[LB782 LB869 LB1043 BRIEFING]

The Committee on Health and Human Services met at 1:00 p.m. on Thursday, February 18, 2016, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB782, LB869, and LB1043, and a briefing. Senators present: Kathy Campbell, Chairperson; Sara Howard, Vice Chairperson; Roy Baker; Sue Crawford; Nicole Fox; Mark Kolterman; and Merv Riepe. Senators absent: None.

SENATOR CAMPBELL: Good afternoon and welcome to the hearing for the Health and Human Services Committee. I'm Kathy Campbell and I serve as Chair of the committee and represent District 25, east Lincoln. This afternoon we're going to do a briefing on the Medicaid program and Director Lynch is here to do that and then we'll proceed with the hearing. So if you're here for the hearings just relax, we will get to you. We'll start with introductions of the senators. And so, Senator, you want to start us off?

SENATOR FOX: Senator Nicole Fox, District 7: downtown and south Omaha.

SENATOR KOLTERMAN: Senator Kolterman, District 24: Seward, York, and Polk Counties.

JOSELYN LUEDTKE: Joselyn Luedtke, committee counsel.

SENATOR CRAWFORD: Good afternoon. Senator Sue Crawford, District 45: eastern Sarpy, Bellevue, and Offutt.

SENATOR RIEPE: I'm Merv Riepe, I represent District 12, which is Millard and Ralston in Douglas County.

ELICE HUBBERT: I'm Elice Hubbert, I'm the committee clerk.

SENATOR CAMPBELL: And, pages, would you like to introduce yourselves?

CAITLIN WELTY: Yeah. I'm Caitlin Welty, I'm from Omaha, Nebraska, and I'm a junior political science student at Nebraska Wesleyan. Jake's out.

SENATOR CAMPBELL: Oh, okay. I keep thinking that he's there. Welcome, Director Lynch, and we appreciate the briefing. We're trying to cover all the divisions and kind of catch up with where you are at, so go right ahead. [BRIEFING]

CALDER LYNCH: (Exhibit 1) Absolutely. Thank you, Senator Campbell and members of the Health and Human Services Committee. My name is Calder Lynch, for the record, C-a-l-d-e-r L-y-n-c-h, and I'm the Director of the Division of Medicaid and Long-Term Care within the Department of Health and Human Services. And thank you for the opportunity to be here today to discuss the Division of Medicaid and some of our activities over the past years and some of our goals for the future. I have a PowerPoint we've prepared to kind of cover at a high level, I think, an overview of what the division does and what we cover just to kind of give a basics. And then, of course, I'm happy to delve deeper into any topic that the committee wishes to explore. First up, just--I think we put this at the beginning of each of our divisions' PowerPoint--an overview of who the department is and what we do to serve Nebraskans. Of course, our mission is to help people live better lives. And that provides our staff with the motivation to really deliver the quality services and help individuals make a difference in their lives and we try to instill that throughout our organization. And our goals, of course, are to be honest, trustworthy, competent, and loyal. And we want to be transparent and accountable to the people of the state as well as to this Legislature. So diving into Medicaid, I think we'll start with just some sort of basic facts around what Medicaid is. Medicaid as a program that was established by Congress and adopted soon thereafter by Nebraska in 1965. It is a federal/state partnership in that it is governed both by the federal regulations as well as individual state plans and regulations and of course is jointly financed. It provides health coverage to needy, low-income children, pregnant women, the elderly, and individuals with disabilities. It's divided really into two authorizing statutes at the federal level, the sort of core Medicaid program, which is covered through Title XIX of the Social Security Act, and then later, the adoption of the Children's Health Insurance Program or CHIP, which is Title XXI of the Social Security Act. In some states these programs are administered almost separately. And in Nebraska we really have merged them and administered them jointly as there are children enrolled both in Title XIX and in Title XXI. And in large ways, the benefits and services and administration of those programs are the same, although there are different matching rates or federal financial participation based on whether an individual is in Title XIX or Title XXI. Today we serve 231,302 Nebraskans as of January 2016; that's our most recent enrollment report. And enrollment over the last couple of years has been relatively flat or declining slightly. We attribute both to a decrease from our spike in enrollment in 2013 when responsibility for eligibility shifted from the Division of Children and Family Services to Medicaid and there was an effort undertaken to kind of go and do a cleanup of the Medicaid rolls. And there was found to be some individuals that had been on that had either left the state or was no longer eligible and so there was a decrease at that point. And since then we've seen enrollment really stay relatively flat. It's also important to remember that for Medicaid programs there are federal requirements in terms of not only who we serve but what we cover. And these programs do vary from state to state, although there are many similarities. Under federal law there are benefits that are both optional and mandatory. Mandatory benefits include examples like in-patient hospital, nursing homes, physician services. Some of those were some basic services that were outlined under federal statute. Over time the federal government has provided

states with the option to expand services to additional categories at their option. And for Nebraska we cover under the optional category, pharmacy services, dental services--particularly for adults--prosthetic devices, etcetera. Although I'll say, too, that in many ways these optional services from a fiscal perspective make a lot of sense to cover like, for example, pharmacy services. Without a pharmacy benefit we'd likely see cost increase for in-patient hospitalizations and emergency room visitations. So those get evaluated individually. In addition to (inaudible), services are also optional in mandatory populations. Under federal law we're required, for example, to cover low-income families, individuals who receive Social Security income, and individuals--like I said--at those certain income levels. We also have optional populations that we cover at the state's choice, which include for Nebraska: pregnant women and women with cancer. And then in terms of how we deliver services to people, we currently deliver healthcare services for the majority of our recipients through a managed care delivery system. And in that regard we currently contract with three health plans for the provision of physical health services and also a separate health plan for the provision of behavioral health services. So today an individual on Nebraska Medicaid who is mandatorily enrolled in managed care chooses one of those three physical health plans for the administration of benefits such as their in-patient hospitalizations, their doctors' visits, home health, etcetera. Everyone is enrolled in the behavioral health managed care plan, which is currently Magellan, and receives their services through them. There are also services that are carved out of managed care, meaning they continue to be administered directly by the state. For example, pharmacy services and long-term care services, like nursing home services or services in the individual's home. Some of that...and then in addition to that there are populations or categories of individuals who are completely excluded from managed care and receive all of their services, with the exception of behavioral health, through the state administered programs. So as you can see, there's a lot of fragmentation in terms of that service delivery model, which is why in January of 2017 we are implementing a program we've called Heritage Health, which will fully integrate behavioral health, physical health, and pharmacy services into our managed care program. So an individual will choose one of those three health plans for the provision of all of those services and no longer have to necessarily navigate those different delivery systems. We still, however, have long-term services and supports carved out and I'll talk in a few minutes about our plans around long-term care redesign. In terms of our division itself, we of course occupy a good deal of the state's financial resources. Our budget for fiscal year '16 is a little over $2 billion. We have 587 full-time employees. The majority of those will actually fall under the operations and analytics team, which is our field operations or eligibility operations. They work in one of our two call centers or in our local offices across the state. So the division is made up in four different units: delivery systems, which I talked a little bit about in terms of administration of our managed care program, our residual legacy program. So the administration of those benefits that we cover directly from the state as well as our home- and community-based waiver programs are administered through that section. We have a new section that was...we formed in the last year, which is called policy and communications. And this is really in an effort to have better consistency in terms of the communications that the

division is putting out to our providers and to our members and to our stakeholders in terms of provider bulletins. We're doing a thorough review of all of our regulatory provisions that guide our programs and making sure that those are consistent and clear in terms of how our providers operate and that we are doing that consistently across all of the different sections of the division. So they really support the entire division. Then we have the operations and analytics team, which includes our field operations, as I mentioned, those customer service centers and field offices; our claims team, which of course continues to pay claims for individuals in the fee for service program through our Legacy systems, and then as well as our systems and technology initiatives. And I'll talk about that more in a second in terms of our vision and our plans to replace some of that antiquated technology that's currently supporting the program. And then finally, another kind of, not necessarily new but reformed section, which is finance and program integrity. And really, we've elevated responsibility to the deputy director level for finance, given just the size of our budget and the relative risk, of course, that we have in terms of waste, fraud, and abuse, and combined those functions with our rate-setting and reimbursement functions, our third-party liability, our recoveries, and all of those financial activities under a deputy director who has a very thorough background in government auditing and she's a CPA as well. So really have a new level of expertise there. We're also recruiting a new finance administrator for the division. In addition to these four sections we also house the State Unit on Aging, which includes federal programs that are administered under the Older Americans Act. And so we have some synergies there in terms of the administration of our long-term care programs, but the director of the State Unit on Aging reports directly to me. And just as a visual of what the division looks like in those four sections. Another key position for us is, of course, our medical director. We have, unfortunately, not yet been successful in recruiting a candidate to that position, although we have now engaged a recruiter to help in that effort and we're hopeful to get somebody in that position. Although I will say, in addition to that position, we have also now entered into an agreement with the Division of Behavioral Health to share some of the time of their chief clinical officer to also serve as the behavioral health medical director for the Medicaid program, recognizing, of course, that there's really no healthcare without behavioral healthcare. And we want to make sure that we're consistent between our two divisions in how we administer those programs and how we view those services. Some of the activities and accomplishments that have occurred over the course of last year and this current year: We did on October 1--you might not have heard about it, which I think is a call for success--was the implementation of ICD-10. That was delayed several times at a national level. This was, of course, the implementation of the new set of codes for billing for healthcare services across the country not just for Medicaid, but all payers and providers. We really did have a very smooth implementation. We were ready. Our systems were ready. We had very few issues in terms of providers' ability to submit those claims to us and our ability to pay those claims. And we conducted a lot of outreach to make sure that that was possible. And so definitely kudos to our team for that successful implementation and I think nationally a smooth process that has been a long time coming. We've heard a lot about the HIPP program, or the Health Insurance Premium Payment program, where the state, when it's cost

effective, will pay an individual's private insurance premium rather than put them on Medicaid, the subject of many past audit findings regarding improper payments. Recently received a letter from the Audit Advisory Committee stating that there had been substantial improvements in that program and they were no longer going to be conducting an audit there. So another area where our team worked really hard to get that program stabilized. We had, I think so far, a successful procurement for the Heritage Health managed care program, which I mentioned earlier. A few weeks ago we announced an intent to award for those three health plans that were chosen from that competitive process. And at this point all the plans have agreed to the terms and conditions of those contracts and we're waiting for the expiration of the protest period and hope to be able to move forward very soon in signing those contracts and beginning implementation activities. Also to support Heritage Health we are in the midst of procuring a new enrollment broker for the program. This is the entity that assists individuals with choosing and enrolling in their health plan. There are new federal requirements proposed that greatly increase CMS's expectations around enrollment broker capability in terms of providing on-line health plan choice selection, outreach to individuals making sure that they are actively engaged in making that important decision about their healthcare. So we have a RFP that closes next week that we've had good interest in so far. So we're excited about onboarding a new enrollment broker ahead of this fall's enrollment period. Something I know this committee has spent a lot of time discussing over the last few years is the replacement of our MMIS system or our Medicaid Management Information System. There's been a few attempts at that that had been unsuccessful in the past. The benefit there, I think, is that we really have a better sense now of where we're going into the future and what our needs are than we did maybe a few years ago. And it really is getting out of the business of paying claims directly but, rather, being a purchaser of services, overseeing these contracts, and making sure that we're delivering high value and good, quality healthcare services. So we've refocused those efforts and are in the midst of procuring or will soon be procuring a data management and analytics platform to support the program. And this will really sit at the center of our program in terms of our data warehouse decision support tools, analytics, staff support for analytics, quality measurement, quality report carding, and program integrity algorithms and analysis to help detect fraud, waste, and abuse. We released a draft of that RFP in January for comment. We did receive comments from ten different entities last week. And we are now taking those comments and moving into the final stages of finalizing that RFP and are planning to release it this spring. We're very excited about that. We're working closely with our federal partners who, of course, are funding 90 percent of that effort. And so they are very supportive of the direction that we are moving with the DMA. In another area of replacing our MMIS capabilities, on December 1 launched a new provider enrollment portal through a contractor, Maximus. That portal is live and it is...we have providers that are enrolling through it today. I will say that that implementation has not been without its challenges and hiccups, I think, as with any new system implementation. But we've been working very closely with Maximus who are increasing their staffing locally, who have been working to update the software to fix some of the technical glitches that were observed. And I think that that process is

now beginning to stabilize. So if you've received any questions or concerns there, I'm happy to address those specifically. But we're working with individual providers who may be having challenges. But we do have lots of success stories in terms of providers that are able to quickly enroll in a matter of days, whereas before it was taking many weeks to get through that process. And, of course, we've heard much testimony and discussion regarding the improvements in our customer service center operations through ACCESSNebraska. We're consistently seeing wait times in Medicaid really even under three minutes lately. And so we are managing that and managing our workflows to make sure we remain under those federal processing time lines. Looking ahead at some of the activities that are coming up, of course we have the implementation of Heritage Health. That will occupy a lot of our time over the next year. As soon as those contracts are finalized we will begin readiness activities, which also include engaging with providers, advocates, and stakeholders in various capacities. We are forming, specifically, a behavioral health integration advisory committee as that service comes into the program with advocates and providers to make sure that's a smooth transition. We're forming a quality committee to help us oversee and determine what those important metrics are that we hold the health plans accountable to. And then of course we'll have very thorough readiness reviews with the plans to make sure they have adequate networks in place, systems in place, and they're able to pay claims and we don't see interruption in either care or cash flow to providers. A few weeks ago we released a concept paper for long-term care redesign. This is a major undertaking for us over the next few years as we look holistically at our long-term care programs, including our waiver services, our institutional services, how we pay, what we pay for, who's eligible, how we determine eligibility, and who those partners are and what roles they play. And really that paper is a catalyst for discussion. It outlines some specific areas and questions for providers and advocates and stakeholders to help give us feedback. And we're also, in the next week, we'll be releasing an RFP for a technical assistance consultant to help guide us through that process and help us organize the engagement with stakeholders and help us research and develop what those best practices reforms will look like so that by the end of this year and beginning of next year we'll have a plan for moving forward with those programs. We're also in the midst of finalizing the requirements for our Medicaid eligibility enrollment system that is expected to implement next spring. We're soon going to be moving into the actual design phase of that project with our vendor. And I think that, while it got off to maybe a bit of a rough start, has certainly stabilized and I think we're seeing good progress there. Another area that we're focusing on this year is review of 30 of our regulatory chapters. I think it's been a number of years since a lot of those were revisited and there's certainly been changes in federal law, there's been changes in the way we administer programs and best practices. So we are working with our policy and communications team as well as our program specialist to do a chapter-by-chapter review and hopefully clarify and simplify many of those regulatory provisions. And we'll actually be sharing those draft chapters with stakeholders prior to moving through the promulgation process to get their feedback in an informal capacity. And I think we're actually about to begin sharing the first draft of the hospital chapters that are the first ones that we've

completed that rewrite on. And then finally, I've already talked a little bit about the Medicaid Management Information System replacement project. In addition to the data management analytics platform, there are other components to support that piece. I'd like to say that we're not really building a new MMIS, we're replacing the functionality of our MMIS through a variety of ways. A big piece of that is of course that data analytics platform. But another piece of it is the ability to pay our health plans so that that scope of work was actually included in our enrollment broker RFP. So that vendor will take responsibility for the monthly payments to the health plans, which is currently something that's handled through our MMIS. Additionally, we know there will be some fee for service claims that we have to pay for some populations that will never be in managed care just by the nature of their eligibility or the services that they receive. So rather than...for that small claim volume, rather than building and owning our own claims system, we actually included as an additional scope of work in our Heritage Health procurement, choosing one of those health plans to take responsibility for processing those claims on an administrative basis for the department so they wouldn't be at risk for those lives or those services like they are their other members. But really we're just leveraging their claims payment capabilities to pay claims based on state rules and state payment methodologies. So based on notice of intent to award we've tentatively selected UnitedHealthcare for that function, but of course we're moving to final contract negotiations and signing there. So with that, I think we've covered a lot of information and I'd be very much happy to answer any questions from the committee. [BRIEFING]

