HOWARD: Good afternoon and welcome to the Health and Human Services Committee. My name is Senator Sara Howard and I represent District 9 in midtown Omaha and I serve as Chair of the Health and Human Services Committee. I'd like to invite the members of the Committee to introduce themselves starting on my right with Senator Walz.

WALZ: Hi, I am Senator Walz and I represent District 15, which is all of Dodge County.

ARCH: John Arch, represent Sarpy County, District 14.

WILLIAMS: Matt Williams, Legis-- Legislative District 36, Custer, Dawson, and north portion of Buffalo Counties.

HOWARD: And we are being joined by Senator Cavanaugh and Senator Murman. Also assisting the committee is our legal counsel, Jennifer Carter, and our committee clerk, Sherry Shaffer, and our committee pages-- we've got Maddy. Is Erika coming today? And Erika is coming later. A few notes about our policies and procedures. We ask that you turn off or silence your cell phones. This afternoon we'll be hearing three bills and we'll be taking them in the order listed on the agenda outside of the room. On each of the tables near the doors to the hearing room, you'll find green testifier sheets. If you're planning to testify today, please fill one out and hand it to Sherry when you come up to testify. If you are not testifying at the microphone but want to go on record as having a position on a bill being heard today, there are white sign-in sheets at each entrance where you may leave your name and other pertinent information. Also I would note if you are not testifying but have written testimony that you would like to submit, the Legislature's policy is that all letters for the record must be received by the committee by 5:00 p.m. the day prior to the hearing. Any handout submitted by testifiers will also be included as part of the record as exhibits. We would ask if you do have any handouts that you please bring ten copies and give them to the page when you come up to testify. We do use a light system in this committee. Each testifier will have five minutes to testify. When you begin the light will be green. You'll have four minutes with a green light and then the light turns yellow and then when it turns red we'll ask-- we will ask you to wrap up your final thoughts. When you come up to testify please begin by stating your name clearly into the microphone and then please spell both your first and last name. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters,

opponents, and neutral testifiers and then the introducer of the bill will have the opportunity to make a closing statement. We do have a strict no prop policy in this committee. And with that, we will begin today's hearing with LB439, Senator Crawford's bill to require coverage for chiropractic services under the Medical Assistance Act. Good afternoon, Senator Crawford.

CRAWFORD: Good afternoon, Chairwoman Howard and members of the HHS Committee. It's wonderful to be here with you today. I represent the 45th Legislative District at Bellevue, Offutt, and eastern Sarpy County. And my name is Sue Crawford, S-u-e C-r-a-w-f-o-r-d. I'm honored to be here today to introduce LB439 for your consideration. The intent of LB439 is to create a cost savings for our Medicaid program and simultaneously combat the opioid, opioid crisis by providing adequate access to more cost-effective treatment choices for patients experiencing pain. The bill requires the Nebraska Department of Health and Human Services to amend existing Medicaid regulations to allow coverage for no less than 24 chiropractic visits per year. It would also require that regulations be changed to allow chiropractic physicians to be reimbursed for all services within their scope of practice that are payable, payable by Medicaid for which other providers are already being reimbursed. Studies show that providing patients with adequate access to chiropractic care results in cost savings by avoiding more aggressive and costly procedures. One study shows a 20 percent cost savings for treatment for lower back pain when the treatment is initiated by a chiropractor when compared to with treatment initiated by a medical doctor or doctor osteopathy. Chiropractic care has also been demonstrated to decrease the use of opioid medications for patients with low back pain. A recent study found that the likelihood of filling a prescription for opioids was 55 percent lower among patients complaining of lower back pain who sought chiropractic care. Chiropractic care has gained increasing attention as an efficient and cost-effective means to treat chronic pain conditions which are often involved with opioid, opioid addictions. In 2017, 37 state attorney generals, including Nebraska's, signed a letter to America's health insurance plans encouraging insurance providers to prioritize access to conservative care including chiropractic care to help cut opioid use. For Nebraska to better follow these recommendations, an adequate number of chiropractic visits must be provided. Current Medicaid regulations state that only 12 visits per year will be covered. The current 12 visit cap is extremely low when compared to other providers and does not allow for adequate treatment in many cases. LB439 also creates parity for

Nebraska chiropractic physicians and their patients. The bill would remove the arbitrary restriction on chiropractic physicians that blocks reimbursement of services that are covered by Nebraska Medicaid that are reimbursed to other providers. This would allow Nebraska's chiropractors to be reimbursed for services such as examinations and physiotherapy which make the patient treatment more effective and more efficient. The amendment being provided to you specifies that the treatments must still be medically necessary. This amendment was requested by the Department of Health and Human Services and clarifies that every patient is not automatically entitled to 24 sessions just to those that are medically necessary. In conversations with the Department, we have determined that there is a possibility that these changes can be accomplished through rules and regulations process which would eliminate the need to change statute. You should be receiving a letter soon from Matthew Van Patton, Director of HHS Medicaid Division, entailing the Department's willingness to update the existing regulations to eliminate the current cap and to cover appropriate medically necessary chiropractic services. In our meeting with the Department staff today, staff indicated they anticipate the changes could be promulgated by the end of the year. LB439 presents an opportunity to improve care for Nebraska's Medicaid patients and provide parity for chiropractic physicians while providing a cost savings to the state of Nebraska and working to diminish issues with opioid addiction. Chiropractic practitioners who are here today to testify can help answer questions about chiropractic care that you have or their experience with Medicaid. I'm happy to try to take any questions that I can answer for you now or at closing.

HOWARD: Thank you, Senator Crawford. Are there questions? Senator Williams.

WILLIAMS: Thank you, Chairwoman Howard. I feel a little awkward sitting in this seat that you've occupied--

CRAWFORD: Yes.

WILLIAMS: --for the last several years. I want to be sure that I understand, Senator Crawford, your comments about the, the, the Department.

CRAWFORD: Correct.

WILLIAMS: If they come through with that, can you demonstrate a need for this legislation then or--

CRAWFORD: If the, if the department promulgates the rules and regulations that reduces the, the limit on number of visits and opens up the care to other appropriate medically necessary care then the statute is no longer necessary.

WILLIAMS: Thank you very much.

HOWARD: When you add the language medically necessary-- so should your bill be needed.

CRAWFORD: OK.

HOWARD: When you add the language medical necessity through the amendment, does that-- would that mean that all treatments for chiropractic care would then subsequently have to be medically necessary?

CRAWFORD: The-- I think the medically necessary right now is applied to the 24 treatments language. But it's a-- I guess we were assuming that the other treatments also would be--

HOWARD: That the--

CRAWFORD: --only what's medically necessary.

HOWARD: OK. Thank you.

CRAWFORD: Sure.

HOWARD: Other questions? Seeing none, will you be staying to close?

CRAWFORD: I will be.

HOWARD: Thank you. Our first proponent testifier for LB439. Good afternoon.

BRADLEY STAUFFER: Good afternoon. Thank you, Senator Howard and thank you to the committee for hearing me today. My name is Bradley Stauffer, B-r-a-d-l-e-y S-t-a-u-f-f-e-r. I am the chairperson for the-- excuse me, the legislative chairperson for the Nebraska Chiropractic Physicians Association. I am also a practicing chiropractor in Gretna, Nebraska. And we are here today about LB439 which does expand from 12 to 24 visits, the number of times we can see

a Medicaid patient. It also expands to all services that we can provide under our scope of practice. I want to thank Senator Crawford for bringing the bill we very much appreciate it. You're gonna hear several testifiers from our group today. They're gonna talk about different aspects of the bill and different parts of the bill. The biggest thing I want you to understand is that we're bringing this forward because we think it's good for all parties involved. We think it's good for the Medicaid patients because it provides them less aggressive and more conservative care. We think it's good for the state of Nebraska and Medicaid program simply because there is a lot of research out there showing that conservative care in chiropractic care is a cost saver. And we also think it's good for the state because there is a significant reduction that's been shown in opioid use when chiropractic care is used. So we kind of see this as a win-win situation for all the parties involved. A lot of the medical-- or excuse me, a lot of the insurance industry is moving in this direction. We're seeing more and more encouragement of conservative care for those very reasons. They're seeing all the things that we've said-- that I just said prior in practice and so they're actually using more conservative care, using more chiropractic care in specific just because they're seeing a positive reaction from that in their bottom line. And then we think that we would like Medicaid to follow along with that and kind of think out of the typical Medicaid box. We think that that will be good for them. We'd like to see them follow the free market and do those things as well. We know Medicaid is facing some challenges right now. We'd really like to be part of the solution to that. So we really think that they will see the same results that they've seen in the insurance industry that costs will actually go down as we use more conservative care and use less of the more aggressive and, and expensive care. Traditional thinking is kind of to-- you know, cut things and save money. And so what we're kind of impressing upon people is that-- you know, taking away chiropractic care or keeping chiropractic care low and sending people to surgeons and emergency rooms and putting them on opioids isn't good for anybody. It isn't good for the cost angle. It isn't good for the patient in many cases if they're-- if it's an opioid issue. And so we really would like to take that path towards using more chiropractic care, providing more conservative care, and having the patient do better that way as opposed to having to go into more aggressive and expensive care. If you have any questions, I'd be happy to answer them. Obviously, I'm, I'm in favor and we would ask that you would move this bill forward. And, and we've talked a little bit about as things are kind of progressing on the other, other side and

discussions with HHS. We may ask to hold the bill in the committee and, and not necessarily put forward, but have it still as a marker so if those things don't move forward that we can still come back and, and use it.

HOWARD: Thank you.

BRADLEY STAUFFER: No problem.

HOWARD: Are there questions? Seeing none, thank you for your testimony.

BRADLEY STAUFFER: All right. Thank you.

HOWARD: Our next proponent testifier. Good afternoon.

LOUIS ANDERSEN: Good afternoon, Senator Howard and other members. It's my pleasure to be here with you today. I'm not a chiropractor. I think I'm the only one here that's gonna speak that's not a chiropractor. My name is Lou-- Louis Andersen. And that's, L-o-u-i-s- A-n-d-e-r-s-e-n. I'm currently the chief executive officer of the Nebraska Chiropractic Physicians Association and its for-profit subsidiary SecureCare. I'm here today to provide you with some perspective on LB439. And I'd like to start out with some-- about perspective, about-- I think, what we're all trying to accomplish together here today. Prior to my current role with the Nebraska chiropractors, I was the chief executive officer of what is now the Aetna Coventry insurance franchise in Nebraska. I spent about 30 years of my career running large for-profit insurance companies. UnitedHealth Group is a company and they recognize-- I worked for them for many years. When we're thinking about what we're trying to accomplish here with the expansion of chiropractic benefits, I think we should pause and ask ourselves, ourselves a real simple question which is why would Blue Cross Blue Shield of Nebraska? Why would UnitedHealthcare? Why would Aetna healthcare and other major players that happen to be traded on the New York Stock Exchange. These are organizations that make very wise fiscal decisions. Have robust conservative care coverages in their health plans that they offer to large self-insured companies. Many of which-- you know, ConAgra for example, Union Pacific Railroad. There's a renaissance going on now where they know these decision makers that are in charge of multi-billion dollar companies. One of their largest expenditures is healthcare costs. And there is a rush now to move utilization away from the OR and pharmacy and into conservative care modalities. There's no one that offers conservative care at a lower

price and more effective than conservative care providers. Physical therapists, for example, and chiropractors. So the strategies of the past, limiting access to conservative care, one of the, one of the most-- you know, obvious ways that's done is through visit limits. You know, we, we need to like keep people away from the, from the chiropractors, right? Because they're just gonna run up costs. Not so true-- not so much true anymore out in the, in the commercial world. So I think we can learn, learn a lot from those strategic moves that these large corporations are making and the gap is starting to close. There has been a historical gap between-- you know, a pretty healthy misunderstanding. Some might even call it a lack of respect for certain conservative care providers. Those biases are evaporating really quickly and they're evaporating quickly because of one really important ingredient, money. And the people paying the bills, which are the large self-insured employers, and the fully-insured employer small business people want cost control. And the only way that we're gonna accomplish that is through a reengineering of utilization and increasing access to con-- to conservative care modalities. So that's what we're really trying to accomplish here. So I just wanted to make a brief comment as well on the fiscal note that's attached to this, this legislation. And I, I understand-- you know, my father worked as-- you know, with Hal Daub and Chief of Staff of the Omaha City Council for decades. And I realize the need to score things and run them through a process to try to size them up, but I would just caution you that the, that the work done on the fiscal note is pretty one dimensional. It doesn't-- you know, it really-- I think there's a note attached to it about the possibility of reducing costs. But if we were to look at the total expenditure for musculoskeletal surgeries, pharmacy costs within the Medicaid program-- and if you believe that all in the efficacy of conservative care-- if we shifted even 1 percent or 2 percent of utilization into conservative care through increased chiropractic benefits, the fiscal note would basically reverse itself. I'm obviously just paraphrasing, but I think you kind of understand what I'm-- the, the point that I'm trying to make about looking at the impact of increasing access to a certain services for lower costs. Best example, everybody wants preventative care. Right? We want people to go get mammograms. We want them to get their cholesterol tested so we increase utilization in these preventative care areas that are-- tend to be less expensive in hopes that we don't have undue breast cancers and so forth in the future. And I see my time is up and so I'd be happy to answer any questions the committee might have of me.

HOWARD: Thank you. Are there questions? Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman. Thank you for being here. I'm just reading over the fiscal note and just wanted to acknowledge for the committee and for you that it says that it assumes the medical necess-- necessity requirement was removed. So the amendment that Senator Crawford brought in would make that-- it, it was eliminating the Medicaid match-- federal match. So it actually-- the fiscal note would be, I guess, half-- or well, there'd be a federal match. So it would-- in the fiscal note is not representative of what the amendment would do. So just wanted to acknowledge that for everyone.

HOWARD: Sure, Senator.

CAVANAUGH: Thank you for bringing that up though.

LOUIS ANDERSEN: You're welcome.

HOWARD: Senator Hansen.

B. HANSEN: I think before I make any other comments I should put a caveat that I am a chiropractor myself, so take all my comments with however you like. So I think whenever it comes to healthcare and importance of healthcare and the importance of anything the state should help pay for when it comes to Medicaid, it comes down to prevention which I think you touched on. Cost- effectiveness which I think you definitely touched on. And also something we tend to forget about when it comes to-- you know, medicine or chiropractic care or preventive modalities is patient satisfaction. I think that's a big important factor that we also need to think about remember gonna pay for anything as a state not just a cost-effectiveness or prevention but also patient satisfaction. Can you explain a little bit about chiropractic-- you know, level of patient satisfaction they have compared to any other modalities?

LOUIS ANDERSEN: Absolutely. There's lots of surveys out there on the satisfaction rate with chiropractic is extraordinarily high. If you think about actual interactions between patients and providers in today's world, the vast majority of people present at a doctor's office never actually get physically touched by the prac-- by, by the provider. They're usually a good-- you know, three to five feet away with a prescription pad in their hand or some sort of an order-- ordering book. Patients that go to see a chiropractor, they may go in with neck or back pain and they walk out with immediate symptom relief

and not in the form of a little white pill. And so practitioners are-- I mean, patients are very, very satisfied with their interactions with chiropractors. And I might also mention on the terms of satisfaction, the Veteran's Administration now has got a major, major effort underway to open up access to chiropractic care for our nation's vets. These are people that have spent their lives protecting the United States and they carry a lot of heavy stuff and they get hurt-- you know, more than the average citizen. And so I was just down talking to the folks at the Veterans Administration last week as a matter of fact and there's a huge, huge effort on the part of the VA. We actually were gonna have somebody here today, I don't think that he made-- was able to make it. He's actually a chiropractor working for the Veterans Administration, and so that's kind of ties into your question about satisfac-- satisfaction.

