HOWARD: Good afternoon and welcome to the Health and Human Services Committee. My name is Senator Sarah Howard, and I represent the 9th Legislative District in Omaha and I serve as chair of this committee. I'd like to invite the members of the committee to introduce themselves, starting on my right with Senator Murman.

MURMAN: Senator Dave Murman, District 38: 7 counties south of Hastings, Grand Island, and Kearney area.

WALZ: Lynne Walz, District 15: all of Dodge County.

ARCH: John Arch, District 14: Sarpy County, Papillion, La Vista.

WILLIAMS: Matt Williams from Gothenburg, Legislative District 36: Dawson, Custer, and the north portion of Buffalo Counties.

CAVANAUGH: Machaela Cavanaugh, District 6: west-central Omaha, Douglas County.

HOWARD: Also assisting our committee is our legal counsel, T.J. O'Neill. This is his first hearing ever, so be nice to him; and our committee clerk, Sherry Shaffer, and our committee pagers-- pages, Hallett and Taylor. A few notes about our policies and procedures. Please turn off or silence your cell phones. This afternoon, we'll be hearing three bills and one gubernatorial appointment, 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 will find green testifier sheets. If you are planning to testify today, please fill one out and hand it to Sherry when you come up to testify. This will help us keep an accurate record of the hearing. 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 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 10 copies and give them to the page. We use a light system for testifying. Each testifier will have five minutes to testify. When you begin, the light will be green. When the light turns yellow, that means you have one minute left. And when the light turns red, it's time to end your testimony and we'll

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'll hear from supporters of the bill, then from those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given an opportunity to make closing statements if they wish to do so. We do have a strict no prop policy in this committee. And with that, we'll begin today's hearing with Dr. Gary Anthone's appointment. Welcome, Dr. Anthone. Good afternoon.

GARY ANTHONE: Good afternoon and thank you, Senator Howard and members of the Health and Human Services Committee. I'm Gary Anthone, G-a-r-y A-n-t-h-o-n-e, Chief Medical Officer and acting Director of the Division of Public Health for the Department of Health and Human Services. I began this position on September 3rd of 2019. I was very honored to join CEO Dannette Smith and the team at DHHS. I've been welcomed into the department by very kind and very passionate teammates. The Division of Public Health impacts the life of every Nebraskan. We are responsible for ensuring clean air and safe water, disease monitoring and prevention, supporting healthy schools, communities, and workplaces, quality health care facilities, and preparing and responding to natural disasters and public health emergencies. This is public health. With an extensive and diverse medical background and a desire to continue to help people in a new way, I'm excited to move the Division of Public Health forward. But before talking about our goals for the future of public health, I would like to provide you an overview of my background that has enabled me to be able to sit with you today. I have lived all but 15 years, 15 of my 65 years, in Nebraska, completing all my elementary and high school education in Omaha. By the time I completed high school, I knew I wanted to be a physician. I was fascinated by how the human body worked and wanted to study it more. My father was a machinist and he taught my siblings and me how machines worked and how to fix them when they broke. I thought of the human body as the ultimate machine. After graduating from Benedictine College in Kansas, I came back to Creighton University medical school for my degree. And I enjoyed working with my hands and with tools, so I knew surgery was the route for me. I completed my general surgery residency at Creighton as well, and during that time this included six months of training in England within the national health system. After residency, I was a fellow at Johns Hopkins Hospital, and then from

there recruited to the Department of Surgery at the University of Southern California in Los Angeles. At USC, I staffed and worked at LA County Hospital, one of the largest hospitals, county hospitals in the country, within one of the largest academic surgery programs in the United States. During my time there, I started the bariatric or weight loss surgery program, and back then it was not as mainstream as it was-- as it is today. At that time, I was not certain whether weight loss surgery was going to have a future, so I took a year off and completed a colorectal surgery fellowship also at USC. Fortunately, however, our weight loss surgery program did well and we were even featured on a national television program. After that, I never looked back. I spent the rest of my surgical career specializing in surgeries, specifically to the morbidly obese patient, something I truly developed a passion for. I'm also proud to say that during my time, up until this point I was a captain and promoted to major in the Army National Guard in the states of Nebraska, Maryland, and California. Well, my wife and I were surprised to discover one day that we were expecting twins and we decided to move back to Nebraska. And we've been back now for 16 years. Prior to taking this position, I practiced surgery at the Methodist Health System and also worked as a private practice surgeon, and was appointed as a faculty member in the Department of Surgery at Creighton University. I believe all these experiences have prepared me for my role as Chief Medical Officer and Director of Public Health in the state that I truly love. And I'm very happy and honored to serve. So in September I focused with meeting with my team members and learning about the Division of Public Health and the department overall. It became very clear early on we have a great team in both the division and the department. My colleagues are motivated, talented, truly committed, and are supporting our vision of helping people live better lives. I know with this team we will continue to accomplish great things and continue to improve Nebraska's public health outcomes. Looking forward, the division will continue to be customer-focused and make sure that healthcare professionals we license are able to obtain their credentials and get to work in a timely manner. We are making sure applications are simplified and screening processes are streamlined, and we are issuing license much more efficiently. I also understand the responsibility of disciplining license holders when necessary, and this is of utmost importance to our division. We remain steadfast in our approach and our processes. The Division of Public Health will continue its efforts to promote good health and wellness across the state. After discussions with my team, I'm looking to focus on improving health in three key areas. Number one, ensuring healthy pregnancies and improving birth outcomes.

Number two is reducing obesity in our state. And number three is to promote, promote healthy aging. These areas will help us focus on our work on improving health across the lifespan and will ensure we're having an impact on every single Nebraskan. Of course, the Division of Public Health can't be successful alone. One major area of concentration will be to continue to build our strengthening relationships, both internal and external. Our external partners, including the local public health departments, do critical work in helping us make sure every Nebraskan receives effective and efficient public health services. Internal to the department there is also a great opportunity for us to work more collaboratively with our other divisions and to integrate the work of the Division of Public Health. It's important that we build these relationships throughout the department to better leverage our resources and expertise in order to have a long-lasting impact on public health in our state. I'm extremely excited to be part of CEO Smith's team. I'm excited to lead the Division of Public Health into the future. And I appreciate this opportunity to be with you today, and I look forward to working with you. Thanks for your time. And I'll be hands-- happy to answer any questions you may have.

HOWARD: Thank you, Doctor. I'd like to start with one that I've asked every Chief Medical Officer when they have come through. One of the main pieces that we rely on from you as a Legislature is your input on the 407 process. Do you want to just give us an idea of sort of your thoughts on scopes and your thoughts on the 407 process as a whole?

GARY ANTHONE: Sure. Thank you. Fortunately, I've had the opportunity to take part in two of the 407 processes in my few months here. So I realize there's two areas. One is for new credentials of health care professionals and other occupations. And the other one is a change in the scope of practice within those professions. So there's four criteria for new credentials and six criteria that need to be met for changing in scope of practice. There's three reports that are generated in the 407 process. The first, by the technical review committee, which is made up of volunteers of both public members and professionals and a member of the Board of Health who chairs that committee. They hold public hearings on the applicants program and process, and generate a report. The Board of Health also has a credentialing review committee that is made up of, I think, seven of the members of the Board of Health, and they also look at the issues in depth that are being applied for. They then present their findings to the full board of Health and a report is generated from the Board

of Health. Fortunately, I've had the opportunity to read reports from both the technical review committee and the Board of Health, and then we generate our own depart-- report within our division, the director's report. Those three reports are then given to the HHS Committee for your review and decision.

HOWARD: Thank you. Are there questions for Dr. Anthone? Senator Williams.

WILLIAMS: Thank you, Chairwoman Howard. And thank you, Dr. Anthone, for your commitment to medicine and being here today. I really appreciated the opportunity to meet you privately and have a good discussion about things. And in that conversation, just as in your communication with us today, you talked about your history of looking at obesity. You also talked in your goals today about that reducing obesity in Nebraska as being one of the health hazards that we have. I remember that day because it was the next morning that some new statistics came out which showed the increase in, in our country and in Nebraska, where I think now it's nearly 50 percent, if not slightly more. What are your ideas about how our state could actively engage in reducing obesity?

GARY ANTHONE: Thank you, Senator. I don't know how, but somehow I developed a huge empathy for the obese patient, and I still have it to this day. There's only 15 states that rank lower than us in the rate of obesity in the United States. So you're very correct, and it's something that was glaringly obvious when we looked at our state health rankings, that obesity is a problem here in Nebraska. I, I spent my surgical career dealing mostly with adult obesity. But one of the things that moved me the most was when my patients would come in to me or our office with their children, and saw the same thing that was happening to their children that they went through, and asked me what could be done. And I think I'd like to focus more on that end of the spectrum now, is more the adolescent and the younger age groups. To sort of take an upstream approach, I guess you could say, to obesity. And I'll be working with some external partners, College of Public Health, some of the other programs around the state, the local health departments, to try to see what we can do about adolescent and younger age obesity.

WILLIAMS: Thank you.

GARY ANTHONE: You're welcome.

HOWARD: Any other questions? Senator Cavanaugh.

CAVANAUGH: Thank you. Thank you for being here. And also, I have to mention that you live in my district, so I'm thrilled to have a member of District 6 here as well. And before I ask you my question, I will, just for Senator Howard's benefit, I'm pretty sure you have one of your children graduating from Duchesne Academy. Is that correct?

GARY ANTHONE: Yes. But my wife is [INAUDIBLE].

CAVANAUGH: Oh, thank goodness. Wow.

HOWARD: Oh, man.

CAVANAUGH: Thank, thank, thank you.

HOWARD: You're lucky that daughter went to Duchesne. I'm just saying.

GARY ANTHONE: Actually we've had two daughters go through Duchesne.

CAVANAUGH: Oh, two daughters. Yes, well--

HOWARD: Even better.

CAVANAUGH: It's a little bit of a rival that we have going-- rivalry we have going on here. I'm glad to know your wife did. I don't-- I'm not sure what choices she made with your daughters, but--

HOWARD: The best kind of choices.

CAVANAUGH: Right, the best kind.

GARY ANTHONE: She wasn't happy about it, let's put it that way.

CAVANAUGH: I have also mentioned to this committee that on a few occasions that your grandson Carter is my daughter Harriet's BFF. So I am familiar with your family. And I appreciate you being here today. He didn't mention something that I'm particularly interested in, which is maternal health. And I know in Nebraska we have an issue with maternal health. And just kind of speaking to your background again in obesity, that it plays a lot into our maternal mortality rates here in Nebraska. So could you maybe talk a little bit about your vision for lowering our maternal mortality rate and how that works with your background?

GARY ANTHONE: Thank you, Senator. Fortunately, I'm on the committee for the child and maternal morbidity and mortality committee. And one of the first eye-opening statistics I saw and was surprised about was how Nebraska ranks in the percentage of preterm births that happen here in Nebraska. My strategic advisor, and CEO Smith was very wise to appoint me a strategic adviser on my first day, who has a lot of public health experience, and one of her expertises is in maternal health and healthy pregnancies. From being on that committee, however, I realize how important it is to obtain prenatal care. Almost all prenatal births, preterm births are due to a lack of prenatal care. So that is one area for sure we're going to focus on. And we'll work again with our external and internal partners with that.

CAVANAUGH: Thank you.

HOWARD: Are there any other questions from the committee? Seeing none, thank you for visiting with us today. We'll look forward to discussing your appointment on the floor.

GARY ANTHONE: Thank you very much.

HOWARD: Thank you, Doctor. All right, that will close our hearing for the gubernatorial appointment for Dr. Gary Athone. And we will open the hearing for LB836, Senator Arch's bill to change provisions governing certain contracts and agreements relating to the medical assistance program. Welcome, Senator Arch.