SENATOR CAMPBELL: Questions? Senator Riepe. [BRIEFING]

SENATOR RIEPE: Thank you, Senator Campbell. Director Lynch, thank you very much. [BRIEFING]

CALDER LYNCH: Thank you. [BRIEFING]

SENATOR RIEPE: Thank you for your service. Thanks for being here today. At times...and I've heard this, I'm just trying to...if it's not true I'd like to dispel it. But I've heard oftentimes that Nebraska has a quote unquote rich benefit program in terms of Medicaid compared to other states. I know you're a recent student from the University of Alabama, I believe, and so... [BRIEFING]

CALDER LYNCH: Alabama-Birmingham. [BRIEFING]

SENATOR RIEPE: Oh, Birmingham. [BRIEFING]

CALDER LYNCH: I'm also an LSU grad, so it's an important distinction. [BRIEFING]

SENATOR RIEPE: Oh, yes, yes. And without a football team there in Birmingham, right? [BRIEFING]

CALDER LYNCH: That's right. [BRIEFING]

SENATOR RIEPE: Can you respond to that? Am I off base or is it...just respond if you can, please. [BRIEFING]

CALDER LYNCH: Yes, sir, of course. I think that it is a bit of a mixed bag. No state is exactly the same in terms of what their requirements are. As I mentioned earlier, many of the benefits are federally required. There are also now interpretations about what those requirements are from the federal level that impact what we cover. We do cover, for example, adult dental; and some states do not. But there are certainly benefits to that as well. As we've seen one of the largest drivers sometimes of emergency room visits for adults can be dental caries and extractions and so there's a cost benefit analysis there. I think this is part of why we're doing that regulation review is to look through and make sure that we're adopting best practices in terms of what we cover, what our requirements are. And it's not always what we cover but it's what processes are in place to control and manage utilization, more than anything else, to make sure that we have the proper prior authorizations in place, that we are steering individuals toward lower-cost care opportunities first. And that's some of the reasons that we've made some of the changes we're making with Heritage Health and bringing some of those services into more of a managed environment, because a lot of times what it is, is it's really more of our capability to effectively...or our systems' capability to effectively manage those services to make sure that we're being judicious in the use of taxpayer funds, but we're also delivering quality care. So it's more complex than the benefit package is rich or not because so much of it is federally required. I think it really goes down more to management of the program. [BRIEFING]

SENATOR RIEPE: Okay. Thank you. [BRIEFING]

CALDER LYNCH: Of course. [BRIEFING]

SENATOR CAMPBELL: Senator Howard. [BRIEFING]

SENATOR HOWARD: Thank you, Senator Campbell. Thank you for visiting with us today. I apologize for coming in late. Could you remind me of the time line for the MMIS replacement? [BRIEFING]

CALDER LYNCH: Sure. So we...it's in multiple stages. The biggest piece of it is the data management analytics platform. That RFP we released for draft in January, we got comments back, we're finalizing, it will be releasing in the next couple of months. I don't have the exact time lines in front of me, although I'd be happy to send you a chart. But we're still probably two years away from implementation, full implementation. We'll have the contractor in place by the end of this year, we hope. But then that really begins the work of building those systems and those connections. And our time line is quicker and cheaper than a traditional MMIS replacement and project where we'd be building our own system or contracting with a fiscal intermediary to take over those services. I expect that by 2019 we'll really be able to fully turn off the current system at some point in that year or maybe early 2020, but pieces of it will come offline over time between now and then. For example, by next year we could have the enrollment broker take over capitation payment processing that's currently handled by the MMIS. And as early as 2018, we could have one of our health plans take over fee for service claims payment. So we'll see elements of that system come offline over time as we bring up those additional capacities. That is one area in which we're lucky in that we are a self-administered state and that we run and manage our own MMIS, which is relatively unusual. But the benefit of that is that we're not having to manage a vendor out. [BRIEFING]

SENATOR HOWARD: So we manage it ourselves, we don't have a vendor? [BRIEFING]

CALDER LYNCH: That's correct. [BRIEFING]

SENATOR HOWARD: And then what type of technology are we on? Are we on Xerox or... [BRIEFING]

CALDER LYNCH: Our current MMIS was certified in 1978. [BRIEFING]

SENATOR HOWARD: Okay. [BRIEFING]

CALDER LYNCH: I like to make the joke, we're probably the only state whose MMIS is older than its director. [BRIEFING]

SENATOR HOWARD: Yeah. Awesome. Okay, thank you. [BRIEFING]

SENATOR CAMPBELL: Senator Kolterman. [BRIEFING]

SENATOR KOLTERMAN: Thank you, Senator Campbell. Director, thanks for coming. Couple of questions: As we look at the managed care aspect of this coming January 2017, three companies have been contracted with? [BRIEFING]

CALDER LYNCH: We've announced contract recommendations based on the scoring that was done. The Division (sic) of Administrative Services really handles it from that point forward in terms of making sure that they agree to the terms and conditions, have the necessary insurance requirements, and they actually manage the signing of those contracts. We're still in the period of time where one of the vendors who was not successful could protest that decision and bring forth those concerns to DAS. I think Monday is the last day for that to occur. So at this point, the department and our staff cannot have any direct contact with any of those vendors until the Division of Administrative Services completes that process. [BRIEFING]

SENATOR KOLTERMAN: Okay. And then...can I keep going? [BRIEFING]

SENATOR CAMPBELL: Go ahead. [BRIEFING]

SENATOR KOLTERMAN: Thank you. I have about three questions. Is that okay? [BRIEFING]

SENATOR CAMPBELL: Okay. [BRIEFING]

SENATOR KOLTERMAN: The budget for this year is a little over $2.25 billion. Does that include all the federal monies that are coming in as well? [BRIEFING]

CALDER LYNCH: It does. [BRIEFING]

SENATOR KOLTERMAN: That's not just our state portion? [BRIEFING]

CALDER LYNCH: That's correct, that includes the federal dollars. [BRIEFING]

SENATOR KOLTERMAN: Okay, that was a little disheartening to me. And then tell me more about this broker procurement enrollment process. How does that work? [BRIEFING]

CALDER LYNCH: The enrollment broker is an entity that will have systems and staffing in place to assist members in selecting their managed care plan. So there are a number of vendors that do this across the country and we expect a number of bids on the contract. And then there will be a competitive scoring process based on those responses. But we have an enrollment

broker today, but their capacity and their functionality is limited to basically receiving calls whenever a member decides to call them and let them know who their health plan is. And today that's only about 30 percent. So more than two-thirds of our members are being autoassigned to their health plan, so they're not really engaging in that decision at all. And also they're not really capable in that autoassignment process of considering a member's provider history in terms of making sure that provider is in that health plan's network. So there's a lot of churn that occurs then in terms of members switching health plans. CMS has published rules that are going to require states have more intelligent autoassignment processes in which the vendor has algorithms in place to consider whether an individual's primary care physician or other key providers are in that health plan's network before autoassigning them to it, as well as having more outreach to members to engage them in making that decision. So in the enrollment broker RFP we, for example, put a performance target in place that beginning in the second year of operations at least 80 percent of our members, as they enroll, need to be proactively choosing their health plan. [BRIEFING]

SENATOR KOLTERMAN: So would that then involve helping them choose the right network to look at, as an example? [BRIEFING]

CALDER LYNCH: That's correct. [BRIEFING]

SENATOR KOLTERMAN: So like UnitedHealthcare doesn't have a very strong network in western Nebraska. And then you start looking at Aetna, who's a little better. Centene last I knew had zero networks. So is that going to be the responsible... [BRIEFING]

CALDER LYNCH: So there's really two pieces to that. The first is, even before we let them begin operations we've got to make sure they have an adequate network. And the contracts with the health plans spell that out pretty precisely in terms of how many of different types of providers they have to have in certain geographic areas based on their membership. And so they give us geo-mapping and provider directories and we make sure that they meet those requirements. Now, of course, there can be variances from plan to plan in terms of their network, but they all must meet those minimum standards to have enough providers in their network or we work them on corrective action to get them there. And so then that second piece will of course be the enrollment point in time. The enrollment broker will need to have access to that plan's provider directory, know who's in what network so that when they assign that member or assist that member in choosing a plan they have access to that information. [BRIEFING]

SENATOR KOLTERMAN: Does it work the same way for the...and you haven't awarded dental yet, have you? [BRIEFING]

CALDER LYNCH: No. We're planning to do a separate--I probably should have mentioned that--a separate procurement for a dental manager for the dental program with an RFP being released this summer. [BRIEFING]

SENATOR KOLTERMAN: So will that go online in January as well or... [BRIEFING]

CALDER LYNCH: No, July. [BRIEFING]

SENATOR KOLTERMAN: Okay. And that's not gone out yet? [BRIEFING]

CALDER LYNCH: That has not been released. [BRIEFING]

SENATOR KOLTERMAN: Do you expect that to be one provider or three again? [BRIEFING]

CALDER LYNCH: Given the size of our state and the limited nature of that program, we expect to receive permission from the federal government to have one dental benefit manager rather than having multiple to ensure that it's sustainable. And also, really, there's some additional benefits for the providers in terms of having one portal that they work through for that service. [BRIEFING]

SENATOR KOLTERMAN: And will that be a managed care network as well? [BRIEFING]

CALDER LYNCH: It will be a bit of a different federal authorization. Rather than being a managed care organization it's actually technically called a prepaid ambulatory health plan or a PATH, but it operates similarly in that they're at risk and they're paid a capitated payment. [BRIEFING]

SENATOR KOLTERMAN: Okay. And then one last question about long-term services redesign. How much work has gone into that and where are you at in that process? [BRIEFING]

CALDER LYNCH: Well, I think that some of the work, Senator, really began even before I got here in that there was a lot of engagement and discussion with providers, advocates, and stakeholders about what we would call managed long-term supports and services, which is when those services would be carved into our health plans. And the managed care organizations would take over responsibility for that. There was a concept paper published; it was a time line for an RFP release. In the last year we have taken a step back from that. And I think...we're working with a team in the division and have really assessed to say, there's more work we need to do first

before we take that step or make the decision to take that step to moving those services into managed care in terms of what we actually cover at all, what authorities we cover through, and how we administer those programs before we shift the responsibility to an MCO. So in the concept paper we released, we still state that we believe a managed LTSS environment delivers the best value for the state and for our members, but that we are not at that point of making that decision. We need to work through these other issues first. And that's the point of the concept paper. [BRIEFING]

SENATOR KOLTERMAN: In your past experience have you worked with a managed care in that arena? And if so, was there significant reductions or...what we can't afford to do is reduce the reimbursements considerably. And yet, at the same time, we want to provide a proper quality of care. So do you have past experience in that arena? [BRIEFING]

CALDER LYNCH: Not in implementing a managed long-term supports and services. I was in Louisiana, we were in the formative stages in terms of putting together policy proposals and concept papers. Certainly I've researched the experience of other states. And it's varied in terms of the policy decisions that a state makes. To your point about reimbursement and requirements, you know, those are decisions that we really need to still make and we have not made yet about what the design of that program might look like, that impacts, you know, impacts access and it impacts quality. I think our goal really is to make sure that our programs are more sustainable as we continue to see an aging population, helping individuals...I think a key goal of ours is to live more independently and live in the community for longer, as that's, you know, what's...that's their preference; and, of course, it's more cost effective generally for us, so. And making sure that we have systems that support those objectives. [BRIEFING]

SENATOR KOLTERMAN: And that will take on the same role of having home healthcare, assisted living now and acute healthcare? [BRIEFING]

CALDER LYNCH: So there are different levels of care, of course. And I think part of what we need to look at is to see...what are we covering today and how are individuals entering that system and being referred for services? There's also a significant part, Senator, in terms of the other ancillary supports an individual receives in their community, their ability to...you know, the social determinants, if you will, that impacts their ability to live in the community and receive those services. So I think we need to look holistically at all those different pieces. [BRIEFING]

SENATOR KOLTERMAN: Thank you, Calder. Thank you. [BRIEFING]

SENATOR CAMPBELL: I'm going to interject here. Senator Schumacher, do you have a bill on another committee? [BRIEFING]

SENATOR SCHUMACHER: No. [BRIEFING]

SENATOR CAMPBELL: Oh, okay. Can we take a few more questions before we go to your bill, because we're running behind? [BRIEFING]

SENATOR KOLTERMAN: Thank you, Senator. [BRIEFING]

SENATOR CAMPBELL: I'm going to ask just a follow-up. The Legislature--and this was prior to Director Lynch so he didn't have a part of this--but the Legislature...a bill was introduced by Senator Krist several years ago at the request of a lot of the long-term care facilities in the state saying, slow down, slow down, slow down. And so that caused somewhat of that slow down to take place and now we're coming back to the issue. And I think the program that you've set up, the process here should engage the stakeholders a lot more than what we were seeing. But the Legislature did step in on that one. [BRIEFING]

CALDER LYNCH: You're absolutely right, Senator. There was actually a provision put into law that prohibited the department from releasing that RFP I think until August of last year. So that provision has expired, but we're still not in a rush. We need to do a careful analysis. [BRIEFING]

SENATOR CAMPBELL: Right. And so it's a whole different tenor, but I just thought that would be important for you all to know from a history standpoint. And I just want to...the enrollment broker procurement, if you look in your proposed budgets all the way along in the temporary, that is what, $3 million? [BRIEFING]

CALDER LYNCH: Three point three, I think, million (dollars). [BRIEFING]

SENATOR CAMPBELL: I think so. [BRIEFING]

CALDER LYNCH: And that's total dollars, I believe. And that is...a lot of that's up-front costs for the systems development and we expect the ongoing cost to be less. There's also a little bit of an overlap in that first year with the current enrollment broker and the new enrollment broker, so I expect the ongoing number to be less. [BRIEFING]

SENATOR CAMPBELL: Okay, so when we get all of these new programs in place and the brokers in place and managed care, will we relook at an assignment of those 587 people, because some of them are doing payment now that other people will do? And so how will you adjust the FTEs at that point? [BRIEFING]

CALDER LYNCH: That's an excellent question. In fact, we've already really begun that process. So any position at the central office that becomes vacant is analyzed by myself and the deputy director to determine if it makes sense to fill as-is, if it makes sense to reapportion. We recently...we have a program specialist that's an RN in that unit. As we continue to see a decline in the fee for service we really don't need as many nurses, so we're reclassifying and moving that over to be a contract manager in the health plan section. So some of that realignment is already beginning to take place. You're absolutely right. [BRIEFING]

SENATOR CAMPBELL: Super, that's great. Senator Riepe, I'm going to take your question. I don't want to get too far behind here. [BRIEFING]

SENATOR RIEPE: I'm just going to ask for one question, if I could. [BRIEFING]

SENATOR CAMPBELL: That's an inside joke so everybody can chuckle. [BRIEFING]

SENATOR RIEPE: And your question...mine was the same as yours about can I admire and respect the idea that with technology and everything else going outside and being a contract manager as opposed to an employer oftentimes makes sense. But at the same time, always worrying about what's the staffing level because your cost of the outside contracting and somewhere (inaudible) you just have to be vigilant about that. And thank you for asking that and thank you for allowing me one question. [BRIEFING]

SENATOR CAMPBELL: Absolutely. Senator Crawford, did you want to follow-up? Okay. Thank you, Director Lynch. We may have you back. [BRIEFING]

CALDER LYNCH: I'll be back a little later on one of our bills that we're, that Senator Crawford is offering. [BRIEFING]