B. HANSEN: I think that's one of those un-- untold-- you know, that [INAUDIBLE]-- talk about how well care is-- you know, how much people-- just ask what they-- the benefit they get out of it. I think patient satisfaction is one of those telling signs about how effective I think care really can be.

LOUIS ANDERSEN: Yeah.

B. HANSEN: Thank you.

HOWARD: Other questions? Seeing none, thank you for your testimony.

LOUIS ANDERSEN: Thank you, Senator Howard.

HOWARD: Our next proponent testifier. Good afternoon.

MARK KNOLL: Good afternoon. Good afternoon, Senator Howard and members of the Health and Human Services Committee. My name is Mark Knoll, M-a-r-k K-n-o-l-l, and I am a doctor of chiropractic. I'm also the medical director for the Nebraska Chiropractic Physicians Association and its for- profit subsidiary SecureCare. Prior to my current role as medical director, I was in private chiropractic practice here in Nebraska for 30 years. I am here today to testify in support of LB439 regarding evidence that supports the cost-effectiveness of chiropractic and how expansion of chiropractic benefits under Nebraska Medicaid can have an overall cost-saving effect. Chronic pain affects about 100 million American adults. This is more than the total affected by heart disease, cancer, and diabetes combined. I would like to describe a recent Medicaid integrated chronic pain project

conducted in Rhode Island. Based on a 2014 report, Rhode Island Medicaid had been experiencing increased rates of emergency room utilization. Medicaid led focus groups of frequent emergency room users identified chronic pain as a significant driver. Clinical practice guidelines were developed to assist healthcare workers in determining the use of complementary and alternative medicine for pain which included chiropractic therapy, acupuncture, and massage. The Rhode Island Medicaid integrated chronic pain program produced the following results: reduced average medical costs of 27 percent; decreased emergency room visits of 61 percent; lowered average total prescriptions of 63 percent; reduced average number of opioid prescriptions of 86 percent. The second piece of evidence I will outline today is a 2010 study published in The Journal of Manipulative and Physiological Therapeutics. The aim of this study was to determine if there are differences in the cost of low back pain care when a patient is able to initiate that care either with a medical doctor or a doctor of chiropractic, provided that the insurance provides equal access to both provider types. For this study, a retrospective claim analysis was performed on Blue Cross Blue Shield of Tennessee's insured population over a two-year period. The analysis was based on episodes of care for low back pain. Paid costs for episodes of care initiated with the doctor of chiropractic were 40 percent less than episodes initiated with a medical doctor. Even after risk adjusting, episodes of care initiated with the doctor of chiropractic were 20 percent less expensive than those initiated with a medical doctor. I believe these two examples clearly illustrate that increased utilization of chiropractic services could lower overall health costs for patients with chronic pain and musculoskeletal conditions. I'd be happy to answer any questions.

HOWARD: Thank you. Are there questions? Senator Williams.

WILLIAMS: Thank you, Chairwoman Howard. And thank you, Doctor, for being here. And, and as the medical director for the Association, can you take me to some of the thought process that moves this from 12 to 24? How, how do we arrive at 24 versus 18 or 36 or something?

MARK KNOLL: You know, one of the things that, that I do as medical director is-- our company SecureCare, we look at a lot of data. And one of the things that we see is that-- well, when you look at national data and you say-- you know, how many visits does the average patient see a chiropractor in a year, it may be seven or eight. So it's relatively low. But there's a percentage of those patients 20 or

so-- 20 percent, maybe 25 percent that need 15, 20, 30 visits. And so when, when patients are only allowed to get 12 visits, we know, we know they're, they're still hurting and they're gonna go somewhere for that care. And if they're going outside of chiropractic to more expensive venues-- injections, surgery, whatever, we know it's gonna cost more money. And so obviously 24 visits is an arbitrary number, but we felt like it gives more opportunity to encompass proper treatment of those patients.

WILLIAMS: Thank you.

MARK KNOLL: You're welcome.

HOWARD: Other questions? Seeing none, thank you for your testimony today.

MARK KNOLL: OK.

HOWARD: Our next proponent testifier. Good afternoon.

JEFF JOHNSON: Good afternoon, Madam Chairman, members of the committee. My name is Jeff Johnson, J-e-f-f J-o-h-n-s-o-n. I'm the current president of the Nebraska Chiropractic Physicians Association and I practice here in Lincoln and thank you for hearing my testimony today in favor of LB439. The current limitations imposed on chiropractors make it difficult to provide quality care for some of the conditions that we treat. I speak for chiropractors and chiropractic patients in Nebraska based on my experience since 1990. Chiropractors treat conditions of the spine and extremities, neck pain, shoulder pain, back pain, stiffness, muscle spasms, and we get really good results with those kind of conditions. But what about the more complicated cases? We see a lot of patients with sciatica. It's nerve compression-- pinched nerve in the lower back, radiates from the spine down the leg, can be numbness, weakness. Or the upper body equivalent of that, it's a pinched nerve in the neck that causes pain, numbness, tingling, radiating from the point of that pinched nerve down through the rest of the body. We'll use it as a pinched nerve just for simplification. There's more to it than that. These conditions are classified as mechanical-- mechanical pain or a physical pain, there's pressure, there's compression, there's irritation and it, it needs to be reduced. It needs to be physically reduced. For these kinds of conditions, manual therapy or chiropractic adjustments are much more effective than pain medications because they don't really address the cause of the problem. Patients with

complicated conditions like pinched nerves, they don't always get better in a preset number of visits. Also there's times where someone may have a condition in January that requires treatment and they have another problem in a different body part-- you know, in December. The 12-visit limit in Nebraska Medicaid, it came from the origins of the Medicare program in the early 1970s and it's never really been updated or even looked at. Currently, Medicare plans cover chiropractic care based on medical necessity not a cap or limit. Private insurance companies, as you've heard, are very concerned about costs. They recognize the savings in quality conservative care. Nebraska Medicaid currently allows 60, 60 visits for physical therapy but maintains a 12-visit limit cap on chiropractic. So what happens to our patients if they don't get better in those 12 visits? Likely, they move on to other medical providers and procedures and emergency rooms often at a much greater cost. Studies show that patients who start with medical care versus chiropractic care for the same condition are more likely to have more expensive imaging tests like MRIs, have more visits to doctors including referrals to specialists like orthopedic and neurology, having a higher rate of surgery and more likely to prescribe drugs including opioids. Now certainly there's a time in a patient population that need those kind of treatments and procedures. Absolutely. We just see that we can be a good intermediary in that, in that mix. So finally, chiropractic resen-- represents a solution for reducing the high costs in healthcare for the treatment of musculoskeletal pain which is one of the most common reasons patients visit a doctor. If you can relieve pain without medication early in the episode, we can help prevent opioid addictions before they start. A recent study in New Hampshire showed that patients who saw a doctor of chiropractic for low back pain were 55 percent less likely to fill a prescription for opioids than patients with back pain that did not see a chiropractor. We hope this committee will support LB439 and I'd be happy to answer any questions.

HOWARD: Thank you. Are their questions? Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman. I feel like you just described me-- like I was your-- I'm your case here. I suffer from a pretty severe pinched nerve, I guess you'd say. And after having three children, it's gotten worse each time and so I have sought all types of care including chiropractic. And the first time it happened, I went to my, my provider and I was prescribed muscle relaxants and they did nothing but make me loopy. And we've had previous testimonies here about the issues with opioids and addictions. And I've been very cognizant of

that in my life that that's an issue for people and so I immediately sought other options. First Tylenol, which didn't cut it. So I went to chiropractic care and I did have to have the first week of the first really bad episode-- I went multiple times in one week. And I went-- I ended up going to the chiropractor I think 24 times in six months and then it got a lot better and then I had another kid and went through it all over again. So I really appreciate what you're saying here and I know it's not easy to, Senator Williams' question, determine the right amount. But certainly giving that flexibility seems to be what we're trying to get at here is to having the ability to determine that right amount. So I just appreciate that and-- you know, I'm happy to talk about my chronic pain anytime.

JEFF JOHNSON: Thank you for those comments and I think that gets to the point it was made earlier that there are some people that just need more care than others. And a lot of them, it's just a neck pain or stiffness, they woke up with it, and two to three visits later-- two weeks later they're fine. They're good. They're done. But there are a, a percentage population that need a higher level of care and we would just like you part of the team that provide all the services.

CAVANAUGH: I did go a full year without seeking chiropractic care after I've done the six months. So I mean, it-- yeah, the, the ability to recover and not take medication is very much appreciated at least in my case.

JEFF JOHNSON: Great.

HOWARD: Other questions? Senator Arch.

ARCH: Thank you for coming. I-- I'm aware that with lower back pain now oftentimes an insurance company-- somebody would require physical therapy prior to going and having an MRI done and, and aggressive treatment. Do you see that in chiropractic practice? And, and of those-- and, and maybe there's no study out there at the present time, but of those that are referred prior to surgery, prior to need of surgery, do you, do you see many being referred onto surgery after chiropractic treatment because that was unsuccessful because certainly within physical therapy they do get referred onto an MRI when that's not the issue but--

JEFF JOHNSON: Yeah, what I've seen in clinical practice and it's, it's changed a little bit in the last five years. Is that a patient with-- like radiating pain like I was describing. There was a time where an

MRI would be the first step. And in chiropractic, our scope of practice, we order those tests. We order them routinely but we would treat the patient for a period of three to four weeks to see if we're making some improvement and if they're getting better. And so what we see now is patients would come-- instead of going to the surgeon or going for the orthopedic consult, they'll come through a chiropractor. And we'll treat it for three to four weeks, and we'll kind of see-- you know, what kind of improvement they made. You know surgeons, they want to do surgery. They, they don't want to mess with the patients that will get better with conservative care. They've got better things to do. And, and so the overall demeanor has definitely changed in the last few years. Percentage wise, how many do we get better and save from that, that's difficult to tell. But you know, there's a good proportion of people that do better with conservative care and if they get started on some exercises and rehabilitation-- you know, they have a much better chance of getting better. And you know, that's one of the other byproducts of this, chiropractors get paid for chiropractic adjustments. We do a lot more than that. We do rehab. We train people to do rehab. We take the time with them to show them how to do those things. We do therapies with them. We get none of that under Medicaid. So the time we spend with the patient is probably less than desirable. But there are a lot more things we could do if we had the time to spend with the patients to get them better, too.

ARCH: Thank you.

JEFF JOHNSON: Thank you.

HOWARD: Senator Murman.

MURMAN: Yes, thanks for your testimony. Myself and, and at least a couple members of my family see a chiropractor once in a while and, and with great success. And I, and I know a few others also that do the same. But everybody I know just usually goes for one or two treatments and then-- you know, they're OK for six months or a year or so.

JEFF JOHNSON: Um-hum.

MURMAN: And maybe you just answered this question I'm not sure, but do you have any ideas on-- you know, the frequency or how many patients would see a chiropractor-- you know, more than 12 times a year or more often I guess?

JEFF JOHNSON: What we often see is the patients who have the difficult conditions for the 12 visits and then we explain to them there's no further coverage so we may lose track of where they went after that.

MURMAN: Um-hum.

JEFF JOHNSON: But there's a good number of probably more than half that don't come in 12 visits a year. They come in two to three times for a condition. They're good for six months, nine months, maybe we don't even see them again that year. We, we see kids sometimes-- you know, two, three visits and they're good and, and see them another year later. So I hope that answers, answers your question.

MURMAN: OK. Thank you. Just a follow up. You mentioned rehab earlier. I guess I didn't really realize that-- I'm thinking more of physical therapy for rehab from like surgery or, or so forth. Do chiropractors-- is that pretty common that chiropractors do rehab also?

JEFF JOHNSON: It is, absolutely. It's part of the healing process. You know, we look to get the pressure off the nerve and get the tissues working better but we also want to teach them. Number one, to stretch out and do something positive-- walk, but strengthening exercises long-term. That's what keeps them from needing care down the road and there are chiro-- chiropractors where that's 50 percent of their office is people doing rehab within the office.

MURMAN: OK. Thanks.

JEFF JOHNSON: Thank you.

HOWARD: Senator Hansen.

B. HANSEN: I'm just gonna play off a couple senators' questions if I could. One of the questions Senator Arch brought up was about the effect that this having chiropractic care before they go to medical doctor in preventing surgeries possibly perhaps. And in the-- I noticed you've got in your handout that you had, there's a nice little graph in there from the Journal Spine that talks about the likelihood of surgeries of workers going ahead with back injuries. Having surgery likelihood of when you go to a doctor of chiropractic is 1.5 percent as opposed to medical doctors which is 42 percent. So interesting study that I saw that they handed out there. And I think one of the things Senator Murman also had a question about was rehabilitation and

it's not really a chiropractor's job I think to replace physical therapists. I think, we actually over the course, especially the last few years, have found that we work, work really well together. Chiropractors addressing the structural issues of patients. Physical therapists addressing more of the rehabilitative portion of it. Even though chiropractors do a lot of rehabilitative services, I think we work really well together and we found it out especially true over the last few years. So also I want to touch on the effectiveness of chiropractic and the reduction of opioid use. I think that's an important topic especially coming up in the years. I think Nebraska's done really well but-- and Sara-- Senator Howard especially is getting ahead of the problem making some either rules or regulations to help control the opioid epidemic and so we make all these rules regulations to help control it. I think what's very beneficial as us as the state Nebraska is to give the patient another option for care besides-- you know, we're trying to control the opioid abuse. But what can we do for the patient who is in pain who doesn't want to use opioids? I think chiropractic care is like the first conservative step I think a lot of patients can use in helping control this opioid epidemic. And I think that's why-- you know, I, I appreciate you guys coming here in, in trying to get more care with Medicaid and I think that's very effective for patients to have. So thank you for coming.

JEFF JOHNSON: Thank you for letting me testify and--

HOWARD: Any other questions? All right. Seeing none,--

JEFF JOHNSON: Thank you.

HOWARD: --thank you for your testimony today. Our next proponent testifier. Good afternoon.