ARCH: Good afternoon, Senator Howard, members of the Health and Human Services Committee. For the record, my name is John Arch, J-o-h-n A-r-c-h, and I represent the 14th Legislative District in Sarpy County. I'm here today to introduce LB836. LB836 would change the provisions governing contracts between managed care organizations and the Department of Health and Human Services to carry out the Medicaid program. First, the bill would remove this section of statute from the Behavioral Health-- the Behavioral Services Act, where it currently is placed, and move it to Chapter 68, the Medical Assistance Act, the chapter covering Medicaid. I'll talk about that more in a second. Second, under the bill, any funds that are result of an MCO not meeting the minimum medical loss ratio and any unearned incentive funds would be credited to the Health Care Cash Fund. In October of last year I received a call from a reporter who wanted my thoughts regarding the proposed expenditures of nearly $20 million in excess profits, that which exceeded the minimum loss ratio, earned from one of our MCOs in 2017. Naturally, this piqued my interest. As directed

under our statutes, the MCOs, with approval from the Department of Health, are to reinvest those excess funds in additional health related services. That, quote, and this is part of the statute: Address the health needs of adults and children, including filling service gaps and providing system improvements. In this particular case, DHHS approved six initiatives proposed by WellCare. Those initiatives included the establishment of the Nebraska Health Sciences Act Collaborative, the establishment of endowed chairs within the research universities, the DHHS IT Enterprise Project, an endowed work study program, an endowed provider education fund, and a competitive submission fund for provider-driven initiatives. Since this enabling language is currently housed under the Nebraska Behavioral Health Services Act, which is Chapter 71, there has also been some question as to whether or not the reinvestments of extra funds should be to behavioral health only. The statute is clearly ambiguous, clearly ambiguous-- certainly ambiguous. So part of the intent of LB836 is to provide clarity. My biggest concern, however, is not how those funds were spent. The decisions as to how those dollars, I-- that was, that was not my largest concern. I believe WellCare acted in good faith in filling service gaps, providing system improvements. DHHS approved those expenditures. But my biggest concern is our policy gives these MCOs authority with, with DHHS to appropriate excess taxpayer dollars. These surplus profits are state dollars, and I believe that the Legislature is the proper body to determine how these funds are appropriated. So this section of statute governing these contracts was first enacted in 2012 as the state was embarking on a new model of delivering Medicaid behavioral health services through at-risk managed care con-- managed care contracts. That's how it ended up, it ended up in the behavioral health section. The Legislature adopted LB1158 to put parameters on those contracts, including establishing caps on administrative spending, putting caps on profits and losses, providing performance guarantees and incentives, and requiring reinvestment of excess funds. In 2016, at the request of the department, this section of statute was amended through LB1011 to adapt to integrated physical and behavioral health and pharmacy benefit managed care contracts. While both these bills established an important framework for contracts, I found in reading through the past transcripts that little to no discussion was had as to whether or not it's good policy to allow a contractor to appropriate state funds. In fact, there was little to no discussion on these bills at all. I do need to mention that during the hearing on LB1011 then director of the Medicaid long-term care division, Calder Lynch, did say in response to a question about MCO incentive funds not meeting the loss ratio of 85

percent, quote, and if they fall below that amount, the difference must be returned to the state. To me, it's pretty clear the department indicated to the Health and Human Services Committee the state funds would come back to the state. I also want to note that during the brief floor debate on LB1158 an amendment from Senator Hadley was adopted that stripped a provision requiring 1.5 percent of the contract automatically coming off the top for reinvestment in children's behavioral services. And while the intention is laudable, Senator Hadley said it best, that this would, quote, constitute a kind of backdoor additional appropriation, bypass our normal appropriation process where it can receive legislative oversight, end of quote. So that's exactly how I feel about the reinvestment directive contained in the contract requirements. The excess state money is the state's money. It is the taxpayers' money of which they have entrusted their elected officials to properly invest. In considering this bill, I thought the funds should at least remain available for investment in health and proposed to direct the money to the Health Care Cash Fund. I've been approached with other suggestions, such as directing the money to the General Fund or putting the money back into the Medicaid program. I'm very open to discussion and am more than willing to work with this committee to determine the best option, as long it is-- as long as it is the Legislature that decides. In reality, it's doubtful, doubtful, perhaps, that there will again be such a number of the $20 million approximate number that exceeds the cap as happened in 2017. That was probably a result of the first year of the Heritage Health contracts, not knowing exactly how, how sick, how well certain clientele would be, and so utilization was a little different. But regardless. So at the moment, this isn't taking money away from any program that's currently receiving those funds, and they are generally reoccurring funds. However, we don't know what the future holds. And with Medicaid expansion, there very well could be another such occurrence, not understanding exactly the population that's going to be covered. And my ultimate goal is simply to make sure that these funds stay within the Legislature's appropriations authority. I do want to note that there's a drafting error on page 2, line 26. The word "medical" was inadvertently left out. It should read "minimum medical loss ratio" and this will need amending if the committee finds LB836 worthy of advancements, which I hope it does. Thank you, I'm happy to answer any questions.

HOWARD: Are there any questions? Seeing none, you'll be staying to close?

ARCH: I will.

HOWARD: Fantastic, thank you. We'll invite our first proponent up for LB836. Good afternoon.

TOPHER HANSEN: Good afternoon. Chairperson Howard, members of the Health and Human Services Committee, my name is Topher Hansen, T-o-p-h-e-r H-a-n-s-e-n. I am the president and CEO of CenterPointe, a member organization of the Nebraska Association of Behavioral Health Organizations, also known as NABHO. I'm here representing NABHO. I come today to support Senator Arch's bill, LB836, and to provide suggested amendments to strengthen it. I want to provide you with information about previous legislation that directed use of excess revenue towards strengthening the behavioral health system, which is how we would amend LB836. NABHO took an active role in bringing managed care for mental health and substance use services to Nebraska. In anticipation of an at-risk contract being let by HHS, NABHO had conversations with HHS that led to a request for information being issued seeking ideas of what a managed care system for mental health and substance use would look like. NABHO submitted the only response to the RFI. We developed our response with the assistance of Dr. Andy Keller, a nationally known expert on Medicaid systems. Dr. Keller was most often contracted by government entities seeking his expertise. Dr. Keller, sorry-- but was able to assist us in preparing a prototype system to develop in response to the RFI. In preparation, Dr. Keller and his team developed the matrix of Medicaid contract provisions from several states that were thought to have successful programs. In doing so, we identified the attributes of a contract that would lead to better success, higher quality services, positive outcomes and savings for the taxpayer. That prototype was used almost in its entirety by HHS in developing the at-risk contract awarded to Magellan in 2012. That is what we develop was dropped into the RFP and later the contract almost in its entirety. In addition to developing the RFI response, NABHO advocated for legislation, LB1158, that would outline how money could be spent in a managed care contract. One element of the legislation in the contract was reinvestment of any revenue in excess of the 3 percent maximum profit, unused incentive dollars, or other excess funds allowed under the law. The point of this reinvestment language in statute is to assist the state of Nebraska in building a robust system of services that benefits people in a way to help them live a healthy, productive life and not just leaving it to chance. Establishing clear parameters and pathways for funds was important for program integrity, accountability, and maintaining the

investment in these specific service areas. The investment was to be guided by identified stakeholders that was in the statute, in the community, and in the behavioral health system. The Nebraska Hospital Association offered testimony at the hearing on LB1158, saying, we think that these are very good provisions to put into a managed care contract with any managed care provider. In fact, we think they're so good that the next time the state negotiates for the physical health or the primary care side of health care, that provisions similar to this should be incorporated in those contracts as well. And with that, we would urge you to advance LB1158. NABHO supports Senator Arch's bill, LB836 in general concept. But like the bill I just described, we support more specific reinvestment of any revenue into the mental health and substance use service system for children and adults. The Health Care Cash Fund is a great asset for health care in Nebraska, but it has many facets. If revenue is saved in the managed care of physical health, pharmacy, mental health, or substance use treatment then we urge you to be specific to earmark it in directing those savings back to the direct health care services where they were saved and not putting the savings into business infrastructure or the general fund of the Health Care Cash Fund. LB836 gives the opportunity for Nebraska to be efficient with the money allocated to health care and saved in health care so we can gain greater value and better outcomes.

HOWARD: Thank you. Are there questions from the committee? Mr. Hansen, before I let you go, the Health Care Cash Fund is one of our major contributors to our Children's Health Insurance Program match.

TOPHER HANSEN: Uh-huh.

HOWARD: And you-- the Children's Health Insurance Program does have a fairly robust behavioral health, mental health service array. Is that correct or--

TOPHER HANSEN: The-- yes, the services to children tend to be Medicaid-based. They're not based in the behavioral health system per se, but more on the Medicaid side. And so that match then goes to assisting that. But it also is more diverse than that. But yes, it would be a piece of that addressing children's services. I guess the point of what we're trying to say is we don't-- we're not interested in reinvesting in the infrastructure or a chair in a department at the university, frankly. So to the extent half of you went out and saved great money in doing what you do, then what we think is that money ought to go back to continuing to promote what you do and not sharing

it with everybody across the board in that, especially in behavioral health. That the struggle to get rates to match the cost of doing business has been a long conversation in the state of Nebraska. And so what we want to do is try and further the efforts to support the health care expenses of direct service. And, and now, because of the way our contracts are, they're integrated. So we have physical health, pharmacy, mental health, and substance that are all addressed in the Medicaid system. So if in providing services in those arenas, we save money, we think that that money ought to be reinvested back into those services and not the infrastructure, IT, and academics, and so on.

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

TOPHER HANSEN: Thank you.

HOWARD: Our next proponent for LB836? Seeing none, is there anyone wishing to testify in opposition to LB836? Good afternoon.

NATE WATSON: Good afternoon. Should I wait till you say--

HOWARD: Whenever you're ready.

NATE WATSON: Thank you. Well, good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. My name is Nate Watson, N-a-t-e W-a-t-s-o-n, and I'm the deputy director for policy and regulations in the Division of Medicaid and Long-Term Care within the Department of Health and Human Services. I'm here today to testify in opposition to the green copy of LB836. LB836 is a bill, excuse me, that would change how certain remitted funds are directed. Current law requires that funds paid by the Medicaid program to the Heritage health plans be reinvested in part in three circumstances. First, if a health plan fails to meet the medical loss ratio. Second, if a health plan fails to meet performance measures. And third, if a health plan does not earn incentive funds. Money reinvestment in any of these three circumstances is used to fund additional services to Medicaid beneficiaries. LB836 would redirect remitted funds related to any failure to meet the medical loss ratio or earn incentive funds to the Health Care Cash Fund. Funds remitted due to any failure to meet performance measures would continue to fund additional services. The agency appreciates the desire to return decision-making authority relative to the use of some of these funds to the Legislature and supports this position. However, because the bill directs these funds to the Health Care Cash Fund, the agency opposes LB836. In essence,

this money constitutes excess dollars, which should be returned to offset the costs of the Medicaid program itself. Additionally, the continued receipt of these funds is sporadic and uncertain as to any amount from year to year, making any reliance on their use to supplement the Health Care Cash Fund unreliable. Also of note it is a needed technical change, which I appreciate Senator Arch addressed in his, his opening. Currently, the statute uses the phrase, quote, medical-- excuse me, quote, minimum medical loss ratio, unquote, in various locations. The proposed legislation would eliminate the word medical in one instance, but not in the other instances. We trust, and indeed it's been confirmed, that this is an inadvertent admission that should be remedied by the rein-- inclusion of the word medical. In summary, though, DHHS supports the desire to amend state law to remit certain funds in a manner subject to legislative authority. The agency does not support directing the funds into the Health Care Cash Fund. For the reasons I've expressed today and in light of the needed technical change I've also described, DHHS opposes the green copy of LB836. And I thank you for the opportunity to testify today, and I'd be happy to answer any questions.