SENATOR CAMPBELL: Oh, okay. But we may do another briefing at some point. As you're getting further into some of these contracts it would just be interesting to know how it's going. [BRIEFING]

CALDER LYNCH: Absolutely. I would love to come back. Thank you. [BRIEFING]

SENATOR CAMPBELL: Okay, thank you. All right. That completes our briefing this afternoon and we will move to LB782, Senator Schumacher's bill. And while he's coming forward I just want to remind everybody if you have a cell phone, please make sure it is turned off so it's not annoying to anyone. If you're going to testify today you need to complete one of the orange

sheets on either side. And you come forward and you can give your orange sheet to Elice, the committee clerk. And you'll sit down and we'll ask you to state your name for the record and spell it. And you have five minutes. It'll be green for a very long time and then quickly, like that, it'll go to yellow and then you'll be at red and I'll be trying to get your attention, so. But opening senators have as long as they would like so, Senator Schumacher, start us off today. Your bill is to provide for a Medicaid state plan amendment relating to coverage for family planning services. Go right ahead. [BRIEFING]

SENATOR SCHUMACHER: (Exhibit 1) Thank you, Senator Campbell and members of the Health and Human Services Committee. My name is Paul Schumacher, S-c-h-u-m-a-c-h-e-r, and I represent District 22 in the Legislature. I'm here today to introduce LB782. And if you think this is deja vu, you're right. You've seen this bill once before. It was a bill last year that was discussed somewhat on the floor with very little modifications. In fact, there might be one modification. We ran across a federal law that probably needs to be cited in there yet to make it complete. But basically the same bill as Senator Nordquist had last year. And it was a bill that got lost in the legislative sludge. It was such a good bill, in my opinion, that I don't want it to be forgotten. And what jumped out at me was not any, you know, liberal heart strings, because I don't have very many of those, but the numbers. Last year the fiscal note on Senator Nordquist's bill indicated a savings of $19 million. That got my attention. That's a big number. And it's not a make-believe number, at least it wasn't last year, because neighboring states were seeing similar things. Now let's back up for a second and put this bill in context and why it's worthy of bringing back and talking about, maybe passing, and doing it again next year. And that is because we're going to face a real financial pickle. We're getting hit...and right now it's just the beginning edge of it, but it's going to be intense by the time that the Nicole...Senator Fox is off the Legislature, it will begin to be getting extensive. And so some of you may be pinched by it. I probably won't, Senator Campbell won't, maybe not even Senator Howard, Senator Crawford. But we have got a huge social demand coming onto the system. And we've also got a continuing drumbeat of tax cut, tax cut, tax cut. We've got a whole bunch of baby boomers who, for one reason or another, did not save, could not save, could not get interest on their investments, who now have very little saved and who will, if our medical science keeps progressing, live a very long time. And they will need a social net that will be very expensive. You want to talk about a scary issue, talk about the discussion that might be had 15, 20 years from now is at what point do we cut off medical care? But, fortunately, that's not a discussion for today. We have folks on disability that probably too hard to retrain, probably can't be gotten off disability. And our social welfare net also includes folks who are in the younger category who are born into poverty. And one of the mathematical parts of the definition of poverty is more kids than you can afford. You can have somebody who's got a rather low-paying job who's not in poverty, because they have no kids. Their job pays them enough to float the boat. Add a kid or two and the chart just works out that they drop into poverty at some point, unless their income goes up proportionately. We can do something about that end of the welfare spectrum. And this strikes me as a proven way of trying

to do something about that end of the spectrum. It's also been proven effective in the efforts in the undereducated and Third World country populations as a mechanism to begin to break that cycle of poverty where mom has a child, does not have the adequate appreciation of finances, the adequate appreciation of biology, the adequate appreciation of career potential, and that child goes and does the same thing. We have to do something about that cycle. The thing that we can do is first of all, educate mom, young women, because that's where the evidence seems to be the most effective bang for the buck is. It may be somebody say, well, you're picking on...focusing on young women, that it takes two to tango. Well, realizing how many tangos a guy can have compared to a girl, it may only take about like 1.1 to tango. At any rate, it works. Those things aside, this works. And so the approach would be to deal with some of the reproductive health issues with this Every Woman Matters program to provide good contraceptive counseling, to provide career counseling, to provide financial counseling so that there is less of a probability of another unplanned for, unwanted pregnancy that will just perpetuate this cycle into a period of time that we cannot afford to have it perpetuated and at the same time, dealing with the problem that we already have with children who are showing up on our school steps who do not have the proper training for below age five and who are already here. I'd like to try to just look across a little bigger spectrum. Senator Mello, for example, has a tax credit bill over in Revenue that tries to deal with how do we provide some type of focused effort on bringing those kids that may be in poverty up to speed as we try to work on this side of the equation with this particular bill. Oddly enough, the fiscal notes--at least the way they were last year--are about offsetting. We may be able to solve this problem for no money, the benefit here offsetting against the cost of such a program. Now, I do notice a substantial difference between the fiscal note of profit of $19 million last year and $5.3 million this year. I'm really disturbed by that because it must signal an impending evolutionary crisis. People must have stopped having sex. There's no other logical explanation for the deviation in a period of one year. And I think that's a number that's going to have to be examined. Either that or Senator Nordquist was a whole lot better at negotiating numbers than I am. But I just saw this earlier today for the first time and so the disparity there, of course, lacks credibility. And I think, on a serious note, such disparity suggests that our fiscal process may be becoming politicized way too much. So this is the proposal that I bring. I think it is worthy because it works. It is our obligation to find things that work. If we don't try to do that at this level of the game, we will find we have to do things far more painful later on. We're running out of time to start acting responsibly toward this tsunami of social need that we're going to be facing as the baby boomers age and as our society has less and less resources to deal with things like preschool education and less and less resources to be able to do the things that are required to maintain a standard of living something better than Third World countries. With that, I'm open for any questions. [LB782]

SENATOR CAMPBELL: Questions, Senators? Information? Senator Howard. [LB782]

SENATOR HOWARD: Thank you, Senator Campbell. Thank you, Senator Schumacher. I just have a few points of clarification. Family planning services are already covered in our Medicaid program, correct? [LB782]

SENATOR SCHUMACHER: Some are, yes. [LB782]

SENATOR HOWARD: Okay. And then for this specifically, our matching rate would be a 90 percent, 10 percent matching rate? [LB782]

SENATOR SCHUMACHER: It's my understanding that that's what this bill enables, to get this to a 90 percent, 10 percent for the family planning and contraceptive services. [LB782]

SENATOR HOWARD: Okay. And our current matching rate is like 56 percent? [LB782]

SENATOR SCHUMACHER: Right. We're not a pioneer in this field. As usual, we are behind the curve. Other folks have done it. Other folks have seen some of the benefits of a program like this. [LB782]

SENATOR HOWARD: And my understanding was that the state of Nebraska already pays for about 51 percent of the live births in the state every year. Is that your understanding as well? [LB782]

SENATOR SCHUMACHER: Yes. And, in fact, I'll have to tell you this, some of the discussions you always hear where people are complaining about welfare end with the line, give them the pill or pay the bill. And there's certain truth in that. [LB782]

SENATOR HOWARD: And so your bill just increases the eligibility level up to 185 percent of the federal poverty level. [LB782]

SENATOR SCHUMACHER: That's correct. [LB782]

SENATOR HOWARD: And then this state plan amendment, because we've been having some conversations about waivers and state plan amendments and waivers needing $1.2 million of a contractor to write them, this state plan amendment is just a check box. Correct? [LB782]

SENATOR SCHUMACHER: As I understand it. [LB782]

SENATOR HOWARD: Okay. Thank you. [LB782]

SENATOR SCHUMACHER: You probably understand that far better than I do, Senator. [LB782]

SENATOR HOWARD: I just want to get it into the record. Thank you, Senator. [LB782]

SENATOR SCHUMACHER: I figured that's what you were doing. [LB782]

SENATOR CAMPBELL: Senator Kolterman. [LB782]

SENATOR KOLTERMAN: Thank you, Senator Campbell. Senator Schumacher, I just had a couple of questions about the qualifications of this bill. On page 4 it talks about the 185 percent of the federal poverty level is permitted. Why are they going so high on this, because these services are covered under the Affordable Care Act at anywhere from 100 percent up. [LB782]

SENATOR SCHUMACHER: This is, I think, the pattern that has been used in other states. I think we can get additional federal money by doing it this way rather than under the method of the exchange. [LB782]

SENATOR KOLTERMAN: But aren't we really duplicating efforts? [LB782]

SENATOR SCHUMACHER: Well, not really. I mean, to the extent we're able to generate a positive impact on this, I don't think we're duplicating because we're already doing the others. [LB782]

SENATOR KOLTERMAN: Yeah, that's my point. We're already covering most of this under the Affordable Care Act. [LB782]

SENATOR SCHUMACHER: I don't think so. [LB782]

SENATOR HOWARD: You mean on the private exchange? [LB782]

SENATOR KOLTERMAN: Yeah. [LB782]

SENATOR HOWARD: These are folks who would be most likely falling into the gap. [LB782]

SENATOR KOLTERMAN: But not at 185 percent. [LB782]

SENATOR HOWARD: Well, 185 percent is required by the state plan amendment in order to get the 90 percent, 10 percent match to pay for it. [LB782]

SENATOR KOLTERMAN: Well, my point is, the federal program, the Affordable Care Act, provides if you're eligible at 100 percent of poverty you can apply for the Affordable Care Act and get these benefits. [LB782]

SENATOR SCHUMACHER: You have to buy a policy. [LB782]

SENATOR KOLTERMAN: Absolutely. You do have to buy a policy. [LB782]

SENATOR SCHUMACHER: That's not my understanding, Senator. And I'd have to check and make sure. [LB782]

SENATOR KOLTERMAN: If you buy a policy under the Affordable Care Act, these benefits are covered. [LB782]

SENATOR CAMPBELL: A testifier behind you might be able to clear that up. [LB782]

SENATOR SCHUMACHER: Yeah. I think I'm probably not the expert you need on that one, Senator Kolterman. Yeah. [LB782]

SENATOR KOLTERMAN: Okay. I'm just seeing a duplication here and that's why I'm wondering the necessity. For 100 percent less, I understand that. [LB782]

SENATOR CAMPBELL: Okay, we're coming around here. Senator Riepe. [LB782]

SENATOR RIEPE: Thank you, Senator Campbell. When I look at this, it looks like under any other...a rose is a rose, it looks like this is Medicaid expansion under the ACA. And with that, I would remind that I opposed this bill last year and was severely reprimanded on the floor for using dynamic forecasting; and obviously this includes dynamic forecasting. So maybe it's different at the committee level than it is on the Chamber floor. The other question that I have, too, is what are the ranges that we're talking about? If we're talking about childbearing ages, a 12-year-old can bear a child. I mean, are there age limitations on this? [LB782]

SENATOR SCHUMACHER: The statistics that I looked at in trying to verify this show that we're generally talking about women in the 15-44 age category. [LB782]

SENATOR RIEPE: Okay. [LB782]

SENATOR SCHUMACHER: That's not to say that this couldn't help somebody at age 14. After all, there are all kind of biblical figures had kids at 14. [LB782]

SENATOR RIEPE: Also I wanted to ask about, on page 4 there's a new section that talks about educational parenting, educational services. I mean, it appears that we move more and more towards full responsibility for raising the children. Is this a move towards we set up communes and...I mean, if we're going to take care of everything, that's... [LB782]

SENATOR SCHUMACHER: It's hopefully a move in the other direction because what ends up happening if we can get folks properly educated, proper appreciation for finances, and for some career aspirations, they will become independent, not dependent on the commune, independently able to support themselves and their families, have families that they responsibly can be taking care of, and maybe we can turn the clock back on the commune progression of society. Whatever we've been doing up to this point ain't been working. And this is an indication that something could work that says to a person, look, you've got to be responsible. And that's my kind of conservative twist adding into this bill is that, look it, you can't just throw money at the situation and say, here's a pill. You've got to also appeal to the positive side of people and saying, look, and not only this, you could have a better life. And we're going to help you with the tools to have a better life and be independent and more like people that we maybe would like to have society look like. [LB782]

SENATOR RIEPE: Thank you. [LB782]

SENATOR CAMPBELL: Any other questions? Senator Crawford. [LB782]

SENATOR CRAWFORD: Thank you, Chairwoman Campbell, and thank you, Senator Schumacher. Just to clarify, because you showed us the two fiscal notes between the two bills, is it your understanding that the bill that you have introduced does the same things that LB77 did? [LB782]

SENATOR SCHUMACHER: As Senator Riepe just pointed out, the only material difference is the additional language saying, look, we want to teach you financial and career responsibility as part of this. It's an essential element I think. [LB782]

SENATOR CRAWFORD: Okay, thank you. [LB782]

SENATOR CAMPBELL: Any other questions, Senators? Senator Schumacher, we'll go over the two fiscal notes but just while everybody is talking, the number last year was serving 27,000 and this--the new fiscal note--is 17,000. And last year the cost was estimated at $252 I think and this one is $143. So we'll do some comparison. [LB782]

SENATOR SCHUMACHER: It's because government got more efficient. [LB782]

SENATOR CAMPBELL: I guess so, but in any case we'll take a look at it and see what the difference is between the two. But just looking at some of the numbers or number served would be sort of helpful I suppose, because there is also a difference between what the department submitted last year versus what the department submitted this year. [LB782]

SENATOR SCHUMACHER: And they may have been busy working on a much bigger project to come up with the cost of Medicaid expansion or something that they got diverted. [LB782]

SENATOR CAMPBELL: I don't have any comment on that, Senator Schumacher. All right, any other questions? Will you be staying to close? [LB782]

SENATOR SCHUMACHER: I might stay for a while. We don't have that many taxes to cut in Revenue today, so I might stick around and listen to this because this is a worthy thing. [LB782]

SENATOR CAMPBELL: All we've heard is how many bills Revenue has, so I just thought maybe you had a jam packed... [LB782]

SENATOR SCHUMACHER: By the time we're through this year, Senator, there's not going to be any taxes left. Thank you. [LB782]

SENATOR CAMPBELL: Okay. I'm counting on that. [LB782]

SENATOR SCHUMACHER: All right. [LB782]

SENATOR CAMPBELL: All right. We'll open up for the first proponent. Good afternoon. [LB782]