DAVID LAUER: Good afternoon, and thank you for having me. I appreciate your patience and, and listening. I'll try not to be redundant. Basically-- my name is David Lauer, D-a-v-i-d L-a-u-e-r, a practicing chiropractic physician here in Lincoln, Nebraska. I've been here for 34 years, maintained a full- time practice that entire time. I'm also in my second term on the Board of Chiropractic which is division of the Board of Health in the state of Nebraska. And so I have a bit of a unique perspective from that. For the past 34 years, my office has accepted Nebraska Medicaid patients without restriction. And that's becoming more the exception sometimes. I know a lot of offices, they're starting to restrict the amount of Medicaid patients because of the reimbursement and because of the limits. And I think that's

unfortunate because Medicaid is gonna become a bigger part of our state healthcare system in the near future. I and the vast majority of my colleagues feel an obligation to serve the Medicaid population similar to what we would serve the rest of the population whether they have back pain, leg pain, headaches, whatever the case may be, we'd like to be able to serve them in the same manner. Medicaid patients are unique. They have fewer options. Many times their inability, inability to advocate for themselves puts them at a distinct disadvantage and they are vulnerable especially in the healthcare system I think because we speak our own language. We have our own methods and it's, it's harder for them to access in many cases. Accepting Medicaid patients certainly isn't a business decision, it's something we don't graph out. And I, I hesitate to even look at it from that standpoint because if I did I probably wouldn't accept Medicaid patients on a regular basis. It's not a winning proposition, but it's a personal decision. It's a decision to serve those who need it the most. And fortunately, we get to see a lot of people only temporarily on Medicaid and get off of Medicaid and become patients with regular insurance and that's always exciting for us. It's not a wise clinical decision either. In many instances, we're so restricted because we can't use our full scope of practice that we're extremely limited in the-- our value to that patient. And in spite of these restrictions, I know many cases in my office and other offices, we still employ traction, ultrasound, electrical stim, and these types of modalities, knowing we will not be reimbursed but knowing it's what the patient needs. The current limitations on our clinical procedures to basically manipulation only creates notable challenges while the arbitrary limit of 12 visits necessitates early discontinuation of care. These-- you know, these, these patients don't just go shake it off and go home they explore other avenues of pain relief. And unfortunately, as you've already heard, many of those are more expensive and more invasive and lead to dire consequences which can be opioid addiction. That's a big buzzword in our healthcare world these days. Twelve visits, twelve visits is certainly sufficient for most uncomplicated cases, people with episodic back and neck pain, chronic or acute, 12 visits is more, more than enough in those cases. But unfortunately the majority of our Medicaid patients are complicated. They're complicated due to their delay in seeking and acquiring care. It's notable in the research that delays of 30 to 60 days beyond onset increases the probability of chronicity and centralization of pain. They change addresses often. They get lost in the system. They have-- it's, it's not easy-- the same, the same habits that get them into a position where they need Medicaid are the same habits to perpetuate

their, their problems in many cases and their access. In general, these patients are complicated because relatively simple conditions aren't handled appropriately and they become chronic conditions. Patients abandoned due to these arbitrary limits eventually seek other care as you've already heard. It's-- there's not a month that goes by that we don't have somebody call wanting to come back in and we have to tell them that, well, you've used up your visits for the year. And so they have to either pay out of pocket or go elsewhere or, or not receive care in some cases. By way of a crude comparison, a spinal MRI-- I called the other day to several places, a spinal MRI out-of-pocket costs for most people without insurance is $1,400 to $2,000 in Lincoln, Nebraska. For that same price at the current reimbursement of Medicaid, I can provide 51 to 68 adjustment visits for those patients. I know that's crude but it's, it's, it's a way to think about it. As a small business owner, as a taxpayer, as a family person putting four kids through college, I have to be able to manage my resources appropriately for the longevity of my, longevity of my business and family. I think the state of Nebraska is no different. I think a wise decision would be to consider LB439 as a cost-saving measure not an increase of utilization. I'll entertain any questions that you might have.

HOWARD: Senator Arch.

ARCH: Given that, given that the current Medicaid population prior to Medicaid expansion is mostly children and adolescents. What, what type of Medicaid patients do you see now?

DAVID LAUER: Actually, mostly adults and adolescents.

ARCH: And, and the adult population then would, would be what?

DAVID LAUER: It takes up the majority of my, my Medicaid. It's, it's regional. I think you can talk to several doctors depending on where they practice and if they're in a rural versus urban environment what they see. But I think that-- I, I would say the majority of my Medicaid patients are adults.

ARCH: OK. So is-- but as I-- yeah, I, I would assume that. But as I understand this, this bill or the fiscal impact would really occur with Medicaid expansion because there isn't that large of a Medicaid population now in the adults. Am I, am I correct in, in assuming that?

DAVID LAUER: Well, I, I couldn't really tell you the numbers to be honest with you.

ARCH: OK, that's fine. [INAUDIBLE]

DAVID LAUER: I wish I had them at my fingertips but I don't.

ARCH: OK. Thank you.

HOWARD: Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman Howard. You mentioned in your testimony that it doesn't cover things like ultrasound.

DAVID LAUER: No.

CAVANAUGH: So the full scope of practice that chiropractors have is not covered under Medicaid. It's restricted.

DAVID LAUER: No, no, basically manipulation only. We get a minor reimbursement for, for x-rays but therapies are not covered and exams are not really covered either. We examine all our patients. We want to know what's wrong. We want to know if they're a chiropractic patient first and foremost. And second of all, if they require referral. But we are not reimbursed for that.

CAVANAUGH: So if you provided a referral as a result of an exam, you're not reimbursed for the exam.

DAVID LAUER: Correct, correct.

CAVANAUGH: OK. Thank you.

HOWARD: Other questions? Senator Walz.

WALZ: And I'm just gonna follow up on Senator Cavanaugh's question. I was gonna ask what the percentage of people need additional therapeutic services that you're not being reimbursed for? What do you think?

DAVID LAUER: Well, I, I would say if we had the full complement of our scope of practice available for Medicaid patients I would say probably 50 to 60 percent of them we would use other modalities on. And usually in the acute stage is when those are most notable. When people are in acute inflammation, muscle spasm, that's when those are most-- mostly used as they get into more subacute care than it's more rehab, home

care, and things like that especially in this population we try to get them involved in their care as soon as possible in an active fashion.

WALZ: All right. Thank you.

DAVID LAUER: Yes.

HOWARD: Any other questions? Seeing none, thank you for your testimony today.

DAVID LAUER: I do have copies of what I brought if any of you want them.

HOWARD: Sure. Our next proponent testifier for LB439. Seeing none, we do have one letter for the record. Douglas Vander Broek from ChiroConsultants. Is there anyone wishing to testify in opposition to LB439? Is there anyone wishing to testify in a neutral capacity to LB439? Seeing none, Senator Crawford.

CRAWFORD: Well, thank you, committee members, for your good questions and thoughtful dialogue. I appreciate that. When our first testifier, Dr. Stauffer, mentioned that this is really a win-win. I believe that is the case and I believe-- I'm very grateful that I believe the Department sees that's the case as well. And I want thank the Department for taking the time to meet with us to talk about how they could make many of these changes and regulations instead. And so we're very, very grateful for that conversation. And very wisely I believe-- just to come back to Senator Williams' question about why 24. I think very wisely the Department is planning the regulations not to put a number there but just to have it medically necessary. And I think that's appropriate language and would be a good move in a good direction to do that instead of having a set number that could be-- that would be arbitrary. So you should be getting a letter from the Department at the end of this week, beginning of next week. They'll outline their commitment to work on this and regulations and expecting to have those regulations promulgated by the end of the year. And so I think that that's great news if they're willing to move forward with regulations then we're happy to see that happen. And we'll have the bill just in case things don't go well-- in case we need to make any judgments or corrections if things don't go well in the promulgation of rules and regs. But it sounds like things are going very well.

HOWARD: Thank you. Are there questions? Seeing none,--

CRAWFORD: Thank you.

HOWARD: --thank you. This will close the hearing for LB439. We will open the hearing for LB260, Senator Ben Hansen's bill to change provisions relating to Medicaid recovery audit contractors. Senator Hansen.

B. HANSEN: It's chiropractor day.

HOWARD: It's chiropractor day.

B. HANSEN: Thank you, Chairperson Howard and members of the Health and Human Services Committee. My name is Senator Ben Hansen, B-e-n H-a-n-s-e-n, and I'm introducing LB260 on behalf of the Department of Health and Human Services. The, the Division of Medicaid and Long-Term Care is in attendance with me today. As such I will allow them to go into the detail of the bill. The purpose of this bill is to remove from state statute the requirement on the Nebraska Medicaid program to hire a recovery audit contractor, or RAC. The majority of Medicaid claims in Nebraska are now processed and paid by the Managed Care Organizations in the Heritage Health program and are thus exempt from federal and state RAC requirements. So at this time, I would be happy to answer any questions.

HOWARD: Are there questions? Do you want to tell us a little bit about what a RAC audit is?

B. HANSEN: A RAC audit from my understanding-- of course, they can explain a little more behind me, was what they used previously to help audit services to make sure things were being used appropriately to weed out fraud or abuse of the Medicaid system. And a practice, if I remember right, primarily through commission. So when they found problems and they got commission on that which then led to some other kind of problems because they dug too deep, they had-- you know where sometimes cause more problems than solved. And so now with Managed Care Organizations, we're no longer needing them because they do self-audits or a different kind of auditing system themselves.

HOWARD: Great, thank you. Any other questions? Seeing none, will you be staying to close?

B. HANSEN: I will.

HOWARD: Thank you. Our first proponent testifier for LB260. Good afternoon.

THOMAS ROCKY THOMPSON: Good afternoon, Madam Chair and members of the Health and Human Services Committee. My name is Thomas Rocky Thompson, T-h-o-m-a-s R-o-c-k-y T-h-o-m-p-s-o-n, and I serve as deputy director for Policy and Communications and Division of Medicaid and Long-Term Care in the Nebraska Department of Health and Human Services. I'm here to testify in support of LB260, proposal to make the state contract with a Recovery Audit Contractor, or RAC optional. Thank you, Senator Hansen, for sponsoring LB260. Medicaid programs are federally required to contract with a RAC to review the payment of fee-for-service claims. This requirement is mirrored in Nebraska Revised Statute 68-974. RACs are reimbursed on a contingency basis, thus reimbursement depends on a number of claims reviewed and the amounts they collect. As you know in January of 2017, Nebraska Medicaid implemented the Heritage Health managed care program and in October of 2017, Nebraska Medicaid implemented its managed care program for dental services through MCNA. Today, the vast majority of services and populations in Nebraska Medicaid are covered through and by managed care. The claims paid by the Heritage Health plans in MCNA are not subject to federal or state RAC requirements. However, each plan performs RAC-like activities to ensure accurate pay claims payment and program integrity. Also the Division's Program Integrity Unit completes RAC-like activities on the remaining fee-for-service claims. Because of low volume of fee-for-service claims, the state has had difficulty in contracting with a RAC. Because of this, the state requested and received a federal waiver from these RAC requirements. This proposed change of state law would allow the Nebraska Medicaid option to contract with a RAC if needed in the future and also ensure the Department remains in compliance with state law. Thank you again, Senator Hansen, for bringing LB260. And I'm happy to answer any questions you may have.

HOWARD: Thank you. Are there questions? Senator Cavanaugh.

CAVANAUGH: Thank you. Thank you for being here. Just to clarify, this wouldn't-- would mean that we no longer have to do it but we still can if you need to.

THOMAS ROCKY THOMPSON: That is correct, yes.

CAVANAUGH: OK.

THOMAS ROCKY THOMPSON: It changes "shall" to a "may."

HOWARD: Senator Murman.

MURMAN: Thanks a lot. Yeah, just to follow up on that. So, so if the audit is not done as much, wouldn't we expect savings?

THOMAS ROCKY THOMPSON: Senator, the issue is that these are contingency contracts so they are reimbursed by the amount of claims they find to be fraudulent. So they get a percentage of that. So there's-- the contract, it's not really a savings because they are reimbursed by the amounts they collect. And we don't actually put out any money for them on the front end.

MURMAN: OK. Thanks.

THOMAS ROCKY THOMPSON: Thank you, Senator.

HOWARD: Any other questions? When did you apply for the waiver?

THOMAS ROCKY THOMPSON: It was in, I believe, September of 2017.

HOWARD: And then when did-- when was it approved?

THOMAS ROCKY THOMPSON: November of 2017.

HOWARD: OK. [INAUDIBLE]

THOMAS ROCKY THOMPSON: And I-- several states have applied for and received waivers especially those with a high managed care penetration. For example, Arizona.

HOWARD: Thank you. All right. Thank you for your testimony today.

THOMAS ROCKY THOMPSON: Thank you, Senator.

HOWARD: Our next proponent testifier for LB260. Good afternoon.

JESSICA MEESKE: Good afternoon, my name is Jessica Meeske, it's spelled J-e-s-s-i-c-a M-e-e-s-k-e, and I'm a pediatric dentist who practices in Hastings and Grand Island. I also own offices in North Platte and in Omaha. I'm here representing the Nebraska Dental Association and the Nebraska Society of Pediatric Dentistry. We have about 30 pediatric dentists in our state all who are committed to seeing children on Medicaid. Having a state where 100 percent of your pediatric dentists see Medicaid is unique. We're proud of that and we

want to continue to see these kids who have the most challenging dental needs, medical conditions, behavior conditions, and often broken families. These children deserve to be free from dental pain and infection so they can play and learn in school. I'm speaking in favor of this bill because we see it as a housekeeping measure. However, since most of you are new to the committee and may not know what RAC audits are, I'd like to share a little bit more about them and how they've affected the dental community in Nebraska. Four years ago, about 300 dentists, roughly one-third of the dentists in our state, received a RAC audit notice from the state. As was mentioned, RAC stands for Recovery Audit Contractor. RAC audits are required by the feds but have the caveat that the contractor gets to keep part of the money recovered. That's something that we feel is disingenuous to the process. Pediatric dentists were affected particularly hard because of the number of kids that we serve. Now we're being hit with a federal audit that is questioning how we treat kids whose dental needs are so severe and they're so young they have to be treated in the operating room. While the audit was initiated by the feds, the state has a say in how it's conducted. There's this disturbing pattern of auditors not utilizing established professional clinical guidelines and allowing same specialists to review same specialists. Hence, a pediatric dentist in Nebraska can be second guessed and face significant financial penalty upwards of $100,000 plus attorney fees for simply doing what they were taught at University of Nebraska Med Center in our residency program. Seeing patients with Medicaid is already a challenge. They're more complicated, they take longer to treat. There's often language barriers in which we absorb the translator costs and we're paid about 40 cents on the dollar. We get that. We're willing to go to the extra effort to see these kids. We understand spot audits of 10, 20 charts here and they're reasonable. And when fraud suspected, it should be investigated. No question about it. What's not reasonable is using audits to over-police us. We need every good dentist in our state who can pitch in. The majority of us have good intentions, even if we need to learn new rules. In the entire list of excluded providers from Medicaid in our state only one's a dentist. I also lecture and mentor predental students, dental students, residents, and new dentists on the important role we play in seeing these kids and adults. It's a tough thing to do in a time that young professionals are facing unprecedented educational debt. About $280,000 when they come out of dental school. They want to buy practices. They want to set up in the state. They have young families they need to support. When they consider their options of taking private dental insurance or knowing dental insurance at all, it's a

much more attractive decision. My e-mails full of ads enticing me to move my practice into Invisalign, cosmetic dentistry, and all kinds of things that would be more profitable. Now you add the risks of being over-audited and I promise we're gonna lose dentists to our Medicaid program. While the Legislature, I understand, can't fix all the inherent problems we face in Medicaid. You can make one better for us and that is controlling the extent of Medicaid audits and how they're conducted. I must admit when I initially saw this law being reopened because this came from the Nebraska Dental Association because of this mass RAC audit, first thing I thought is let's go. Let's make it even more restrictive because of everything we had gone through. However, I want you to know we're in the process of having talks with Medicaid and long-term care. And we're having talks with CMS tomorrow in the regional office in Chicago about conducting more fair and reasonable audits. We're gonna go the diplomatic route as opposed to the legislative one this go around. Dentists aren't against audits, we understand the state has to be accountable for how these funds are spent. But what we do have a problem with is when our charts, charts are audited by nondentists, by dentists who are not of the same specialty, by dentists who don't provide Medicaid services or dentists who practice outside in Nebraska, that's not fair. At this time, we're optimistically confident that MLTC and CMS are thoughtfully considering our recommendations.

HOWARD: Thank you. Are there questions? Senator Arch.

ARCH: Just, just a question-- thank you by the way for coming. Just a question of clarification. You're currently in a managed care plan, right?

JESSICA MEESKE: That's right.

ARCH: MCNA manages the dental side of, of the MCOs? Correct?

JESSICA MEESKE: Correct.

ARCH: So are you getting RAC audits on top of the audits that are currently being conducted?

JESSICA MEESKE: No, not-- no, the RAC audits that came were through-- I think four years ago and they were prior to managed care. So-- but when I hear the Department talk about RAC-like audits, I'd like to

think that they will have to hold to this statute and the intent of what was in the original bill.

ARCH: OK. And that would then would flow through to whatever Managed Care Organization is, is responsible for dental services.

