. It definitely would behoove you to do that rather than reading 62 pages because it takes you section by section in terms of where we are. Finally, LB1017 names a Poison Control Act statute pertaining to poisonous substances exist throughout Nebraska law. And the Poison Control Act tends to bring many of these sections of law under one act. The Nebraska Pharmacists Association has an amendment which has some technical cleanup changes that will be presented to the

committee. I look forward to discussing the bill, and technical questions should be addressed to them. I will say this, I was aware because it was distributed to me...a letter from Dr. Acierno. [LB1017]

SENATOR CAMPBELL: Yes. [LB1017]

SENATOR KRIST: I did share that with Joni Cover, to make sure that she was not...that she...and she had not seen it at that point. So I'm hoping that the technical changes do, again, address some of Dr. Acierno's concerns. But I can't tell you that that's true or not true at this point. [LB1017]

SENATOR CAMPBELL: Okay. Thank you, Senator Krist. Are there any questions? He would refer them all to the people behind him as we are apt to do. First proponent. [LB1017]

SENATOR CAMPBELL: Good afternoon. [LB1017]

CHRIS SHAFFER: Good afternoon. [LB1017]

CHRIS SHAFFER: (Exhibit 13) Senator Campbell and members of the committee, my name is Chris Shaffer, C-h-r-i-s S-h-a-f-f-e-r. I'm one of the thumbs that the senator pointed to. And I'm here today on behalf of the Nebraska Pharmacists Association in support of LB1017. I'm a pharmacist, past president of the Nebraska Pharmacists Association, and served as the chair for the Practice Act Update Committee for the last 18 months. Thank you again, Senator, for introducing LB1017 on our behalf. As Senator Krist mentioned, LB1017 is an update to pharmacy practice laws and to create a Prescription Drug Safety Act. The purpose of this safety act is to put in statute and regulations aspects that govern the safe and proper procedures for providing medications to our patients. As you know, a number of healthcare professionals and others ask what is the best way to provide medications to their patients? But many of them do not understand, both on a state and a federal level, the aspects that entail the safe delivery of medications. We hope that by creation of the Prescription Drug Safety Act it elevates the safe medication delivery process. Most of you are probably familiar with the New England compounding company that happened in the Northeast, where there were a number of errors that occurred. Patients throughout the country became infected with fungal meningitis and other aspects. One of our goals as part of this act as we clean up the act that has not been addressed since the early 1990s is to refer back to the federal guidelines USP 797 and 795 that are part of the United States Pharmacopeia in optimizing the medications...the safety of the medication use in the citizens of Nebraska. LB1017 updates many of our pharmacy practice laws. As I mentioned before, the last update was in the early 1990s prior to 1999, as was mentioned previously in these hearings. I have...obviously lots of aspects have changed in healthcare over the past 20 years. I'd like to highlight some of the significant changes

that we would like to mention. As I defined it before, the definition of "compounding" is being updated to include compliance with United States Pharmacopeia Chapter 795 and 797 to improve patient safety. We moved the definitions of "prescription" and "chart order" out of the pharmacy practice regulations and into statute. In addition, we will allow "chart order" dispensing for noncontrolled substances for patients in long-term care facilities. We are clarifying the provisions of electronic prescribing. We removed hospitals from being exempted from the practice of pharmacy, which was very problematic and confusing since pharmacists working in hospitals are not exempt from pharmacy practice. In addition, we defined "hospital pharmacy." We will now require that hospitals name a pharmacist in charge and put policies and procedures in place to optimize medication use within the hospital. We added a definition of "radiopharmaceutical services." We added physician's assistants to the list of providers who can give drug samples to the patients. There is significant cleanup as relates to the pharmacy technicians or pharmacy extenders changing the ratios so that a pharmacist can supervise up to three interns and pharmacy technicians. And we've eliminated some of the cumbersome requirements as it relates to the manual, the pharmacy technician manual. And finally, as was mentioned previously, LB1017 names the Poison Control Act and moves statutes pertaining to poisonous substances into the act, including substances incorrectly placed in the Pharmacy Practice Act. In closing, since the time LB1017 was introduced, we've received comments and suggestions from various stakeholders, including the Department of Health and Human Services. We've taken these amendments and incorporated them in two amendments we'd like to...the committee to consider adopting for LB1017. I, too, will use the thumb and acknowledge that Ms. Cover will also elaborate on some of these amendments. Thank you for your time today, and I'll answer any questions that you may have. [LB1017]