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

WILLIAMS: Thank you, Chairman Howard. And thank you, Mr. Watson, for being here.

NATE WATSON: Yes, sir.

WILLIAMS: We had this unusual circumstance happen where there was a substantial amount of extra money. Can you describe to us how that money was used, and did it come back in a way that would come back like you suggest, should be returned to offset the costs of the Medicaid program itself?

NATE WATSON: Well, Senator, with regard to that, we followed the current statute, which requires the moneys to be the help-- the MCO puts forward a plan subject to the approval of the department after public input, which was all done. And, and it gets reinvested into additional services for beneficiaries. The proposed law change would, would redirect the money in two of the instances, including the instance, that issue you describe profit in excess of the cap.

WILLIAMS: Can you give me an example then of, if we had funds like that, how you would take those back in under your suggestion here?

NATE WATSON: Well, under our suggestion, Senator, the money would simply be returned, any excess profits. So profits above the cap and above the minimum loss ratio would be returned to the general fund for credit to the Medicaid program. In essence, off-- since it's excess funds, it would offset the costs of the program itself.

WILLIAMS: Right.

NATE WATSON: It wouldn't fund additional services.

WILLIAMS: I just wanted to be sure that I was understanding that correctly. And we--

NATE WATSON: Yes, sir.

WILLIAMS: --were all on the same page. Thank you, Mr. Watson.

NATE WATSON: Certainly, Senator.

HOWARD: I want to clarify that. So your preference is that the money would go to the general fund for a credit to the Medicaid program?

NATE WATSON: Yes, Senator.

HOWARD: Does the general fund work like that? If the money goes into the general fund, do we say, oh, this a little bit of the general fund goes to the Medicaid program?

NATE WATSON: It's my understanding that returning it to the general fund would support treating, would in essence offset the expenditures that have already occurred. That's my understanding.

HOWARD: There would be no way for us to know that we would be using the general fund dollars for the Medicaid program outside of what we would normally be budgeting it for. It just sort of goes into the pot, is that sort of what you're suggesting?

NATE WATSON: Well, it would go into the program account, Program 348. Yes, Senator.

HOWARD: Are we able to line-item funds back like that?

NATE WATSON: It's my understanding that that is possible.

HOWARD: OK. I've never seen that done before. But I mean, can you tell me a little bit about the public input that you had for the WellCare funds that were returned? Sorry, I'm battling a cold already.

NATE WATSON: Sure, I appreciate that. Well, I'm here to, to speak to the green copy of LB836. I can say that in that case I'll, I'll generally tell you that we, we did refer that to the [INAUDIBLE], the process by which we sought public input and gave the public an opportunity to, to express an opinion as to the MCO's plan. We received very little input as it happens.

HOWARD: So did you have a public meeting or--

NATE WATSON: Yes, ma'am.

HOWARD: OK. Where was it? When was it?

NATE WATSON: I couldn't give you that off the top of my head.

HOWARD: OK, could you follow up with that information?

NATE WATSON: Of course. I'd be very glad to.

HOWARD: Thank you.

NATE WATSON: Yes, of course.

HOWARD: Senator Cavanaugh.

CAVANAUGH: Thank you, Chairman Howard. I just wanted to follow up on the public input piece. How was that advertised that there's a meeting or that you're accepting public input?

NATE WATSON: Again, I'm here to speak to the green copy of LB836, but I'd be happy to give you a copy and get you the information with regard to how that meeting was advertised under the current law.

CAVANAUGH: OK. Do you know, generally speaking, if the department is hosting public meetings, if you would generally-- protocol would dictate that you would invite this committee to attend that meeting?

NATE WATSON: I cannot, as I sit here, say one way or the other. I'd be happy to get you that information.

CAVANAUGH: Yeah, that would be helpful. Because I would like to know about those meetings. Thank you.

NATE WATSON: Certainly. I'll be glad to get you that information.

HOWARD: And I would, I would also love sort of an example of a statute where we've line-itemed funds to go into a specific line item that's not the appropriations bill. So remitting funds to a specific line item, I would, I would like some statutory language. I think if we develop that, we would need to see what other bills have that language in it. So if you could find that for us, that would be great.

NATE WATSON: We'll be glad to look, Senator.

HOWARD: Thank you. All right, any other questions? Seeing none, thank you for your testimony today.

NATE WATSON: Thank you very much.

HOWARD: Our next opponent for LB836? Seeing none, is there anyone wishing to testify in a neutral capacity? Seeing none, Senator Arch, you are welcome to close.

ARCH: Thank you, Chairwoman Howard. I, I think that this has helped began, begin an important discussion on, on the appropriation of these funds, and we'll continue that. We will continue that discussion. You can see that, that there seems to be some broad understanding of the purpose of the bill and then we get down to exactly how these funds will come back to the appropriation. Again, my purpose in all this was simply to make sure that the decision as to how to expend those dollars would be a decision of the Legislature. So with that, I would answer any questions.

HOWARD: Any last questions? Seeing none, thank you for visiting with us today.

ARCH: Thank you.

HOWARD: All right, this will close the hearing for LB836 and it will open the hearing for LB825, Senator Hilkemann's bill to change provisions relating to infant health screenings. Welcome, Senator Hilkemann. Good afternoon.

HILKEMANN: Good afternoon. My name is Senator Robert Hilkemann, it's R-o-b-e-r-t H-i-l-k-e-m-a-n-n, and I represent District 4. I'm here to

introduce LB825. Essentially, this is a bill that will save lives. How often can we say that? LB825 would add spinal muscular atrophy to the newborn screening panel. SMA is the number one genetic cause of death for infants. I'm not an expert or-- on genetic conditions, but there are testifiers here today that I am confident will be able to answer your questions about SMA and the FDA-approved treatments that are making a profound difference for those children who have been diagnosed. I want to thank Children's Hospital and Medical Center for working closely with me on this legislation and for their support. We did encourage a few proponents of the bill to send written testimony in lieu of appearing before you today out of respect for your limited time. I'm sure you have those copies in front of you. I want to highlight a few points on SMA and the statistics for Nebraskans. From the letter from Kenneth Hobby, the president of Cure SMA. Mr. Hobby states that SMA is a progressive, neurodegenerative disease caused by a mutation in the survival motor neuron gene 1. In a healthy person, this gene produces a protein that is critical to the function of the nerves that control our muscles. Without it, those nerve cells cannot properly function and eventually die, which can significantly impact an individual's ability to walk, swallow, and in the most severe cases, breathe. The disease impacts 1 in 11,000 births in the United States. In Nebraska, an estimated two babies with SMA are born each year, adding to the more than 80 state residents already living with SMA, according to the Cure SMA estimates. In addition, more than 38,500 Nebraskan residents are actually carriers of the SMA genetic mutation. I want to thank you to your ACMA for supporting this legislation and for their work in finding a cure. In 2018, SMA was added to the federal Recommended Uniform Screening Panel by the United States Secretary of Health and Human Services. At the state level, it has been recommended to the Department of Health and Human Services that it be added by the Nebraska Newborn Screening Advisory Committee. Now, this Newborn Screening Advisory Committee advises newborn screening program within the Nebraska Department of Health and Human Services on matters related to population screening of newborns for congenital and inherited infant and childhood-onset diseases, disorders, or complications-- conditions. It is comprised of newborn and pediatric primary health care providers, medical and allied professionals from the subspecialties associated with treatment for the disorders screened, clinical laboratorians, consumers with technical, professional or personal experience with newborn screening for congenital and inherited disorders, as well as representatives from other stakeholder organizations and agencies. This committee is responsible for reviewing the state-of-the-art for newborn screening

practices across the United States and recommending policy for appropriate adoption of newborn screening practices for the state of Nebraska. The committee monitors quality assurance data for pre-analytical, analytic, and post-analytic aspects of the newborn screening system, reviews evidence and makes recommendations on candidate conditions, and provides technical advice relevant to newborn screening practices and procedures. In short, their recommendation is a significant element of this legislation. In Nebraska, all babies are screened for 32 different genetic and metabolic conditions. While each condition is individually rare, collectively, 1 out of every 500 to 600 babies in Nebraska is identified each year with one of these diseases. In 2015, this resulted in identifying and treating 58 newborns in time to prevent or reduce problems associated with identified conditions. In 2016, it was 57; in 2017, it was 39. In 2018, 50 newborns were diagnosed, 3 of which were a direct result of adding X-linked adrenoleukodystrophy and Pompe disease through legislation in 2017. And some of you on this committee were there and supported that legislation. And thank you, you made a difference in the lives of those children and their families. And now you can make a difference with LB825. Thank you for your time and consideration today. Dr. Rathore, the interim clinical service chief of neurology at Children's Hospital, and Medical Center will be testifying next. And she is probably better to answer most of your questions about this disease. But if you have anything more for me, I would be happy to answer those questions.

HOWARD: Thank you, Senator Hilkemann. Are there questions? Seeing none, will you be staying to close?

HILKEMANN: I will be staying to close. Thank you.

HOWARD: Fantastic, thank you. We'd like to invite our first proponent up for LB825. Good afternoon.

GEETANJALI RATHORE: Good afternoon.

HOWARD: It's a really low chair.

GEETANJALI RATHORE: I'm short. Good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. My name is Geetanjali Rathore, G-e-e-t-a-n-j-a-l-i R-a-t-h-o-r-e. I'm a pediatric neurologist, I am also the interim service chief at Children's Hospital and Medical Center. I also direct the neuromuscular clinic at Children's Hospital. I am very grateful to be here today, to be on

behalf of Children's Hospital to testify in support of LB825, which seeks to add spinal muscular atrophy to the current newborn screening protocol. So as-- you got a little bit of summary, but spinal muscular atrophy is a devastating neurological disease in children and it is actually the leading genetic cause of death in children. And it affects about 1 in 11,000 live births. But almost 1 in every 50 Americans is a carrier for this disease. So it's not uncommon. It is caused by one gene defect in the SMN 1 gene. And that codes for a very important protein that's needed for the survival of nerve cells in the spinal cord. The children typically present in the, either in the newborn period or in the infancy period with muscle weakness, low tone, and quickly progress to almost complete paralysis of the body. Most kids will never sit, never walk, never be able to talk. They do over time lose their ability to feed by mouth or breathe on their own. And most, if left untreated, will not live to celebrate their second birthday. So within first years of life they will die without life support or treatment. And until recently, we were not able to give any help to these parents. But now we have life-saving therapy, potential cure for SMA, and we're very excited. There's been a lot of research on spinal muscular atrophy, and several studies which have shown even within the first few days of life there is already irreversible damage to nerve cells and muscle cells. And nerve cells can never regenerate, so once they're gone, they're gone. And that makes early treatment even more important. There was a study where they looked at 25 patients that were diagnosed with spinal muscular atrophy, and they got treated within the first six weeks of life. And they were followed for two years and at their two-year follow up, all 100 percent of patients were alive. They were all talking. They were all breathing on their own and following normal development milestones compared to normal peers, unaffected children. And this is huge. And we don't think about it much, but about, you know, 90 percent of them were walking unassisted and were able to talk. So that just shows early treatment is very, very crucial. And the newborn screen, if we do as SMA newborn screening, it's going to be the same sample of blood. So there's no extra pokes or procedures for the babies, and the testing is very sensitive with 100 percent predictive value. There's no false positive that's been reported to date. So it would be a very good test for us to quickly diagnose these patients and start treating early. They actually-- there was one of the reports from one of the advisory council that showed if we do screen children with this, we could save 50, about 50 patients, 50 children nationwide from-- preventing them from death by first year of life. So that would be a huge impact nationwide. I feel that these children are the brightest kids that we

see because their brain is not affected. It's in the spinal cord and it affects their muscles. So they are the brightest, the most bright-eyed, biggest eyelashes kids that you'll see. And, you know, we have to give them that opportunity to live a full, healthy life and be able to participate in our community. And, you know, I tell them some of that could be future doctors and could work on more research on other neurological disorders. So in conclusion, I would like to thank Senator Hilkemann for his support to protect every child that's born in the state of Nebraska. And I would like to thank him personally and on behalf of the Children's Hospital. And thank you all for your time, and I would be happy to answer any questions that you may have for me.