JESSICA MEESKE: Right. And something I'd like to say about that is since MCNA took over in October of 2017, I have been so pleasantly surprised of how they have approached dentists when they see concerns about billing. Maybe you don't look like your peers as opposed to immediately jumping into the penal route, the intimidation route, they call out to those offices. They say, can we come in and visit with you. You're not looking like your peers. We'd like to see why. And the response that I get back from the dentist throughout the state is they've actually been helpful and they've welcomed when they've come in. And that's the kind of thing that we want to see take place is more of that type of thing if they want a behavior change as opposed to a hard core let's send out a letter-- you know, spending countless hours, attorney fees to try to fight these audits. It doesn't even matter if you win your audit or your appeal. By the time you've spent the time, the attorney fees, the loss of production, all the hundreds of kids that now can't be seen has far outweighed what was gonna be recovered in my opinion.

ARCH: So that's not been your experience with MCNA at this point?

JESSICA MEESKE: No, I think MCNA has really gone about it the right way.

ARCH: OK.

HOWARD: Senator Murman.

MURMAN: Yeah, I just want to thank you for your service for especially the vulnerable children in the Hastings area. That's very dear to my heart.

JESSICA MEESKE: I see a lot of kids from your district for sure, yeah.

MURMAN: And thank you for-- I'm new to the committee of course. So thank you for educating me more on what the RAC is so thank you.

JESSICA MEESKE: You're welcome.

HOWARD: Any other questions? Seeing none, thank you, Dr. Meeske.

JESSICA MEESKE: All right. Thank you.

HOWARD: Our next proponent testifier for LB260. Seeing none, is there anyone wishing to testify in opposition? Is there anyone wishing to testify in a neutral capacity? Good afternoon.

CLAIRE KOUKOL: Hello, my name is Claire Koukol, C-l-a-i-r-e K-o-u-k-o-l. I grew up in Bellevue and I'm a second year pediatric dental resident at the University of Nebraska. I want to be clear my views are not that of the University of Nebraska. While completing dental school at UNMC, I chose to pursue a career in pediatric dentistry. I have a passion for children's health and wanted to learn how to care for children the best that I am able to. I'm here to testify in a neutral position on LB260 today. I'm committed to serving patients from a disadvantaged background whether it be due to socioeconomic status or disabilities they have been burdened with. As a native Nebraskan, I'm hoping to stay and practice in Nebraska. There are many factors to consider when choosing where to practice including patient population, insurance participation, and reimbursement rates. I think it is important as a pediatric dentist to take care of all children regardless of their socioeconomic status, family situation, or medical disability. Reimbursement rates impact whether or not providers see Medicaid patients in their practices. The fear of these audits and low reimbursement rates should not be pushing providers away from seeing the children of Nebraska. It is important that these children are cared for and if fewer pediatric dentists are Medicaid providers, it will become increasingly challenging for them to find care. While audits are necessary, as residents we worry about them dissuading dentists from seeing those Medicaid patients. When I hear pediatric dentists in Nebraska are audited contrary to the same standards of care that we are being taught that's concerning. Upon completion of my residency in June, I will have over $200,000 in educational debt. In looking for opportunities next year, that is something I have to take into consideration. As I am planning on staying Nebraska-- in Nebraska, I want to be sure that the state of Nebraska continues to have providers to care for all of Nebraskan children. In order for this to happen, it is important that the state is a good faith partner in the care of all children with Medicaid. Thank you. I'd be happy to answer any questions.

HOWARD: Are there questions? Senator Cavanaugh.

CAVANAUGH: Thank you. Thank you for coming and testifying today. Where do you want to end up after you graduate?

CLAIRE KOUKOL: Being from Omaha, I'd be really pleased to stay there. But we'll have to see.

CAVANAUGH: Well, you'll have to let me know because I have, I have pediatric patients in my house.

CLAIRE KOUKOL: OK, yes.

HOWARD: Any other questions? Seeing none, thank you for your testimony today.

CLAIRE KOUKOL: Thank you.

HOWARD: Our next neutral testifier.

KILEY DOHM: Good afternoon, my name is Kiley Dohm, it's K-i-l-e-y D-o-h-m. I am a first year pediatric dental resident at the University of Nebraska Medical Center. I want to be clear that my views are not that of University of Nebraska Medical Center. After completing four years of dental school education and a one year general practice residency I decided to pursue a residency in pediatric dentistry. I have a passion for the field of children's health and I want to become proficient in caring for children. I'm here today to testify in a neutral position on LB260. I am committed to serving patients of an underserved background. As I am completing my first year of residency training, I'm finding the patients with diverse backgrounds and extensive dental needs to be the most rewarding patients. I'm beginning to look for towns in North Dakota, Minnesota, South Dakota, and Nebraska to set up a practice or to join an existing practice. With that, there are many factors I need to consider including the patient population, insurance participation, and reimbursement rates for procedures. I have to take into account what the Medicaid environment is in each of these states. When I talked to practices in different locations and I'm told that they see very little Medicaid because of the reimbursement rates being so low, it's frustrating and discouraging that that factor is what determines which children are being seen and cared for. All children need to be cared for and if there are fewer providers available to them it's only making it more challenging for them to find adequate access to care. While I understand audits are necessary, as a resident I worry about them and will consider states that treat pediatric dentists fairly. I'm

committed to seeing children with Medicaid, but I will have to consider if it's worth the risks. When I hear the pediatric dentists in Nebraska are audited contrary to the same standards of care that I am currently being taught it can be frustrating. When I complete my program, I will have an excess of $400,000 in educational debt. I hope to join, purchase, or start up my own practice. I have enjoyed my time and training in Nebraska and greatly appreciate my education. This is a great state for me to potentially live and work in and I just want to be sure that it will be a good faith partner in the care of all kids with Medicaid. Thank you.

HOWARD: Thank you. Are there questions? So where are you from?

KILEY DOHM: I'm from North Dakota originally, Bismarck, North Dakota.

HOWARD: And is there any way we can get you to stay in Nebraska?

KILEY DOHM: Yeah, absolutely.

HOWARD: All right, we'll work on that.

KILEY DOHM: OK, sounds good.

HOWARD: All right. Any other questions?

WALZ: I have-- can I--

HOWARD: Senator Walz.

WALZ: --just ask one quick question because I don't understand it? Thanks for coming today.

KILEY DOHM: Yeah.

WALZ: When I hear that pediatric dentists in Nebraska are audited contrary to the same standards of care that I'm currently being taught it's frustrating. What do you mean by that?

KILEY DOHM: Well, I think with the audit that was previously discussed, when they're doing procedures that we're taught at appropriate intervals and then they're getting questioned for doing it at such intervals. I mean, we're just treating-- we're treating patients to the standard of care and according to the established guidelines that we're provided in residency. And I think that's come up in question is if the intervals are appropriate--

WALZ: OK.

KILEY DOHM: --and the treatment that we're rendering--

WALZ: All right.

KILEY DOHM: --is appropriate.

WALZ: Thank you--

KILEY DOHM: Um-hum.

WALZ: --for clarifying that. Thanks.

HOWARD: Any other questions? Seeing none, thank you for your testimony.

KILEY DOHM: Yeah, thank you.

HOWARD: Our next neutral testifier. Senator Hansen, you are welcome to close.

B. HANSEN: Thank you again. I think passing this bill might be the first step in keeping some qualifying dentists in the state of Nebraska. So that would be nice. I'll do my best to answer any questions if any of you have any of me.

HOWARD: Are there questions? Seeing none,--

B. HANSEN: All right.

HOWARD: --thank you, Senator Hansen.

B. HANSEN: Thank you.

HOWARD: This will close the hearing for LB260 and the committee will take about a five-minute break. We'll reconvene at 2:45.

[BREAK]

ARCH: And we will now have the hearing on LB423 and Senator Howard you are-- you may present.

HOWARD: Thank you, Senator Arch. Good afternoon, Vice Chairman Arch and members of the Health and Human Services Committee. My name is Senator Sara Howard, H-o-w-a-r-d, and I represent District 9 in

midtown Omaha. Today, I'm presenting you to LB423 a bill that cleans up the language surrounding school-based health centers so I'll read that later. So my first job out of law school was working at a nonprofit that did maternal and infant health policy so it was called the Illinois Maternal and Child Health Coalition. I was hired as a staff attorney to specifically look at policies that would impact-- federal policies that would impact providers in their work. But housed under Illinois Maternal was-- were different coalitions: one that focused on vaccinations, one that looked at maternal infant mortality on the south side of Chicago, and I managed a group of providers for premature infants looking at expanding access to RSV treatment. And then one of our biggest programs was running the Illinois Coalition for school-based health centers. So Illinois has a lot of school-based health centers. But the model is this, it's basically a mini doctor's office in a school. So that if a parent doesn't have to leave work to take their kid to the doctor and essentially they function as satellite clinics or a larger hospital or a federally qualified health center. I mean, it is basically a doctor's office, it's not a nurse's office. And so they are-- they follow all parental consent and all HIPAA requirements exactly the way a doctor's office would. It's just that they are co-located on the school grounds in order to improve access. Most likely for kids who are living in poverty. So these tend to be placed in areas of high free and reduced lunch rates and high areas, areas of either "uninsurance" or, or a high Medicaid population. So the best models are models that have a robust primary care offering and then they also integrate mental healthcare and then some really premier school-based health centers also will have a dental chair. So this means that a child or a youth or a student is able to access a full range of healthcare services right in their school from a provider who not only is subject to all of those provider requirements like HIPAA and parental consent, but is also able to bill for it. So then the schools aren't feeling as though the burden of providing and paying for healthcare falls back on them through their nursing staff. So the school-based health center model has actually changed over the years. So it used to be predominantly primary care and now we're seeing more, more services that could be offered as well as more opportunities for say the general public to be able to utilize them whether it's ensuring that parents of children are also able to receive healthcare services within a school-based health center setting or faculty members for example. But then some models actually will have maybe a separate waiting room for the public. So if you're in a small town and your biggest thing in that small town is a school and they have a school-based health center then

perhaps the-- there would be a separate waiting room for the general public. And then they can share that, that healthcare related space and share that facility's license and be able to bill for services that way. So in 2010-- so let me think, I graduated from law school in 2008, got my first job in 2009, and I was working at a school-based health center coalition and a group from Nebraska came and visited because they wanted to have some school-based health centers in the state of Nebraska. So that was all the way back in 2010-- or maybe it was '09. And they came to look at that Illinois model because it is one of the most premier models in the sense that they insure a broad range of services and a broad range of access for kids and families. And so when the first bill was passed by Senator Nordquist in 2010, there were some political machinations that went around with him. I actually texted Senator Nordquist, and I was like, we have a question, I'm working on your area of law. Can you tell me a little bit about why things went down the way that they did and why this language is so prescribed around school-based health centers. And what he told me was that at the time Medicaid would have been able to allow them to bill as school-based health centers administratively. However, the Medicaid Director, Vivianne Chaumont, was, was very ill and so the deputy didn't feel as though they could make those administrative changes. And so they decided to put it into statute and be very prescribed. And because of that this language is fairly limiting. In the state of Nebraska, they can only, they can only work during school hours. They can only see students. They cannot be considered a primary care home. If you look at the language, they-- and then it's, it's very prescriptive in what type of services they're able to provide which means that if they wanted to say bring, bring a chiropractor or a PT Specialist on-site through a school-based health center, it wouldn't be able to do that by statute. And so I really wanted to sort of dig into how do we make sure that these school-based health centers are-- our statutes are reflecting the realities of their work. When the bill was first put in, our school-based health centers were only in elementary schools or at least the intention was to start with elementary schools. Now our school-based health centers are actually in high schools as well. And so that brings me to the issue that I'm sure you've gotten several e-mails about which is the stricken language that says, "Does not perform abortion services or refer or counsel for abortion services and does not dispense, prescribe, or counsel for contraceptive drugs or devices." So you have a copy of the federal regs. They're very clear that a school-based health center can't perform abortions and so to me because we have an overarching federal statute that we have to follow already, it made sense to

remove this language. That being said, I understand that there are concerns from opponents about this language specifically. And from the one that I've heard from, which is Julie Schmit-Albin from Right to Life. She did contact my office in advance. I have committed to working with her and Senator Hilgers on language. Which I have done before on this topic, and I hope that I have shown a willingness to work with individuals when they do take the time to come tell me that they have issues with my bills beforehand. So that being said, I do feel as though this is, this is legislation that will help providers do their jobs more ably and improve access to care for kids and families. I am committed to working on the language around abortion services and contraception services to better reflect the realities of working with teenagers in the state of Nebraska and their unique health status issues. Again, I would remind you everything is subject to HIPAA. Everything is subject to parental consent the same as a medical office. So when you walk into the door of a school-based health center, you're essentially walking into a clinic the same way you would be any other clinic in the state of Nebraska. I am happy to try to answer any questions you may have about this bill.

ARCH: Oh, yes, that's right I'm supposed to call on [INAUDIBLE].

HOWARD: I'll, I'll start doing it.

ARCH: Senator Cavanaugh, you may address Senator Howard.

CAVANAUGH: Thank you, Vice Chairman. Thank you, Senator Howard, for bringing this bill. So something that I have always been passionate about is School as Hub and allowing your school-based health center to be the primary care home really opens that up significantly for families because School as Hub isn't just about the child it's about the whole family. So thank you first of all, for, for doing due diligence on that. How many-- and you might not know this question, but how many, if any, school-based health centers are based in private schools or are they all in public?

HOWARD: Ours were all in public schools.

CAVANAUGH: In Nebraska?

HOWARD: In Nebraska.

CAVANAUGH: OK.

HOWARD: Other states may, may have them in private schools, but ours are in public schools.

CAVANAUGH: OK. And then the next thing-- I, I really wanted to just get this out here for some of our colleagues who are not of the female persuasion, when we talk-- and may be coming out further down the line. But when we talk about contraceptive services and contraceptive drugs, it's really important that people understand that there's more than one use for those. And young women, especially teenage women, need to take contraceptive pills to manage the flow of their period. And I've had friends who have suffered from severe migraines and severe loss of blood as a result. So I appreciate that, that that has been considered here because when we are talking about adolescents we're not just talking about birth control, we're talking about medications that are medically necessary for them to live and thrive at school. So I appreciate that and I just wanted that to be on the record because it's kind of awkward and if any of you have teenage daughters you probably know that. But--

HOWARD: And, and thank you for highlighting that issue. I want to make sure that providers who are working in this setting do feel as though they can provide the full range of services, of course with parental consent and, and parental understanding, but, but this shouldn't be like if you go to the school-based health center you can only get a quarter of the services that you would normally get at a doctor's office. We want to make sure that you can get the full spectrum because I think patients and students and families deserve that.

CAVANAUGH: Thank you.

HOWARD: Thank you.

ARCH: Other questions? Senator Williams.

WILLIAMS: Thank you, Senator Arch. And thank you, Senator Howard. You've certainly brought out the fire and rain today and I appreciate the fact that you're here to shed a little light on this important issue and my e-mails have been-- had a steamroller effect on them. Now the rest of you will understand what I've just done to, to Senator Howard after we go into Executive Session. How many of these facilities exist today?

HOWARD: In, in Omaha, we have five in, in elementary schools, one in a middle school, and two in high schools. And then there is one in Grand

Island which is kind of an outlier. It was there even before the statute was put into effect in 2010.

WILLIAMS: Yeah, I, I would like to give you an opportunity to respond. I think we all received a series of e-mails that had some similar things in them and I'm sure some other people are going to respond to these, too. But you know the questions were, if this bill were passed this would allow a school-based health clinic to perform abortions. Can you respond to that, please?

HOWARD: So I, I refer back to the, to the federal requirements that I passed out to you initially, that there is no way that a school-based health center can perform an abortion. Not by federal statute, not by state statute. There, there is absolutely no possible way that they could perform an abortion. They're also not equipped under their facility's licensure to do that either just by way of a technical issue. So to, to me that was sort of a, a spurious argument I would say.

