HOWARD: [RECORDER MALFUNCTION] Mr. Neumiller, can you hear us OK?

DION NEUMILLER: Yes, I can. Can you hear me?

HOWARD: OK, so I'm going to have the members of the committee introduce themselves. I'm Senator Sara Howard, and I represent District 9 in midtown Omaha. I serve as Chair of this committee. And I'll start on my right with Senator Murman.

MURMAN: I'm Senator Dave Murman from District 38: Clay, Webster, Nuckolls, Franklin, Kearney, Phelps, and southwest Buffalo County.

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

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

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

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

HOWARD: This will open the hearing for the gubernatorial appointment of Dion Neumiller to the Board of Emergency Medical Services. Mr. Neumiller, we were hoping you could tell us a little bit about yourself and your interest in serving on the Board of Emergency Medical Services.

DION NEUMILLER: Sure. And I am 50 years old, and I live currently in Broken Bow. And I--

HOWARD: Mr. Neumiller, you can hear us OK but, unfortunately, we're not able to hear you very well. Are you on speaker phone or anything?

DION NEUMILLER: No.

HOWARD: OK, all right.

DION NEUMILLER: Is that better?

HOWARD: That's a little bit better. OK.

DION NEUMILLER: OK. I apologize.

HOWARD: OK.

DION NEUMILLER: As I was saying, I'm 50 years old. I currently live in Broken Bow, and I am currently assigned to the Troop D Investigative Services Unit for the Nebraska State Patrol; that's my full-time job. I was-- I, I've been there for about 13 years, in Broken Bow. I have lived-- or I grew up in Nebraska, way north in Naper, Nebraska. I attended college at the University of Nebraska-Lincoln. After that, I worked for a short while in Ogallala, Nebraska, where I also volunteered for the Ogallala Volunteer Fire Department. I worked for the police department and sheriff's office out there, and I eventually worked full-time as the assistant fire chief for the Ogallala Fire Department. I did do a brief stint, for about four years, down in Arizona, the Phoenix, Arizona area, where I worked as a full-time paramedic. And in 2007, I returned to take an appointment at the Nebraska State Patrol-- and I still work. I guess I've always been interested in EMS. I started way back in 1991, and became a [INAUDIBLE], which was the lowest level of emergency medical technician back there-- or back then. And I've currently-- while I was in Ogallala, I became a paramedic, and I still am a paramedic. And I work part-time at Phelps Memorial Health Center down in Holdrege, a PRN on the ambulance service there. I was approached to, to become the law enforcement representative on EMS Board, by [INAUDIBLE]. I put an application in, and I'm here today, I guess.

HOWARD: OK. So let's see if there are any questions from the committee. Are there questions? Senator Williams.

WILLIAMS: Thank you, Senator Howard. And thank you for your willingness to serve on this board. Could you tell us a little bit about what you're doing right now? Is it on a volunteer basis with the medical services? And then if, if it is,'s what your full-time job?

DION NEUMILLER: Currently I am a paid part-time paramedic down in Holdrege, at Phelps Memorial. My full-time job, I'm an investigator with the Nebraska State Patrol, assigned in Broken Bow, and I work out of Troop D, here at North Platte.

WILLIAMS: OK. Thank you.

HOWARD: All right. Any other questions from the committee? Seeing none, we very much appreciate you taking the time to speak with us

today, Mr. Neumiller. And we appreciate your willingness to serve on the Board of Emergency Medical Services. OK?

DION NEUMILLER: Thank you.

HOWARD: Thank you. All right. All right. This will conclude the hearing for the gubernatorial appointment of Dion Neumiller to the Board of Emergency Medical Services. We'll do our openings now. All right. Also assisting the committee is our legal counsel, Jennifer-- T.J. O'Neill, and our committee clerk, Sherry Shaffer. And our committee pages today are Nedhal and Taylor. A few notes about our policies and procedures in this committee. We ask that you turn off or silence your cell phones. This afternoon, we'll be hearing four bills, and we'll be taking them in the order listed on the agenda outside 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 to testify. This will help us keep an accurate record of the hearing. If you are not testifying at the microphone, but to 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 handouts submitted by testifiers will also be included as part of the record, as exhibits. We would ask, if you do have any handouts, that you please bring ten copies and give them to a page. We do use a light system in this committee. Each testifier will have five minutes to testify. When you begin, the light will be green. When the light turns yellow, that means you have one minute left. And when the light turns red, it's time to wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone, and then please spell both your first and last name. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters, then from those in opposition, followed by those speaking in a neutral capacity. And the introducer of the bill will then be given the opportunity to make closing statements, if they wish to do so. We do have a very strict no-prop policy in this committee. And with that, we'll begin today's hearing with the gubernatorial appointment of John Kuehn to the State Board of Health. Welcome, Senator Kuehn.