MOLLY McCLEERY: (Exhibit 2) Good afternoon, Chairman Campbell, members of the committee. My name is Molly McCleery, M-o-l-l-y M-c-C-l-e-e-r-y, and I'm a staff attorney in the healthcare access program at Nebraska Appleseed. Nebraska Appleseed is a nonprofit, legal advocacy organization that fights for justice and opportunity for all Nebraskans. And I'm here today to testify in support of LB782. A couple of questions that were brought up during the introduction I think I can, hopefully, shed some light on. In terms of...this is a state option that has existed since the mid-90s. It was a much more complicated process; states had to go through a waiver process. But the 90 percent, 10 percent match and allowing for states to cover this somewhat outside of their traditional Medicaid program has existed for quite some time now. To incentivize states to take it up, due to a number of the positive benefits that Senator Schumacher mentioned, there is that 90 percent, 10 percent match, but also it's a state plan amendment now that you can do versus a waiver. So it is just that check box. So this would provide coverage for just family planning benefits for those who are ineligible for Medicaid up to a 185 percent of federal poverty level. One hundred eight-five percent is our pregnant woman eligibility threshold, so a lot of times states will set the family planning level up to their Medicaid eligibility level for pregnant women since they sort of work together in terms of preventing people from becoming eligible at that threshold. There is somewhat of a duplication, as you mentioned. But since this was an option that existed prior to the Affordable Care Act we do see some of what you're saying with that duplication. It would cover primarily, to Senator Riepe's question as to who would be covered under the bill, it would be primarily those who are ineligible for Medicaid as adults. Since children are eligible for CHIP at 200 percent of the federal poverty level and down, they would be eligible under CHIP. This would be adults ages 19 to 64 essentially. To echo Senator Schumacher's point, LB782's state plan amendment aligns itself well with a number of priorities that the Legislature is looking at this session. It works well with work being conducted by the Intergenerational Poverty Task Force as well as the ongoing focus on ensuring high quality early childhood experiences for children in our state. I mentioned in my written testimony that some of our communities have very high, increasing rates of sexually transmitted infections, predominantly Douglas and Lancaster County. Those are at an all-time high in Douglas County. The services provided under this, not only some of the contraceptives but also the contact with a family planning provider, could help address some of these issues that our communities are facing. The state plan amendment, I know there's been much discussion about the fiscal note already. In my written testimony I cite some national statistics and estimates of cost savings that the Fiscal Office as well as the department cited in their fiscal notes as well. It's generally estimated to be that for every $1 of publicly funded family planning services there is a savings of $4, which makes sense when you think about the point that Senator Howard brought up. If we have 51 percent of births being covered by Medicaid, if you can prevent some of those costs through doing preventive measures on the front end, that can lead to cost savings. Finally, the Every Woman Matters program isn't a program that we talk about a lot, but it does very good work in our communities. For women ages 40 to 74 it can provide crucial services that are essential to women being able to live long and healthy

lives. These are preventive screenings for illnesses like heart conditions, breast and cervical cancer screenings, and things like that that are necessary that women have access to preventive services for. So with that, we would respectfully request the committee's support of LB782. And I can be happy to answer any questions at this time. [LB782]

SENATOR CAMPBELL: Let's go to...Ms. McCleery, if you would address Senator Kolterman's question with regard to, is this covered in the ACA? Is this a duplication? [LB782]

MOLLY McCLEERY: So under the ACA, preventive services is an essential health benefit in private plans. So any marketplace plan that you buy has to cover preventive services. And contraceptives and family planning are considered a preventive service. So... [LB782]

SENATOR KOLTERMAN: Zero deductible. [LB782]

MOLLY McCLEERY: Right. Yeah. So that if you go for a well-woman check, if you get a prescription through your provider it should be zero cost sharing for the individual. So it is covered but this is, like I mentioned, not an option that came from the Affordable Care Act, it was in existence prior to that. [LB782]

SENATOR KOLTERMAN: Okay. I have another question. [LB782]

SENATOR CAMPBELL: Sure. [LB782]

SENATOR KOLTERMAN: Ms. McCleery, thank you for coming. You mentioned just before you closed something about young children quality healthcare. Would you expand on that a little bit for me? [LB782]

MOLLY McCLEERY: So I think every year for the last several years we've seen a number of bills, and Senator Schumacher mentioned this as well, that we're talking about high quality early childhood education, making sure that children are ready to go to school and ready to participate in their communities and having good early life experiences so that they are healthy and productive adults. And so if we can work on addressing the number of children born into poverty we can...that is, addressing that on the front end rather than coming in after those children are sort of already in our communities. [LB782]

SENATOR KOLTERMAN: And you think this bill will do that? [LB782]

MOLLY McCLEERY: I think that if you're under 185 percent of the federal poverty level, you're low income. You don't have a lot of income and so you...I'm trying to think of how to say this in a way that makes sense. But if you have the option to control the number of children that you have at a level that is financially best for your family and make sure that those children are well provided for, I think that this bill would go a long way towards making sure that women have those services that they need to do that. [LB782]

SENATOR KOLTERMAN: Okay. [LB782]

SENATOR CAMPBELL: Other questions? Senator Riepe. [LB782]

SENATOR RIEPE: Thank you, Senator Campbell. Thank you for being here. You talked a little bit about sexually transmitted diseases in Douglas and Lancaster County. My question would be is, I know it's been an ongoing problem in Douglas County for a very long time, almost at the top of the charts in the country, which is obviously not a bragging point. Have there been over those years--and I don't know how many years it's been high--but it's been more than just... [LB782]

MOLLY McCLEERY: Several, yes. [LB782]

SENATOR RIEPE: Yes, several. Is any progress being made or... [LB782]

MOLLY McCLEERY: The last data that I saw when I was looking at this was from 2015 and I think I cite to this article on the first footnote. It's from February 2015 and it's Douglas County chlamydia rates are at an all-time high. So it seems like it's not getting any better, from what I have read. I do know that there are a number of different community efforts being engaged in by nonprofits and local organizations to try to address some of these things. But I think that this would help towards that as well. [LB782]

SENATOR RIEPE: It's fair to say then those programs are falling short, the ones that are in place I mean, if it's continuing to grow? [LB782]

MOLLY McCLEERY: I think it's a big problem and it's not an easy problem to solve. I think that there are a lot of factors at play. And some of them were mentioned in the senator's opening. Kind of thinking through, there's economics, there is where you live in the community, your access to care, there are all sorts of different things that play into the choices that folks can make. [LB782]

SENATOR RIEPE: I hate to be too much of a downer, but if we're not being successful there, will we be successful with this particular clause that puts us into the parenting education business of this? I don't mean to sound hopeless, I just think it's a huge problem and I don't know how to...if it had been easy to solve it would have been solved. And it's not just a Nebraska problem, it's a national problem. [LB782]

MOLLY McCLEERY: I have talked to several advocates around women's health issues, especially for low-income women. And one point that continually comes up is that the primary access point of low-income women to the healthcare system is for women's health issues or for contraceptives or family planning services. So they might not get their ongoing preventive care, but they will go get their well-woman check yearly or they will go get mammograms or things like that. And so if we can sort of open the doors to more low-income people being able to access those types of services, I think that does a lot in ensuring that they have access to the whole system, kind of the whole healthcare picture. And I think when we talk about financial things like that, part of providing birth control or providing family planning services is that counseling aspect. I would say that, as Senator Kolterman mentioned, this is under the Affordable Care Act as an EHB. Counseling is also considered part of the preventive service--and that is similar in Medicaid--is that when you go in and meet with your doctor they counsel you on your options, both from a health perspective but also is this going to be cost effective for your family. What's sort of the best option for you? So I think that that language really goes well with what doctors are probably already engaging in somewhat. [LB782]

SENATOR RIEPE: Excuse me, but many of these people have no skin in the game and so there is no option about what it's going to cost you, it's just a matter of can you get them to show up and then what are you going to do? [LB782]

MOLLY McCLEERY: Well, there might not be financial skin in the game in terms of if you're not...if it's Medicaid versus private insurance, that looks different. However, I would say that determining the number of children in your family or addressing sexual health issues or reproductive health issues can have a significant financial impact on your family if you're not dealing with them in a preventive way. [LB782]

SENATOR RIEPE: Thank you very much. Thank you, Chairman. [LB782]

SENATOR CAMPBELL: Just a quick comment. I'd be very remiss if I did not acknowledge the work of former State Senator Brenda Council on the STD issue in Omaha. And at the Children's Summit last December, I mean they're doing so much to try to reach a population that probably doesn't read newspapers or the typical ways that you would get information. And quite honestly, Senator Council's report was very encouraging about the access to it. Another part of this issue is

the importance of being able to sit down with a husband and a wife and not at an immediate point, but to begin looking at how many children would you like and the spacing of those children and how important that the spacing can be. Research tells us that if you have children too close together what that means for the health of the mother. And thinking ahead, thinking into the future, it seems to me that that's a part of what we could help here. And this is really like families, it isn't just women that need... [LB782]

MOLLY McCLEERY: Right. I'm sorry, I didn't mean to interrupt you. [LB782]

SENATOR CAMPBELL: Oh, that's all right. Go right ahead, Molly. [LB782]

MOLLY McCLEERY: I was pleased to see that the fiscal note did mention that this is eligible or eligible for...men and women would be eligible for this program. So I think that ties really well with what you were saying, that it's both the husband and wife can go and sit down together or a man can go in and talk about his family planning options with his provider as well, so. [LB782]

SENATOR CAMPBELL: Right. Senator Riepe. [LB782]

SENATOR RIEPE: I'll be quick. Talking about early intervention and I know the Omaha Public Schools is up to their ears in appropriate or inappropriate sex education. It would seem that, I don't know where, but they have some role to play in this or they're doing something. I'm just trying to figure out how do we put that all together if we do it. I don't know what OPS is doing. I haven't followed that. [LB782]

MOLLY McCLEERY: I'm not sure in relation to this. I know that there has been changes in terms of what the curriculum is for teaching sexual education, but I'm not sure how this could tie into that. I do think that in addressing--if we're looking at what Senator Campbell was mentioning in terms of taking a more family approach to family planning counseling--if we can go in there, and parents become more educated about what their options are, that we see that children end up having more understanding of what those options are as well. So I think it can really be a good kind of two-generational strategy. [LB782]

SENATOR CAMPBELL: Anything else, Senators? Thank you, Ms. McCleery. [LB782]

MOLLY McCLEERY: Thanks. [LB782]

SENATOR CAMPBELL: Our next proponent. Anyone else? Okay. Those in opposition to the bill. [LB782]

TERESA KENNEY: I have one copy of my testimony but it certainly can be accessed. [LB782]

SENATOR CAMPBELL: Okay, that's fine. Good afternoon. [LB782]

TERESA KENNEY: (Exhibit 3) Good afternoon. My name is Teresa Kenney and I'm here representing... [LB782]

SENATOR CAMPBELL: Could you spell that name? [LB782]

TERESA KENNEY: Yes. [LB782]

SENATOR CAMPBELL: Thank you. [LB782]

TERESA KENNEY: Teresa is T-e-r-e-s-a, Kenney is K-e-n-n-e-y,... [LB782]

SENATOR CAMPBELL: Thank you. [LB782]

TERESA KENNEY: ...here representing myself as a healthcare provider. I am a woman's health nurse practitioner, I've been in practice for 15 years providing healthcare to women of all ages, spoken to hundreds and hundreds of women over the years regarding their healthcare desires and needs. First I'd like to say that the Every Woman Matters portion of LB782, I'm not opposed to. I am currently a provider for Every Woman Matters. It's my opinion, though, that the greater access to certain family planning services or contraceptive services are not in the best interest of women and their families. It has been the hypothesis for years that greater access to contraceptives improves outcomes for unplanned pregnancy and abortion rates. After birth control began to flood the U.S. market in the 1960s and after the 1970 passage of the federal Title X program providing large-scale contraception handouts and after the legalization of abortion in 1973 we have seen all rates of problematic outcomes shoot up instead of decline. In Nebraska, according to the PRAMS report, which is a Pregnancy Risk Assessment Monitoring System, the rate of unintended pregnancy in Nebraska averaged 40.5 percent during the years 2000 and 2003. PRAMS also reported that 48 percent of those women who became pregnant were using a method of contraception when they became pregnant with an unintended pregnancy. Studies show that there has not been a robust or consistent reduction in rates of unintended pregnancy in states with Medicaid family planning demonstrations. And in some states some rates have even increased. Research has consistently shown that the rates of unwed childbearing go up as well as abortion rates, which has led to over 57 million abortions in our country since 1973--which I think we would all agree is not a positive outcome--which is why the Guttmacher Institute reports that 50 percent of pregnancies continue to be unintended and

half of those pregnancies end in abortion. And they also report that 54 percent of women were using a contraceptive in the month that they conceived. And they stated, imperfect use as a method of being the most common reason they felt they became pregnant. Adolescents are largest group of individuals who are noncompliant users of contraceptives and if you have a teenager, of course, this would be no surprise. In the first 12 months of contraceptive use 16.4 percent of teenagers will become pregnant. If the teen is cohabitating the pregnancy rate will go up to 47 percent. And among low-income cohabitating teens the failure rate is 48.4 percent for birth control pills and 71.7 percent for condoms. I'm especially concerned about unmarried adolescents and young adults who are given a false sense of safety when given access to contraceptives. In my opinion, the starting point should always be abstinence is the only 100 percent safe sexual health. If you take other adolescent risk behaviors such as smoking or drugs, you can see that the message over the years has been different. We have used messages like, don't do drugs or smoking kills. You wouldn't take an adolescent and set them down and say, do drugs safely or if you smoke, use a filter. In 1980, the U.S. Surgeon General's report reported that smoking was extremely unhealthy and could kill. Over the last years and up until 2012 there's been a 42 percent reduction in smoking for women and 25 percent for men. So those messages send a clear message to people and it can change the way our culture's behaviors are. So with sex I don't understand why we expect less when the health impact is so significant. I've witnessed the negative health impact of hormonal contraceptives in women's health over my years of practice and have heard woman after woman state that they were never told about these hormonal risks to the medicines that they were taking. And if they would have known about the risk they would have not taken them. Physicians and other healthcare providers have a duty to explain all the relevant risks to contraceptive use. Dr. Peck and Dr. Norris who have studied risks of oral contraceptives in detail state that: Oral contraceptive pills fail the most important test of preventive medicine. They increase the risk of disease. First and foremost, oral contraceptive pills are classified as a Group 1 carcinogen. This means they have a known carcinogen risk to humans, most notably the risk of breast, liver, and cervical cancer. Oral contraceptive pills increase the risk of HPV which leads to cervical cancer. One of the most well known and devastating side effects of hormonal contraception is cardiovascular. This includes: DVTs, which are peripheral blood clots; pulmonary embolisms, which is a blood clot in the lungs; myocardial infarction, which is a heart attack; and strokes. The risk of blood clots are three to six times that of nonusers and depends on the contraceptive. It is well known that a severe blood clot can lead to a pulmonary emboli, which can be fatal. Research suggests that oral contraceptives are associated with a significant risk for breast cancer. A recent meta-analysis from the Mayo Clinic looked closely at the data and demonstrated over a 50 percent increase for women who use oral contraceptives four or more years before their first full-term pregnancy. I believe that women deserve better. They deserve access to family planning that is not only effective, but does not increase their risk of disease. They should fully understand their risks of hormone contraceptives. They should be provided alternatives such as natural fertility regulation methods that are backed by research and are as effective as all hormonal birth control. This is the type of care I believe we

need for women in this state and I'm opposed to the bill, LB782, for that reason. Thank you for your time and I'll take any questions. [LB782]

SENATOR CAMPBELL: Thank you, Ms. Kenney. Questions, Senators? Any questions? Ms. Kenney, I know you've testified before and I'm sorry I don't remember, but do you practice on your own? Are you with a clinic? [LB782]

TERESA KENNEY: Yes, I practice for two different clinics, actually. [LB782]

SENATOR CAMPBELL: Oh, okay. [LB782]

TERESA KENNEY: I practice for a family practice office and an OB-GYN clinic. [LB782]

SENATOR CAMPBELL: I couldn't remember and I thought, I'm just going to ask her because I know she's testified in front of us before. Thank you. [LB782]

TERESA KENNEY: Thank you. [LB782]

SENATOR CAMPBELL: Any other questions, Senators? Thank you for coming today. [LB782]

TERESA KENNEY: Thank you. [LB782]

SENATOR CAMPBELL: Our next opponent. Good afternoon. [LB782]

KATHLEEN McGLYNN: Good afternoon. My name is Dr. Kathleen McGlynn, I'm an obstetrician/gynecologist in Omaha. I received my medical... [LB782]

SENATOR CAMPBELL: I'm sorry. You will have to spell your name for us. [LB782]