WILLIAMS: Thank you.

HOWARD: Yes, I've seen sunny days that I thought would never end, Senator Williams.

WILLIAMS: Well, I want you to know you have a friend.

HOWARD: There it is, there it is.

ARCH: All right, Senator Hansen you had a question.

B. HANSEN: So there are-- you know, obviously other ways to, to perform abortions that do not require medical procedures-- you know,--

HOWARD: Certainly.

B. HANSEN: --nonsurgical approaches which are the way, the way most abortions are provided now in the state of Nebraska through chemical means. Does that include when it says does not perform abortion services under federal statute? Does that include all forms of abortion like a Plan B pill or chemical means?

HOWARD: So, so that's a good question because I think that falls under the dispensing. It's not, it's not considered a performance because it's not a surgery when you look at the practice acts. Dispensing medication is different than performing. But I would, I would actually

leave that to a provider to answer that question. My understanding is that they wouldn't be dispensing a Plan B out of a clinic anyway--

B. HANSEN: OK.

HOWARD: --because that doesn't-- obviously, it's a, it's a clinic so they don't have a, a pharmacy on-site and so dispensing in that manner doesn't seem appropriate.

B. HANSEN: OK, because that was also a big concern like, like Senator Williams was talking about with all the e-mails is.

HOWARD: Right.

B. HANSEN: But I think about 55 to 60 percent of abortions are now done through-- like, like I mentioned through a chemical means--

HOWARD: Right.

B. HANSEN: --and so they can-- which can be up to seven to eight weeks after they found out that they were pregnant they could still get a pill and they can still abort the fetus. And so I didn't know for sure if that's included with part of this because those are some e-mails that I got as well. Just trying to clarify exactly what can happen and what can't happen--

HOWARD: Right.

B. HANSEN: --and we change and so maybe somebody else can clarify that a little bit later, too.

HOWARD: Sure.

B. HANSEN: And also just so I can wrap my head around this here a little bit more, what is the main purpose of moving it off of the school now and to just like a hospital?

HOWARD: Oh, they're not moving.

B. HANSEN: OK.

HOWARD: This-- nothing is--

B. HANSEN: OK. I thought you said--

HOWARD: They're gonna stay there.

B. HANSEN: Stay in the school?

HOWARD: They're gonna stay in the school.

B. HANSEN: OK.

HOWARD: But they always have to be connected--

B. HANSEN: That's where I was a little confused.

HOWARD: Oh, I apologize. I probably misspoke.

B. HANSEN: Nope, that was my-- probably my fault.

HOWARD: So they always have to be connected to a federally qual-- a sponsoring facility. They have to be connected to that. That helps with the facility's licensure and it helps with the billing because we want them to be able to bill. It helps not just with paying for services and making sure that services are available but also for continuity of care.

B. HANSEN: OK.

HOWARD: And then they're connected to a larger electronic health record which ideally would connect to NeHII and so say you present at clinic and you have something that needs to be referred out to a bigger medical facility or one with specialists than they would refer to that sponsoring facility. Just like a regular sort of clinic that you would go to-- primary care clinic.

B. HANSEN: OK.

HOWARD: Yeah.

B. HANSEN: Thank you.

HOWARD: Thank you.

ARCH: Questions? Senator Murman.

MURMAN: I'll come right out and ask, would Planned Parenthood be a part of these clinics?

HOWARD: No, no.

MURMAN: They wouldn't be included at all?

HOWARD: Planned Parenthood, I don't believe would fall necessarily under a hospital, a public health department, or a federally qualified health center.

MURMAN: OK, thanks.

HOWARD: Thank you.

ARCH: I have a couple questions.

HOWARD: Sure.

ARCH: Under our present language we, we, we say, "Does not perform abortion services or refer or counsel for abortion services and does not dispense, prescribe, or counsel for contraceptive drugs or devices." We don't, we don't-- I, I don't see that language in federal statute. Correct?

HOWARD: Right. So that's not in federal statute.

ARCH: The abortion is in there--

HOWARD: Um-hum.

ARCH: --and I mean, Senator Hansen's question would be very helpful to have that answered. Because as I understand, it-- under the state statutes, independent providers can dispense.

HOWARD: Yes, they can dispense--

ARCH: Doesn't require pharmacy, doesn't require pharmacy, doesn't req-- if they can dispense--

HOWARD: --samples.

ARCH: Well, they can, they can dispense because they have the ability to educate and to, and to hand that prescription to a patient--

HOWARD: Yes.

ARCH: --under our, under our regulations. So I-- that would be very helpful to clarify that, whether that can actually be done in a school-based clinic. And now I have a more philosophical question.

HOWARD: So let me,--

ARCH: Go ahead, please.

HOWARD: -- let me do the first one which is the, the question around dispensing contraception overall or dispensing at all?

ARCH: Well, the, the language, right, does not dispense, prescribe, or counsel. And that-- I'm just, I'm just saying that the, the cannot perform abortion is in, is in federal statute,--

HOWARD: Right.

ARCH: --but it has no reference to contraception which is in our current statute.

HOWARD: Right. And so my understanding is that, that, that made sense when they were going to be an elementary school, but makes less sense when you're going to be working with teenagers and talking about STDs and things like that. Because if you can't even discuss something, it essentially functions as a gag clause-- a gag rule for our providers and, and, and their ability to have a, have a broad range of healthcare discussions with their patients.

ARCH: The second question. And, and that has to do-- and as I say it's more of a philosophical question. It, it seems as though school-based clinics are moving and, and of course schools are education they're not healthcare clinics. But now we're moving and we're talking about adults being cared for and broader array of services. And are you concerned at all that in this, in this move to broader expansion of the services and the health that we are somehow diluting the original intention of a school and that is education?

HOWARD: Oh, well that-- gosh, that's a, that's a big philosophical question.

ARCH: I said it was philosophical. But--

HOWARD: So, so my view-- well, this will, this will be fun. My view has always been that kids can't learn when they're not healthy. And so our best way to ensure that they can learn effectively and that our

schools can be effective is to make sure that they're healthy whether it's addressing an STD or making sure that they're getting for a fluoride varnish and addressing a cavity or making sure that an eye doctor addresses their ability to see the chalkboard. So to me I feel like healthcare in schools are very-- are intertwined and that a school-based health center is, is one of those innovative ideas to really ensure that kids have access to the healthcare they need in order to learn effectively. I would never think that by allowing outside groups like faculty and parents to be able to access the school-based health center would move them away from their primary mission which is ensuring that all kids are healthy in that school-based setting.

ARCH: As I, as I recall the history of school-based clinics, they were originally perhaps episodic. So that, so that if there was an acute, acute episode of a child where, where they would be home for a period of three days because they didn't receive any care, if that acute episode were to occur and can get immediately involved in some care and diagnosed correctly and so forth they can stay in school and that-- that's how I recall the original intent school-based clinics. And now I hear primary medical home. I hear adults coming in and that's-- that, that just is what prompted my question.

HOWARD: No, that's a great question. My understanding was that we were seeing nurses who were sending kids home because they had needs that were greater than the nurse-- the school nurse could deal with, but, but below what somebody would need in a primary care setting. And so that meant that a kid was missing a full day because they were being sent home by a nurse who really couldn't provide them with the care that they needed. So this ideally-- you know, then a child can go directly to the school-based health center, come right back out and go back to school with parental consent. I just keep emphasizing that because you can't go to a school-based health center without your parents consenting to that care. And, and they would also see the billing so all of this-- it revolves around parental consent.

ARCH: OK. Senator Cavanaugh.

CAVANAUGH: Thank you, Vice Chairman. I want to go back to a question that Senator Hansen had about Plan B or the pill. So as far as that being a dispensary, that doesn't require a prescription. Correct? Well, you're not--

HOWARD: I haven't recently--

CAVANAUGH: We'll let, we'll let those behind you--

HOWARD: Yeah, let's do that.

CAVANAUGH: --answer that question but that's a question I, I feel fairly certain that that's an over-the-counter you-- anybody can walk into Walgreens or CVS or-- I, I don't want to--

HOWARD: That is correct. I, I phoned a friend.

CAVANAUGH: And you phoned a friend. So I just wanted to clarify that, that, that the, the idea of getting any sort of early intervention abortion medication is something that a person can just do.

HOWARD: Right.

CAVANAUGH: They don't have to go to see anyone.

HOWARD: Yeah.

ARCH: Other questions for Senator Howard? Thank you.

HOWARD: Thank you.

ARCH: And I'm sure we'll see you at closing.

HOWARD: Oh, yes, I'll hang out here.

ARCH: All right.

HOWARD: OK.

ARCH: OK. Next proponent for LB423. Welcome.

TIFFANY SEIBERT JOEKEL: Thank you. Thank you, Senator Arch, members of the committee. My name is Tiffany Seibert Joekel, T-i-f-f-a-n-y S-e-i-b-e-r-t J-o-e-k-e-l, and I'm here to testify in support of LB423 on behalf of the Women's Fund of Omaha. Due to the direct access to students, school-based health centers can address the health needs of youth and promote preventive healthcare all without extended disruption to learning. In reaching otherwise medically underserved students and communities, these centers can decrease school dropout rates among adolescents by reducing hospitalizations, managing illness and injury, and preventing unintended pregnancies that may otherwise

pose additional barriers to school attendance. It's important to remember that school- based health centers are bound by the same laws, rules and regulations, and standards of practice that govern any other healthcare clinic setting in Nebraska. There just happened to be landed in a school setting, except that there are additional regulations that LB423 attempts to address. I would also note that I do have some personal experience in the history of this bill. I was a legislative aide involved in writing the original bill back in 2010. So to the extent that my memory functions back that far I'm happy to answer kind of any historical questions if that's helpful. Some of these regulations and restrictions that we created in the drafting of this bill is that a school-based health center cannot serve as a medical or dental home at the time. That was done out of concern that lots of students would seek their care at the school-based clinic, not clinics where they had previously gone. I think the reality has been that many of the students that are served by the clinics either did not have a medical home or their medical home is already the federally qualified health centers that are the sponsoring facilities of the clinics. Under the-- these existing regulations in the bill, the clinics cannot operate outside of school hours. So I think in particular as we consider mental health needs of students and how we may evolve to meet those if there is a mental health crisis outside of the time frame in which the school is open and the school-based clinic can be open. This language limits that clinic for meeting those needs. It also is limited to serving students. So if faculty have a healthcare need or in the case where a family member might want to seek care there, I think this language precludes that. And then similarly what-- you know, we, we hear a lot is if a student presents with a positive STI test or needs a pregnancy test, a medical provider cannot discuss with that patient how to prevent STI infection in the future or how to prevent an unintended pregnancy because of this language. This has serious implications for the reproductive health of young people. The Youth Risk, the Youth Risk Behavior Survey in Nebraska tells us that 29 percent of Nebraska high school students have had sex and 20.5 percent are currently sexually active. We also know that Douglas County holds alarmingly high STI rates compared to the national average and the state average. In 2017, according to the Youth Risk Behavior Survey only half-- about 53 percent of sexually active high school students reported using a condom during sex and 7 percent reported using no method of contraception at all. Nationally, more than 80 percent of pregnancies among teens, young women are unintended. So we think by eliminating these unnecessary restrictions that solely govern the behavior of school-based health centers, we can

help better meet the health needs of, of adolescents in particular. I want to take a couple of minutes to talk about a distinction that I think is really important that, that Senator Howard made, but it is about a medical provider serving a patient in a clinic. And the, the parents have to consent-- sign consent forms before their child can even be seen by a provider in these clinics under current practice-- under current service. So parental consent is already a part of the way they function. I want to just address the concerns that you all have been receiving and try to address some of the questions. So there was a concern that abortion, particularly medical abortion, will now become available in school-based health clinics. So Senator Howard extensively discussed that federal law already precludes that in a number of ways. We have state law that does not allow young adults to access abortion without notarized consent of their parents. And the definition of abortion does include surgical and medical. So any pill-- and I have a definition if you're interested, but the pill form of medical abortion would fall under that requirement of needing notarized parental consent or judicial bypass. Nothing in LB40-- 423 changes that. Excuse me. Similarly so I want to also make an important distinction between medical abortion which is, I'm not a medical provider, but mifepristone and, and one other form, it's two kinds of medication that are delivered that does terminate an existing pregnancy. Plan B or an emergency contraception prevents pregnancy, it prevents ovulation, prevents fertilization, and prevents implant, implant-- implantation into the uterus of a fertilized egg. So with that I think it's an important distinction to make. Red light. Thank you.

ARCH: Thank you. Questions? Senator Cavanaugh. Oh, I'm sorry [INAUDIBLE].

CAVANAUGH: Thank you. Thank you for making those clarifications.

TIFFANY SEIBERT JOEKEL: Sure.

CAVANAUGH: Considering the fact that I've had three children you think I would know the distinction but I don't so I appreciate that. And I know you were kind of rushing through at the end there. Is there anything else that you would like us to know about the history of this legislation?

TIFFANY SEIBERT JOEKEL: So I would say at the time we were considering it, the federal definition that Senator Howard referenced exists in federal CHIP statutes, or the Children's Health Insurance Program.

When that was being reauthorized in 28-- 2008, 2010, they did include this definition that Senator Howard has provided. At that time the main goal of this bill, when Senator Nordquist introduced it, was to ensure that Medicaid would reimburse. And that language still exists in 68-908. That clear-- clearly says that if a sponsoring facility is a federally qualified health center for example as the ones in OPS are they will receive medical reimbursement. It always-- also says something, something to the effect of it doesn't need preauthorization to be authorized. So I think that component still exists that was the main intent. The rest of it was a bit of the Wild, Wild West about what we needed in this bill to ensure that intent. And then some of them were political calculations, one being the medical home so trying to ensure that there wasn't concern from existing providers that they'd lose all their pediatric patients. And then the other piece was then being in elementary so making very clear that-- you know, abortion and, and need or concern for contraceptive was not included.

CAVANAUGH: Thank you.

TIFFANY SEIBERT JOEKEL: Sure.

ARCH: Senator Walz.

WALZ: Thanks for coming.

TIFFANY SEIBERT JOEKEL: Sure.

WALZ: I was just wondering if you could give us like an idea of how this is set up initially and the process that you go through. I know that the school is like the organizer but you have a sponsoring facility. So how does that-- how do you make that happen? What are the steps?

TIFFANY SEIBERT JOEKEL: You know, I would-- not, not ducking that question, but Andrea Skolkin will be testifying behind me and she's actually done it so I think--

WALZ: OK.

TIFFANY SEIBERT JOEKEL: --she'll give you a better answer.

WALZ: OK, great. Thank you.

TIFFANY SEIBERT JOEKEL: Sure.

ARCH: Senator Hansen.

B. HANSEN: Just to clarify it for me. What is the age of consent that you need a signature from a parent?

TIFFANY SEIBERT JOEKEL: So I think it is 19, I believe, for healthcare. And the reason I believe this is because I went to Creighton. I went to college in, in Omaha and when I moved here I had to get a special notarized or special notarized healthcare consent form from my parents to allow me to consent to my own healthcare when I was 18 and 19 at Creighton. I did some googling last night and I believe that that still exists. I found the notariza-- the form for UNL. So I think technically for healthcare the age of consent is 19 unless you have this specialized notarized permission otherwise.

B. HANSEN: OK, thank you.

TIFFANY SEIBERT JOEKEL: Um-hum.

ARCH: Other questions?

MURMAN: I have one.

ARCH: Oh, go ahead, Senator Murman.

MURMAN: Thanks a lot for coming in.

TIFFANY SEIBERT JOEKEL: Sure.

MURMAN: Did you say something about you wrote the original statute?

TIFFANY SEIBERT JOEKEL: Yes, I had the great honor of working for Senator Jeremy Nordquist in District 7 for a few years so I had the opportunity to dig into this a little bit as a legislative aide.