JOHN KUEHN: Thank you, Chairwoman Howard and members of the committee. Start-- had to think about whether I needed to open on a bill from old time's sake [LAUGHTER] or how to, you know, address this. So I know you have a full day today, as we approach the end of hearings, so I will keep my comments brief. I am Dr. John Kuehn, and I'm here today for confirmation for the Board of Health, representing the veterinary medical profession. I'm a 2000 graduate of Kansas State University College of Veterinary Medicine. I have been licensed to practice veterinary medicine in the state of Nebraska since 2000. I am also a USDA Level 2 accredited veterinarian and part of the federal livestock accreditation process. In addition to my veterinary professional activities, as a veterinarian, I also hold the title of professor and department chair of the Department of Biology at Hastings College, where I also work with undergraduates and preprofessional preparation for students pursuing a wide variety of graduate and professional programs. It is my honor to receive the appointment to the Board of Health. During my time, as Senator Howard alluded to, in the Legislature, I was actively involved in a number of legislative processes that involved scope of practice, involved healthcare issues. Some of my greatest achievements are the work that I did and worked with and some senators regarding significant advancements in Nebraska's healthcare system; and I'm very proud of that. So it is an honor to have the opportunity to represent my profession and the state in this capacity. So with that, I'm open to any questions.

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

MURMAN: Thank you, Senator Howard. And thank you, Senator Kuehn, for being back here. Just wondering, do you miss being a state senator?

JOHN KUEHN: I miss the people-- many, many wonderful people.

MURMAN: Also, what do you think of your replacement [LAUGHTER]?

JOHN KUEHN: Excellent-- an excellent man [LAUGHTER]. Actually, I don't know if he remembers, but in 2001, I did a dairy call near Glenvil, Nebraska, in a professional capacity. So I'm, I'm concerned my replacement might have a comment about me, as a veterinarian. So there, that could be the challenge.

MURMAN: OK, if you don't answer, I won't answer.

HOWARD: Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman Howard. Thank you. Now, should I say Senator or Dr. Kuehn, which one is more--

JOHN KUEHN: Either is fine today.

CAVANAUGH: So I thought that Senator Murman was going to ask you a question that we often ask in these situations, which is, what is the best district in the state? He did not, so--

HOWARD: He missed his opportunity.

CAVANAUGH: --clearly, he thought that it-- your answer might be different than 38. I just thank you for being willing to do this. And I'd be interested, as someone with not a medical background, the 4O7 process is--

JOHN KUEHN: Um-hum.

CAVANAUGH: --something that we rely on in this committee a lot.

JOHN KUEHN: Yeah.

CAVANAUGH: And is that something that you had familiarity with in your capacity as a veterinarian, or is it something that you gained more familiarity when you were here in this body?

JOHN KUEHN: Yeah, it-- as a veterinarian, if you said that, the 407 process to most licensed medical professionals in the state, they would have no idea what that is. So I gained my familiarity with the 407 process and the scope of practice issues from a policy perspective during my time as a legislator. And you know, as we've looked at, and, and as the trend towards occupational licensing reform continues to be a political and policy buzzword, I think that processes like the 407 process take an even greater importance in, in how we ensure both safety and competency of all of our licensed medical professionals across the state. So I have. I have great respect. And during my time as a, as a legislator, I'm on the record supporting the 407 process as the most important process for occupational licensing, especially when it comes to the, the health professions.

CAVANAUGH: Well, thank you. I appreciate that someone who's been on both areas of this will be part of that process, so we can continue to rely on the integrity of that. And I appreciate your willingness to continue your public service for the state.

JOHN KUEHN: Thank you.

HOWARD: All right. Any other questions? I was going to ask you who your favorite senator was that you got to work with, but I already know the answer, so that's fine. But do you want to-- just because we've talked about NeHII and we've talked about the Prescription Drug Monitoring Program, do you want to talk a little bit about your background with that, because you did amazing things?

JOHN KUEHN: Oh, well, I certainly am always happy to talk about the PDMP, in part because I think it represents an excellent, outstanding policy achievement that doesn't necessarily get all of the credit for what happened and, and the years and years of dedicated work from senators that predated me and predated everyone in this room, to build and take Nebraska from-- I like to call it, say-- going from a laggard to a leader. So to go from essentially no PDMP to one that is a model in the nation for patient safety, not just addressing a single crisis, whether it's opioids or others, but really a comprehensive program that was inclusive, has certainly been helpful. My involvement in that has been the source of a lot of great conversations with legislators in other states who are looking to modify their existing PDMPs, whether that's add other professions into their reporting or how to improve their reporting. And so I think it, it represents a really significant policy achievement. Of course, that is to your credit and the credit of the prior Senator Howard, but it was probably one the best experiences I had to work with during my time in the Legislature. And I'm actually willing to take on this challenge and excited about it because it means that, to some degree, I'll still have an ability to be involved in the policy and continue to see that grow from a different perspective, but one in which I still have an opportunity to observe that policy change and grow.