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

B. HANSEN: Thank you for coming and sharing your testimony with us. I don't know if this is a question that might be-- you might be able to answer, maybe I can save it for later. But when we do blood tests, what happens to the blood test after this, all the testing has been concluded with it? Is it saved in the hospital, is it recorded in permanent record, or is it destroyed? Do you know by chance?

GEETANJALI RATHORE: I do not know the exact details. I know it goes to the newborn screening program, but we could get back to you and let you know--

B. HANSEN: That's fine, just curious.

GEETANJALI RATHORE: --what they exactly do.

B. HANSEN: That's fine. Thank you.

HOWARD: Other questions? Senator Arch.

ARCH: Thank you. Thank you for coming. Do you happen to know the additional cost of this test? I mean, I'm sure it's a range, it's not an exact number. But approximately?

GEETANJALI RATHORE: When I was with the Department of Health, my understanding, I know the sample is going to be the same. So there is no additional--

ARCH: Right.

GEETANJALI RATHORE: --costs for collecting.

ARCH: Right.

GEETANJALI RATHORE: I do not know if this--

ARCH: OK, well maybe somebody that follows could, could answer that as well. Thank you.

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

GEETANJALI RATHORE: Thank you for your time.

HOWARD: Our next proponent for LB825.

MATT SCHAEFER: Good afternoon, Chairwoman Howard, members of the committee. My name is Matt Schaefer, M-a-t-t S-c-h-a-e-f-e-r, test-- testifying today on behalf of the Nebraska Medical Association. The NMA supports the addition of spinal muscular atrophy to the newborn screening panel. As you've already heard, it is one of the leading genetic causes of infant deaths. And the new advancement in treatment means the earliest, earlier it's detected, the higher likelihood of slowing or even stopping the terrible effects of the genetic disorder. For those reasons, we urge you to advance the bill to General File. Thank you.

HOWARD: Thank you. Are there questions?

MATT SCHAEFER: Thanks.

HOWARD: Thank you. Our next proponent testifier for LB825.

CHRIS ARNOLD: Chairperson Howard, members of the committee, my name is Chris Arnold, C-h-r-i-s A-r-n-o-l-d. I'm a longtime Nebraska resident. I grew up on a ranch near the Nebraska-South Dakota border. I attended college here at the University of Nebraska-Lincoln. I currently live in Omaha with my family. I am pleased to be here today to strongly support and speak on behalf of LB825, introduced by Senator Robert Hilkemann. The bill would ensure that all Nebraska newborns are screened for spinal muscular atrophy, commonly known as SMA. My connection to SMA began almost 10 years ago. On July 10th-- I'm sorry, July 9th, 2010, my wife Paula gave birth to our son Wyatt, our first child. It was a normal pregnancy and successful delivery. We went home after a typical hospital release and we thought we had a perfectly healthy baby. Wyatt was very attentive and observant, always interested in things around him. But his motor skills were not

progressing as we expected for an infant his age. He wasn't rolling over, his arm movement was limited. We enrolled Wyatt into an early childhood development program to focus on his motor skills. We also sought additional testing to figure out why our son was missing early childhood development milestones. In mid-October, 2010, three months after he was born, we learned Wyatt had SMA. Like most parents receiving this diagnosis, we had never heard of SMA. The genetic condition is very rare, affecting about 1 in 11,000 births in the U.S.. In Nebraska, an estimated two babies are born each year with SMA, according to Cure SMA, a national organization dedicated to the treatment, care, and cure for SMA. The condition affects muscular development, robbing individuals of physical strength, compromising their ability to-- ability to walk, eat, and breathe. Wyatt was diagnosed with the most severe form of SMA, known as Type 1. Our doctor gave us the unfortunate news that Wyatt was going to die. Two months later, on December 12th, 2010, Wyatt passed away. It was Sunday. He was five months, three days old. It was agonizing for our family. Wyatt is the reason I'm here today. He didn't have a chance to write his own story, but he did have a great story. Paula and I, along with our seven-year-old twins, Penny [PHONETIC] and Paxton [PHONETIC], proudly share his story every chance we get to, to create awareness and raise funds for SMA. Today, I tell Wyatt's story to inspire action by this committee and this Legislature to add SMA to the state's newborn screening program so that children born today with SMA can tell their own stories. And today's stories are stories of great hope and possibility thanks to breakthrough SMA treatments introduced in recent years in advancements in care. These treatments were not an option for Wyatt, but they are for the current and future families. Our family remains very committed and connected to the SMA community. Our Nebraska friends who have children with SMA are seeing remarkable and sustained physical changes as result of these new treatments. SMA, SMA care and treatment are most effective when delivered early, before SMA starts to destroy the nerve cells needed to control movement and functions. An early diagnosis at birth is critical for Nebraska families living with SMA. That is why I'm so pleased that this committee is holding this hearing to discuss and why it's important to include SMA in the list of conditions currently being tested for in Nebraska newborns. With continued advancements in science and technology, I believe we can eliminate SMA. If not in my lifetime, certainly my children's lifetime. But in the meantime, we need to provide Nebraska families with an early diagnosis so their children can achieve great things and tell their own stories. We need to

approve LB825 and that can only be done with your help. Thank you for consideration of my views. I'm happy to answer any questions.

HOWARD: Thank you, Mr. Arnold. Are there questions? Senator Cavanaugh.

CAVANAUGH: Thank you, Senator Howard. Thank you for being here today, Mr. Arnold. And thank you for sharing Wyatt's story. I just wanted to thank you on behalf of our committee and give you my condolences to you and your family for your loss. It sounds like he was a special child. So thank you.

CHRIS ARNOLD: Thank you, Senator Cavanaugh.

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

CHRIS ARNOLD: Thank you.

HOWARD: Our next proponent testifier for LB825. Good afternoon.

ROBERT RAUNER: Good afternoon. It's nice to see you all, members of the Health and Human Services Committee. I see we have some new members on this committee, so that's nice to see. My name is Robert Rauner, it's R-o-b-e-r-t R-a-u-n-e-r. There always is some confusion when I mention my name, so I don't want any of you to be confused. I'm not Dr. Bob Rauner, which I know many of you have dealt with over the time. Instead, I'm a parent who was thrown into the rare disease world 27 years ago, and I've been involved ever since that time. Today I'm here in support of LB825, brought forward by Senator Hilkemann. This bill is to change the provisions relating to infant health screenings to add spinal musc-- muscular atrophy, SMA, to the Nebraska newborn screening panel. I've been before this committee two years ago when I was advocating for the addition of X-ALD, Pompe Disease and MPS 1 to our state screening panel. I'm also a parent of a child that passed away from X-ALD. And I have a son who has the adult form of a disease called adrenomyeloneuropathy. At this point in time, he is on disability because of his mobility issues and not able to work. So he's got his challenges too. So this disease hasn't disappeared from our household. I think that's one thing that keeps me going. What this has done is really led me to be an advocate for newborn screening, and especially for diseases that they have treatments. That's the key. And if they can be diagnosed by newborn screening, that's just the key. So free information on these diseases has been added to the federal Recommended Uniform Screening Panel, also known as RUSP. It's gone

through a very rigid evidentiary process. And it's, is a challenge before it can be added to the panels. I've been involved directly in this process to add another disease, so I've seen that panel in action. And part of that comes from my role as president of the United Leukodystrophy Foundation, which is a rare disease foundation that deals with my son's disease. My work with this Nebraska legislative body to add the three diseases to the Nebraska panel in 2017 has afforded me the opportunity to be asked to become a member of Nebraska's Newborn Screening Advisory Committee. So I've taken full advantage of the opportunities to represent those families. So it's key to me. The panel a year, almost a year ago added, recommended adding SMA to our panel. So it's taken us a year to get to this point, which is a little frustrating part. The one thing that you need to know is obviously it was added to the RUSP. But our committee itself did their own investigation of the disease to make sure that we were following the right protocols and that everything was in proper order. So that was, that's real important. Last year I was in Washington, D.C., I was attending a rare disease week. And Nebraska and Iowa people that were there, I was the only Nebraska one and I think Iowa had three members to go out. We did-- had a lobby day talking about issues, rare disease issues. And so we were able to go see the representatives and senators from both states. So that was really interesting. But two of the ladies that I was with were parents of SMA kids. So that was my first education of that disease. One of the children had had Spinraza treatment for the, their child and the other one hadn't had. So the-- fortunately the one family was fortunate enough to figure out what they were dealing with, so they were able to get in the Spinraza trial. The other family, their child was a little too far along to be [INAUDIBLE] outside of the parameters of the trial. So, yeah, I watched the struggles that they'd been through, it reminded me of the struggles we had been through 27 years ago. So their children, my children, none of them had the benefit of newborn screening to be aware of these diseases. So the key for me is, you know, there's therapies available and there are several trials just for SMA that are out there. And so I think it's very important that this body move the LB825 out of committee into the legislative floor, and we pass it into law so we can start screening babies for this horrible disease. You've heard from a parent today that's lived through the worst of having a child with SMA. Please heed, heed their lessons to you so that many other families do not have to deal with that same outcome. And I believe that's all I have. I appreciate your time. And if you have any questions, I would be more than happy to answer them. I can answer one question, Senator Hansen, that our blood

spots are 90 days that we keep them for. And then they're destroyed. Some states keep them forever, but Nebraska keeps them for 90 days.

HOWARD: Thank you, Mr. Rauner. Let's see if there are any questions. Senator Hansen.

B. HANSEN: Thank you for coming again. I was gonna extend that same question I did ask for Dr. Rathore, Rathore earlier about what happens with the blood test. And another question that I did have, that Senator Arch asked as well, if he doesn't mind me asking is, what is the approximate cost of a test like this? And with, with the addition of adding this additional test, does that increase the cost for the patient or the lab? And then where does that money, like, who pays for that?

ROBERT RAUNER: This money is paid for through a fee, a fee that is charged to the hospitals for every newborn screening test. So they, I think this, I think this run will run somewhere around the-- don't quote me for sure, but roughly around the $4 range is what I am understanding. But in 2017 we increased the fees for the newborn screening and to help cover the costs of, increased cost of the testing. Plus we also needed a full-time employee because our newborn screening program was short on people. And the only way that we could actually add these other diseases was to get another full-time person on the payroll.

B. HANSEN: OK, so the hospital incurs this cost?

ROBERT RAUNER: Yes.

B. HANSEN: OK. That's what I was wondering. And I appreciate the work that you guys do. I think this is a lot of effort, I think it's an important tool to have our-- parents to have at their discretion to use for newborns. We did it for my newborn. But some of the other questions that I have, and I did ask Senator Hilkemann and his staff is, from my understanding, all the tests that we do for newborns are optional, that the parent can choose whether they want to have it or not except for this one.