MURMAN: So maybe you would be knowledgeable on this or else maybe someone behind you would, would know, but Reproductive Health Services kind of-- could you just kind of explain exactly what that would involve?

TIFFANY SEIBERT JOEKEL: Sure. Are you seeing that in the bill in specific? Just so make sure I'm looking at the right spot.

MURMAN: It's in the bill summary. It-- is this striking these in this section?

TIFFANY SEIBERT JOEKEL: So the bill is striking the specific language on page 2, lines 27 through 29 that refer to reproductive healthcare so does not perform abortion services which we've discussed is already precluded by federal law, does not dispense, prescribe, or counsel for contraception drugs or services [SIC]. So those are very specific reproductive services. Others would be included, STI testing, for example, sexually transmitted infections. And I believe that that can already be done. They-- because of this language, cannot talk about how you prevent those. So if condom use, for example, is not something. If they come in with a positive STI test, this language precludes the provider from talking about-- you know, there are ways to prevent this in the future. A range of ways, abstinence being one of them but also prophylactics, condoms, etcetera. I think this language bans them from having that conversation.

MURMAN: OK, so that conversation cannot be provided.

TIFFANY SEIBERT JOEKEL: I believe so. Again, I would defer to the providers that will follow but I think it's pretty clear does not describe-- prescribe, dispense, or counsel for contraceptive drugs or devices is, is currently in language is prohibited behavior for the providers.

MURMAN: OK, thanks.

TIFFANY SEIBERT JOEKEL: Um-hum.

ARCH: Any other questions? All right. Thank you very much.

TIFFANY SEIBERT JOEKEL: Thank you.

ARCH: Next proponent. Welcome.

ANDREA SKOLKIN: Welcome, Senator Arch, glad to see you and committee members. My name is Andrea Skolkin, A-n-d-r-e-a- S-k-o-l-k-i-n, and I am the CEO of OneWorld Community Health Centers. And today I'm testifying in support of LB423. And I wish to thank Senator Howard for introducing this bill to change and eliminate language relating to school-based health centers under the Medical Assistance Act. The OneWorld provides healthcare in medically underserved areas in Douglas, Sarpy, and Cass counties. Our patients are primarily from low-income working families. And as a federally qualified health center, we are part of a network of 1,400 health centers in the nation that have a special focus on the medically underserved. We are also

part of a national network of about 2,000 school-based clinics working to ensure healthcare access to children so they can grow up healthy and have success in school and in their future lives. OneWorld serves 4,000 students annually at 4 school-based health centers in eastern Douglas County and one in Sarpy which is the one that is in high school. School-based health centers are staffed by healthcare professionals that collaborate with the schools to address a broad range of concerns and adverse experiences that affect students' healthy development. School-based health centers are a tool for achieving health equity for children and adolescents who experience disparities in outcomes simply because of their race, ethnicity, or family income. We provide critically needed services including medical, behavioral, and we actually don't have in our school-based health centers dental but we bring that to the schools through a, a mobile clinic so that all students will have equal opportunity to learn, grow, and be healthy. We primar-- we provide primary medical care including sick visits for coughs, pink eye, sore throats, rashes, well-child checks that include asthma action plans, inhaler refills, ongoing management, schools/sports physicals, and vaccinations. Other services include counseling that includes some psychiatry, mental health evaluation, and telebehavioral health to address problems with behavior, emotions, school, friends, or thoughts that interfere with functioning at school or at home. Which in turn leads to effective learning which is more in-seat time at school and hopefully better achievement in graduation rates. We believe it's important to periodically review and update the statute in, in the healthcare arena and LB423 eliminates unneeded and dated language leaving the sponsoring facility and partners, meaning the school districts, with the ability to administer operations based on the most current practice, community needs, and school district preferences. We urge the committee to advance LB423, and I'm happy to answer some of the questions that were earlier. Thank you.

ARCH: Senator Walz.

WALZ: Yes, can you answer the question that I asked-- like how does this happen?

ANDREA SKOLKIN: How does this happen?

WALZ: How does the process--

ANDREA SKOLKIN: The school-based health centers in Omaha began as a collaboration several years ago about what were the needs of children,

went through several focus groups and groups and eventually came to this model and worked with the Omaha Public School Board and the school district officials to bring school-based health centers to communities in need. So it was really a cooperative discussion between the schools and the health community. And then seeing that federally qualified health centers are dedicated to this population and have some avenues for reimbursement because of how we're paid there might be an opportunity to be more sustainable with the sponsoring entity being an FQHC. And that we have relationships with the school, we ended up the entity, or the Charles Drew and OneWorld, the sponsor organizations for the school-based health centers in Omaha.

WALZ: So do you also provide services? Is it just to the students or the kids or are you also providing services to family members, to senior citizens in the community?

ANDREA SKOLKIN: This-- our school-based health centers are currently open in Omaha Public Schools and open to any student in the schools-- a sibling of someone that might be at the school, but we are not open to the general public. We all have the faculty of the, the schools where we're located have asked to be able to be seen and we have done that. Probably I shouldn't be saying that publicly, but we, we have done that. But we don't have doors that are open to the public.

WALZ: Is that a plan?

ANDREA SKOLKIN: And that is not a plan.

WALZ: OK.

ANDREA SKOLKIN: Though, I, I can say as we established our high school-based clinic that it was the desire of the principal. But after talking things, things through it's better for security purposes that within the schools they're just open to the schools.

WALZ: Yeah, and I guess the reason I ask that is just I think about the rural communities who don't have a lot of resources and what a benefit that could be to the community itself.

ANDREA SKOLKIN: And I-- yes, Senator, I do believe for rural communities as the school is the hub, Senator, it would be a great model.

WALZ: Yeah, thank you.

ANDREA SKOLKIN: Um-hum.

ARCH: Other questions? Senator Cavanaugh.

CAVANAUGH: Thank you. Thank you for being here--

ANDREA SKOLKIN: Um-hum.

CAVANAUGH: --and for your testimony. We've previously had a robust conversation already about some of the reproductive services that are included in this. And this additional language in the bill that's being struck, how does that open up the services that you're able to provide? With other services, will you now be able to provide to children that are being restricted under the current law?

ANDREA SKOLKIN: Primarily it would enable us in the high school setting related to being able to talk further about STDs or STIs and contraception which is the ability that we don't have now and have to send students elsewhere to some of our other locations so that they can get it. We have no way to really know unless they're in our electronic health record system if they were able to obtain that.

CAVANAUGH: When you-- and here you talked-- your testimony you talked about telebehavioral health. Is that something that you under the current law are able to offer?

ANDREA SKOLKIN: We are currently offering that, yes,--

CAVANAUGH: OK.

ANDREA SKOLKIN: --full-service care. We find particularly in the high schools a lot of emotional-- is quite a growing period for young people. And the support that they need is much greater than the one or two counselors at the high schools can use. And so we have branched into that with the consent of the schools.

CAVANAUGH: Thank you.

ARCH: Senator Hansen.

B. HANSEN: I want to play off of Senator Cavanaugh's question. So you say you're able to talk about the use of contraception?

ANDREA SKOLKIN: Um-hum.

B. HANSEN: And so then are you-- would you dispense and prescribe as well?

ANDREA SKOLKIN: What-- that is a great question to ask because as I view this change in statute this is something that would be a statewide statute. That doesn't mean that the school district that we work with might allow that. And I've had that discussion with them and that would be an additional process before we would move it to doing that to obtain-- we, we don't want to just because it's here, move ahead and do it. We would want to do that with consent of the school board but it would give us the opportunity in the high school whether we were able to prescribe it or do it on-site. It would give us that opportunity.

B. HANSEN: And you probably still need parental consent before describing-- prescribing?

ANDREA SKOLKIN: We have parental consent for everything we do. However, under federal and state Title X regulations which is the Reproductive Health Program, adolescents are able to access that without parental consent but we encourage parental consent and parental engagement in everything that we do. But today in any Title X clinic or reproductive health any adolescent can seek contraceptives without parental consent.

B. HANSEN: Thank you.

ARCH: Other questions? I have a couple.

ANDREA SKOLKIN: Sure.

ARCH: At, at the present time, do you, do you have a licensed independent practitioner in all of your, all of your school clinics while they're in operation?

ANDREA SKOLKIN: Yes, Senator, we do.

ARCH: And they're nurse practitioners? Is that--

ANDREA SKOLKIN: Primarily nurse practitioners or it could be a physician assistant but they are primarily nurse practitioners.

ARCH: OK. So, so if this is, this is certainly more than a nurse clinic. This is a--

ANDREA SKOLKIN: Yes.

ARCH: --if you got an LIP there, you're, you're--

ANDREA SKOLKIN: Right, fully credentials. Each of our locations is licensed by the state of Nebraska.

ARCH: I would think you would have problems with compliance on prescription medication, amoxicillin-- I mean, strep throat, whatever might be diagnosed at the time, here's a script or electronic prescribing, however, however you do that. Do you-- at the present time you do not dispense. Do you dispense samples? Do you dispense anything?

ANDREA SKOLKIN: Senator, another great question. We are not-- our philosophy over time has changed and we really do not hand out samples because it creates complications in accounting for those samples.

ARCH: Yes, it does.

ANDREA SKOLKIN: So we, we do use prescriptions and sometimes that could be a barrier that the family not pick it up. We do budgets and resources to help pay for them. There are a large number of children that are enrolled in Medicaid, so Medicaid as a payer. We also have a pharmacy located on our main campus premises so we, we hope that they're picked up. I don't have the data today to say was it picked up or not picked up.

ARCH: Yeah.

ANDREA SKOLKIN: Um-hum.

ARCH: Yeah, I would think that compliance with now going-- I mean, if they're having trouble going to the physician office to get care now going and getting your medication afterwards as well. And that would-- you know, transportation and everything else may be a, may be a barrier to that. But-- OK, I guess, I guess as-- because I had a very similar question I think to Senator Hansen. You know, if you left the language as is, what other services would you want to provide that you can't do now? And what I heard was really the counseling for STIs.

ANDREA SKOLKIN: And counseling and contraceptive. The ability to counsel and be able to give-- what is going on among high schoolers today. What we want to do is educate and help guide our young

adolescents down the best path that we can and prevent unintended pregnancy. So in addition to the STIs would be the contraception.

ARCH: OK.

ANDREA SKOLKIN: We do not in any of our practices do anything with the-- what I learned what was being discussed yesterday in the RU486, we do not do that.

ARCH: All right. Any other questions? OK. Seeing none, thank you very much.

ANDREA SKOLKIN: Thank you.

ARCH: Thank you for your testimony.

ANDREA SKOLKIN: Um-hum.

ARCH: Other proponents?

COLBY COASH: Good afternoon. Thank you, Vice Chairman Arch. My name is Colby Coash. I'm here today speaking in support of LB423 on behalf of the Association of School Boards but primarily on behalf of the Child Health and Education Alliance of which School Boards are a member. The Alliance is a coalition of statewide health and educational partners that recognize and value the connection between the child's health and his or her ability to reach their full potential in the classroom, thereby setting the stage for productive and fruitful adulthood here in Nebraska. School-based health services lie at that intersection and as was mentioned this is the ten year anniversary of these services. But since that time, the healthcare landscape has changed. Over the last ten years, we've learned a lot about the health-- complexity of health, trauma-informed care education, and the social determinants of health have become a foundational concepts being discussed in school districts and educational institutions throughout the country as we begin to understand the impact on the-- on a child's educational outcomes. School-based health services in Nebraska are evolving with the times and have implemented new and innovative models of care to address accesses in gaps-- access gaps in vision care, mental health care, primary care, and oral health care. This expansion of services has created a new strategic partnership between healthcare providers, school districts, and families resulting in delivery to many, many children. Today, the current legislative language, language defining the health services as limiting and doesn't reflect the operation, the

partnerships that are being provided in schools. So we are in support of this bill. We, we feel that school-based health centers are an enhancement to our educational system as they, as they ensure the children of our schools are healthy and ready to learn. And with that, we would appreciate your favorable movement of this bill. Thank you.

ARCH: Senator Walz.

WALZ: Thanks for coming. Hey, I just want to make a clarification hopefully. So there is the funding-- the educational funding and the-- I don't know, the medical funding completely separate. There is no educational funding that's going into this.

COLBY COASH: It's simply a partnership.

WALZ: Right.

COLBY COASH: School-based health centers-- well, the ones that are in operation now. They-- all the, all the funding comes from a sponsoring organization so the partnership they do their work in the mental health-- mental health-- the health side and the schools do there's. Schools just seem to be an easier avenue to get at the children especially those, those children who are in high- poverty areas where these are typically located so there is a separation there. But if you want to provide services to a student health services, a lot of times it's-- takes a kid out for three-- you know, for, for a day, day of classroom learning and so these become ways to limit that out of classroom time which is, which is helpful to the student. And as was mentioned earlier, there-- one of the very first ones happened in Grand Island and they did it just out of a need to keep kids in the school longer because they were consistently out for-- to meet their health needs. And so when, when this bill was put in, in in 20-- 2009 for 2010 kind of expanded that and allowed-- it kind of kickstarted it more in the metro area as well.

WALZ: All right. Thanks.

ARCH: Other questions? All right. Seeing none, thank you very much.

COLBY COASH: Thank you.

ARCH: Other proponents? Welcome.

WILLIAM MUELLER: Thank you, Senator Arch, members of the committee. My name is William Mueller, M-u-e-l-l-e-r. I appear here today on behalf

of Methodist Health System and the page is handing out to you a letter from Stephen Goeser, the president and CEO of Methodist. Methodist does support Senator Howard's LB423. According to Mr. Goeser, over decades school-based health centers have provided important supplemental service to children in our community. LB423 would help the centers serve even more students. Methodist supports advancing this bill to the floor. Be happy to answer any questions.

ARCH: Thank you. I, I have one.

WILLIAM MUELLER: Yes.

ARCH: Does, does Methodist conduct a school-based clinic themselves?

WILLIAM MUELLER: I wish I knew.

ARCH: OK, I'm sorry.

WILLIAM MUELLER: I do not. I will find out.

ARCH: [INAUDIBLE], but I, but I--

WILLIAM MUELLER: I do not know. I'm guessing those behind me would know. I, I do not know that.

CAVANAUGH: We're getting a no head shake.

WILLIAM MUELLER: Actually, the answer is no. Thank you.

ARCH: OK. All right, all right. Thank you very much.

WILLIAM MUELLER: Thank you.

ARCH: Other proponents? Seeing none, there-- we, we received four letters in support of LB423. One was from Dr. Debbie Tomek, herself; Josie Abboud, Methodist Hospital and Methodist Women's Hospital; Jeanee Weiss, Nebraska Child Health and Education Alliance; and Amy Behnke, Health Care [Center] Association of Nebraska. No further proponents. Are there any opponents that would like to speak? Welcome.

MARION MINER: Thank you. Good afternoon, Vice Chairman Arch and members of the Health and Human Services Committee. My name is Marion Miner, M-a-r-i-o-n M-i-n-e-r, and I'm here to speak on behalf of the Nebraska Catholic Conference. The Conference advocates for the public policy interests of the Catholic Church by engaging, educating, and empowering public officials, Catholic laity, and the general public.