HOWARD: That's wonderful. Thank you. All right. Any other questions? I told you we were really quite mean, in advance.

JOHN KUEHN: It's what I expected.

HOWARD: But we're very grateful for your willingness to serve on the State Board of Health. And it's very nice to see you again.

JOHN KUEHN: Great to see all of you. Thank you.

HOWARD: OK. Thank you. All right. This will close the gubernatorial hearing for John Kuehn, and we will open the hearing for LB1170,

Senator Cavanaugh's bill to provide for implicit bias training, coverage under the Medical Assistance Program for doula services, and postpartum women instruction to health professionals, and a pilot program. Welcome, Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman Howard and members of the Health and Human Services Committee. My name is Machaela Cavanaugh, M-a-c-h-a-e-l-a C-a-v-a-n-a-u-g-h. I did that without even reading it off. Now I found my introduction. I am here to introduce LB1170, which is a beginning point to address adverse outcomes for black mothers during pregnancy and through the first year after giving birth. Over the last 30 years, even as maternal mortality rates around the world have dropped significantly, they've actually increased in the United States. African-American women born-- have borne the brunt of this, with an increase in maternal mortality rates triple or quadruple that of white mothers. This is a crucial issue because we, we haven't dealt with it yet here in Nebraska. LB1170 works to address four key areas: implicit bias-- let me go through the four, I'm sorry-- expansion of Medicaid coverage to include maternal Medicaid coverage, postpartum from 60 days to 12 months; to create a reim-- state reimbursement for doula services in Nebraska; and to create a pilot program. I'll take you through a little bit of the details on this. So implicit bias would be training for healthcare providers that is defined as: the unconscious-- conscious attribution of particular qualities to a member of a certain social group. Implicit stereotypes are shared by experience and based on learning associations between particular qualities and social categories, including race and/or gender. So one of the reasons to be doing implicit bias is, as it relates to maternal health for black mothers, is that it is-- studies and statistics show that maternal health for black mothers is across all socioeconomic status. So it is not the education or the financial background of the mother that is the problem. It is the society bias in our healthcare system. The CDC recommends hospitals and healthcare systems implement standardized protocols and quality improvement initiatives, especially among facilities that serve disproportionately affected communities. And they recommend, identify, and address implicit bias in healthcare that would likely improve patient-provider interactions, health communications, and health outcomes. The next thing this bill seeks to do is to expand the Medicaid coverage for postpartum from 60 days to 12 months. This is, again, a recommendation of the CDC. Half-- a full half of pregnancy-related deaths occur in postpartum period with a fifth of those happening in the period where Medicaid cap coverage disappears. Extending Medicaid coverage to include the full postpartum

year is expected to result in a large decrease in maternal mortality. The CDC pregnancy-related mortality service, surveillance system defines a pregnancy-related death as the death of a woman during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy or the aggravation, aggravation of unrelated condition by the physiologic, physiological effects of pregnancy. So one thing that is a big issue is postpartum depression and suicide rates. And so by continuing the coverage up to a year, the intention is to ensure that women that might not otherwise have healthcare would have access to those services, to make sure that they're being identified, that they're struggling with such an issue and get them the healthcare supports that they need. The next piece is to reimburse for doula services in Nebraska. Nebraska does not require licensure for doula services, and I am not seeking to create a new licensure. We will not be going through a 407 for this. However, there is evidence that including coverage of a doula service for expecting and new mothers have dramatic positive effects. A 2017 review, that analyzed more than 20 different studies, found the following: a 15 percent increase in the likelihood of a vaginal birth; a 10 percent decrease in the use of medications for pain relief; shorter labors by 41 minutes, on average-- that would be amazing; a 38 percent decrease in the risk, the baby's risk of a low five-minute Apgar score-- another really amazing thing; and a 39 percent decrease in the risk of a Caesarean, which, of course, has many other complications associated with it in postpartum, but also just safety and amount of time that you're doing surgery and then, of course, costs related with a Caesarean versus vaginal birth. The final piece is for the Department of Health and Human Services to develop and implement a pilot program regarding racial disparity for black mothers and the social determinants for health for pregnant women and mothers. This program would include housing assistance and home visitation for expecting or new mothers. One thing I frequently talk about is how vital that is when it comes to building a solution to any problem. This pilot program will help us determine the best practices for supporting new mothers and how to ensure that both mother and baby have a long and successful life. So as I mentioned to this committee earlier today, I have met with the department about this bill and the fiscal note, which I also-- though it is a long fiscal note, it's eight pages-- I really appreciate this fiscal note because it's very detailed, and I found it very helpful in, in seeing some of the, the points for clarification and things that we could work on together with the department. I don't believe all pieces of this bill are, are ready to be moved forward in this