SENATOR CAMPBELL: Questions from the senators? I don't see any. So thank you very much for your testimony and the work. [LB1017]

CHRIS SHAFFER: Thank you very much. [LB1017]

SENATOR CAMPBELL: Um-hum. Our next proponent. [LB1017]

JONI COVER: (Exhibit 14) Good afternoon again. Senator Campbell, members of the 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'm here in support of LB1017. Thank you, Senator Krist, for introducing this legislation for us. Yeah, I'm the cleanup act here. After we drafted LB1017 it became apparent that there were some things that we needed to go into further and fix. I've spoken with the hospital lobbyists. There's a couple of things with regard to compounding that we need to clarify for hospitals. We need to clarify some of the definitions and provisions on nuclear pharmacy. And so I have a partial amendment started. And as soon as I get some additional clarification, I will certainly get that amendment to you as soon as possible. Senator Krist pointed out...or brought

up that the department had sent a letter to him. While I had not seen the letter, I was aware of some of these concerns. And the issues that they outlined in their letter are also things that we will be addressing in our amendment. So I have had extensive discussions with the department in trying to iron all this out so that we...everybody is good to go when we get the amendment to you. I also handed out to you a letter that I was asked to provide to the committee from the National Association of Chain Drug Stores. Their representative could not be here today, but they wanted to offer that letter in support of LB1017. So if you have any questions as you're working through this...I realize there are 63 pages and Chris's testimony included the section-by-section summary. Hopefully, that will give you some guidelines as to what exactly we're trying to do. We've tried to touch base with all of the providers that this would impact and have dialogue with them. So, again, if there's something that we missed, we're willing to fix and adjust, so... [LB1017]

SENATOR CAMPBELL: Okay. Questions? Senator Gloor. [LB1017]

SENATOR GLOOR: Thank you, Senator Campbell. Joni, I think this is just a little question; I think it's just an issue of wording on it. But it's the issue of pharmacist-to-technician ratio. [LB1017]

JONI COVER: Yes. [LB1017]

SENATOR GLOOR: Is that...and that's 3-to-1? [LB1017]

JONI COVER: Yes. It is currently found in pharmacy practice regulations and it is currently: a pharmacist can supervise three individuals, but no more than two technicians at a time. And so what we're doing is we're taking that provision out of regulation and moving it into statute because believe it or not it's easier to get things changed through statutory language than sometimes it is in regulations. [LB1017]

SENATOR COOK: Hmm. [LB1017]

JONI COVER: And we are saying that they can supervise three individuals. So it can be a combination of three technicians or three interns or some combination thereof. It in essence raises the technician ratio by one. [LB1017]

SENATOR GLOOR: Well, this says pharmacists can supervise three individuals, but I'm betting that it means a pharmacist can supervise three individuals. In other words... [LB1017]

JONI COVER: Yes. [LB1017]

SENATOR GLOOR: ...if you had two pharmacists on a shift... [LB1017]

JONI COVER: Right. [LB1017]

SENATOR GLOOR: ...they can supervise up to six. [LB1017]

JONI COVER: Correct. [LB1017]

SENATOR GLOOR: Okay. [LB1017]

JONI COVER: Correct. Correct. And I'm not sure, I will double-check to make sure that that's clear in the statute. [LB1017]

SENATOR GLOOR: Yeah, wherever it is in the statute, I'm guessing, it's probably correct. [LB1017]

JONI COVER: Yes. I hope so. I will check as soon as we get done here. (Laugh) [LB1017]