And I'm here today to testify in opposition on behalf of the Conference to LB2-- 423. There are several things I'd like to get to with regard to this bill. So I, I may run out of time but I'm gonna do the best that I can. So LB423 would strike many of the requirements in our state law regarding what constitutes a school-based health center. Some of those state requirements that would be struck are simply reiterations of what federal law already requires. One of those things being mentioned is that under-- for example, 42 U.S.C. Section 280h-5. It requires that school-based health provider not provide abortions or not perform abortions. I can't remember exactly the-- does not perform abortion services. So that's correct. However, there are other requirements in our state law that would be struck by the bill which only have partial overlap in federal statute or no overlap at all. And their repeal would have consequences in Nebraska. So first as I already stated while federal law does already provide that a school-based health center does not-- may not provide abortions. It does, it does not forbid referral for abortion or counseling a child to have an abortion. Furthermore, school-based health centers are not barred by federal law from providing contraception, including hormonal birth control, including intrauterine devices to children as well. And it is certainly our position that school-based health centers should not be referral centers for abortion and neither should they be a place where children are given hormonal birth control. And hormonal birth control oftentimes-- in fact most hormonal birth control prescriptions or forms also operate in many instances as abortifacients depending on at what time it's taken and at what point in the process in the woman's cycle after conception those are taken. So school-based health centers should neither be referral centers for abortion nor they should be a place where children receive hormonal birth control. They could become both under LB423 if the language is struck as provided for and under current federal law. It's also worth pointing out that this proposed change in the law must be read in tandem with the rest of the MAA which among other things requires that, "Each public school district shall annually, at the beginning of the school year, provide written information supplied by the department to every student describing the availability of children's health services provided under the medical assistance program." And that's statute as cited there on, on my written testimony. Therefore, under LB423 contraception products may receive free annual advertising which would be targeted at grade school and high school students from their own public school districts each year. Finally, LB423 repeals outright another statute which until now has required that: to ensure that the interests of the school district, community, and healthcare

provider are reflected within the policies, procedures, and scope of services of school-based health centers, every school district shall have a School Health Center Advisory Council which must include at least one parent. So the proposed removal of this requirement is also the only removal-- or is also the removal of the only provision that ensures some parental involvement in school policy regarding how the program works. So in summary, I would say this bill is bad policy because it allows for the provision of contraceptives, many of which also have abortifacients properties, to Medicaid-eligible schoolchildren under the guise of offering them healthcare. Second, these practices will get free advertising through our public school districts. Third, parents will be cut out of the loop about school-based health services including policy regarding the provision of hormonal birth control in schools and the fact that it will be poor families who feel the consequences of this policy, as is usual when it comes to abortion and contraception is only a compounding factor. Finally, this is another point that hasn't been brought up yet but there is no guarantee that the federal prohibition on abortion providers operating as school-based health centers will continue indefinitely. Federal law can change and the State Legislature in Nebraska has no control over that. The statutes we have in place now, and which LB423 seeks to strike, operate as a safeguard against those practices. So that's another reason to keep those, those particular lines in place which are struck by this bill because we don't want to leave the goal wide open in the event that federal law changes and open the school-based health centers up to participation by abortion providers. So for all those reasons and, and because my time is up, I'll simply conclude by asking you to indefinitely postpone the bill or at the very least remove the, the-- insure that the language regarding an abortion and contraception remain in place. With that, I'm happy to take questions.

ARCH: Questions? Senator Cavanaugh.

CAVANAUGH: Thank you, Vice Chairman. Thank you, Mr. Miner, for being here today.

MARION MINER: Sure.

CAVANAUGH: I have a few questions. First of all, the opposition to birth control-- I don't know if you were here when Senator Howard opened,--

MARION MINER: Um-hum.

CAVANAUGH: --but I did specifically comment to her the importance of that inclusion as a woman with reproductive organs, as a teenager going through hormonal changes, birth control can be very helpful to young women to manage the symptoms that come when you start to menstruate. I have had-- my college roommate who would pass out from pain and loss of blood and she had to go on hormonal birth control. So I'm a little confused as to why you have an objection to that being included here. It is clearly something that some patients need that is medically necessary and restricting a doctor's ability to care for a patient in my view is abhorrent. So I'd like to know how in your view it's OK to say that even though this is going to make it impossible for this young lady to get through the school day she shouldn't have access to that?

MARION MINER: Thank you for the question. So first of all, if that if, if, if that were the intent here and we wanted to preserve that as a possibility, I think there are ways that you could make that-- that you could word the language-- change the language to allow for that possibility but not for purposes of using birth control as birth control first of all. The second thing is-- and I don't, I don't want to get into, into an argument about you with this, but I would also be happy to refer you to many, many healthcare providers in the state who would testify that birth control is never medically necessary to treat any medical condition and that there are other ways that you can treat that.

CAVANAUGH: But you want to supersede parental consent and, and a medical provider's ability to provide adequate care based on your belief that birth control shouldn't be allowed. But it is medically necessary. Medical providers would not be prescribing it unless it were medically necessary. And we have heard multiple people today reiterate parental consent and the idea that the federal law could somehow go away does not supersede the authority of the school board to still require that school-based health centers require parental consent. And it does not supersede school-based health centers from deciding themselves to have parental consent because they are dealing with minors and they want to have that sort of coverage. So let's just say parental consent exists in all levels. It's-- it is preserved in Senator Howard's bill. It's preserved federally. It's preserved at the school board level and it's preserved with the healthcare provider level. It is your assertion here that we should allow parental consent

to be superseded. That if a parent thinks that their child needs this, that that should be superseded by your beliefs.

MARION MINER: I'm not sure exactly, exactly what you're referring to, but I would say that although certainly parental consent is provided for because that's, that's provided for in other places in the law. What you're doing here is-- and, and I don't know-- when we're talking about the School Health Care Advisory Council-- Health Center Advisory Council which exists and which would be struck here. What-- I'm not, I'm not asserting that making that go away would remove the requirements of parental consent that are, that are elsewhere in the law. What I am saying is that it removes an avenue-- the only avenue in statute right now that provides for a formal opportunity for parents to engage in how policy is formulated for how that's going to look in their own school district.

CAVANAUGH: Parents currently have to consent to whatever treatment their child receives.

MARION MINER: I'm, I'm not contesting that.

CAVANAUGH: Right.

MARION MINER: Uh-huh.

CAVANAUGH: But what you are saying is that you want to restrict what care their child receives without giving them the choice. I as a parent, I have two daughters, if they need something medically it will be up to me to decide with their doctor if that is acceptable or not.

MARION MINER: Um-hum.

CAVANAUGH: It would not be up to you, Mr. Miner. I would not like to have you come to the gynecologist with my daughters. That is not your role. And that is what I am hearing from you today that you believe that it is your role to be in the gynecologist office with my daughters.

MARION MINER: I'd be happy to disabuse you of that conception if you'd like to talk about that out-- you know, in another setting.

CAVANAUGH: I'd like to talk about it here.

MARION MINER: OK, so I'm not, I'm not quite sure how to respond to it other than to say that's certainly not what my-- that's not what I'm asserting nor is it what I believe.

CAVANAUGH: But you are, you are serving--

ARCH: Senator Cavanaugh, I'm sorry, do you have, do you have another question that we could--

CAVANAUGH: I have several more questions.

ARCH: OK, that'd be great.

CAVANAUGH: Yes.

ARCH: I, I think we want to move on. But if you have other questions--

CAVANAUGH: I do.

ARCH: --please, please continue.

CAVANAUGH: OK. I will move on to the fact that it will be poor families who feel the consequences of this policy.

MARION MINER: Um-hum.

CAVANAUGH: You are familiar with intergenerational poverty?

MARION MINER: I'm familiar with the concept and that it exists, yes.

CAVANAUGH: It, I believe, is a-- an issue that is a top of mind for the Nebraska Catholic Conference that intergenerational poverty is a significant and severe issue--

MARION MINER: Sure, yeah.

CAVANAUGH: --in this state and in this country.

MARION MINER: Um-hum.

CAVANAUGH: And one way to address an intergenerational poverty is unplanned pregnancies. And unplanned pregnancies happen because children are not educated and don't have access to healthcare. And everything that you testified to here today is contrary to combating intergenerational poverty and contrary to combating unplanned

pregnancies in youths, especially youth of color. So I would just like to hear from you how you reconcile that.

MARION MINER: OK. So I'm gonna try and answer the question as I, as I understand the question and, and that's simply by saying this, that shoving birth control at poor children is not the way to lift them out of poverty especially considering the, the many health effects that have been shown-- negative health effects that have been shown to occur quite frequently, frequently with people who are-- who practice hormonal birth forms, forms of birth control.

CAVANAUGH: So what is your solution?

MARION MINER: This--

CAVANAUGH: How are you going to prevent unplanned pregnancies in youth, especially minorities?

MARION MINER: One of the, one of the things that you mentioned as, as being important in combating the intergenerational poverty is education. And I certainly would agree with you that that is important. That would be something that would be helpful. Part of that actually-- what I would disagree with you on is what should be encompassed within that education? And hormonal birth control is a Band-Aid on a larger problem that doesn't solve the issue. And in fact there are studies that show-- I don't have them with me, but there are studies that show that, that when a person is on birth control-- when they're, when they're using some form of contraception it does not lower-- in fact, it usually raises the level of their sexual activity whether they're a child or an adult. And it doesn't lead oftentimes to lower, lower instances of, of unintended pregnancy. And in fact, in many instances a person becomes pregnant without, without intending it in the same month or even in the same week that they're using birth control. So that's why I'm saying it's not a solution. I understand why people see that as being, as being part of the solution. But there's plenty of, of evidence out there that shows that it's not a solution to the problem.

CAVANAUGH: So, so what is the solution? You didn't answer what you believe the solution to be.

MARION MINER: So--

CAVANAUGH: I'd, I'd like to, I'd like to have solutions to these problems because these problems exist. Even if we don't strike this language, the problems don't go away. So if you could give us the--

MARION MINER: I--

CAVANAUGH: --solutions in your mind that would be helpful.

ARCH: I-- could I, could I please interrupt because I, I think we want to, we want to limit the, we want to limit the questions to the testimony that you've provided and make sure that we understand your testimony. And, and perhaps these questions-- I mean, I understand, Senator Cavanaugh, these are deep meaningful questions and,--

CAVANAUGH: Yes, they are.

ARCH: --and if they're-- perhaps it can be set up at a time after that, that these questions can be probed more in depth. I think that would be helpful. But, but that would, that would be,--

MARION MINER: I would be happy to do that.

ARCH: --that would be a suggestion. I, I would, I would say do you have other questions concerning his testimony? Do you--

CAVANAUGH: I-- I'm-- I, I guess I felt like I was asking questions that were pertinent to his testimony. He's representing my religion in his testimony for a organization that's an advocacy organization. So I feel like these are legitimate questions to be asking. And talking about addressing poverty for families and having the Nebraska Catholic Conference show up today to testify against access to healthcare to children but not showing up for SNAP benefits and not showing up for early childhood subsidies. It's frustrating when you're talking about poverty. It's frustrating for me to have you show up for this and not offer solutions but just criticize the language. If you want to have a constructive conversation, let's talk about solutions to the problems.

MARION MINER: I'm, I'm happy to do that anytime you'd like. What I, what I, what I came prepared to testify on today is what this bill would do with regard to specific policy.

CAVANAUGH: But I think it's fair to say that if you're coming to testify about your problem with it you should be prepared to be asked what your solution is. I think that's a fair question.

MARION MINER: And I, and I would be, I would be happy to do that in another context.

CAVANAUGH: Great.

ARCH: Thank you. Senator Hansen.

B. HANSEN: So can I go back to the hormonal contraceptive care? So if the student cannot receive it like in a, in a school-based healthcare setting, are they still able to go to another clinic and receive it?

MARION MINER: Well, one of the-- I think it was Miss Skolkin had testified earlier that under Title X adolescents can get contraceptives even without parental consent. They would just have to do it somewhere else in a school-based health center. So there are opportunities to access that under other programs.

B. HANSEN: Thank you.

ARCH: Senator Walz.

WALZ: I just have a really quick question. I know that when Senator Howard started out-- her opening, she did talk about being able or the ability for her to talk about changing any language that people might want to have changed. Did you have the opportunity to talk to Senator Howard prior to today?

MARION MINER: That's, that's a good question. I, I did not talk to Senator Howard beforehand. Although I do think-- that's a good question. It would have been, it would have been a good thing to do I think.

WALZ: OK. I was just curious. Thank you.

MARION MINER: Yeah. Even after having listened to her testimony, however, the, the concerns that I have are the same.

ARCH: Thank you. Other questions? Senator Murman.

MURMAN: Thanks a lot for coming in. I wasn't gonna bring this up but, but because of some of the other earlier discussions, the way our-- these school health centers are structured in this state that they are in low-- high poverty areas, more culturally diverse areas. If they-- if these centers do encourage birth control, I like-- I think of myself as trying to be as, as against racism as possible, but I see

this as a racist issue. We're trying to control the culturally diverse populations. I just wonder if you'd like to comment on that?

MARION MINER: Yeah, I don't, I don't want to comment on the-- I, I certainly wouldn't think that that's the intent here. I, I, I wouldn't put that on anybody but, but historically there have been some troublesome things about policies regarding birth control that have had exactly those, those problems.

MURMAN: Thanks, a lot.

MARION MINER: Um-hum.

ARCH: Other questions? All right. Thank you very much.

MARION MINER: Thank you.

ARCH: Other opponents? Welcome.

NATE GRASZ: Good afternoon, members of the committee. My name is Nate Grasz, N-a-t-e G-r-a-s-z, and I'm the policy director for Nebraska Family Alliance. We represent a statewide network of thousands of individuals, families, and faith leaders who support the rights of parents to guide their children's lives and to be responsible for their care including all health and sexuality related decisions. In addition to striking language prohibiting abortion providers and those who refer or counsel for abortion services or contraceptives from serving as school-based health centers, LB423 removes an important component of parental involvement and oversight by striking a provision requiring official parental involvement in this program. An accompanying statute from the same section also requires school districts to advertise to students the health services available to them which would include contraception and abortifacients from the providers who would now be eligible to serve as school-based health centers under this bill. Attempting to simultaneously authorize providers who refer or counsel for abortion services or contraceptives while removing a component of parental involvement is an overreach that removes essential protections from state law. Federal law can change and the federal language referred to today does not prohibit counseling in favor of or referring for abortion or providing contraception. School-based health centers should not be encouraging abortion or providing referrals for abortion providers and they should not be dispensing contraceptives to schoolchildren. We believe the current definitions for who is eligible to serve as school-based

health centers should remain in place. And in order to ensure that the interests of the community are reflected within the policies, procedures, and scope of services provided, parental involvement and the decision making process with regard to what services will and will not be offered at their schools is a must. Therefore, we respectfully urge the committee to vote no on LB423. Thank you.

ARCH: Thank you. Any questions?

WALZ: I just have one.

ARCH: Yes, Senator Walz.

WALZ: Thanks for coming today. I'm, I'm just curious again, did you have an opportunity to talk to Senator Howard before the hearing today?

NATE GRASZ: Sure, I, I appreciate the question, Senator. And no, I did not. But we would be more than happy to talk and work with the Senator on resolving our, our concerns that we expressed here today.

WALZ: Thank you.

NATE GRASZ: Thank you.

ARCH: Any other questions? Senator Murman.

MURMAN: Yeah, I'd just like to thank you for coming in today, Nate. I have just one comment and I'd like your response to it. You know, we've talked a lot about parental consent. I, I just think by having these health centers in the schools we are-- you know, even though parental consent may be required there, we are going around the parents because if the centers weren't in the schools parents would have to-- you know, if the, if the kids are gonna get these services the parents would have to take them somewhere to get it. So, so we've got to do everything we can to encourage the parental involvement with the students.

NATE GRASZ: Yeah.

MURMAN: And, and just like your comment on that.

NATE GRASZ: Sure. Well, thank you for your question and comment, Senator. And I think I would just say that I think everyone agrees that parental consent is essential whether-- whichever side of this,

this issue or this bill that you, that you find yourself on. And I think we all can appreciate wanting to, to safeguard and keep parental consent at the forefront of the conversation.

MURMAN: Thank you.

WALZ: I just have one more question.

ARCH: Senator Walz.