Legislature. But I do think that it's worth us, as a committee, and the department to have this conversation, because this is a big problem in Nebraska. Maternal health in Nebraska, maternal mortality in Nebraska is high. It's higher across all races. but if we focus on the race that it is the highest, it is my hope and intention that we increase positive outcomes for all mothers, by focusing on the disparities that we're seeing in a particular population. And that has been proven to be successful in other communities. So that's where I started with all of this. I do have some things that I would like the committee to consider, that we may amend into this to include or things that we might change. One is, in Iowa, they have-- it's a, it's called-- I apologize, let me grab this-- Count the Kicks program. It's a very low-cost program where they actually have a free app that moms can put on their phones, and they will count the kicks, which means that stillbirths decrease significantly. Iowa has seen amazing results in this. And it has come to my attention that our new director of Child Family Services [SIC] has actually implemented this in Indiana. So hopefully, this is something that we can discuss with her and bring it here to Nebraska, which I think would be a really amazing thing. I have not spoken with her yet, but that's the word on the street, as the kids say. I don't know what kids say that, but-- so maybe It's just me. We have some submitted testimony today from some advocates. They're not coming in today, and I won't belabor the points. They outlined some of the reasons why this issue is so important. And with that, I will take your questions.

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

CAVANAUGH: I will. I, I'm not sure if we have any proponents today, so we may be just hearing from the department, and I might not close. So we'll see.

HOWARD: OK. Thank you. Is there anyone wishing to testify in support for LB1170? Good afternoon.

JULIA ISAACS TSE: Good afternoon, Chair Howard and members of the Health and Human Services Committee. For the record, my name is Julia Isaacs Tse, J-u-l-i-a I-s-a-a-c-s T-s-e, and I'm here today on behalf of Voices for Children in Nebraska. We are supportive of LB1170 because it invests in healthier pregnancies for more Nebraska mothers. Together Medicaid and the Children's Health Insurance Program, also known as CHIP, provide health insurance coverage to nearly 29 percent of all Nebraska children, which was about 140,000 Nebraska children in

total. Pregnant women can currently receive coverage through CHIP at a higher income level than other adults, at 194 percent of the federal poverty level, and are currently eligible for a 60-day postpartum period after delivery, as is currently required by federal law. Nearly one-third of all Nebraska births were covered by Medicaid in 2016. I'm going to skim over some of my testimony on maternal mortality rates, and just expand on that by saying that infant death rates have also been really alarming in the last few years. And the United States infant death rates were 76 percent higher than in other wealthy nations like the U.S. And although that death rate has declined over time, disparities have actually widened. So black and American Indian or Alaska Native infants experienced the worst outcomes at 11.2 and 8.5 deaths per 1,000 live births, respectively. In Nebraska, the infant mortality rate has been on the rise since 2013. In 2017, there were, there were 144 infant deaths, at a rate of 5.6 deaths per 1,000 live births. Black babies experience a higher mortality rate at 10.2 per 1,000 live births. And for Native infants, that rate was 8.3 deaths per 1,000 live births. Health disparities for women of color are the result of a range of systemic barriers that have deep historical roots in our nation, that include: access to reproductive health care, exposure to chronic stress well before that woman becomes pregnant; and even the availability of quality hospitals in communities of color. LB1170 addresses one aspect of health equity for women of color, which is discrimination and an implicit bias in healthcare institutions. Study after study has found that black patients are treated differently by healthcare providers when compared to white patients with the same symptoms. A recent national survey of nearly 1,600 American women found that 22 percent of black women and 29 percent of Native women reported being discriminated against during a recent doctor healthcare visit. We are further supportive of the investments in doula care for Medicaid-eligible women, as Senator Cavanaugh mentioned. This is supported in research. A recent systematic review of 22 studies of more than 15,000 women found that this form of support during childbirth results in positive, positive outcomes. And currently, there are two states that have expanded such coverage through a state plan amendment in their Medicaid programs. So we would recommend, if this committee considers this issue moving forward, that we look at federal funding, because our understanding is that other states have been able to draw down those funds for those, for those services. Finally, we are supportive of the expansion of postpartum Medicaid coverage for Nebraska mothers. This fills a critical and often overlooked gap in maternal and infant health in our state. Post, postpartum health conditions can require treatment well

beyond the first two months after birth. And this ensures that mothers, during a otherwise [SIC] already very stressful time, can address childbirth complications, lactation difficulties, pain, depression, repro, reproductive needs, and anxiety. And until there is full implementation of Medicaid expansion to all adults under 138 percent of federal poverty, many low-income mothers will, will likely find themselves uninsured after that 60-day period. There is some research out there about Medicaid expansion that could shed some light on the benefits of extending coverage in this way, which is that mothers and nonexpansion states were three times more likely to be uninsured postpartum than their counterparts in expansion states, and states that have expanded see earlier initiation of prenatal care and, most importantly, lower rates of maternal and infant mortality. Two states have pending-- or have submitted a Section 1115 waiver to expand coverage in this manner. December -- in December, South Carolina received approval for this expansion. I haven't had a chance to review that letter to see if that, this 12-month provision, was included in that approval, but also worth taking a look at. And with that, I'd just wrap up and thank Senator-- the senator for introducing this bill, and this committee for their time and commitment.