ROBERT RAUNER: No, I think all test, everything is mandatory.

B. HANSEN: OK.

ROBERT RAUNER: The newborn screening, I believe, is all mandatory.

B. HANSEN: Yes, that's what I was wondering. OK.

ROBERT RAUNER: Yeah.

B. HANSEN: Has it always been mandatory?

ROBERT RAUNER: There's been some struggles, there's been some people that have fought against it. But it's, it has never, long as I know, it's you do it. And I know we had it done with our kids when they were born so.

B. HANSEN: OK.

ROBERT RAUNER: I think there's some people on a religious backgrounds that fought against it. But the DHHS did not change their position on the screening.

B. HANSEN: OK. And can any of this information be used like, say, at a later time, maybe when the child is older for insurance purposes? Or can some of the other people have access to this information where it might, somebody might use it to maybe determine premiums on insurance down the road for any reason?

ROBERT RAUNER: That I could not answer.

B. HANSEN: OK. That's what I was wondering. OK, thank you.

ROBERT RAUNER: Very good. Thank you.

HOWARD: Are there any other questions from the committee? Seeing none, thank you for visiting with us.

ROBERT RAUNER: All right, thank you.

HOWARD: Our next proponent testifier. Good afternoon.

EDISON McDONALD: Hi. Hello, my name is Edison McDonald, I'm the executive director for the Arc of Nebraska. We advocate for people with intellectual--

HOWARD: Could you spell your name?

EDISON McDONALD: Oh. E-d-i-s-o-n M-c-D-o-n-a-l-d. We advocate for people with intellectual and developmental disabilities, and that includes a variety of rare conditions. We're writing in support of LB825. We'd like to thank Senator Hilkemann for bringing this bill

forward. Spinal muscular atrophy is a condition characterized by muscular atrophy and weakness. Early diagnosis can be a tremendously important step in ensuring the survival of infants and the long term health of the individual. According to the National Human Genome Research Institute, spinal much-- muscular atrophy affects 1 in 6,000 to 1 in 10,000 people. One thing that I just wanted to add, I think the comments today have covered a whole lot of what we wanted to say. I just wanted to add that there are three types of SMA, and one of the things that we find tremendously important is making sure to get that early diagnosis. The third type of estimate is called Kugelberg Welander disease is a milder form of SMA, and symptoms usually appear past that typical time. So ensuring that we get those screenings is tremendously important. And that's important to ensure that we can have the long-term support that's needed to go and ensure the long-term health of the individual. We're very supportive of this bill and thank you very much for your time. Have a great day.

HOWARD: Thank you. Are there any questions? Seeing none, thank you for your testimony today. Our next proponent testifier for LB825. Good afternoon.

DAVID SLATTERY: Good afternoon, Senator Howard, members of the Health and Human Services Committee. My name is David Slattery, D-a-v-i-d S-l-a-t-t-e-r-y, and I'm the director of advocacy for the Nebraska Hospital Association. And I don't have much more to say than what's already been said. I just wanted to say that the Nebraska Hospital Association supports this bill. We thank senator Hilkemann for bringing it. I'd like to thank the families that came up here as well to experience-- to share their stories firsthand. I know it can't be easy. The only-- just want to reiterate that we just think that early detection on this test and, you know, the 30 other, 30-plus tests that are done during the newborn screening panel, just how important those are. And just that we think this is one that should be added to that list. So thank you very much.

HOWARD: Thank you. Are there questions?

DAVID SLATTERY: Thank you.

HOWARD: Thank you for your testimony today. Any other proponents wishing to speak for LB825? Seeing none, is there anyone wishing to testify in opposition? Seeing none, is there anyone wishing to testify

in a neutral capacity? Seeing none, Senator Hilkemann, you are welcome to close.

HILKEMANN: Senator Arch, we understand that the hospitals charge $85 for this test and that the, that the new test will add possibly $5.50. Dr. Hansen-- Senator Hansen, the answer to your question is, from best we understand that when in the very infancy of newborn screening, there were some challenges to this before the test became as, as precise as it is today. And so there was a period, don't know exactly what year, but very early on in the process when there was an opt-out period. But that's not been the case for a long period of time. It's no longer an opt-out. I certainly, you know, I know that you and I are both pro-life individuals. Why would we, why would we not take advantage of this? And it's basically a lottery for what child wouldn't be getting that test. So at either rate-- so it is a mandatory test here in the state of Nebraska. So thank you for your time today. As you have heard, advancements in medicine are improving outcomes for individuals born with SMA. And the most important factor is early detection. That's crucial. I shared some handouts with you. You will see that over a four-year period of time, listing by the condition the number of newborns diagnosed following screening, in that brief snapshot of time, it totals 204 babies, not including last year's data, which will be added to those numbers. That's 204 babies identified and treated in time to prevent or reduce problems associated with those conditions. That's 204 children who otherwise would be facing unimaginable challenges, hardships, and in the story of the Arnolds, even death at far too young of an age. It's also 204 families whose suffering would only be compounded by exorbitant expenses. Our newborn screening program makes a difference in the lives of Nebraskans, and thanks to continued scientific efforts, will continue to do even better. I hope your questions have been answered through the testimony. If not, please talk to me. It is my hope that we can pass LB825 this year and begin testing babies when the law goes into effect this summer. The longer we wait, it is a statistical certainty that a baby or babies will be born with SMA and their parents won't know. Without that knowledge, their parents won't have the opportunity to seek the treatments that are available right now that could save their child's life. Thank you again. And I ask you, ask your vote to advance this bill to General File.

HOWARD: Thank you. Are there any final questions for Senator Hilkemann? Seeing none, thank you, Senator Hilkemann.

HILKEMANN: Thank you.

HOWARD: This will close the hearing for LB825, and the committee will take a brief break. We will reconvene at 3:00 p.m., so in about eight minutes.

[BREAK]

HOWARD: [RECORDER MALFUNCTION] --Senator Blood's bill to adopt the Audiology and Speech-Language Pathology Interstate Compact. Welcome, Senator Blood.

BLOOD: Well, thank you, Chairperson Howard. And good afternoon both to Senator Howard and the entire Health and Human Services Committee. My name is Senator Carol Blood, and that is spelled C-a-r-o-l, B as in boy, l-o-o-d, as in dog, and I represent District 3, which is composed of western Bellevue and southeastern Papillion, Nebraska. Thank you for the opportunity today to share LB753 with all of you and to those listening in on today's hearing. As you know, there are more than 200 active interstate compacts in the United States, encompassing everything from fisheries to driver's licenses. Twenty-two of them are national in scope, including several with 35 or more member states and an independent commission to administer the agreement. All regulatory interstate compacts are certainly not alike. However, the professions of medicine, nursing, and physical therapy are great examples of effective compacts that Nebraska has chosen to support. Medicine constructed as compacts to address expedited licensure, while nursing and physical therapy's compacts create a multi-state license. Nebraska reaps the benefits as a member of these and other interstate compacts. Now I'm hoping to have another compact move forward here in Nebraska for audiologists and speech-language pathologists. In Nebraska, we have approximately 175 licensed audiologists, which equates to about 9 audiologists for every 100,000 people. We have 1,285 licensed speech-language pathologists, which is about 67 for every 100,000 Nebraskans. An audiologist is someone who diagnoses and treats a patient's hearing and balance problems using advanced technology and procedures. The majority of audiologists work in health care facilities such as hospitals, physicians' offices, and audiology clinics, and some work in schools. Speech-language pathologists, sometimes called speech therapists, assess, diagnose, treat, and help to-- help to prevent communication and swallowing disorders in children and adults. Speech, language, and swallowing disorders result from a variety of causes such as a stroke, brain injury, hearing loss, developmental delay, Parkinson's disease, cleft palate, or autism.

Now, as you read in the bill, the purpose of the Audiology and Speech-Language Pathology Compact is to increase public access to audiology and speech-language pathology services by providing for the mutual recognition of other members' state licenses. Also to enhance the state's ability to protect the public's health and safety, encourage cooperation of member states in regulating multi-state audiology and speech language pathology practice, support spouses of relocating active duty military personnel, always one of my favorites, enhance the exchange of licensure, investigative and disciplinary information between member states, allow a remote state to hold a provider of services with a compact privilege in that state accountable to that state's practice standards, and allow for the use of telehealth technology to facilitate increased access to audiology and speech-language pathology services. Upon review of the state participation section, you should note that the requirements that must be met by states to join the compact are very clear and state the professional must hold a home state license in a compact state to-- and then participate in an FBI fingerprint-based criminal background check and meet the licensure, licensure requirements noted in the compact. So when a participant gains a privilege to practice, they may only have one home state license at a time. The privilege to practice is renewable upon the renewable of the home state license, and they must function within the laws and regulations of the remote state. If the home state license is encumbered, the licensee shall lose the compact privilege in all remote states until the home state license is no longer encumbered and two years have passed since the adverse action. Active duty military personnel or spouses may designate a home state where the individual has a current license in good standing. The individual may retain the home state designation during the period the service member is on active duty. Now, I want to be clear that nothing in the compact, nothing, will override a compact state's decision that an audiologist or speech-language pathologist's participation in an alternative program may be used in lieu of adverse action, and that such participation sal remain-- shall remain nonpublic, if required by the compact state's law. The home state may take adverse actions against an audiologist's or speech-language pathologist's license, a remote state may take adverse action on it-- on an audiologist or speech language, language pathologist's privilege to practice within that remote state. In a nutshell, this compact creates a mechanism that allows the legal, ethical and regulated practice of interstate practice by granting qualified audiologist and speech-language pathologists the privilege to practice in other compact member states, allows for telehealth to be practiced in member states, allows for

increased access to underserved communities, and gives our military personnel and spouses a means to maintain their profession when relocating. Now, I will note that this bill is also on a yearly policy priority list that we received from the Department of Defense, Military Community and Family Policy Office to help our state continue on the path to becoming a leader in military-friendly policy. Martin Dempsey, who I know most of you have, have met before on compacts, had planned on attending today, but the treacherous roads kept him from completing his mission. But I believe you do have a letter of support. The contract clearly addresses the obligations of the home state, obligations of the member states, how adverse actions are resolved, and compact funding and governance. Also, if you are currently licensed in your state to practice, you are not mandated to expand your license beyond that and forced to join the compact. The compact is an optional tool for those who choose to partake in the benefits of the compact. Now here's the kicker to the bill. Nebraska has an opportunity to be the first state in the compact. Many states are rushing to accomplish this compact, and I've met with many of those other states. But it is likely, should you vote this bill out of your committee in a timely manner, that we can be a leader when it comes to this particular compact. In fact, we were challenged in a public forum by a representative from Utah. We are competing to see who will be the victor, and I hope you will help me make Nebraska the leader on this particular compact. I say this is the kicker because I am also aware of some concerns about us being first in line. So it's my understanding that Mr. Klein from DHHS is here to testify against this bill. Chief among their concerns is the fact that we would be first to pass this compact. They have told us that because of this, they're concerned they wouldn't be able to come up with a total cost of being a part of this compact. And so this is where I have to be frank and say that I don't understand that reasoning. While we'd be first in this compact, it's certainly not the first compact that Nebraska has entered into. I've handed out to all of you the fiscal notes for two of the last compacts the Legislature has passed, those being the physical therapist compact, LB88 from 2017, and the PSYPACT, LB686 from 2018. You'll notice the fiscal note for LB88 is no fiscal impact and the PSYPACT has a net expenditure of around $950. So when you look at something like the nursing compact, which was much, much bigger in scope, and affects more professionals on a yearly basis, we think that compact's $6,000 price tag is the upper limit and don't see how that number could be completely unknowable for a new compact. If DHS really wants to figure out how much this bill would cost, the state could poll the state boards involved in compacts and find out what they