WALZ: I'm sorry, I don't really ask that many questions but today I am. I, I would just like to know if you see any benefits to this program? What kind of things--

NATE GRASZ: The, the program as a whole?

WALZ: Yeah, the school based.

NATE GRASZ: Oh, absolutely. We're, we're certainly not, not opposed to the concept or existence of the school-based health centers, only the, only the, the specific language and protections and definitions of who is and is not eligible and what types of services they can provide that are being struck out under this bill. We certainly don't have an issue with the existence of school- based health centers and, and the services and care that, that they do provide to, to students which is very important, absolutely.

WALZ: All right, all right. Thank you.

NATE GRASZ: Thank you for the question.

WALZ: Yeah.

ARCH: Other questions? All right. Seeing none, thank you very much.

NATE GRASZ: Thank you.

ARCH: Other opponents?

AMBER PARKER: Hi, my name is Amber, A-m-b-e-r, Parker, P-a-r-k-e-r. Dear, Senators, my request is to add to public record on why I strongly oppose LB423 and urge you to indefinitely postpone LB423. LB423, just a part of the bill wants to strike out "Does not perform abortion services or refer or counsel for abortion services and does not dispense, prescribe, or counsel for contraceptive drugs or devices." I find it very interesting that the whole key point it seems

in this discussion here in this committee has been on birth control. Where is the focus of reading, writing, and education in our schools? I am not against school-based health centers in, in areas like that but what I, I question is as Senator Walz's bill of LB727 that you had introduced the point of mental health, and I've heard someone mention mental health today as a proponent to LB423 and my question to you, Senator, would be how the two connect and the resources and is Planned Parenthood involved in some of the organizations and things like that so if a student had come in. And I want to tie that to LB423 here is that if the goal is really not abortion then I would say that any organization that would support abortion or things like that then would not be welcomed within this school-based health centers. And if abortion is not the goal then why strike out the language in which I had just shared. I think that it's very important that I do share with you, I, before coming, I, I spoke with a family member and they had some loved ones deal with something with the Omaha Public Schools pertaining to sex education and I want to tie this together because it's very interesting that most of these health-based centers are in Omaha. There's been a great concern growing with parents and taxpayers of saying that they don't want to support Planned Parenthood sex education, and I just think that there's just too many gray areas in LB423 in questions. I think it's a wolf in sheep's clothing bill trying to hide the true goals. And the story goes like this, a parent had even written on a paper or, or signed their name that they didn't want their child participating in any of the Omaha Public Schools sex education and the schools didn't abide by it. The child came home one day, told the parent and the parent went back up. I think it's really important also to address what we know on the federal side of Title X which I'm new to that information of saying that children can get birth control. And I want to talk about as a woman and, and things like that without getting too personal. But I do feel that there are women to further what agenda that they have disrespect men in such a way and I don't think that's right to do. Because there are men that really do care, and my husband is one of them. And what I want to talk to you about is that birth control, handing it out like candy to kids. First of all, this shouldn't even be done in public schools. But are you aware that there was a study and they were trying to link birth control to endometriosis. And I don't know if you know anything about the disease of endometriosis, but I'm greatly concerned. And after this hearing, I'm actually gonna go back to the study and see what their connections are. I actually had to-- I, I thought my only choice was to go on birth control after a horrific car accident where I had internal bleeding and things had changed my life for the worse. So I

thought I had to do that to help me because I would end up in the emergency room with cycle pain so bad. And long story short and without getting so personal, I feel it's so important to tell you this because I, I just-- I'm concerned at what birth control can do. I actually stopped taking it because I found medical treatment. Now I myself, I'm not a Catholic, but I found medical treatment other than birth control and it was surgeries and because of their great loving care and helping me it has helped me and delivered me from what very likely could have happened and taken my life at a young age. It's one of the worst diseases any woman can face and I actually had a friend where it spread to her heart. So I really think before we start giving things and we look at the warning labels, look at the lawsuits, do we want to make our, our schools lawsuits in this area? But schools aren't meant for abortion, they're not meant to hand out birth control, they're meant to educate children. Please indefinitely postpone LB423, and I'll be glad to answer any questions. I feel that-- I, I didn't want to share such a personal testimony. But now is the time to do so because I could very likely be one of those women ahead of it and stop what other women could be in great pain from.

ARCH: Thank you. Are there any questions? Seeing none, thank you very much.

AMBER PARKER: Thank you.

ARCH: Thank you for coming today to testify. Are there other opponents? Welcome.

LARRY STORER: Thank you. Larry Storer, 5015 Lafayette, Omaha, Nebraska. That's spelled S-t-o-r-e-r. We're talking about constitutional issues--

ARCH: I'm sorry, we have, we have a rule regarding props so--

LARRY STORER: OK. All right. Well, it's always [INAUDIBLE] anyway, yeah.

ARCH: --if you could put those away and just [INAUDIBLE].

LARRY STORER: Constitutional issues today-- it's no wonder people are running towards homeschooling when you have people knocking on their doors doing this kind of stuff in the school systems now from age 0 to 3. This was not talked about in the constitution. It's not there. And it's not in the state constitution. The state constitution says you

will not make any special laws, etcetera. So let's get back to working on the U.S. Constitution and what the Founding Fathers envisioned your roles as. Not knocking on my doors and not forcing me to listen to that stuff today. We're talking about education not periods. OK. And as I read some of these bills, I keep thinking well everything seems to tie together to the Learning Community Council which it, it really isn't a Learning Community Council anymore. You know, it's changing names. And the tax dollars that they collect are kind of disappearing around in different parts of the Legislature. That's what those shell games are for you know. That the-- you put your money down and maybe you'll pick the right one and you win. But who wins? The, the taxpayer doesn't win. They didn't refund the money. They're, they're disbanding it, but they're not really disbanding it. Words matter. We used to have common sense way back in the early days there was a pamphlet about common sense. But now we have best practices. Well, one of the best practices says that the, that the child does not-- the brain does not mature till their age 25 or 26. The early testifiers here-- I don't know their ages, but a lot of them are probably not 26 yet. So maybe they don't have enough common sense to be writing the bills for you. If that's, if that's true-- because I'm 76, and maybe three times their age, maybe I have more common sense than they do or the 501(c)(3) organizations that they work for and that are drafting the bills for you. We don't have a whole lot of say in it. And I say Bellevue, as well as Omaha, probably now want to say citizens like me cannot come and talk that you don't have to. If that's not good enough you [INAUDIBLE] Omaha and Douglas County form a private corporation so that they can hide the testimony and hide the facts under the shell game because you don't have to disclose things. Well, pretty soon they'll be part of a, a triad of state, counties, and cities so that nobody can find out anything. But, you have a, you have a law that says open meetings. Well, what the hell does that mean? When you couldn't decide that you're not gonna let the public testify like in Bellevue or you can change the rules as you go along in Omaha at the City Council. The Douglas County Board, their meeting-- their, their rules are a little different. One of them says-- I think in the morning, oh, you can testify on anything that's not on the agenda today. Well, what if you said that today? I wouldn't be able to testify on this would I? Common sense again. Now City Council, they're a little easier. You can talk on certain times like the Board of Equalization. You can talk on that as long as it's not on the agenda and they don't have to talk back to you. But they feel free to ask you a question, they can talk all they want. At least you people do ask questions. But it is strange that you ask very few questions of the

people that are in opposition or ask the people that work for a living and they're getting paid to be here and have all day, sometimes six hours, before the opponents get to speak. That's not quite open and transparent is it. So it kind of goes back to the shell game. I wish I had more time because there's quite a few comments that I do want to make and I'll close with this, this bill is not very clear. But what it doesn't say, is a problem. Some of the words stricken out-- well, boy, I get the impression that I could drive my pickup up, up onto the school grounds and that would be a facility. And I could maybe perform abortions and I could prescribe medicines. I remember getting kicked out of a psychologist's office when I had permission to be there by my grandson and my daughter and I asked a question about the medications and the side effects. Well, guess what?

ARCH: Thank you, sir.

LARRY STORER: I'm done. He walked me out because privacy laws, laws protects it. That's kind of ridiculous. Thank you.

ARCH: Are there any questions? Seeing none, thank you very much. Are there other opponents to the bill?

THOMAS ROCKY THOMPSON: Good afternoon, Vice Chairman Arch and members of the Health and Human Services Committee. Again, my name is Thomas Rocky Thompson, T-h-o-m-a-s R-o-c-k-y T-h-o-m-p-s-o-n, and I serve as deputy director for Policy and Communications for the Division of Medicaid and Long-Term Care in Nebraska Department of Health and Human Services. The Department was not originally planning on testifying today but because of the confusion this bill might cause, the Department has to be opposed to LB2-- 423 at this time as it's currently written. Based on conversations that my staff has had with Senator Howard's office, Nebraska Medicaid understands the purpose behind this legislation is aligned with current best practices related to school-based health centers. And as written, the bill does not appear to notably impact the Medicaid program or the services delivered to Medicaid members. However, the stricken language regarding abortion services may confuse providers and Medicaid members and members of public as we saw today. As Chairman Howard said, Nebraska Medicaid cannot receive federal funds for abortion services except under very limited circumstances and additionally there are restrictions about using-- abortions being performed in school-based health centers. However, striking this language would appear to be an expansion of services provided by Nebraska Medicaid. However, these are services that Medicaid cannot receive federal funds for. As such

the Division of Medicaid and Long-term Care opposes LB423 at this time. I appreciate, I appreciate Chairman-- Chairwoman Howard's willingness to address this language as she said in her testimony. Thank you for this opportunity to testify. And I'm happy to answer any questions you might have.

ARCH: Any questions? Seeing none, thank you very much.

THOMAS ROCKY THOMPSON: Thank you.

ARCH: Are there others in opposition to this bill who would like to testify? Seeing none, we did receive several letters from opponents, and Julie Schmit-Albin from Nebraska Right to Life submitted a letter. In addition to that, we have received letters from 69 individuals who also sent in letters in opposition. I'm not gonna take the time to read all 69 names, but be assured that, that while the names are not gonna appear in the transcript, the letters that have been submitted will appear in the official record. Are there any that would like to testify in a neutral position on this bill? Seeing none, Senator Howard you may close.

HOWARD: So first, I want to thank the committee for their time and attention to this bill. I kind of don't know where to start. So I think what I, what I most want to do is emphasize my willingness to work with the opponents on the specific provision. I-- my, my preferred method of working in this body is usually to identify challenges and then bring something that is complete to a committee hearing or an amendment to a committee hearing. But one can only do that when they know exactly what an opponent is looking for in terms of changes. And so I will, I will certainly-- and I am committed to working with the opposition on this bill to try to make it better because I do think that there are several options for clarifying language that, that can really help with what they're looking for. I do want to note for the record though the advisory councils are not functioning and have not done so for several years. And so we talk a lot about outdated statutes, and statutes that don't reflect actual practice. And in that regard, there is no input because they do not exist. And finally, I, I agree, Senator Murman, that parents should always be involved in their kids' healthcare. Right? That is a best case scenario. I was raised by a single parent. My mom worked for the state of Nebraska for 34 years. She was a social worker. She was paid not very much for a thankless job. She worked overtime. And when I got sick often she couldn't leave work to come pick me up. Sometimes that fell to my older sister, Carrie. But a lot of times she would say wait

until I finish this home visit or wait until I can get off of work. But when your kid's sick you shouldn't have to wait and you shouldn't have to worry about them. And I think there are a lot of parents who maybe don't have the ability to leave work at a moment's notice. And my mom certainly didn't have that opportunity and there wasn't another parent to help. So I think school-based health centers are really designed for ensuring that all kids have access to quality healthcare wherever they may be and whatever their circumstances may be. I would hate to think that anyone would consider a bill that I brought to be inherently racist. And so I want to be really clear that that was never my intention. Right now my concern is that there is a class of, of youth who are, are not able to access the same brand of care as a more affluent youth in another area of town. And to me that seems like racism. To me it seems like we have a prohibition that means that one youth can't get the same level of care or the same level of conversation with their provider as another. And that seems inherently unfair. But I appreciate your questions and I appreciate your time and passion. When you think you're doing a cleanup bill and it becomes something bigger that's always a really fun experience. I do want to note for the record, I did not know the Department was coming in and I think there is an opportunity here because I really considered just getting rid of the entire statute because all of it should be living inside of our Medicaid state plan regardless. There are Medicaid providers, they should live inside our state plan. We actually don't really need a lot of legislation to clarify their work. But we wanted to make sure that if there was ever a question of their ability to bill that we leave at least the parameters of what the, what the facilities can do. So once again, I reiterate my willingness and commitment to work with the opponents on this bill in the language. And I do appreciate your time and attention to LB423. I'm happy to try to answer any final questions.

ARCH: Any questions for Senator Howard? Senator Murman.

MURMAN: Yeah, thanks a lot for bringing this in, Senator Howard. I certainly didn't want to imply that, that you meant this, this bill to be racist. I'm just looking at-- there's so many things in our society include-- including this that seem to turn out that way. And they're always-- they're usually intended for something good--

HOWARD: Yeah.

MURMAN: --and, and not only the racist part-- racism-- poss-- possible racism part of it, but also parental involvement. You know, I know

it's not intended to limit parental involve-- involvement but so many things that we do in, in education and society in general by our laws, it seems like in the end they, they tend to limit parental involvement where we really should be encouraging parental involvement with family. You know, a family in every way we can. So-- but thanks a lot for bringing it in. I know that wasn't your intention. So thank you.

HOWARD: Thank you, Senator Murman. And I would actually say that with some of the clarifications it actually means that parents and families could be more involved because they can go to the same clinic that their child is going to. Right now, we wouldn't let them go. And so this actually could be a, a welcome introduction of more parental involvement if they're able to go to the same provider as their child.

MURMAN: Um-hum. Yeah, I realize every community is different. You know, what works in one community or one, one part of the state wouldn't work in another part of the state or community. So thank you.

HOWARD: Absolutely. Thank you.

ARCH: Other questions for Senator Howard? I guess I just have one. You, you obviously saw and you, you mentioned even in your closing remarks that, that this issue, this issue has broad implications to other societal issues as well. Societal issues that we all recognize as very real and very difficult to solve. I, I guess it's just a request that if, if asked, would you be willing to even facilitate discussions amongst the parties? You, you saw even amongst the committee that there, that there are strong feelings on these issues and even amongst testifiers. And if asked, would you be willing to facilitate some of those discussions as well. Not directly related to the-- not directly related to your bill but there are parties that maybe need to have some of those broader discussions of society.

HOWARD: I'm not sure what you're asking.

ARCH: OK. Your willingness, your, your willingness to facilitate some other discussions and I guess we can do that discussion off--

HOWARD: Are you asking to bring together sort of the pro-life and the pro-choice community?

ARCH: No, no, no, no, no.

HOWARD: Oh, OK. I was-- because I was like, oh, gosh, that's a--

ARCH: No, no, no, I'm not asking that.

HOWARD: --big ask.

ARCH: I'm sorry, that, that was a bit too vague but we can have some other discussions regarding that question.

HOWARD: So what I will say is that last year I was one of the five people who came up with a compromise on Title X last year to move the budget. Because the budget was important and it had so much good in it. And I couldn't see a way to preserve access without modifying the language that had been presented preserving access to the services. I feel as though the reputation that I want to put forward is as a person who is willing to work and ensure that language in our statutes works for all parties involved. And so that is I think why it's especially difficult for me when somebody doesn't come and tell me what I need to do to make a bill better. And so if that's the conversation you would like me to facilitate, absolutely.

ARCH: Thank you.

HOWARD: But also I am happy at the will of the committee to facilitate any other conversations you would like me to facilitate. Thank you, Senator Arch.

ARCH: Thank you. OK, I believe that closes our hearing for LB423 and, and closes the committee hearings for the day. Thank you.