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

JULIA ISAACS TSE: Thank you.

HOWARD: --your testimony today. Our next proponent testifier for LB1170? Good afternoon.

BECKY SHERMAN: Thank you, Senator. Howard and committee. My name is Becky Sherman, B-e-c-k-y S-h-e-r-m-a-n. I'm on the board of directors for Doulas of Lincoln, a local association of professional doulas practicing here in Lincoln and the surrounding areas. I've been a doula for 13 years, and I've attended over 100 births, and I've also received the benefit of having a doula present at all four of my own births. I would like to take a moment to explain to you the profession of doula. A doula is a noncritical-- clinical support person who helps a birthing person before, during, and after their birthing time. This might include physical support, emotional, informational and processing information, as well as specific needs of the birthing family. And every birthing family has their own unique needs. Doulas are often working for extended periods of time. This makes it difficult for me to personally accept doula clients who cannot pay. I incur my own costs for when I am also at work. I budget each year to take three free or reduced-fee clients, and I wish that I could do

more for more families. As we have seen time and again, women who are in any way part of a marginalized group, including socioeconomic hardship, are often unable to procure what they need to truly survive and thrive in their personal lives. This leads to a lot of complications, including postpartum depression. As an administrator for Doulas of Lincoln, I can testify that we receive many requests for doulas at a free or reduced cost, and often, as a group, we have to turn the families away. Working for free is an unsustainable business practice, yes? However, doulas can reduce overall birth costs, having been proved time and again that the presence of a doula reduces the need for interventions, medication, pain relief medications, instrument delivery, and Caesarean delivery. Doulas provide a unique place in the birthing team and can offer and often help with communication, information intake, and, at times, play the role of moderator on the team. We are a special kind of advocate, giving all birthing women a voice for their own care. I hope to see this bill continue through the process. It really is a win-win situation for birthing families and doulas alike.

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

BECKY SHERMAN: Thank you.

HOWARD: Our next proponent testifier for LB1170? Good afternoon.

JOYCE DYKEMA: Good afternoon, the committee. My name is Joyce Dykema, J-o-y-c-e D-y-k-e-m-a. I am a professional birth doula here in Lincoln, and I am testifying in favor of LB1170, reimbursement to Medicare [SIC] recipients for doula services. I have worked as a birth doula since 2009. I trained with DONA International, which is an internationally recognized doula training and certifying organization. I have achieved and maintained my certification as a birth doula with DONA International since 2012. I hold additional certification with Hypnobabies as a trained Hypnobabies hypno-doula and I am an evidence-based birth instructor, providing continuing education and contact hours for nurses, doulas, and other birth professionals, as well as parent classes, including childbirth education. I have served as a birth doula for 118 births, largely here in the Lincoln, Nebraska area. Birth doulas provide professional emotional support, physical support, and informational support to childbearing families before, during, and immediately after childbirth. Doula care is best described as professional support. Doulas are not trained in and do not provide clinical care. We're nonmedical support professionals. Despite all

this, doula care is evidence-based, and it's shown to decrease Caesarean risk by 39 percent, decrease the mother's request-- use of pain medication by 10 percent, increase the likelihood of a spontaneous vaginal birth by 15 percent, so that's not using a Caesarean birth or forceps or vacuum to deliver the baby. Shorten-- doulas shorten labor by an average of 41 minutes. We decrease the baby's risk of a low Apgar score, at five minutes of age, by 38 percent, and we decrease the likelihood that the mother will be dissatisfied by her birth experience by 31 percent. Doula care reduces maternity care costs. As a trained and certified professional doula, I spend an average of 24 hours with a family providing doula care, including prenatal preparations, answering questions, referring my clients to appropriate resources, care for the actual labor and birth, and postpartum support. On average, I charge $900 per birth client. I am only able to take a small number of birth clients per month to reasonably guarantee my availability for their birth. I am available to my clients at all hours of the day and night, whenever they go into labor, and I provide in-person supportive care, no matter how long their labor lasts. These costs can be prohibitive to at-risk populations, especially those receiving Medicare for their maternity care. Setting aside funds for Medicare reimbursement for low-income families to receive doula care would help to make doula care possible for at-risk families, and would help to offset maternal health disparities that cost the state money and resources. Thank you.

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

WALZ: Thank you. I'm just curious. How many doulas are in Nebraska?