KATHLEEN McGLYNN: Oh, I'm sorry, spell it. Yeah. K-a-t-h-l-e-e-n M-c-G-l-y-n-n. I received my medical degree from Florida State University and underwent my OB-GYN residency training in St. Louis, Missouri. I'm currently practicing in Omaha, Nebraska, in obstetrics and gynecology with a particular interest in infertility. I'm operating mostly at Creighton University Medical Center. I'm here to testify in opposition to the portion of LB782 that would expand contraceptive coverage, because I believe there are significant risks to women. I also want to make clear that I support the Every Woman Matters program. Time and time again I've been surprised how many women tell me that they've never been told of the risks of the medication

that they're on, the hormonal birth control. And once we go over the risks, benefits, alternatives, they feel uncomfortable with the risks and end up wanting to change. I know that it's our duty as physicians to provide informed consent for all medications and medical procedures for our patients so that patients can make fully educated and informed decisions. And I want to help to fully inform you today, as you'll be making decisions for people in this state. Some of the main risks I want to review are: cardiovascular risks, the increased cancer risk, increased risk of STDs, and the risk associated with IUDs, intrauterine devices. Ms. Kenney already reviewed a lot of the cardiovascular and cancer risks, so I'm not going to repeat everything that she said. But the cardiovascular risks in general, like she said, are the DVTs or the blood clots in the legs; pulmonary emboli, blood clots to the lungs; heart attacks; and strokes. And then the cancer risks are breast cancer, cervical cancer, and liver cancer. So to move on to the sexually transmitted infections, as we were discussing earlier, chlamydia rates are at an all-time high in parts of Nebraska, including Douglas County. It also increases in rates of gonorrhea and syphilis as well. While using hormonal contraceptives women are at increased risk of contracting sexually transmitted infections. Contraception leads to riskier sexual behavior, more exposure to STIs, and it does not prevent against transmission. In addition, the hormonal contraceptives thin the lining of the uterus and contraceptives decrease the function of women's immune systems. So STIs are also easier to contract in addition to all those things. There are several health implications for women resulting from this including: possibility of pelvic infections that can lead to sepsis; development of chronic pelvic pain; formation of adhesions and scar tissue that could block the ability to become pregnant in the future. In dealing with infertility patients on a daily basis I see the effects of prior infection with sexually transmitted infections. I've seen prior infections with chlamydia that have led to blocked tubes on both sides and these infections happened many years previously, but now the patient desires pregnancy and is unable to achieve it. If it is surgically treatable, which is not guaranteed, it exposes a woman to the expense and the risk of surgery. And as a final topic I wanted to discuss the risks of long-acting reversible contraceptives or LARCs, such as the intrauterine device or the IUD. There's been a push to increase access to this method of contraception recently because they can stay in place for long periods of time, like five years. So the thought is that it would increase cost savings. And also compliance is supposedly better because the patients don't have to rely on taking a pill at the same time every day. However, it carries risks of its own. So placement of the IUD itself can lead to perforation of the uterus and the device itself can end up embedded somewhere in the abdomen. In residency I saw many cases of IUD perforations and took them out of several areas that they did not belong. This can cause pain, scar tissue, and adhesion formation and in extreme cases can lead to bowel perforation, infection, and sepsis. There is an increased risk of pelvic inflammatory disease that's highest in the first initial period after insertion at a rate of 3.5 percent. Even if a patient can afford an IUD and it's placed, many of them request early removal due to side effects. The clinical trials reported by the IUD company stated that 31.9 percent of patients experience unscheduled bleeding; 22.6 percent experience abdominal or pelvic pain; 16 percent experience migraine headaches; and 6.4 percent experience depression and depressive

moods. Patients with these side effects often request early removal and feel better after the device is removed. And then if it's early, then the projected cost savings is eliminated because the patient will need something else. And then also, IUDs do not contain estrogen so they do not inhibit ovulation, which means that break-through pregnancies can occur. The problem with this is, if pregnancies do occur, up to 50 percent of them result in an ectopic pregnancy, which if unrecognized can lead to a surgical emergency and increase morbidity for the woman. Secondly, because the lining of the uterus is thin due to the medication, it can cause spontaneous abortions because the embryo is unable to implant in the lining of the uterus. So the woman may not even know that she was pregnant and the embryo passes through. So in conclusion, hormonal contraceptives should not be considered part of preventive care in my opinion, as they seek to alter a normal and healthily functioning woman and carry serious risks of their own. For this reason, I oppose the expansion of the family planning coverage contained in this bill. Thank you very much. [LB782]

SENATOR CAMPBELL: Thank you, Dr. McGlynn. Questions, Senators? Senator Riepe. [LB782]

SENATOR RIEPE: Thank you, Senator Campbell. Are you on the staff of the John Paul Institute? [LB782]

KATHLEEN McGLYNN: The Pope Paul VI Institute. [LB782]

SENATOR RIEPE: Oh, the Pope Paul VI. I'm sorry. I get my popes mixed up there. [LB782]

KATHLEEN McGLYNN: Yes, sir. [LB782]

SENATOR RIEPE: I thought maybe coming from out of town that that brought you to Omaha. [LB782]

KATHLEEN McGLYNN: That's correct. [LB782]

SENATOR RIEPE: I guess at the same time we have this terrible problem and short of abstinence, trying to figure out what we can do. [LB782]

KATHLEEN McGLYNN: It's true, it's a big problem. [LB782]

SENATOR RIEPE: Maybe you can help us out particularly on lower socioeconomic situations. [LB782]

KATHLEEN McGLYNN: I think that one thing that hasn't been explored in dealing with this problem is teaching women about their fertility, even in the low socioeconomic population and the adolescent patients, because...and I've dealt with some people in that position and I'm surprised how open they are and how excited they are to learn about their own bodies. And they feel empowered and they are able to learn, based on biomarkers, when they're fertile, when they're infertile. And so we do...I do purport abstinence, but I think that it can be really empowering for women of all ages to learn about their body. And I think that's something that would be worth exploring. [LB782]

SENATOR RIEPE: What would be the start age? You said all ages, but. [LB782]

KATHLEEN McGLYNN: Start...menarche, so the start of their first period they would start charting and learning the signs to identify. [LB782]

SENATOR RIEPE: Okay. Okay. Thank you for being here. [LB782]

KATHLEEN McGLYNN: Thank you. [LB782]

SENATOR CAMPBELL: Any questions? Okay. Thank you, Doctor, for coming today. Our next opponent. Good afternoon. [LB782]

MARIS BENTLEY: (Exhibit 4) Thank you. My name is Maris Bentley, Ma-r-i-s B-e-n-t-l-e-y, and I reside in Omaha, Nebraska. I am on the board of directors of Nebraskans United for Life and am here as a representative of that organization to testify against the contraceptive portion of LB782. Nebraskans United for Life has been protecting women and unborn babies since the 1970s and we have thousands of members throughout the state of Nebraska. The expansion of Medicaid funding for contraception for women will not help women. It will actually hurt women. Now, no doubt, there's many of you and many in the world that believe that contraception is a good, a wonderful scientific advancement for humankind. Right? Well, I challenge you to listen to the testimonies of women such as myself. I challenge you to think beyond the little narrow box of conventional wisdom. I challenge you to look at contraception through the big picture of human history and especially at the trends in recent history that show that as oral contraception, the pill, was first introduced in the 1950s and began over the decades to gain widespread use, the incidence of harmful behaviors such as promiscuity, adultery, cohabitation, divorce, and abortion also began to increase. Kind of paraphrasing what Senator

Schumacher said, contraception is what we've been doing and it ain't been working. I have personally lived and seen the great harmfulness of contraception, not only in my own life but also in the lives of many women who have been family members, friends, and those young women whom I have worked with over the years. I am a wife. My husband and I have been married for 39 years. I'm a mother of four and grandmother of nine. And I'm a retired K-12 school counselor. I graduated from high school during the height of the sexual revolution in 1974, a year after the legalization of abortion. Even at 17 years of age I knew that abortion was murder. After all, when a woman is pregnant it's a baby. Right? But for many years I bought into the lie of contraception, thinking that contraception merely prevented a pregnancy. Well, I was wrong. There is no merely when it comes to contraception. When I realized years later that birth control pills actually can act as an abortifacient by preventing a newly formed human being from implanting in the mother's womb, it was literally a come to Jesus moment for me. With that revelation I began to look even more deeply into the history, the implications, and the results of contraception for women, for children, and for humankind. Contraception has allowed women and men to become more promiscuous through a false sense of security that pregnancy won't result from sexual intercourse. Actually, when a woman becomes pregnant through sexual intercourse things have gone right. That's part of the purpose of sexual intercourse. We forget that. With increases in premarital and extramarital sexual intercourse, who is most hurt? Women and children. With increases in the divorce rate, who is most hurt? Women and children. With increases in STDs and abortions, who is most hurt? Women and children. And make no mistake, contraception and abortion go hand in hand. Do not buy the lie that increased contraception means decreased abortions. That has never been true and it will never be true. Increased contraception means increased chemical and surgical abortions, because abortion becomes the contraceptive choice of last resort; some choice. Senators, contraception is the real war on women and voting to provide more contraception, whether done with good intentions or not, will only mean more damage. I wonder if it has occurred to Senator Schumacher and others who think similarly, that we've "contracepted" and aborted ourselves into the financial and moral mess that we're in. And as I listened to his testimony about this bill, it sounded so very utilitarian and a materialistic approach to human life. So if we're going to go down that road, you know if we're going to say look at human beings in that way, why would we rid ourselves of the younger members of our culture who could potentially be more productive? If the baby boomers are the problem, why not just knock them in the head when their intake exceeds their output? That's the mentality of contraception. On behalf of myself, the thousands of members of Nebraskans United for Life, and all the women and girls who've been so greatly harmed by contraception whether they realize it or not, I urge you to vote against LB782. Thank you. [LB782]

SENATOR CAMPBELL: Questions, Senators? Thank you for your testimony today. Our next opponent. Good afternoon. [LB782]

GREG SCHLEPPENBACH: (Exhibits 5, 6) Good afternoon, Senator Campbell and members of the committee. My name is Greg Schleppenbach, S-c-h-l-e-p-p-e-n-b-a-c-h, and I'm executive director of the Nebraska Catholic Conference. Conference, which represents the mutual interests of the Catholic bishops of Nebraska, opposes LB782 because of the expansion of Medicaid family planning services poses significant moral, social, and health implications. And we also believe there are serious flaws in the primary arguments propelling it. We do not oppose the additional money for the Every Woman Matters program that's proposed in this bill. One of the moral concerns we have about expanding the use of our tax dollars for contraception is the fact that many forms of contraception can cause early abortions. As any product insert in any package of hormonal contraception spells out, these drugs work in three ways: first, by preventing ovulation; second, by preventing fertilization if ovulation occurs; and third, by preventing implantation of an embryo in the womb if fertilization occurs. That third mode is an early abortion and it is particularly prevalent with some forms of emergency contraception. We also believe that the cost-savings argument behind this bill is deeply flawed. It asserts that, if Nebraska expands government funding for contraception, two results will occur. One, more women in the target population will use contraception; and two, as a result fewer pregnancies will occur in this population resulting in a cost savings to our state by reducing prenatal, delivery, and postnatal costs that would otherwise be paid for by Medicaid. The first assumption is undermined by studies showing that cost plays a small role in women's decisions about contraception. In a 2010 Institute of Medicine report citing Centers for Disease Control data, cost does not even make the list of "frequently cited reasons for nonuse" among the 11 percent of sexually active women not using contraception. It appears that women currently rejecting contraception are doing so because of its side effects, health risks, and failure rates. The federal Department of Health and Human Services bluntly conceded this point in a 2014 request for proposals to develop new, nonhormonal forms of contraception. HHS said, "hormonal contraceptives have the disadvantage of having many undesirable effects." The second assertion that this would reduce pregnancies and save the state money is undermined by one of the primary studies cited in the fiscal note, a 2004 study commissioned by the Centers for Medicare and Medicaid Services. The study examines six states that already had implemented a Medicaid expansion of contraceptive coverage. It claims that all six states experienced a net cost savings by reducing the number of pregnancies and births that would result without this expansion of contraception. The study's conclusions, however, are based entirely on estimates and assumptions, not empirically based data. In fact, the study admits that not every state of the states it studied saw an increase in contraceptive use and only two of the six states "appeared" to experience a reduction in unintended pregnancies. That is referenced in the Guttmacher memo that I handed out. How can the study credibly claim that all six states saved money by averting births due to better access to contraception when not every state experienced an increased use of contraception and four of the six states did not experience a decline in unintended pregnancies. That strains credibility. There is little or no meaningful data to support the claims that free contraception causes improved women's health. No one has demonstrated any causal link

between either greater access to contraception and fewer unintended pregnancies and abortions, nor between greater usage of contraception and fewer unintended pregnancies. It is simply assumed that what may work on an individual level will work on a societal level. The data and experience contradict this assumption. On a national level, unintended pregnancies have risen along with increased access to contraceptives through various public programs and billions of dollars spent on them. The Guttmacher Institute acknowledged in a 2015 fact sheet entitled "Unintended Pregnancy in United States" that unintended pregnancy rates are highest among women receiving free and low-cost contraception via government programs. Also contrary to common assumptions, numerous studies conducted by family planning proponents demonstrate that greater access to contraception does not reduce unintended pregnancies and abortions. A number of different studies I'm happy to provide if you're interested. For these reasons, we urge you to oppose LB782. Thank you. [LB782]

SENATOR CAMPBELL: Thank you, Mr. Schleppenbach. Questions? I think everyone is reading the material. Thank you for your testimony. [LB782]

GREG SCHLEPPENBACH: Thank you. [LB782]

SENATOR CAMPBELL: Our next opponent. Okay. Anyone here in a neutral position? Okay. Senator Schumacher, would you like to close? [LB782]

SENATOR SCHUMACHER: Thank you, Senator Campbell and members of the committee. This was certainly more fun than listening to people complain about taxes. You know it occurred to me that how we often long for the simple and the old and the inability to go back in time. And we always remember the past as being kind of better than what it probably really was. You know, you hear about folks wanting to go back to the gold standard. Gee, if we just could balance the federal budget. Gosh, if they didn't fight in Washington like they do. All the things that we'd like to think worked in the 1950s and '60s. Mom stayed at home. No need for birth control. Plenty of big space for the world to expand into. It was simple and it was easier, so we'd like to think it was. But we've moved beyond. Whether we like the move beyond, whether we like the consequences of our ability to deal with medical issues, all kinds of things--including contraception--and we can't turn back the clock no matter how hard we want to. The reality of it is, we've got to try to manage the ship in the waters in which we are sailing, not by choice, but by destiny. There was a deal at Harvard, oh, six, seven years ago, and they thought they had the birth control and the population problem under control. It looked like that even in the deepest areas of Africa things were stabilizing and that we would see a leveling out in rural population by the year 2040 or '50. And the population, which went of course from when some of us were young in the 2 billion category to now at 7 billion category, would level out at 9 billion. Recent projections by the World Health Organization, World Bank, that's not going to happen. The trend

line and the failure of the ability to control births looks like we're headed toward 11 billion by the end of this century. And that is far beyond our capacity not only to grow food and necessities, but to deliver them in a socially responsible way. The little problems we have here about too many baby boomers and our state budgets and not being able to cut taxes are miniscule in the context of the pain and the suffering of either worldwide famine or of some type of disease and contagion--miniscule. You want to talk about suffering? You want to talk about risk and nuclear war? You want to talk about risk of all the problems that that type of density of population brings? We can talk about those things. And international organizations have a responsibility to talk about them responsibly, not driven by dogma that just doesn't fit today. So in the big picture, that's it. There's risk all over; that's life. But some of our society has shifted. Moms almost all work. Our economy couldn't survive if moms didn't work. Times are tough. And this bill, in one incremental step, can maybe help a little bit in a state that sorely is going to need the financial resources to minimize risk for our society over the next couple of decades. Happy to answer any questions. [LB782]

SENATOR CAMPBELL: Any questions? Seeing none, thank you, Senator Schumacher. [LB782]

SENATOR SCHUMACHER: Thank you. [LB782]