believe this will cost. The bottom line here is that this isn't our first rodeo when it comes to interstate compacts. But this might be the first time we've heard unknown cost has been a big sticking point for opposition, especially the day before a hearing. I want to address one more issue I know has been bizarrely raised to the committee. A letter of opposition submitted to you claims the compact would be a burden on local schools. I'd first point out this particular concern has also been raised with the organization that specializes in these compacts at the Council of State Governments, and they have discussed this issue with the same organization that sent the letter several times over the last year. Secondly, I'll point out that school districts [INAUDIBLE] speech pathologists that have a state license and some schools require speech pathologists hold a teaching certificate. State licenses are used for billing Medicaid and public schools and providers receive an NPI. Contractors, as well as school employees, currently are eligible for those with proof, proof of state licensure. I see nowhere that this compact would impact the current status or affect a district's ability to continue to contract out. You will note that one of our letters of support comes from Ralston Public Schools. They reached out to us after they heard about the bill because they were thrilled at the opportunity of being able to find more people that they might be able to hire. I will add that anyone who has talked to me about one of my bills knows that if there is a problem that can be fixed, I'll work to fix it. To that end, I want to point out that I have brought a proposed amendment in your handouts that I ask that the committee adopt and attach. The amendment is actually addressing two separate parts of the bill. The first is on page 2, lines 9-11 where it strikes the original language and reads: or who does not have a privilege to practice under the Audiology and Speech-Language Pathology Interstate Compact. We think the right terminology is "privilege to practice" rather than "licensed in a member state." The second aspect of this amendment is going on page 22 of the bill and is changing the immunity language to be a better fit for Nebraska. And I'll add that this is identical language to what we added to LB686, willingly, in 2018. Lastly, I'm referring back to the letter of opposition we discussed, many of the inaccurate concerns in that letter is with the NMA, NMA over lunch today, because everything has happened quite quickly, and they agreed with us that the content was shockingly inaccurate, which is why they are not here to oppose. With that, I'll close by saying licensure, licensure is constitutionally a state power. Let's work together and move this voluntary expedited pathway forward and facilitate multi-state practice here in our state, along with what will soon be an additional

nine states for a total of 10 states to implement this compact. I'd be happy to answer any questions you may have, and I do plan on staying for the closing. I do, I believe, I don't know with the weather, have folks here to testify, so you may want to allow them to speak, knowing that some of your questions may be answered in their testimony.

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

CAVANAUGH: Thank you, Chairwoman. Thank you, Senator Blood, for being here today with this bill. The, the sort of the idea or the purpose behind this, I think kind of want to get clarification, is not to because there is necessarily an access issue for these services in Nebraska, but it is to create an opportunity for those that are coming into Nebraska, whether it's they're moving for their own work or because of a, perhaps, a spouse, like you said, military, so that they can then practice their, their professional background here in Nebraska more easily?

BLOOD: Good question. Actually, it would be for both.

CAVANAUGH: OK.

BLOOD: So as you know, in rural Nebraska, we do have some concerns when it comes to being able to provide services. And one of the ways that we do that is through telemedicine. But you can also look at it as an economic development benefit in the fact that if indeed you were an audiologist and you were able to practice across state lines, you could increase your income--

CAVANAUGH: Sure.

BLOOD: --by crossing state lines. So I would have to say yes to both.

CAVANAUGH: OK. Thank you.

BLOOD: You're welcome.

HOWARD: Other questions? Senator Hansen.

B. HANSEN: Thank you. Who has-- maybe it's I'm still unfamiliar with that interstate compacts. Who has oversight like over this one? Who would determine how many hours are needed and what, what the rules and regulations are? Who has oversight?

BLOOD: Good question. So I-- and I know, I think you may not mean oversight as much as how, how do these come to be?

B. HANSEN: No--

BLOOD: [INAUDIBLE] exactly.

B. HANSEN: --like, is there a board that then determines, oh, like if the state breaks rules and they're not following along with rules--

BLOOD: Uh-huh.

B. HANSEN: --who determines, OK, that state is kicked out and they can't be part of this interstate compact anymore?

BLOOD: And that is laid out, who would be responsible, within the bill. You should know that an interstate compact usually takes years of work. I've been following, tracking this one since my freshman year here in the Legislature. And so they meet with these organizations across the United States and attorneys and CSG, because they have a-- particularly people that are responsible or-- don't know if responsible is the right word, that help people form these compacts. This will be my fourth one, I think, that I've brought forward. The previous three, three or four have passed. So they are, they-- there is oversight. And the way that the oversight is put together within your state and combined as part of the interstate compact is all described within the bill.

B. HANSEN: Uh-huh.

BLOOD: And I can find the page for you, if you like.

B. HANSEN: No, it's all right. Just kind of curious.

BLOOD: And you should know, one of the things that I'm not sure was really clear, unlike full reciprocity, the nice thing about interstate compacts is it creates a layer of safety. So if indeed Dr. Hansen was a ne'er do well and had done something, not that you are a ne'er do well, had done something in Nebraska that was inappropriate, perhaps with a female patient. And what we often see is then that doctor will move to another state in hopes of staying under the radar. But the wonderful thing about this compact is that we track things like that. And so we've air-- added an extra layer of protection. So that's one of the key differences behind between just having a license and being a member of the compact. It also allows you-- I'm surprised

chiropractics hasn't done it yet. It also allows you to practice across state lines without having to get a secondary license. But, but you're still under the purview of your own state board and then with under the purview of the compact, which is all the states together. And again, readily described within the bill of how it works.

B. HANSEN: OK, thanks.

BLOOD: Hope I answered that question.

B. HANSEN: Yeah.

HOWARD: Senator Arch.

ARCH: I have a follow-up question, if you would, to what Senator Hansen was asking. So if, if the state of Nebraska, the state board says-- I'm just gonna use an example, 50 hours of continuing education, whatever it might be, to maintain your license, and the compact says 40 hours, how is that resolved?

BLOOD: So it is always that you respect whatever the rules are in the state that you're practicing in. So Nebraska says 50 and you're in Mississippi and it's 30. And quite frankly, what they put in this compact was almost the same across the United States. So they, they found the median. But you have to, you have to respect and follow the laws in that particular state that you're practicing in.

ARCH: But we would be the first state.

BLOOD: We would be the first state ever.

ARCH: OK.

BLOOD: And we've never done that, we always bring up the rear.

ARCH: OK.

BLOOD: And beat Utah, who deserves to be beat.

ARCH: Thank you.

HOWARD: I just have a question about the amendment. So on page 22, line 2, the modifying the immunity provision. Generally, when we adopt a compact, we have to adopt the language in its entire, and its-- in its entirety with no changes.

BLOOD: Uh-huh.

HOWARD: And so your amendment would modify the language of the compact itself.

BLOOD: Right.

HOWARD: Are we able to do that?

BLOOD: We are. We actually did that in the previous one. We did that, I think I mentioned that in the introduction--

HOWARD: OK.

BLOOD: --with the PSYPACT.

HOWARD: OK.

BLOOD: It was actually one easy phone call. So on things like this, it doesn't really change the compact as much as change our expectation here in Nebraska on what the definition of immunity is about. So they were fine with it and there was no problem.

HOWARD: Can you remind me what we changed on the PSYPACT?

BLOOD: The exact same thing. I mean, it's--

HOWARD: The immunity.

BLOOD: Exactly. I think it's the exact same language too.

HOWARD: OK, perfect. Thank you. Any other questions? Seeing none, thank you for visiting with us.

BLOOD: My pleasure. I will stick around for closing.

HOWARD: We'll now invite our first proponent testifier up for LB753. Good afternoon.

JANET SEELHOFF: Good afternoon, Senator Howard and members of the Health and Human Services Committee. My name is Janet Seelhoff, J-a-n-e-t S-e-e-l-h-o-f-f. I serve as executive director for the Nebraska Speech-Language-Hearing Association. And I am here to testify in support of LB753 on behalf of our members, which are audiologists, speech-language pathologists, and students across the state of Nebraska. We support the passage of this legislation because it would

provide a mechanism to assist our audiologists and speech-language pathologists who work in Nebraska and other states; it would ensure the ethical and legal provision of services and reduce regulatory barriers while still protecting the public; and it would establish consistencies in the regulatory requirements around the provision of services. Our state association has worked very closely with the American Speech-Language-Hearing Association, known as ASHA, to help ensure that LB753 meets the requirements of an interstate compact. We support this legislation as a measure to make it easier for audiologists and speech-language pathologists to practice in Nebraska. There are shortages of providers, particularly in the rural areas of our state, which impacts access to services. And I won't go into all the details of the services that our members provide because Senator Blood gave you a really thorough list of that. But it's there on the copy of testimony for your reference. One of the opportunities that a compact offers is telehealth technology to help facilitate increased access to these services. Nebraskans receive speech therapy through telepractice services at the University of Nebraska Kearney's RiteCare Clinic. This technology allows Nebraskans to receive speech therapy services by graduate student clinicians who build rapport and provide quality services, just as though they were in a face-to-face setting with the client. UNK's RightCare Clinic calculated the number of miles that families would be required to travel to UNK if the technology wasn't available to provide speech therapy services. In one semester, it added up to more than 43,000 miles. One of the families served lives in a remote area of Nebraska and has driven to the end of their driveway at times due to better internet reception. And the telepractice services are delivered to the son in the vehicle through their phone. This is the extent this family will go to, to receive speech services for their son. Telepractice opens the door for more families across Nebraska to receive or have access to much-needed services. We understand there have been some concerns sent to Senator Blood, and she referenced many of those in her opening comments. And we just wanted to again reiterate our state's requirements that a speech-language pathologist working in Nebraska must meet high standards. Requirements include national certification and state license. Speech-language pathologists that work in schools are also required to have a teaching certificate. Nebraska holds speech-language pathologists to the highest standard, beyond most states. Our state has a shortage of speech-language pathologists, particularly in the rural areas. And this bill does not mandate that an audiologist or speech-language pathologist must be hired. It allows an employer to do so if the candidate is available because they have

met the competency requirements. This allows employers to hire candidates without delay, and speech-language pathologists receive certification and must continue to complete the continuing education requirements every two years to maintain their certification. We greatly appreciate your consideration of this legislation and opportunities to access-- to increase the access of speech language hearing services across our state. I'd be happy to answer any questions that you might have.

HOWARD: Thank you, are there questions? Senator Arch.

ARCH: Thank you. Are, are the issues concerning telehealth separate from the issues concerning the compact? Are those related in some way? In other words, you need to participate in the compact in order to get, to do telehealth or--

JANET SEELHOFF: No.

ARCH: No.

JANET SEELHOFF: No.

ARCH: Those are separate issues?

JANET SEELHOFF: Right? And it's always optional for any provider in our state to offer telehealth services.

ARCH: OK, thank you.

HOWARD: Any other questions? Seeing-- oh, Senator Murman.

MURMAN: Thanks for coming in. So the advantage would be that a, a audiologist from another state could provide telehealth into Nebraska?

JANET SEELHOFF: If they're part of the prop-- of the compact. Yes.

MURMAN: Yeah. OK, thank you.

HOWARD: All right, seeing no other questions, thank you for your testimony today.

JANET SEELHOFF: Thank you.

HOWARD: Our next proponent testifier for LB753. Is there anyone wishing to testify in opposition?