SENATOR CAMPBELL: Other questions? Senator Cook. [LB1017]

SENATOR COOK: Thank you, Madam Chair. And thank you for your testimony. I will admit to not having reviewed the statute, all sixty... [LB1017]

SENATOR KRIST: Three. [LB1017]

SENATOR COOK: ...-two, -three, -four pages. But I saw that the physician's assistants were lucky enough to be added to the providers who can give out drug samples. [LB1017]

JONI COVER: Yes. [LB1017]

SENATOR COOK: Did the nurse practitioners get any consideration? I remember that... [LB1017]

JONI COVER: They're already in there. [LB1017]

SENATOR COOK: Okay. [LB1017]

JONI COVER: They are already a part of that. [LB1017]

SENATOR COOK: For...not...for the samples. But I'm remembering a bill that I brought... [LB1017]

JONI COVER: Um-hum. [LB1017]

SENATOR COOK: ...when I first got here, and it was... [LB1017]

JONI COVER: Yes. [LB1017]

SENATOR COOK: ...a bigger deal if we paid for the pills... [LB1017]

JONI COVER: Yes. [LB1017]

SENATOR COOK: ...than if they were free. [LB1017]

JONI COVER: Yes. That provision... [LB1017]

SENATOR COOK: Or...has that been addressed? [LB1017]

JONI COVER: The nurse practitioners can still...have always been able to provide drug samples. [LB1017]

SENATOR COOK: But not... [LB1017]

JONI COVER: But not... [LB1017]

SENATOR COOK: ...if they were... [LB1017]

JONI COVER: Correct. [LB1017]

SENATOR COOK: ...free to the clinics. [LB1017]

JONI COVER: Because they can't have a pharmacy license. [LB1017]

SENATOR COOK: Okay. [LB1017]

JONI COVER: And so... [LB1017]

SENATOR COOK: Does anybody get added to the pharmacy...can anybody do that now, other than pharmacists? [LB1017]

JONI COVER: A physician. [LB1017]

SENATOR COOK: Okay. [LB1017]

JONI COVER: A physician. We did realize when we were going through this that

physician's assistants, for some odd reason, were never included in the list of providers who could provide drug samples, which...we don't know why, because they do, or they...I think they do. Anyway...so we thought we should probably add them. So...very good question. [LB1017]

SENATOR CAMPBELL: Okay. We had a discussion this morning, Ms. Cover, about striking out some of the sections on the tech. [LB1017]

JONI COVER: Yes, the technician manual. [LB1017]

SENATOR CAMPBELL: And I thought maybe for the record you ought to have a chance to... [LB1017]

JONI COVER: Sure, I would be happy... [LB1017]

SENATOR CAMPBELL: ...give the same answer you gave me. [LB1017]

JONI COVER: I would be happy to try to explain that. So I believe, back in the day when technicians were first being utilized in pharmacies across the state, one of the concerns was we had this new group of individuals who were assisting pharmacists; there was some "uncomfort" with that provision. And so one of the "uncomforts" was that this group of individuals maybe wouldn't have the knowledge base to assist pharmacists. So I believe that in order to make everyone happy they came up with a technician manual, which was basically a guideline of what the technicians needed to know in order to assist pharmacists in doing their job. Remembering that technicians in Nebraska have to be registered now, we have that provision in statute, and that they're not to use professional judgment; so they cannot practice pharmacy, but they can assist. Well, now as we move forward in 20-some years later, we look at that provision and go: we are so far past that, because in essence a technician in your pharmacy is no use if you don't train them how to do their job and to assist you. And one of the things that we were asked by the pharmacy inspectors, who actually work for the department and go in and inspect pharmacies is this is really sort of a cumbersome thing we have to do now, to look at these. They have to be submitted to the Board of Pharmacy for permission, and it's really an archaic, sort of outdated system we have in place. And since technicians are just sort of now pharmacy business and practice, it's time that we eliminate that provision. So that was I guess something that we agreed with the department to get rid of, that requirement. It still doesn't mean your technicians aren't going to be educated and trained, because otherwise again they're not of use to you in your pharmacy or in your hospital or wherever they're working. So that's why we're eliminating that provision. [LB1017]