SENATOR CAMPBELL: That closes our hearing today on LB782 and we'll proceed to...oh, sorry. Now you're all getting in a chorus here. Letters for the record. [LB782]

ELICE HUBBERT: (Exhibits 7-14) We received letters of support from: the Holland Children's Movement; Methodist Women's Hospital; the Nebraska AIDS Project; the National Association of Social Workers, Nebraska Chapter; Planned Parenthood of the Heartland; Women's Fund of Omaha; Dr. Sofia Jawed-Wessell, Assistant Professor of the University of Nebraska-Omaha School of Health, Physical Education and Recreation. And the one you just got was received late and it's a letter in opposition by Calder Lynch, Director, Division of Medicaid and Long-Term Care. And that's all. [LB782]

SENATOR CAMPBELL: Okay. We will open the hearing on LB869, Senator Crawford's bill to require that certain providers under the Medical Assistance Act be subject to a national criminal history record information check. Senator Crawford, go right ahead. [LB869]

SENATOR CRAWFORD: Good afternoon, Chairwoman Campbell and fellow members of the Health and Human Services Committee. My name is Sue Crawford, S-u-e C-r-a-w-f-o-r-d, and I represent the 45th Legislative District of Bellevue, Offutt, and eastern Sarpy County. I'm here to introduce LB869 today for your consideration. I bring LB869 at the request of the Department of

Health and Human Services to bring our state laws into compliance with new federal regulations. New Medicaid provider screening and enrollment requirements in federal law require states to complete criminal background checks on high risk providers and individuals with at least 5 percent ownership in businesses that employ these types of providers. CMS requires states' definition of high risk providers to be at least as stringent as their current definition under the Medicare program. This Medicare definition includes home health agencies and durable medical equipment, prosthetics, orthotics, and supplies. As you will hear from Director Lynch, Nebraska Medicaid also included nurses and other healthcare providers, when they are practicing independently in a home health setting, to this definition. This decision was based on an assessment of historical cases where issues of program integrity have come up. The patients these providers serve tend to be the most vulnerable and at greatest risk for fraud and abuse since it is often difficult for homebound patients to report fraud when it means turning down the care they need to stay in their homes. It is important to note that if the provider or individual with at least 5 percent ownership in a business employing such provider is already enrolled and screened through Medicare, he or she does not have to reenroll and submit fingerprints again. Director Lynch and others have worked closely with Nebraska State Patrol on this Legislation, as the Nebraska State Patrol would be responsible for processing the requests for fingerprinting as part of the criminal background check. With that, I'm happy to try to answer any questions that you have, but please keep in the mind that the experts on this bill and the federal policy are behind me. [LB869]

SENATOR CAMPBELL: Questions? Seeing none, Senator Crawford, we'll proceed. Our first proponent. Good afternoon again. [LB869]

CALDER LYNCH: (Exhibit 1) Thank you. Good afternoon, Senator Campbell, Senator Crawford, and members of the Health and Human Services Committee. My name is Calder Lynch. For the record, that's C-a-l-d-e-r L-y-n-c-h, I am the Director of the Medicaid and Long-Term Care Division in HHS. And today I'm here to testify in support of LB869. Again, thank you to Senator Crawford for introducing this important bill on behalf of the department that will make sure that our Medicaid program complies with federal law and helps prevent fraud and abuse in our state's Medicaid program. LB869 requires high risk Medicaid providers and persons with 5 percent or more ownership stake in those providers submit fingerprints for nationwide criminal background checks to the Nebraska State Patrol. The State Patrol will then submit these fingerprints to the FBI to complete the background checks. The results will be given to Nebraska Medicaid and if the providers do not pass the background check they may no longer be able to serve or may be denied as Medicaid providers. This legislation is necessary because new Medicaid provider screening and enrollment requirements in federal law, that were codified in 42 CFR (Part) 455 Subpart E, require that states complete fingerprint-based criminal background checks on high risk providers and their owners. If Nebraska does not comply with these requirements we, of course, put the federal financial participation in our Medicaid program at

risk. This legislation permits the department to deny a provider's participation in Medicaid if the results find certain criminal history. Providers, of course, will have the opportunity to appeal that decision through our state fair hearing process. Thank you for this opportunity to provide testimony regarding LB869, as this bill will help to strengthen and protect Medicaid and vulnerable recipients, as Senator Crawford mentioned, and our mission to help Nebraskans live better lives. I'm of course happy to answer any questions that the committee may have. [LB869]

SENATOR CAMPBELL: Senator Howard. [LB869]

SENATOR HOWARD: Thank you, Director Lynch. It's nice to see you again. Can you tell me how long, on average, it takes for somebody to become a Medicaid provider? [LB869]

CALDER LYNCH: Well, it does vary and, historically, we've been tracking this data. We had seen the provider application process probably early in 2015 peak at around nine weeks. [LB869]

SENATOR HOWARD: Okay. [LB869]

CALDER LYNCH: We've since seen that time come down to average less than 6 weeks. We, of course, as I discussed earlier in the briefing, have implemented a new provider enrollment portal where we are now seeing providers successfully move through the process in a matter of days. We, of course, know that there are still some issues there with some specific provider types that have gotten hung up. But we're expecting to continue to track. This is actually one of our dashboard-tracked items and so we'll be monitoring that process and how this impacts it as well. [LB869]

SENATOR HOWARD: And how long would the fingerprint background check take? [LB869]

CALDER LYNCH: My understanding is...and this...I don't know exactly. I think it's less than 30 days is my understanding, but I will follow up on that precisely. [LB869]

SENATOR HOWARD: Thank you. [LB869]

SENATOR CAMPBELL: Other questions, Senators? Director Lynch, I have a question. In the fiscal note it talks about that this will be directed at those who have 5 percent interest in it. [LB869]

CALDER LYNCH: Correct. [LB869]

SENATOR CAMPBELL: But I thought you talked about in your testimony that there may be other people impacted by this...or is it just the owners to begin with? [LB869]

CALDER LYNCH: For provider agencies that have owners, for example a home health company or a durable medical equipment company, you know, the individual that we would have to fingerprint background check would be those owners with 5 percent or a greater stake. For those high-risk providers that we have identified as from Nebraska Medicaid, that would include a lot of the personal assistance providers who are just individual providers that enroll individually so there aren't owners, per se, it's just that individual. [LB869]

SENATOR CAMPBELL: Okay. The owners. [LB869]

CALDER LYNCH: Yes. So if they are an individual person providing service, it would be them; or if it's an agency of some kind, it would be the owners. [LB869]

SENATOR CAMPBELL: Okay. I spoke earlier today to the home healthcare people and I may have given them some poor information then, because I had read the fiscal note thinking, okay, this is really owners of this. But if they're the sole provider and they're subcontracting, they're going to have to go through this. [LB869]

CALDER LYNCH: If they are an individually-enrolled provider with the program, then they will have to submit to the fingerprint background check. One thing I will note is that the original time line the federal government gave states to come into compliance was by June of 2016. We knew that that was going to be very difficult, if not impossible, even once we had the statutory authority to do this. CMS has since come back and told states that we could develop compliance plans by that time line that, if they approved, would allow us some time. So we're developing that plan now. And we don't anticipate that we would require everyone to go through this at once. We would do a portion, maybe 10 percent to 13 percent of providers at a time, where we would send the notifications and give them a certain amount of time to submit the fingerprint checks to try and ease some of that burden. [LB869]

SENATOR CAMPBELL: Okay. I'll make sure to get back to their lobbyist and indicate to them that if they're the sole provider, they're going to be impacted by this. [LB869]

CALDER LYNCH: Sure. And we would also be very happy to talk to them and sit down and explain this as well. [LB869]

SENATOR CAMPBELL: It might be worthwhile, because I think there were some questions around this. One of the questions I had is, how far into the future do you think we're looking at in which every healthcare provider is going to have to run through a check? [LB869]

CALDER LYNCH: It's difficult to say. At this point, we're not proposing any further expansion of these high risk categories, other than the ones we've outlined at this time. And that certainly is compliant with federal requirements, but it's difficult to predict if they will increase them further. But I will note that, as Senator Crawford mentioned, many of these folks have probably already completed the background checks as part of their Medicare participation. If they have done so, they will not have to do it again. [LB869]

SENATOR CAMPBELL: I bet that's true. Exactly. Other questions, Senators, that you might have? Thank you, Director. [LB869]

CALDER LYNCH: Thank you very much and (inaudible). [LB869]

SENATOR CAMPBELL: Our next proponent. Good afternoon. [LB869]

KEVIN KNORR: (Exhibit 2) Good afternoon. Senator Campbell and members of the Health and Human Services Committee, good afternoon. I am Captain Kevin Knorr, K-e-v-i-n K-n-o-r-r, I'm a commander of the Criminal Identification Division within the Nebraska State Patrol. I would like to thank the committee for giving me the opportunity to appear before you today in support of LB869 so that I may share some perspective regarding the bill's effect on the Nebraska State Patrol. The Nebraska State Patrol has been part of several discussions regarding LB869. These discussions have included the Department of Health and Human Services and other stakeholders. We've also met with Senator Crawford and have shared the projected impact the legislation would have on our agency. We look forward to continuing these beneficial discussions moving forward. Fingerprinting involves obtaining and handling sensitive information which is unique to each individual. Currently, the Nebraska State Patrol provides fingerprint-based background checks, meeting the needs of over 20 individual and unique categories. These include, but are not limited to: adoption, foster care, concealed weapon permits, sex offenders, teachers, and the bar exam. One area of concern is the increase in workload based on the recent numbers projected by HHS. This will require the Nebraska State Patrol to make adjustments in order to handle the increased volume. In 2015, the Nebraska State Patrol handled over 16,300 fingerprint-based background checks. HSS, within the first year of implementation, has anticipated approximately 4,600 individual fingerprint-based background checks related to this legislation and approximately 2,400 each year thereafter. This is a significant increase and cannot be absorbed within our manpower, equipment, and facilities. The Nebraska State Patrol has absorbed previous mandated fingerprint-based checks in the past without augmenting agency resources.

The most recent occurred during the addition of the nursing licenses, which added approximately 3,000 checks each year. We provided information to the various stakeholders of this legislation that outlines the essential adjustments to manpower, equipment, and facilities the Nebraska State Patrol would need to meet the requirements of this legislation. We understand the need for this legislation and the goal of HHS to strive to meet their needs, but felt that it would be necessary to provide the committee with information concerning the impact of this legislation on the Nebraska State Patrol. A fiscal note regarding LB869 has also been submitted. In closing, I want to thank Senator Crawford for bringing this bill forward and hope that, through continuing discussions, that we can work together to accomplish the goals of this legislation. I'm happy to answer any questions that you may have. [LB869]

SENATOR CAMPBELL: Captain Knorr, thank you very much for coming. I was trying to scan the fiscal note as quickly as I could. And the Legislative Fiscal Office has included the estimates that you have given. And so our fiscal note includes your request for additional funding. Senator Kolterman. [LB869]

SENATOR KOLTERMAN: You know, I just have...thank you for coming. I have just a question. I know that this is probably necessary. Do you do...does the State Patrol do, like, security exams where somebody is applying for a security license has to get fingerprinted as well? Is that all handled under your office, or... [LB869]

KEVIN KNORR: Not necessarily security exams. Those aren't one of the categories that we do fingerprint-based background checks for. [LB869]

SENATOR KOLTERMAN: Okay. And the only reason I'm asking is back when I did that a long time ago, we just went down to our local sheriff and they fingerprinted us and we sent it off. I don't know if that still goes on. Are there other organizations that require fingerprinting like Medicaid does or are there private companies that would fingerprint people? [LB869]

KEVIN KNORR: Not within our state. The only entity that is able to submit fingerprints to the FBI for a national check is the Nebraska State Patrol. [LB869]

SENATOR KOLTERMAN: Okay. Thank you for that point in clarification. [LB869]

SENATOR CAMPBELL: Any other questions? Okay. And we should note for the record that the fiscal note I was referring to, it's Cash Funds, not General Funds. Okay? [LB869]

KEVIN KNORR: Yes, Senator. [LB869]

SENATOR CAMPBELL: All right. Thank you, Captain. [LB869]

KEVIN KNORR: Thank you for your time this afternoon. [LB869]

SENATOR CAMPBELL: Always good to see you. Our next proponent. Are you testifying sir? Anyone else? Those who oppose the bill? Those in a neutral position? Okay, Senator Crawford, we're back to you. [LB869]

SENATOR CRAWFORD: Thank you so much. I just, in closing, am going to put on the record, I know there is work between HHS and the State Patrol to work on the fiscal note and what that means. And so it will be important as that work proceeds that there's a recognition of the plan to do this...to go slowly in terms of how many people get fingerprinted per each year and also that those discussions recognize that some of these providers are already getting the prints...may already be complying for Medicare already. However, another complication, as you see in the fiscal note, is the fact that the fees currently are lower than the costs, so that's also something that's being discussed by others in working out the final fiscal note, so. [LB869]

SENATOR CAMPBELL: Senator Crawford, is the fee in statute or is that a fee that can be increased by the department? [LB869]

SENATOR CRAWFORD: I do not know the answer to that question. [LB869]

SENATOR CAMPBELL: I wouldn't know either. Okay, well, we'll let you continue your work on the bill. Letters for the record? [LB869]

ELICE HUBBERT: We have no letters on this bill. [LB869]

SENATOR CAMPBELL: I always ask it when there are no letters for the record. Okay, thanks. Our next bill is LB1043, Senator Howard's bill to create a palliative care program and advisory council for the Health Care Facility Licensure Act. Senator Howard, please start us off. [LB1043]

SENATOR HOWARD: Good afternoon, Senator Campbell and members of the Health and Human Services Committee. My name is Senator Sara Howard, S-a-r-a H-o-w-a-r-d, and I represent District 9 in midtown Omaha. Today I bring you LB1043, a bill to create the Palliative Care Consumer and Professional Information and Education Program and the Palliative Care and Quality of Life Advisory Council. Palliative care is an approach that improves quality of life for patients and their families facing the problems associated with life-threatening illnesses through

the prevention and relief of suffering by means of early identification and treatment of pain and other problems besides physical, such as psychosocial and spiritual. Integrating palliative care into mainstream medicine for all patients and families facing serious illness offers an essential opportunity to deliver person-centered and family-focused care, achieving better health, better care, and lower cost. Despite the rising amount of evidence showing its benefits, many professionals mistakenly equate palliative care with end of life and hospice. Because of this lack of understanding, both of what palliative care is and when it should be provided, this lack of understanding remains one of the chief barriers to preventing access to it. The purpose of LB1043 is to improve quality and patient centered and family-focused care in Nebraska. LB1043 creates two entities. The first is the Palliative Care Consumer and Professional Information and Education Program, which is a big name. This program relates to information sharing about palliative care by the department's Web site--so DHHS's Web site--very similar to our Down syndrome bill that we heard previously. It would include: continuing education opportunities for professionals around palliative care; delivery of palliative care in the home; information about best practices; educational materials; and referral information. The purpose of the education program is to maximize the effectiveness of palliative care initiatives in the state by ensuring that comprehensive and accurate information is available to the public, healthcare providers, and healthcare facilities. The second piece of LB1043 is the Palliative Care and Quality of Life Advisory Council. This council brings together health professionals that have palliative care experience and/or experience in palliative care delivery models in a variety of in-patient, out-patient, and community settings with a variety of populations. The Advisory Council will consult with and advise the Department of Health and Human Services on matters relating to palliative care initiatives, especially the educational components that would go on the Web site. Significant progress in advances in medicine have meant many of us will live longer and also live better, even in the face of serious illness. Helping patients and their families achieve these dual outcomes, longer life and higher quality of life, is a key objective of palliative care. Thank you for your attention to this important issue. I would urge the committee to advance LB1043--even though we're past the priority deadline--and I would be happy to try and answer any questions you may have. Thank you. [LB1043]