DARRELL KLEIN: Good afternoon, Chairperson Howard and members of the Health and Human Services Committee. My name is Darrell Klein, D-a-r-r-e-l-l K-l-e-i-n, and I'm the deputy director for the Division of Public Health within the Department of Health and Human Services. And I am here to testify in opposition to LB753, which, as you know, would adopt the Audiology and Speech-Language Pathology Interstate Compact. Essentially, there are three grounds that we're doing that, that affect the fact that we're in opposition. If you-- eventually I'll refer to this later, but if you look at page 11 of the act, member states have to comply with the bylaws and rules and regulations of the commission, and those would be adopted by the delegates to the commission. So essentially we're committing to follow rules and regulations that we don't know exist. Secondly, the bill as written is not self-executing and would require a number of other amendments to Nebraska law to be able to fully implement it. And thirdly, and this is probably another big issue here, is the membership. The delegates of the commission under this bill would be members of the Audiology and Speech Language Pathology Board. And the department's position is that the members need to be selected by the department so that they are accountable to elected officials in Nebraska. In this case, it would be the Executive. So with having given that overview, I'll get back to what I've got written here. The language in this bill does not allow the department to fully implement and administer the interstate compact as it is currently written. The compact is not functional in Nebraska as designed and would take significant changes to work for our state. And then even with those changes, the department would be opposed to the bill. The compact does not yet exist and Nebraska would be the first state to join the compact. And this is significant because we would be unable to determine what costs of joining this compact would be and what the impact would be on the department. The state has the constitutional requirement to balance the budget, and it is inadvisable to join a currently nonexisting compact which may require unknown fees that would have to be incorporated into the budget. The best approach, and this is the approach Nebraska has taken in the past with compacts, is to see how the compact operates once it's up and running, learn what neighboring states join-- which neighboring states decide to join the compact, and then evaluate whether Nebraska should join and how it would impact our state. And back to my comments on page 11, after the compact has been formed we would be able to take a look at the rules and bylaws that the compact has adopted and to be able to evaluate them. Section 4 of the bill, which is Section 3 of the compact, that page 8, does obligate the state to require a fingerprint or other biometric-based criminal

background check for audiologists and speech-language pathologist licenses in Nebraska. This would be a new requirement for these licensure types. We do have infrastructure that exists between the department and the Nebraska State Patrol to process fingerprint criminal background checks with the FBI. However, as written, LB753 lacks the specific statutory language in, in the, which both the FBI and the State Patrol require to authorize and perform such checks. In other words, additional statutory language is necessary to implement that concept. We could do that in 38-131, which is a provision in the Uniform Credentialing Act. And we could specifically include audiologists and speech-language pathologist, and then doing so would provide the statutory authority for the State Patrol to run fingerprint criminal background checks for this group of applicants. In past experience in other areas where we're doing the national FBI check, they are very particular on the type of language that they require. And we know 38-131 works. So that's what we would do. So we would need additional statutory changes not contained in this bill. As a matter of fact, some of the provisions of the bill, and this is the key one, the language in the proposed compact language in the bill is kind of a directory towards states, basically saying: you state you're going to have to do this. The bill itself doesn't accomplish that. Finally, Section 4 of the bill, which is Section 8 of the compact, has the language about compact membership. And the bill throughout is, is based on what some other states do, where the, the professional board is a standalone and is the board that issues the licenses and takes the discipline on its own. And that is not consistent with Nebraska law. So similar to that, the bill and the proposed compact language require the two delegates from Nebraska to be members of the board. And then again, here I mentioned that the bill has the licensing board as the agency responsible for licensure and regulation. They have a role, but they are not the agency responsible, which is the department. State Board of Health does appoint professional boards, and that is what the Audiology and Speech, Speech-Language Pathology Board is. They give advice, they do adopt continued competency and fees. But the rest of their role is advisory. It's a very important advisory role, so we get the viewpoint of the profession. But once everything is said and done, the department sits atop the regulation of these professions. A number of professions. So we take into account the sometimes slightly conflicting views of different professions and, and apply what we believe is the right course accordingly. The board members, as I mentioned, participating in the compact commission, might not represent department policy when voting on compact issues. And back to page 11, the commission sets by bylaw and rules things

that we would agree to be bound by if we adopt this language. So if the compact would eventually be something we'd be interested in. We would recommend language changing the two members to be selected by the department. Generally in our compacts we have the individual program manager too, who supports the boards. Those are the folks who go and represent the department in compact matters. In speech-language pathology, this person would be Claire Covert-Bybee. I'm over time, so to summarize, we wouldn't be able to fully implement it without additional statutory changes, membership as delegates to the commission need to be from the department, and lastly, we would be committing to the unknown. And we believe a better course of action would be to wait until the compact is up and running so that we could look and see what we are actually committing ourselves to. With that, I will answer any questions to the best of my ability.

HOWARD: Thank you, Mr. Klein. Are there questions? Senator Cavanaugh.

CAVANAUGH: Thank you. Thank you for being here and for outlining the point of view of the department. So if the statutory changes were made and, that are necessary to authorize the fingerprinting, and the members of the, the compact membership, I guess, the two people were able to be designated the way that the department wishes, then the remaining opposition is that we're the first to do it?

DARRELL KLEIN: The fact that we're the first to do it means that we don't have control over what potential rules and bylaws are adopted. If, if, if the additional nine states would come in and adopt rules and regulations and levy fees that Nebraska found to be unacceptable then we would have to quit the compact.

CAVANAUGH: So we could leave if we didn't--

DARRELL KLEIN: You can do it, yeah.

CAVANAUGH: If we did not like the direction that the compact was going in, we could then leave the compact.

DARRELL KLEIN: Yeah. We just think it's a, it would be a wiser approach to look and see what the compact, what it's going to be, what the fees are going to be. The, the fiscal impact is the difficult thing because leaving doesn't, the leaving is effective six months later. I don't know what impact that would have on fees that were levied that were unpaid. Would that be a debt of the state? I don't

know. If the compact is up and running, we'd be able to look and see, as we have with all the other compacts, what, what we're getting into.

CAVANAUGH: I'm sorry. I'm just, I'm a little confused about the department's stance on the being the first to do it. I'm trying, I'm trying to understand the stance, but it sounds like we just don't want to--

DARRELL KLEIN: It's--

CAVANAUGH: To simplify what I'm hearing, is it sounds like we just don't want to try something new because we don't want to try something new.

DARRELL KLEIN: No, it-- sorry. Yeah, I can certainly understand. That is not our intention, and we're not opposed to being first. It's the fact that there-- that we don't know what it will cost and we don't know what we'll be committing to.

CAVANAUGH: But we don't know what anything will cost, that's why we have forecasts.

DARRELL KLEIN: Well, if you look at the language here--

CAVANAUGH: And fiscal notes.

DARRELL KLEIN: True. But if you look at the language here, it commits us to do whatever the delegates think should be done. And we'd rather have that fleshed out. It's, it's the unknown. It's not the newness of it, it's, it's--

CAVANAUGH: So if we, if we don't like what the delegates do and we project what the fiscal cost is and the fiscal cost ends up being exponentially more than that, we can withdraw from the compact?

DARRELL KLEIN: Yes, but it's not effective immediately. It's six months.

CAVANAUGH: The withdrawal is not effective immediately?

DARRELL KLEIN: Correct. Correct.

CAVANAUGH: How long does it take to be effective?

DARRELL KLEIN: It's six months, according to this compact. And the Legislature would have to withdraw us from the compact. So overall, it could be longer than that. I don't know. In the meantime,.

CAVANAUGH: So--

DARRELL KLEIN: Theoretically, fees could be levied. I don't know if that would constitute the debt. I assume it would.

CAVANAUGH: So the, so the department is in opposition because, hypothetically, it could cost more than we want to spend. And if that were to happen, we would then have the opportunity to withdraw. But we might not withdraw.

DARRELL KLEIN: But we also can't budget for it. So we don't even know what our share would be.

CAVANAUGH: OK.

DARRELL KLEIN: That-- it's the unknown, is what it really comes down to.

CAVANAUGH: Thank you.

HOWARD: Mr. Klein, I have a question about, so you're anticipating that there would be a fiscal impact. But then when I look at the Legislature's fiscal note, it impact-- it, it indicates that there would be additional cash, cash funds coming in. So would we as a state get to decide how much we would charge people for the privilege of coming into the compact in order to cover our costs?

DARRELL KLEIN: I think there's a provision in there that, that allows. I'm trying to think who sets it, the fees to charge. If, if an audiologist wanted privileges to practice under the contract-- or compact, excuse me, then fees can be-- there is a fee that can be imposed. And again, I don't remember right now whether the compact sets those fees or the state does. So then the question would be, would that cover the costs? On page 21, it empowers the contact. The commission may levy on and collect an annual assessment from each state or impose fees on other parties to cover the cost of operations. So the compact can cover its costs by bypassing that down to the states. I am unclear whether we would be able to totally offset the costs from folks coming in and asking to practice under privilege. Just as a hypothetical, the number of audiologists in this state are relatively low. So if the, if the costs, if the assessment to Nebraska

for participation for a year was a thousand dollars and we had one audiologist from Iowa ask to come over under the privilege, we would, you know, to cover the costs then we'd have to set a thousand dollar fee. And we'd probably have to set that fee by rule and regulation. So we would have to guess in advance. Whereas if it's in operation, we'd have real figures to look at. You would have real figures to look at, I guess, would be the better way to put it.

HOWARD: So I, so the fee to enter into the privilege of the contract doesn't come from our home state. We wouldn't be charging it for our home audiologists in order to get into the compact to go into another state.

DARRELL KLEIN: Looks like it.

HOWARD: [INAUDIBLE] from another state would want to--

DARRELL KLEIN: Right.

HOWARD: But we don't care about them.

DARRELL KLEIN: Yeah.

HOWARD: I'm kidding.

DARRELL KLEIN: No, I, I understand what you're saying. No, I believe, I believe the way it would operate, and I haven't studied on this point. But if a Nebraskan asks for the privilege to practice in another compact state, that compact state could charge for that application for the privilege. The main costs are going to be the costs that the commission levies on member states.

HOWARD: So we're in multiple compacts, which we're in-- can you tell me, remind me which ones we're in?

DARRELL KLEIN: Well, there's the nursing compact, I believe there's PT, and then, I guess, medicine and surgery. And we also, those are ones that touch on Health and Human Services. There's, there's a driver's license compact. It's why we can drive in other states under our licenses. And in each of those interests-- in each of those instances, we've got a road map where we can see what the terms, what it's going to mean to join the compact. There's just a lot undefined in this bill that I guess could conceivably be defined in the legislation. I mean, you could say the fee is capped at $100 and put that in the statute. But right now, and that's impractical, I'm not

urging that. But right now, it commits the state, it commits the state to join a compact that can levy an assessment on us, and we don't know what that would be. And it commits the state to follow the compact's rules and bylaws, and we don't know what those would be.

HOWARD: So, Mr. Klein, I want to be mindful of our time, but I do have a few more questions for you. So we're going to stick to our topic at hand. I am very curious, what are the levies like on the other compacts?

DARRELL KLEIN: You know, I don't have that information. I'm not sure they, I'm not sure how they fund themselves.

HOWARD: Oh, OK.

DARRELL KLEIN: So.

HOWARD: Do they, are they able to levy on us?

DARRELL KLEIN: Sadly, I, I wasn't looking at the fiscal impact when we had this reviewed compared to some of the other compacts. I think we could, we ought to be able to get that to you.

HOWARD: That would be really helpful--

DARRELL KLEIN: Uh-huh.

HOWARD: --just for comparison. And then how long have you been doing our 407 work?

DARRELL KLEIN: I have done 407 off and on for 30 years, and now it's under me as a deputy. Before it was supporting the program as an attorney.