JOYCE DYKEMA: Ooh, in Nebraska? I'm not exactly sure.

WALZ: Or in your area?

JOYCE DYKEMA: Here in Lincoln, there's probably 10 to 15 who are active

WALZ: OK.

JOYCE DYKEMA: On average, we're going to be taking no more than about five or six doula clients a month, so that's not that many. I, I personally only take two doula clients a month.

WALZ: I see. Thank you.

JOYCE DYKEMA: Yeah.

HOWARD: All right. Other questions? Senator Hansen.

B. HANSEN: Thank you. Just to make sure I'm clear, I'm pretty familiar with doulas and the profession, but who do you, who are you allowed to work under? Is it a medical professional? Is it-- does it really matter, it can be much anybody?

JOYCE DYKEMA: I'm self-employed, so I work for the, the family. I work for--

B. HANSEN: Yeah.

JOYCE DYKEMA: --the family who hires me.

B. HANSEN: That's what I figured. I'm just trying to figure out, in, in, in the absence of med, medic-- or reimbursement to the state, how that works, and then how much, and--

JOYCE DYKEMA: Certainly.

B. HANSEN: --is that a receipt-based system? Or, you know, I don't know, I don't know for sure how that would work. So I was just kind of curious to know--

JOYCE DYKEMA: Yeah.

B. HANSEN: --more how that would work, OK? Thanks.

JOYCE DYKEMA: Yeah.

HOWARD: All right. Seeing no further questions, thank you for your testimony today.

JOYCE DYKEMA: Thank you.

HOWARD: Our next proponent testifier for LB1170? Seeing none, is there anyone wishing to justify an opposition? Good afternoon.

JEREMY BRUNSSEN: Good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. My name is Jeremy Brunssen, J-e-r-e-m-y B-r-u-n-s-s-e-n, and I'm the interim director for the Division of Medicaid and Long-Term Care within the Department of Health and Human Services. I'm here to testify in opposition to LB1170, which would change provisions surrounding Medicaid eligibility

for pregnant women and require payment for doula services directly to beneficiaries. LB1170 provides for a number of changes surrounding provider training and healthcare for pregnant women, the department does not necessarily oppose many of the provisions of the bill, such as those requiring implicit bias training. There would, however, be costs associated with this training. Even if these costs could be lessened by changing the training from annual to biannual, most Unified Credentialing Act [SIC] professions, or UCA professions, renew credentials biannually and the implicit bias training requirement could be implemented as part of the existing credential renew process, if the training were also biannual. Of concern to Medicaid, from a fiscal note perspective, LB1170 extends the Medicaid eligibility for pregnant women, as noted previously, from the current 60-day postpartum period, to 12 months. The current eligibility period for pregnant women is based in federal law. And, and so in order to implement this bill, Medicaid would likely need to seek an 1115 waiver authority to waive the 60-day postpartum requirement, in favor of the longer eligibility period. But as we've mentioned in testimony on other bills, 1115 waivers must be budget neutral and cannot lead to any additional expenses for the federal government. We have concerns that the 1115 waiver demonstration could meet budget neutrality and requirements, based purely on the fact that the additional months of eligibility directed by the bill. The department would also like to share its concerns related to paying for the services of a doula. The language in Section 7 of LB1170 directs DHHS to reimburse a recipient of medical assistance for the services of a doula. Such reimbursement shall be paid by state funds. Given that this would be non-Medicaid covered service, operationalizing this could be difficult. The Medicaid Division does not currently have processes in place to reimburse beneficiaries directly for services. In summary, LB1170 would change Medicaid eligibility for pregnant women in a way that goes beyond federal law, and will not allow the state to maximize federal funding. It also requires DHHS to reimburse different-- through Medicaid, to reimburse beneficiaries directly for doula services. As such, we respectfully oppose this legislation. I would like to add a note, that the members of my team and myself appreciated the opportunity to have a productive conversation with Senator Cavanaugh. And we really-- it was productive in that we got to understand more of the intent behind it. And as written, there is a fiscal note that we'd have to oppose. Thank you for the opportunity to testify, and I'd be happy to answer any questions.

HOWARD: Thank you. Are there questions? I just want to make sure you know that I appreciate you taking the time to talk to our members in advance of the hearing. I think that's often more productive for when you come talk to us.

JEREMY BRUNSSEN: Sure. Thank you.

HOWARD: Thank you. All right. Our next opposition testifier for LB1170? Seeing none, is there anyone wishing to testify in a neutral capacity?

KELLY LOVRIEN: Hi.

HOWARD: Good afternoon.