SENATOR CAMPBELL: Questions, Senators? Yes, Senator Kolterman. [LB1043]

SENATOR KOLTERMAN: Thank you, Senator Campbell. So, Senator Howard, how palliative--whatever it is--that type of care, under your health insurance you've got hospice care, which is for terminally ill. [LB1043]

SENATOR HOWARD: Right. You are definitely... [LB1043]

SENATOR KOLTERMAN: This is for those that are not going to die immediately. Correct? [LB1043]

SENATOR HOWARD: Yes. [LB1043]

SENATOR KOLTERMAN: And under hospice care, that's usually covered by most health insurance policies,... [LB1043]

SENATOR HOWARD: Yes. [LB1043]

SENATOR KOLTERMAN: ...including the stay in the nursing home (inaudible). Would this pick up that same type of exposure, because this could be for a lot longer period of time? [LB1043]

SENATOR HOWARD: No, I don't think so, although there are folks behind me who know a little bit more about the billables for palliative care, specifically. I think there are components of palliative care that are covered and billable, but not all of them. [LB1043]

SENATOR KOLTERMAN: And I'm just wondering if...and I'll ask people coming behind if whether or not this would coordinate with long-term care coverage and things of that nature. [LB1043]

SENATOR HOWARD: That is a great question for someone behind me, definitely. Thank you. [LB1043]

SENATOR CAMPBELL: Senator Riepe. [LB1043]

SENATOR RIEPE: Thank you, Senator Campbell. My question is, has DHHS taken a position on this? [LB1043]

SENATOR HOWARD: Not to my knowledge, no. [LB1043]

SENATOR RIEPE: Do you think they will? [LB1043]

SENATOR HOWARD: They've not spoken with me about it at this point. [LB1043]

SENATOR RIEPE: Okay, thank you. [LB1043]

SENATOR HOWARD: Thank you. [LB1043]

SENATOR CAMPBELL: To follow up Senator Riepe's comment, this is probably one of the smallest fiscal notes I've ever seen. The department is estimating $7,358. [LB1043]

SENATOR HOWARD: Actually, I sure hope we can find that in the budget. [LB1043]

SENATOR CAMPBELL: Yeah. I don't know if we can do that. And it's mainly to cover the expenses of the Palliative Council. [LB1043]

SENATOR HOWARD: Just mileage. [LB1043]

SENATOR CAMPBELL: Mileage and that kind of thing. Senator Kolterman. [LB1043]

SENATOR KOLTERMAN: Thank you. Palliative...the council already exists, is that correct, this organization? [LB1043]

SENATOR HOWARD: No. [LB1043]

SENATOR KOLTERMAN: This would just be creating it? [LB1043]

SENATOR HOWARD: Yes. I think it's because there's a lot of misunderstanding about what palliative care is. And so this is a great opportunity for us to raise awareness about the work of palliative caregivers. [LB1043]

SENATOR KOLTERMAN: And I assume that would make up the people that...are they people from the industry primarily that would be involved in the committee or... [LB1043]

SENATOR HOWARD: Sure. So our recommendation for the council is at least two positions are nurses, certified under the Hospice and Palliative Medicine certification program administered by the American Board of Medicine. And actually Senator Fox may know a little bit more about this as well. The remaining members should have experience with palliative care work experience, have experience with palliative care delivery models in a variety of settings, be representatives of palliative care patients and their family caregivers, or be a Department of Health and Human Services employee who is familiar with hospice and palliative care. [LB1043]

SENATOR KOLTERMAN: Okay. Thank you. [LB1043]

SENATOR CAMPBELL: Senator Riepe. [LB1043]

SENATOR RIEPE: I happen to know that CHI Health has had a palliative care physician in the department for a long period of time, so I'm trying to figure out if we're into needless...and I would only guess that the Med Center probably has one and Nebraska Methodist probably has one. You know, when one hospital has one they all have one. [LB1043]

SENATOR HOWARD: You know, my understanding is that there isn't a wellspring of information about palliative care across the state. So we may have palliative care educators in our more urban areas, but certainly not in our more rural areas. And this is an opportunity for us to streamline the type of information around palliative care that is being distributed. [LB1043]

SENATOR RIEPE: So this is more of a rural health program? [LB1043]

SENATOR HOWARD: You know, actually, I think it's to get everybody on the same page about the role of palliative care. [LB1043]

SENATOR RIEPE: I'm just...when I think of CHI, I mean, they're not only urban but they are rural as well, so I'm just...I don't know where they're at on terms of the education and (inaudible), you know, with the patients that they have. But they're probably in a catbird position to spread that information and, particularly, coming from a physician that's specifically trained in it to...I'm just curious about that. I'll do some follow up. Thank you. [LB1043]

SENATOR HOWARD: My understanding is that the Hospital Association is very comfortable with this bill. [LB1043]

SENATOR RIEPE: Well, that doesn't surprise me. It's not costing them anything, so...believe me...knowing the Hospital Association, I'm sure they wouldn't. But thank you very much. [LB1043]

SENATOR HOWARD: Thank you. [LB1043]

SENATOR CAMPBELL: We have a long-term care facility in Lincoln that does provide this, but it's not well understood what it is... [LB1043]

SENATOR HOWARD: Absolutely. [LB1043]

SENATOR KOLTERMAN: I never even heard of it. [LB1043]

SENATOR CAMPBELL: ...and who can use it and what the best practices are. It would seem to me that you would benefit from bringing some of these folks together and sharing information. I think it's a rural and an urban issue, frankly. [LB1043]

SENATOR HOWARD: Absolutely. Thank you. [LB1043]

SENATOR CAMPBELL: I think a hospital may have it or an isolated...you know, or a long-term care facility, but the general public I don't think has a great understanding until you get to that point. And they'd be much better off if they understood it ahead of...I mean, I had a very long orientation from Tabitha that does it here that talked with me about it, because I'd not heard about it. This was several years ago and it was fascinating to listen to what they can do for people. [LB1043]

SENATOR HOWARD: Thank you. [LB1043]

SENATOR CAMPBELL: Senator Riepe. [LB1043]

SENATOR RIEPE: I'm sure it's much like most of the things in our lives, until we absolutely have it in front of us there's just not enough mental capacity to learn about everything. And so you're right, you really get someone's attention when they have to have it. But then they found out a lot real fast. [LB1043]

SENATOR HOWARD: Absolutely. Thank you. [LB1043]

SENATOR CAMPBELL: Okay. Thanks, Senator Howard. [LB1043]

SENATOR HOWARD: Thank you. I will stay to close. (Inaudible) you guys. [LB1043]

SENATOR CAMPBELL: You bet. Okay. Our first proponent. Good afternoon. [LB1043]

DAVID HOLMQUIST: (Exhibits 1, 2) Good afternoon, Senator Campbell, members of the committee. My name is David Holmquist, I appreciate the opportunity to testify today. My name is spelled D-a-v-i-d H-o-l-m-q-u-i-s-t. I'm a registered lobbyist and I represent the American

Cancer Society Cancer Action Network as Nebraska director of government relations. ACSCAN is the nonprofit, nonpartisan, advocacy affiliate of the American Cancer Society. We support evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. ACSCAN is in full support of LB1043. We believe that palliative care or what we refer to as quality of life care is an essential component of care for cancer patients and, by extension, their families and loved ones. But what does palliative care mean? The National Hospice and Palliative Care Organization uses the National Consensus Project's definition of palliative care--and we are in conversation with that group--I quote: Palliative care is patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care, throughout the continuum of illness, involves addressing physical, intellectual, emotional, social, and spiritual needs and facilitates patient autonomy, access to information, and choice. I believe there is some confusion in the public perception of palliative care. While palliative care and hospice care may be linked, palliative care is not always end-of-life care. Palliative care can be used from diagnosis forward to treat people with serious and chronic diseases. These might include: cancer, congestive heart failure, COPD, lupus, and many more diseases that are not necessarily life threatening. In an article yesterday in the edition of the Omaha World-Herald the writer factually defines pallia as relieving pain. However, the author further says, it's used to describe end-of-life care. And while that is correct, the statement is not completely correct because it is also quality-of-life care, not end-of-life care. Further, in an article in Tuesday's edition of The New York Times which I have provided you with, the author interviewed a primary caregiver who initially resisted the suggestion of palliative care. The word palliative he says, I quote: I thought of it as synonymous with hospice. And that echos a common misperception. I didn't want to face the possibility, I didn't want to think it was time yet. He's referring to his mother. Palliative care is about treating the person beyond the disease. It's about improving quality of life and providing an extra layer of support to relieve pain, symptoms, and stress of serious illness and can be provided alongside curative treatment. Palliative care is provided by a specially trained team of doctors, nurses, and other specialists who work with the patient's other doctors to provide an extra layer of support. A palliative care team might also include a social worker, an occupational therapist and/or physical therapist, a mental health professional, a dietician, and, if appropriate, a chaplain. Each team is designed to treat a specific patient. I would offer the example of a patient diagnosed with CML or chronic myelogenous leukemia. Drugs known as tyrosine kinase inhibitors, TKIs, have been developed to treat patients with CML and are generally known to provide long-term success. In other words, CML is no longer a death sentence. However, the treatments may cause side effects that must be monitored by physicians and others. And the treatments may require support from a palliative care team to address other physical, emotional, social, financial, and spiritual needs. The purpose of LB1043 is to improve quality and delivery of patient-centered and family-focused care in Nebraska by establishing a state advisory council on palliative care and quality of life, a palliative care consumer and professional information and education program. We understand from conversations with some other entities that the bill may need to be amended to satisfy some

concerns, but we welcome and encourage a dialogue to amend the bill in a manner that will achieve support from all concerned. Assuring the availability of palliative and quality-of-life care over the long term is a priority. While Nebraska currently gets high marks for having palliative care plans in place--and currently 93 percent of our hospitals...critical care hospitals report having a plan in place--we believe the creation of a council composed of professionals and providers can help us achieve improved outcomes for patients and their families. In other words, we're not sure what the plans mean, what is in the plan that makes it appropriate. So 93 percent is a great number, but is it 93 percent of 100 percent or is 93 percent of plans that only include 10 percent? I would also share with you some personal experience. Wearing another hat I am an ordained deacon in the Episcopal Church and, as such, I trained with CHI Health at one of the medical centers in Omaha. And we had discussions in our chaplain's office about some of the palliative care consults that might take place. And often they forgot to invite chaplains in if a chaplain had been requested by a family. And this was a concern we had. And I think by bringing a group like this together we can establish some guidelines that would make it easier for the health providers to be able to understand what is appropriate. It is a rural and urban issue. We need to address issues of quality of life for people who live in North Platte as well as people who live in Omaha. I don't know how many providers are available right now. I know that Methodist has a new palliative care physician on board. There are two at the Med Center. There are one or two here in Lincoln. I understand one of the people here in Lincoln also practices outside of Lincoln in the western part of the state. But I don't have any other facts. I can get more for you if that would be helpful. Anyway, that's my testimony and I would be happy to answer questions that you might have to the best of my ability. [LB1043]

SENATOR CAMPBELL: Thank you, Mr. Holmquist. Questions? Senator Riepe. [LB1043]

SENATOR RIEPE: Thank you, Senator Campbell. One of my hot buttons is always needless duplication. I got out of grad school in the mid-70s and at that time we talked about continuity of care. And I can't help but think that the new oncology center at the Med Center, which is about $853 million, that they're not going to have in that continuity of care all of the palliative components and everything that you could hope and dream of. So I just want to make sure that we're not, you know, same old meals, just new flies. You know, just more of the same under a new name called palliative care and it used to be called continuity of care. Maybe you can help me get over that. [LB1043]

DAVID HOLMQUIST: My understanding is that those are different concepts. One of the issues we faced at the federal level is that there...we don't have a large enough group of providers at this point who are trained specifically in palliative care and how to work with a team. So we are developing or trying to help develop more opportunities to have physicians and nurse practitioners trained in this area so that they can then go out and spread that training to others. So there are two bills at the federal level that are, in the overall scheme of things at the federal level,

I think each one is $5 million over five years--so drops in the bucket, if you will--that we have been supporting for a number of years and that we actually have majorities in the House signed on for to create a palliative care training program--it would be a pilot program--and another one that would get more information out to the general public about palliative care. But I think we all know that all politics is local. And I think we all believe that states' politics is important and this would be an opportunity for Nebraska to learn...for the professionals to learn more about sharing information and also an opportunity to provide more information to the general public about this. As you said, you don't know about it until you are confronted with your own family member needing some additional assistance. [LB1043]

SENATOR CAMPBELL: Senator Riepe. [LB1043]

SENATOR RIEPE: Thank you, Senator. Are they talking about training of primary care doctors for...because some of the palliative care doctors that I'm aware of, that's their new, quote unquote, specialty. [LB1043]

DAVID HOLMQUIST: It is more of a specialty. [LB1043]

SENATOR RIEPE: Well, therein lies a problem, too. We can barely, and not satisfactorily, get primary care or clinical nurse practitioners out to the western parts of the town let alone getting a palliative care specialist out there. I think there is a little, slim, and none chance of that going on. They're going to have to be a circuit rider and then being in the right place at the right time. I hate to be pessimistic, but I have to be questioning; it's our job. [LB1043]

DAVID HOLMQUIST: I think...exactly. And I think we can hope that there will be some opportunity for some nurse practitioners and perhaps others to be trained by existing palliative care teams in what would be the most appropriate. And we have telemedicine. That might be an opportunity for the physicians on the ground in Crawford to be able to have a consult themselves with a palliative care specialist in Omaha or in Lincoln or wherever--maybe Scottsbluff, I don't know--to design a consult that would be appropriate and most helpful for the patient and the patient's family. That's...it really comes down to quality of care and quality of life. Not even quality of care, I misspoke. It's about quality of life. We don't determine what the best quality of care is, we simply try to determine the best quality of life. [LB1043]

SENATOR RIEPE: Thank you. [LB1043]

SENATOR CAMPBELL: Any other questions? Thank you, Mr. Holmquist. [LB1043]

DAVID HOLMQUIST: Thank you. [LB1043]

SENATOR CAMPBELL: Okay. Our next proponent. Good afternoon. [LB1043]

GEORGE VOIGTLANDER: Good afternoon. Chairman Campbell and members of the Health and Human Services Committee, thank you for allowing me to testify before you on behalf of the Nebraska Medical Association in support of LB1043. My name is George Voigtlander, that's G-e-o-r-g-e V-o-i-g-t-l-a-n-d-e-r, I'm a board-certified family physician from Pawnee City, Nebraska, where I've practiced since 1981. As I have aged so have my patients. Most of my patients now are Medicare age and on many days the average age of my patients is 84. I've taken numerous courses on hospice and palliative care over the last 15 years. As the medical director of three nursing homes in southeast Nebraska, I've witnessed the end of life of many of my neighbors and patients. For eight years I was the medical director of CIMRO of Nebraska, the state quality improvement organization, and reviewed thousands of charts. There did seem to be a problem with end-of-life care and symptom control in people with chronic diseases. I think having a source of information and education on palliative care is a laudable idea. When I was in training the concept of palliative care was not formally discussed and only touched on infrequently by some of the family practice physicians and oncologists while on hospital rounds on dying patients. Even do not resuscitate orders at that time were considered to be extreme. I think having a Web site and other resources would be very helpful. Both UNMC, Creighton, and the University of Kansas have medical, PA, and APRN students rotating through Pawnee Rural Health Clinic for their family practice and geriatric outstate experience. Although the students are aware of palliative care they have only received an introduction to the concept. End-of-life care is defined by anticipation of less than six months of life. It's usually well served by the Medicare hospice benefit. However, not every patient appropriate for palliative care qualifies for the hospice benefit. These people depend on their primary care physicians and other providers to provide the relief of suffering and the stresses of dealing with life-limiting, chronic diseases. I have one concern that, once established, voluntary programs slowly transform into mandatory programs with cumbersome regulation and prescribed punishments for noncompliance. Another concern is that, although there are procedure codes to request payment for time coordinating care and counseling, actually getting reimbursed for these services rarely happens. I'm concerned that this worthwhile proposal may become another unfunded mandate. And I appreciate the fact that the bill addresses that palliative care is intended to neither prolong nor shorten life. Some of us are concerned that this bill may be used as a way to introduce the concepts of euthanasia. Thank you for allowing me to comment on this legislation. Thank you. [LB1043]