HOWARD: OK. So, so then where-- would you have been around in February 2018 when we got the fiscal note on LB686, the psychology compact?

DARRELL KLEIN: I did. I was around. It wasn't one of my areas.

HOWARD: Oh, you weren't doing the 407 in 2018?

DARRELL KLEIN: No, I, I started January, 2019.

HOWARD: That's what I thought.

DARRELL KLEIN: And it wasn't one of my assignments as an attorney in 2018.

HOWARD: OK, have you had a chance to look at that fiscal note?

DARRELL KLEIN: I have not.

HOWARD: OK. And then just for my last question, this committee is very familiar with fingerprints and fingerprints issues.

DARRELL KLEIN: Yes.

HOWARD: When an audiologist or a speech-language pathologist is applying in Nebraska, they don't have to submit fingerprints and there's no background check?

DARRELL KLEIN: Right now, I think that they have-- the universal is that they be of good moral character. I don't believe they're on the specific ones that require the background check. Why? I don't know. Probably cost is a consideration, as you've probably heard. It's, it's, it's an issue for some folks, it's not an issue for others.

HOWARD: OK.

DARRELL KLEIN: So.

HOWARD: Thank you.

DARRELL KLEIN: Yeah.

HOWARD: All right, any other questions? Senator Cavanaugh.

CAVANAUGH: I'm sorry. I that-- I just want clarification on the background checks, because we were talking about audiologists that oftentimes will be working with children. Do we not require anyone that's working with children to have a background check?

DARRELL KLEIN: There's a, there's a background check. I think it's the distinction between the FBI background check. I don't want to wait, wax philosophical here, and mindful of the hours. Looking at-- when you've looked at one database of criminal history, you've seen one database of criminal history. So if you look at the Nebraska NDEN or the justice system, you're going to get-- I think the justice system is pretty good and you're going to get convictions that have occurred in Nebraska. If you adopt a fingerprint standard, not all of the

counties' fingerprint folks that can get arrested or even convicted. And then the FBI is, is seen as kind of the gold standard, where if there's a fingerprint, it's fed into the FBI database. And so by triangulating-- when I was prosecuting a child care provider, we looked at Nebraska's criminal history stats, we looked at Iowa's, which is where they were from, and we looked at the FBI. And then we took the common convictions and tried to match them up for date. So just like everything else human nature, it's an inexact science. But the FBI database is seen as the most comprehensive and therefore most reliable.

CAVANAUGH: And one final question, which is it, sounds like Senator Blood in her opening remarks is very open to working on this bill. Is the department open to working with her to address the concerns that you've stated today?

DARRELL KLEIN: We actually met. I want to thank Senator Blood for asking us to come over to discuss things early on, and then not me, but my staff has exchanged some, some information. The part that I can't promise an answer to is the unknown eventual impact, fiscal and potentially sub-- substantive from the compact not being in existence. So we don't know what they're going to come up with. That, that would be the hard part.

CAVANAUGH: Would you and the department be willing to look through these previous fiscal notes and see if there's an opportunity to create a little bit more certainty in rejecting?

DARRELL KLEIN: I mean, yes, but I can't promise anything. I mean, yeah, am I open to talking with people and trying to work out differences? Always.

CAVANAUGH: OK, thank you.

DARRELL KLEIN: That last part, though, with not being able to see how it's going to be implemented, might be insurmountable, just to be honest.

CAVANAUGH: Thank you.

WALZ: Can I ask--

HOWARD: Senator Walz.

WALZ: --one question, just because I don't understand. So LB686, it says the bill adopts the Psychology Interjurisdictional Compact. What does it mean to adopt it? Does it mean to start it?

DARRELL KLEIN: If you-- it basically means you're passing-- when, when a compact comes in, a compact can essentially have all of the substantive matters, but the compact is going to govern written and ready to apply and then with whatever tweaks you need to make to match your state constitution or whatever other policy things. If you adopt a compact, you as the Legislature are taking that language and enacting it into law. That's what it really comes down to. Compacts are like a special creature. They're provided for in the U.S. Constitution. They're when a group of states get together and want to do something, and the federal government generally has to approve a compact because otherwise you're kind of setting up a little fake nation. But the compact clause allows, allows the states to get together and agree to do common things. Sometimes it's water usage along a shared river, sometimes it's disposal of low-level radioactive waste, which didn't come to pass. But so that-- what they're basically saying is we, we're we're joining.

WALZ: We're joining, we're not going into the unknown.

DARRELL KLEIN: If you've got it all spelled out.

WALZ: LB686--

DARRELL KLEIN: If you've got everything covered then there wouldn't be an unknown. I guess I would just ask you folks to look carefully at the bill and see what we'd be committing to, because it would be you as the Legislature committing to what a bunch of people we haven't met decide to adopt by rule, regulation, and assessment of fees.

WALZ: Can I ask, can I ask one more question?

HOWARD: Sure, Senator Walz.

WALZ: Just about the, the fiscal note on LB686. So I get-- I don't understand what is different from other compacts that we've passed. Why it's so hard for us to come up with a fiscal note on this one, as opposed to-- what's the difference?

DARRELL KLEIN: Senator, my, my apologies, I have not looked at the psych compact that you're talking about's fiscal note. So I'm in the dark.

WALZ: OK.

HOWARD: All right, any other questions? Seeing none, thank you for visiting with us today.

DARRELL KLEIN: Thank you.

HOWARD: Is there anyone wishing to testify, anyone else wishing to testify in opposition to LB753? Is there anyone wishing to testify in the neutral capacity for LB753? Seeing none, Senator Blood, you're welcome to close.

BLOOD: Thank you, Chairperson Howard. There's so many things I want to, to cover about the last testimony, and I'm going to try and be concise because I know that your day is very long. When I brought forward the previous approved interstate compacts, I believe they were like six, seven, or eight on pretty much all of them. And when we join those interstate compacts, they were not operational. Not operational. So whether we're first or whether we're seven, the circumstances do not change. The exception would be if we were number 11, because 10 states make a compact in this particular case. I want to clarify for you, Senator Walz, so the federal government does have to approve compacts and they do give states, as he-- was previously stated, the ability to do things like the interstate compacts. They don't get involved unless it touched down on federal laws. And that's when they stand down for states, such as in the case of interstate compacts. Page 11 clearly states that member states can charge a fee, Senator Howard, for compact privilege. As, if you look at our other interstate compacts, you'll see that we did do that and it does-- is reflected in our budget, if you look at our budget. One of the statements that I thought was curious was interstate compacts with people we haven't met yet, and so we can't trust them to do the right thing by our state. I, I find that very concerning. And the reason I find that concerning is that interstate compacts are not made in a month, in six months, in a year, interstate compacts take years and years of work. And I've been in on one of those meetings. And in that meeting we had 10 or 12 other states. We had people who practice in multiple states across the United States, we had attorneys from across the United States, and of course we have our guides from CSG who help us with our interstate compacts. To make it sound like this is the unknown, I would argue is

not accurate. This is written-- I encourage you to look at the previous interstate compacts that have been passed in the last two or three years, specifically this PSYPACT and the PT compact. You're going to find that the language is basically the same. But yet, we've had absolutely no issues with those compacts that we're aware of. And perhaps HHS has heard something in a hearing or in a report that there's been an issue, but we have been told when we've asked that there have been no issues. And we did indeed meet very early, as we do with all of our bills with DHHS. And the woman who was responsible for compacts, and I want to be really cautious how I say this, since she's not here to testify, but did not reflect to us that there had been any concerns with the previous contacts-- compacts, nor did she seem concerned with this compact. But of course, they're never allowed to tell us whether they're in support or not support. And we have been in contact with them over and over and over and over again, and we didn't hear of any concerns until yesterday. And I find that concerning because we made multiple phone calls, we had multiple requests, because we want to make sure the compact is right. But to say that something does not jive with the state, state statute, I find concerning, when again they mirror our previous compacts. And I have to say that similar concerns were brought up when I brought forward our previous compacts. And again, to my knowledge, and I assume yours, none of those compacts are dysfunctional. So with all due respect, I completely disagree with the opposition. And I rarely do that. I think sometimes it's really easy to get lost in the words and not really, truly see what it does to say that it's an unknown number. The other states aren't going to want us to charge $20,000, right? Are other states going to be really enthusiastic in having to pay a whole bunch of money to be along to this compact? I don't think so. So we're basically saying that they're not smart enough to know what an appropriate level would be. And then if you look at, like, page-- the questions that you had are on page 16 and 17 in reference to how the board works and how punishment is implemented. I didn't think I was going to do my closing saying why I oppose the opposition, but I think you've been misinformed. And this bill deserves to come out. This bill deserves to come out because it is a priority for the Department of Defense, we need this for our military families here in Nebraska. That's the number one priority. Number two priority is that interstate compacts work. They're beneficial. They're good for economic development, they're good for your personal income if you happen to be one of the people who participates in the interstate compact. I am very unhappy that there have been scare tactics put out today, but I know there's a lot of smart people here on this committee who will

have their staff, if not themselves, compare the compacts and see that it is apples to apples and not apples to oranges. And you'll see that they've been successful. And I'd love to walk you through how they're crafted because it takes years of multi-state participation. And I ask that you really do your research on this, because I think you'll find that you agree with me. I would ask that you would please vote this out of committee because it does deserve to be passed. And gosh darn it, we can't get number one in football, can we be number one in this particular interstate compact. That would be great so.

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

CAVANAUGH: Thank you. Sorry, could you just clarify for me something that you just said in your closing. LB686, this fiscal note, when we entered into this compact, this is the psychology interjurisdiction--

BLOOD: It was known as the PSYPACT.

CAVANAUGH: Thank you, the PSYPACT.

BLOOD: To make it much easier.

CAVANAUGH: It was not operational yet? So this fiscal note was a projection.

BLOOD: Uh-huh.

CAVANAUGH: OK, thank you. That's just--

BLOOD: As was, I believe, the one for the PT compact as well.

CAVANAUGH: OK. Thank you.

HOWARD: And how many states need to enter into this one before it's operational?

BLOOD: Ten states.

HOWARD: Any other questions? Seeing none, thank you, Senator Blood.

BLOOD: Thank you, Senator Howard.

HOWARD: This will close the hearing for LB753, but I'm going to remember the letter, so keep sitting there. OK, I forgot all the letters today. So you don't have to sit there.

BLOOD: I thought you were telling me to sit.

HOWARD: So for LB836, the proponents were Todd Stubbendieck, AARP Nebraska; Jenifer Acierno, LeadingAge Nebraska; Joni Cover, the Nebraska Pharmacists Association. There was one neutral letter: James Watson, the Nebraska Association of Medicaid Health Plans. For LB825 the proponent letters were from the Nebraska Child Health and Education Alliance; Dr. Carl Smith and Kari Simonsen from the Nebraska Medicine; Andy Hale and David Slattery from the Nebraska Hospital Association; Kenneth Hobby from Cure SMA. There was a neutral letter from Dr. Gary Anthone, the director of the Division of Public Health, Department of Health and Human Services. For LB753 there were proponent letters from Laura Ebke at the Platte Institute; Andy Hale and David Slattery from the Nebraska Hospital Association; Katie Brennan from the Board of Audiology and Speech-Language Pathology; Todd Stubbendieck from AARP Nebraska; Dr. Mark Adler, Ralston Public Schools. And one opposition letter from Dr. James Denneny III from the American Academy of Otolaryngo-- laryngyo--

BLOOD: Otolaryngologists.

HOWARD: --and Head and Neck Surgery. Thank you. This will close the hearings for the day.