KELLY LOVRIEN: My name is Kelly Lovrien, K-e-l-l-y L-o-v as in Victor-r-i-e-n. I'm actually neutral about it because there are some components that I know nothing about; and I will admit that. But there is one component of such a bill, the implicit bias training, that I have a significant need to try and convince everyone that is a proper motive in how this state works. As was once told to me, the-- every beginning of a country begins in the heart of one singular person who wants to change the world. And in order to change, we have to enact something that would go for every aspect of the socioeconomical aspects of our lives, in everyday factors that include how the medical system treats us, how we can maintain a stability within our state, within our very cities, communities of people, souls that need others to be able to just sustain who we are. And the medical system is failing. I have personally almost been killed six times this year alone because the misunderstanding of disorders. And I know this is irrelevant to the actual bill and what it pertains to, but I have to speak up. You people are killing us. You're not allowing us to live our lives to the fullest, to sustain ourselves. If you were to ever be put into a position like mine or anyone else's, where we have no choice but to move out of this state to get the medical care that we need-- it is time for a change. And I will take this as far as I can because I will not let anyone else fall for this. And I will not become the statistics that you all see every day; I won't, I refuse to. My family, my biological family, we are warriors. We are meant to stand up to those who oppose life, who oppose what we can do in life to change the world for the better. And given the circumstances, I am sadly unimpressed. And that's all I have to say.

HOWARD: Thank you. Are there questions from the committee? Seeing none, thank you for your testimony today.

KELLY LOVRIEN: You're very welcome.

HOWARD: Our next neutral testifier for LB1170? Seeing none, Senator Cavanaugh, you are welcome to close. While she's coming up, we do have some letters in support: Dalton Meister, the, the National Association of Social Workers-Nebraska Chapter; Scout Richters, ACLU Nebraska; Megan Mikolajczyk, Planned Parenthood of North Central States; Tiffany Seibert Yo-- Joekel-- Joekel, Women's Fund of Omaha. No letters in opposition, no neutral letters. Welcome back, Senator Cavanaugh.

CAVANAUGH: Thank you. And thank you to those that came and testified today. It does kind of make me wish I had a doula when I delivered my three children, though it was a wonderful experience I-- with my midwives, but it seems like maybe it would have been an added addition for my life. But the, the doula piece of this actually first came to me from one of the youth in foster care that I am sure you all have met her before. And so it was at one of these events, during the interim, with parenting teens in foster care. And one of the young women came up to me and she said: You know, it would have been really helpful for me is if I had a doula in the delivery room, because it wouldn't have been somebody who was court appointed to be there, it wouldn't have been a guardian or, or, you know, foster parent. It would've been somebody that was there, just for me, to be my advocate. And the father wasn't involved in the, in the delivery, and so that would have been a nice thing to have. And she said: I know that Medicaid covers this. And I was like, oh, OK. So I started looking into it. And I said: Well, the reason that we can't get it covered by Medicaid in Nebraska is that we don't license doulas. And the doula community has not asked us to be licensed, and so I'm not going to seek that route for them. So the idea of creating General Fund appropriation to pay for those services came out of some other states have been doing that. So as far as the logistics of how that piece of it would work, I think I-- if we were to move that piece forward, we could work with other states to see how they've done the General Fund appropriation and distributed the funds through their programs. I believe it might be Georgia that has done it, maybe a few other states. So if we are to move forward with doula reimbursement, I think that we do have some opportunities to find ways to do that. And the reimbursements, in my mind, would be based on the Medicaid reimbursement rate for doulas, if they were licensed in the state. I

am more than happy-- and I actually told Deputy-- or Interim Director Brunssen that I'd be happy to change the time line on the bias training. I don't think we need to spend more on a postcard. We can just have it start when their training starts, because every, every dollar does matter. But I do think it's important to have that as a part of the training. The 60 days to the 12 months is, again, something that I said that we could work on together. Possibly, I would say, if we were to move this forward, I would remove that piece entirely right now. And then after Medicaid expansion is implemented, see what the remaining population looks like because this is a population that, starting in October, could already be covered. And if there are people that are falling through that, then we could revisit that piece of it. I will send information out to the committee on the Count the Kicks program. I really hope that's something that we can consider-- very low cost. And something that I forgot to mention but, again, the data nerd in me loves, as you might know from Twitter-- Ne-HII-- I "heart" Ne-HII. I think that NeHII would be a great partner in helping improve healthcare outcomes. One of the things that they do is identify social determinants of health. And if we were to do a pilot project around the socioeconomic disparities on race, I think that NeHII really could play a significant role in this. And so I will work with the department on this, and see if there is an amendment to bring back, bring back to the committee this year. If not, we will probably be doing an interim on it, and do further legislation next year. So with that, I will take questions.

HOWARD: Thank you. Are there questions? Seeing none, thank you, Senator Cavanaugh. This will close the hearing for LB1170. We will open the hearing for LB1044, Senator Hansen's bill to change provisions relating to the practice of medical nutrition therapy. Good afternoon.