SENATOR CAMPBELL: Thank you, Doctor. Questions? Senator Riepe. [LB1043]

SENATOR RIEPE: Thank you, Senator. My question is this: What is the role of the training programs in a primary care residency? I mean, this is a new field. People living longer, ergo the need for it. What is their role in terms of training residents that come out of primary care residency? Second question gets to be is, what role does the state have in terms of continuing medical education? Many of the physicians now work for hospital institutions who have nice, healthy continuing education budgets that in nice places...what's the role for us as a state versus their employer? [LB1043]

GEORGE VOIGTLANDER: Well, I think in answer to the first question concerning the training programs, I think it would certainly be appropriate for this to have an expanded role. When you're 23, 25 years old what catches your attention are the dramatic and exciting type things: the heart attacks, the cardiac arrests, the traumas and things like that. A lot of times you don't spend much time learning about how to talk to a family whose son has muscular dystrophy and may well die before their 30th birthday or spend the last days of their life on a ventilator. It's difficult and it may be difficult to even come up with a curriculum that would address all the appropriate things. That's one of the reasons that I think it would be very good to know where the specialists are and ask them to contribute to the developments of these curricula. I know in some of the meetings I went to for nursing home directors, people from Los Angeles and New York and other areas that are national thought leaders in this would have a number of good ideas about how to do things. And I think something as prestigious as a state committee requesting information from these people might have more influence than if it came from Pawnee County Hospital who they don't even know where Nebraska is, let alone Pawnee County. As far as the role of the hospitals, I think some of this has been done, you're quite correct. A number of the hospitals have excellent training, educational programs in cardiology and some of the other specialties. I can't give you the exact numbers, but cardiology procedures are pretty good from the standpoint of the bottom line for the hospitals. So pulling those sorts of consults into their hospital is lucrative and helps support some of the other less cost effective or money generating programs. As far as the state, the state does quite a bit of education on a number of things, especially in the emergency medical services. Many of the very good programs are sponsored by state organizations, the EMS Council and so forth. So I think there is a role for the state of Nebraska as being kind of a catalyst and a clearinghouse for some of this type of information and training. [LB1043]

SENATOR RIEPE: Do you know of other states that have oversight boards? [LB1043]

GEORGE VOIGTLANDER: I do not. [LB1043]

SENATOR RIEPE: Okay. Thank you. Thank you very much for being here for me...for my perspective. [LB1043]

SENATOR CAMPBELL: Thank you Doctor, very much. [LB1043]

GEORGE VOIGTLANDER: Thank you. [LB1043]

SENATOR CAMPBELL: Our next proponent. [LB1043]

HEATH BODDY: (Exhibit 3) Good afternoon, Senator Campbell, members of the committee. [LB1043]

SENATOR CAMPBELL: Good afternoon. Absolutely. [LB1043]

HEATH BODDY: My name is Heath Boddy, spelled H-e-a-t-h B-o-d-d-y, I'm the president and CEO of the Nebraska Health Care Association. NHA is an umbrella organization that represents the Nebraska Hospice and Palliative Care Association, the Nebraska Nursing Facility Association, and the Nebraska Assisted Living Association. I want to thank the committee for taking up this important topic today and especially thank Senator Howard and her staff for bringing this issue to light. The Nebraska Hospice and Palliative Care Association is very supportive of this conversation. We think it's the right thing to talk about palliative care. As you've already identified, it's a topic that not many people are rock solid on what it means in every situation and so we really support that. However, we do have a few concerns about a couple of the sections. And so to not be redundant with testimony that's already been given, I thought I would just identify those things. As you already discussed, this bill would set out an advisory group and create a couple of parts that from an advisory capacity, again it's already been discussed. And so I just thought I'd like to say, as those things unfold the Nebraska Hospice and Palliative Care Association would love to be a part of any of those future discussions and collaborative movements that go forward. You heard a couple of the people before me talk about the interdisciplinary approach of hospice and palliative care. And so the first verbiage or technical thing that we would offer is that we think that medical care in this terminology should be replaced with interdisciplinary care. I think the testifiers before me really identified that it's the interdisciplinary approach to this type of care, both palliative care and hospice care, that make it so different. On behalf of our nursing and assisted living facility associations I wanted to talk a little bit about Section 8 of the bill. Our members are pretty concerned about that, because it would be required to facilitate access to a service that's not currently licensed, it's not currently regulated, and frankly as you've already discussed, it may not be available wall to wall, top to bottom in the state of Nebraska. And so it seems like that could be a problematic area, especially for those other health facilities that we have in membership. You know, one of the things that I really enjoy about Nebraska is that when we put thoughtful people together to work on meaningful things, we can get somewhere with that. And so again, I want to thank Senator Howard for bringing this discussion up. I think there are lots of opportunities. I don't just think

the Hospice and Palliative Care Association would offer that there's lots of opportunities to create some clarity and to see where palliative care in Nebraska might evolve. I do have a couple of things I would share as related to earlier questions if you're interested, Senator, but... [LB1043]

SENATOR CAMPBELL: Sure. [LB1043]

HEATH BODDY: There was a 2015 state report card on access to palliative care and it was done by the Center to Advance Palliative Care or CAPC. Now it ranks Nebraska as an A, but let me just tell you a little bit more about what that report says. As I see it, the reason it ranks us as an A is because 100 percent of our four major hospitals with more than 300 beds have palliative care programs. However, it's interesting to know that only 9 percent, or 2 out of the 23 with less than 50 beds, are identified in the report as having palliative care programs. So again I'm just sort of bringing in a little different light what's been said that we're not sure we have heard about CHI and some of those programs that are there. We're not convinced, and part of the reason that we've been taking this up as a strategic level at the Hospice and Palliative Care Association is, we're not convinced that there is any sort of a pattern across the state in that way at this point. You've already heard that palliative care by itself does not have billable hours under the Medicare and Medicaid program. For the palliative care you can get physicians and nurse practitioner billing in that, as we understand it, but not for the palliative care program itself. So I just thought that might be interesting to note. And you know, Senator Kolterman, you asked about its coordination with long-term care policies. While I'm not a long-term care insurance expert, I would say that it would seem that that would have...it might not be highly correlated because this palliative care thing not only isn't severely old in nature as it relates to the rest of the healthcare sector, I don't think there are high levels of coordination across the country, so it would surprise me if there's lots of long-term care policy coordination as it relates to that. But again, somebody way smarter than I could tell you that. Be happy to answer any...be happy to try to answer any questions if it makes sense. [LB1043]

SENATOR CAMPBELL: Senator Riepe. [LB1043]

SENATOR RIEPE: Thank you, Senator Campbell. Are you familiar with not only CHI, which is not clear across the state but quite...pretty good penetration, but there's also the organization with Methodist, Bryan LGH--Bryan LGH, I'm dating myself--Bryan and I think about 15 or 18 other hospitals that routinely program together. I'm just curious that they're pretty good about covering all bases of needs that are out there. And I would think that if Bryan and Methodist both have palliative care programs, they're going to be doing something across the state. I'm just trying to look at existing structures as opposed to necessarily trying to recreate a new structure. [LB1043]

HEATH BODDY: Senator, it would strike me that that line of thought makes sense. I do not know, however, when it seems like based on the reports and what we experienced at the Hospice and Palliative Care Association, it seems like the urban areas have a lot more of a foothold on this theory than we do across the rural areas. So whether from those larger environments, whether those are permeating across the state, I'm sorry, I can't answer that. I don't know. [LB1043]

SENATOR RIEPE: Yeah. I don't know either, but thank you. [LB1043]

SENATOR CAMPBELL: Any other questions? Senator Kolterman. [LB1043]

SENATOR KOLTERMAN: Yeah. Thank you for coming, your testimony. The reason for my question, this is new to me, palliative care. Is that correct? [LB1043]

HEATH BODDY: Look at that. [LB1043]

SENATOR KOLTERMAN: Okay. It takes a while. Anyway, under a long-term care policy, as an example, you...there's seven activities of daily living that have to be implemented before--at least two of those--before you can collect. Do people that are on palliative care necessarily...are they disabled, are they able to function just regularly? It's not terminal, but it's long term. [LB1043]

HEATH BODDY: Sure. [LB1043]

SENATOR KOLTERMAN: You see where I'm going with that? [LB1043]

HEATH BODDY: I do see where you're going. [LB1043]

SENATOR KOLTERMAN: It's just a question that I have because of my curiosity about, I guess, of the diagnosis because that's what it is really, isn't it? [LB1043]

HEATH BODDY: You know, so two things strike me with your question. I'm not sure the programs are solidified enough across the state and across the nation to be able to answer that carte blanche. I think my answer right out of the gate would be, it would depend. But one of the things that we see with palliative care when we look at it--and again, we're really on the front side of this in Nebraska as it would relate in the healthcare space--a lot of palliative care can be done in the home. And so when you talk about a program in a hospital, inside the hospital walls, that may have a very different effect and support level and those things than when it goes out in

Gordon, Nebraska, in somebody's home. So it would seem that some people would have ADLs, activities of daily living, that would fit. I'm sure there's other experiences where it wouldn't. You know, one of the things that strikes me about long-term care insurance policies--I've been a long-term care administrator for 25 years--when assisted living started coming on the scene policies only were written for skilled facilities and assisted living facilities weren't included. Where palliative care is not licensed and regulated it would surprise me that the policies would help cover that. That doesn't mean they won't, but it would surprise me from that perspective. So I'm not sure if anybody behind me or if we've got more information at the office--I know that we're watching this on NET as well--I'd be glad to provide it to you. [LB1043]

SENATOR KOLTERMAN: Well, not just in long-term care, even in a regular health insurance policy or a Medicare or Medicaid type of policy, are they...do they have to be coded differently so that the institution can collect, because I don't want to...I mean, it's already created, but you don't want to continue to grow something where you end up doing it for free. You have enough mandated things to do, let alone... [LB1043]

HEATH BODDY: In my understanding today, with Medicare and Medicaid you cannot bill under a palliative care code. You would have to bill under some other physician or nurse practitioner type service. [LB1043]

SENATOR KOLTERMAN: Okay. Thank you. [LB1043]

HEATH BODDY: You bet. [LB1043]

SENATOR CAMPBELL: Okay. Senator Fox. [LB1043]

SENATOR FOX: Thank you for your testimony. I definitely appreciate your support of this bill, but I have some concerns about your requesting that we consider or that it be considered the use of the term interdisciplinary care as opposed to medical care because, in my mind, palliative care is a form of medical care. Somebody can...I mean, the difference would be that instead of somebody getting curative care they're getting supportive care, they're getting symptom management. So I still see it as medical care. At the Med Center somebody may have leukemia and not wanting a bone marrow transplant but they still want blood transfusions, they still want various IV medications. And to me that's medical care. Or, again, they might be getting...they may have a metastatic cancer, they may not be getting...and because of that they were not going to give them curative chemo therapy, they're going to get palliative chemo therapy more to just slow down the tumor growth. So to me, again, that's medical care. Do you want to expand why you would, say, take that out? [LB1043]

HEATH BODDY: I see your line of thought, Senator, and I don't know that I can disagree. I think our stance on that was that it was really important to emphasize the whole team, the interdisciplinary. So much of hospice and palliative care is the spiritual side, is the...it's the whole person piece of that as opposed to sometimes you get--not you, Senator--but people get monofocused with the medical piece. And not that medical can't have holistic pieces in it, but traditionally--at least in my experience traditionally--that tends to put people in a little bit different vision path, and so that was our approach. I don't know that we're necessarily stuck, but it seemed really important to emphasize that whole team, the whole person approach to...and interdisciplinary seemed to be the word that made sense, but it may not be the right word. [LB1043]

SENATOR FOX: Thank you. [LB1043]

HEATH BODDY: You bet. [LB1043]

SENATOR CAMPBELL: Anything else? Thank you, Mr. Boddy. Oh, sorry. Senator Crawford, you didn't have a questions, did you? Thank you. [LB1043]

HEATH BODDY: Thank you. [LB1043]

SENATOR CAMPBELL: Our next proponent. [LB1043]

GREG SCHLEPPENBACH: (Exhibit 4) Good afternoon, Senator Campbell and members of the committee. My name is Greg Schleppenbach, S-c-h-l-e-p-p-e-n-b-a-c-h, I'm executive director of the Nebraska Catholic Conference and am here to put our support behind this bill, LB1043, and to thank Senator Howard for bringing it forward. We support this bill because it begins to raise awareness, more awareness, about the importance of palliative care and hospice care and we believe that palliative care, again, like hospice care, embodies a truly human response to persons with serious illness. It focuses on the whole person--body, mind, and soul--and addresses the pain and suffering that can be experienced as a result of serious illness, not only the physical suffering, but suffering that can be emotional, psychological, relational, and spiritual. There's a great need to increase emphasis and resources on ensuring good quality, end-of-life hospice and palliative care. One of the factors that tempts people to consider supporting or seeking assisted suicide is a lack of sufficient good, quality palliative and end-of-life care and the unnecessary suffering that results. Next week I'll be testifying in opposition to Senator Chambers' proposal to legalize assisted suicide or doctor-prescribed suicide. That we believe is the wrong response to bad medical or end-of-life care. This bill is the right and truly human response to bad end-of-life care. And that's the reason why we are very pleased to support this bill and continue discussions on how we can raise more awareness and more training in the medical profession on good,

quality palliative and end-of-life care. So we encourage you to support this bill. Thank you. [LB1043]

SENATOR CAMPBELL: Thank you. Any other comments? Thank you, Mr. Schleppenbach. Our next proponent. Okay. Anyone in the room in opposition to the bill? Okay. Anyone in a neutral position? All right. Senator Howard, we're back to you. [LB1043]

SENATOR HOWARD: I'll be brief. I'd just like to thank the committee for taking the time to consider this issue. I want to clarify that this bill has nothing to do with euthanasia or assisted suicide. It's more about ensuring that providers and the general public are on the same page about our expectations about the role of palliative care as a part of the continuum of care for patients in our state. I loved the testifier from the Medical Association who said that this is really more of a catalyst and a clearinghouse for education about palliative care. It's not an oversight board, to be very clear; it's an advisory board. And other states have actually already implemented this type of board and this type of education, so Florida, Texas, Illinois, and Oklahoma, just to name a few. And so I very much appreciate the committee's time and attention to this issue. It is the beginning of a broader conversation, I'm sure, but thank you so much for your time. [LB1043]

SENATOR CAMPBELL: Any other questions? It just seems to me that for a long time all we had was hospice care. And sometimes people would look at that and think, oh, I'm going to die within several months. And really, this creates a different stage for people and families where that person is not in eminent...looking at death, but does have a serious enough injury or illness that they need help facing it and dealing with it. So I appreciate that. All right. [LB1043]

SENATOR HOWARD: Thank you. [LB1043]

SENATOR CAMPBELL: That concludes our hearing today. Yes, we do have a letter for the record on this one, I think. [LB1043]

ELICE HUBBERT: (Exhibit 4) We have one letter of support from the National Association of Social Workers, the Nebraska Chapter. [LB1043]

SENATOR CAMPBELL: All right. That does conclude and we'll ask you all to leave as quietly as you can because... [LB1043]