SENATOR CAMPBELL: And they still have to be registered. [LB1017]

JONI COVER: Yes, they still have to be registered. In fact, one of the provisions that...thank you for that cue. One of the provisions that we are striking...when we print in the provision that pharmacy technicians had to be registered in Nebraska, we gave them a 30-day window. So they could be, in essence, apply for their registration within 30 days of hire. And what we've been told is that that is a very problematic thing both from the pharmacies and the hospitals that are hiring them, as well as the department, because sometimes they will apply for registration and it takes more than 30 days to get them registered. So now you have these people sort of in limbo going, well, can I work or can I not work? So we've removed that provision and just said, if you're going to work as a technician in the state of Nebraska, you must be registered before you can start employment. [LB1017]

SENATOR CAMPBELL: We'll use--Senator Krist always gets a kick out of this--but let's suppose Andy Campbell was in high school. Could he be a pharmacy...a high school student? [LB1017]

JONI COVER: A technician? [LB1017]

SENATOR CAMPBELL: Right. [LB1017]

JONI COVER: Is that what you're asking? [LB1017]

SENATOR CAMPBELL: Yes. [LB1017]

JONI COVER: Yes. There's a minimum age requirement...well, they have to meet an education requirement and they have to apply and meet the standards for the department, which is the registration, so... [LB1017]

SENATOR CAMPBELL: Okay. [LB1017]

JONI COVER: ...whatever that process is that the department has. I do think the department now does some background checks for our technicians and things like that. So if Andy Campbell could pass the requirements... [LB1017]

SENATOR CAMPBELL: I don't know. [LB1017]

JONI COVER: ...I believe that he could become a pharmacy technician in our state. [LB1017]

SENATOR CAMPBELL: I think we were just trying to figure out that someone just cannot walk off the street... [LB1017]

JONI COVER: Oh, absolutely not. [LB1017]

SENATOR CAMPBELL: ...and be one, and... [LB1017]

JONI COVER: No. [LB1017]

SENATOR CAMPBELL: ...and really, if there is some kind of description in the statutes... [LB1017]

JONI COVER: Yes. [LB1017]

SENATOR CAMPBELL: ...it also, it would seem to me, sets out a protection for the public. [LB1017]

JONI COVER: Yeah. There is a whole section in the Pharmacy Practice Act that talks about technician registration. And since we only messed with one part, you didn't see the whole, big...I could have added some more pages to our 63-page bill... [LB1017]

SENATOR CAMPBELL: (Laugh) Well,... [LB1017]

JONI COVER: ...or I can just give those pages to you and let you see them (laugh), whichever...but that provision is still in place. [LB1017]

SENATOR CAMPBELL: That...but I thought we should put that on the record. [LB1017]

JONI COVER: Correct. Correct. [LB1017]

SENATOR CAMPBELL: Okay. [LB1017]

JONI COVER: You still have to be registered and duly blessed by the state before you can become a technician. [LB1017]

SENATOR CAMPBELL: Any other questions? Thank you very much, Ms. Cover. [LB1017]

JONI COVER: Thank you. [LB1017]

SENATOR CAMPBELL: Our next proponent? Okay. Anyone who wishes to speak in opposition? Opposition to the bill? Anyone who wants to provide neutral testimony on the bill? Okay. Senator Krist, we are back to you, I believe. [LB1017]

SENATOR KRIST: I like these kinds of bills. (Laughter) I waive. [LB1017]

SENATOR CAMPBELL: (Exhibits 16, 18, and 19). Okay. Before we conclude, we do

want to know that there is a letter of...in a neutral position from the Hospital Association; a letter of support from the Nebraska Grocers Association; and a letter from the Department of Health and Human Services, which Senator Krist has already provided to the pharmacy. And with that, we will close the public hearing on LB1017. (See also Exhibit 20) [LB1017]