B. HANSEN: Good afternoon, Chairperson Howard and members of the Health and Human Services Committee. My name is Ben Hansen; that's B-e-n H-a-n-s-e-n, and I represent District 16. I'm here today to introduce LB1044, an important piece of legislation for the practice of medical nutrition therapy. Interesting, interestingly, most of the time when we introduce bills, we are doing so to change the current state of things. However, this-- today's bill that I am introducing is needed to maintain the current state of medical nutrition therapy in Nebraska. If or when we pass the bill, we will be clearly stating that is, that what is already in the law, that when a licensed medical nutrition therapist is ordering patient diets, the nutrition, the

nutrition therapist does so in consultation with a physician, but the approval of a physician for the diet order is not required. As we all know, the Department of Health and Human Services has undergone many rule and regulation changes in recent months. One such change was a sweeping reduction in the rules and regulations surrounding licensed, medical nutrition therapy. While most of the proposal included deleting unnecessary language, one change was, was substantive and actually added new requirements on LMNTs. Language was proposed to be added that would require an LMNT order a patient diet with the approval of a medical practitioner. This is not required in statute, and it was not an appropriate require, requirement to write into regulation. While there was quite a bit of opposition testimony at the hearing of the change. The proposed changes were still adopted and approved by the Board of Health. The good news here is that the rule change has not been officially approved by the Governor and, thus, is not in effect. In fact, when the bill was introduced, it was done so as a backstop to what we thought would have already been reassessed and addressed at the Board of Health's January meeting. But that meeting was canceled and the next Board of Health meeting will not take place until later in March. Because the outcome of that meeting is still unknown, I am asking the committee to take action here. There are those following me who will give you more information about how LMNTs are ordering patient diets, and how they do so in consultation with physicians. Again, we are not changing a scope of practice here, but maintaining a practice that is already working across our state. Thank you for your time on this issue, and I'm happy to answer any questions the best that I can.

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

CAVANAUGH: Thank you, Chairwoman Howard. Thank you, Senator Hansen. Do you know, did the medical practitioners request this change?

B. HANSEN: I'm uncertain--

CAVANAUGH: OK.

B. HANSEN: --about that one. I can, I can get back to you and let you know.

CAVANAUGH: It just strikes me as more work for them, but--

B. HANSEN: Um-hum.

CAVANAUGH: --maybe they requested it. Thank you.

HOWARD: Just, just so I understand it, it's, it's that the new regulation requires them to consult-- or they need approved. Is it approval?

B. HANSEN: I believe they change it to the-- before, for many, for many years, in my understanding, they've always just consulted with a medical--

HOWARD: OK.

B. HANSEN: --professional. And for some reason with the language change, they have changed it to you can-- they needed the approval now. So which is, in my personal opinion, kind of odd because they're not allowed to do their jobs--

HOWARD: OK.

B. HANSEN: --with that one more step that, yes, Senator Cavanaugh would say would be a little redundant and would take more time.

HOWARD: OK. Thank you.

B. HANSEN: Yep.

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

B. HANSEN: Yes.

HOWARD: Thank you.

B. HANSEN: Thank you.

HOWARD: All right. We'd like to invite our first proponent testifier up for LB1044. Good afternoon.

LISA GRAFF: Hello. My name is Lisa Graff, L-i-s-a G-r-a-f-f. I'm testifying today in support of LB1044 on behalf of the Nebraska Academy of Nutrition and Dietetics, or NAND. NAND represents 600-plus nutrition professionals across Nebraska, many of whom are licensed medical nutrition therapists, which are referred to as LMNTs. We are also the primary professional organization for LMNTs. As Senator Hansen mentioned in his opening, LB1044 will maintain status quo and allow LMNTs to continue practicing in consultation with physicians, as

stated in the current LMNT scope of practice and regulations. As Senator, as Senator Hansen said, this fall, the Department of Health and Human Services proposed regulatory changes, in which a line was added stating that dietitians, or LMNTs, can order diets with the approval of a physician. This new word is problematic because it changes how we, as LMNTs, currently practice, and it restricts LMNTs from practicing at the highest level within our scope. Currently, in Nebraska law, we are allowed to practice under the consultation of a physician. Consultation is then defined in the LMNT Practice Act and in current regulations as conferring with a physician regarding the activities of the licensed medical nutrition therapist. When new regulations were proposed by DHHS to add a line stating that diets are to be written with the approval of a physician, this alarmed me personally because I knew many of my colleagues would soon be practicing out of their scope or in violation of their licenses without making any actual changes to the way that they practiced. This one new phrase that was added to the LMNT regulations creates a new and unnecessary layer to the nutrition care process, and slows patient care. We have presented our strong opposition to the rule changes to DHHS at their regulation hearings and beyond. And we believe they understand that this change is quite substantive and what's not appropriately included in the word-striking exercise that took place this summer and fall. However, as you heard from Senator Hansen, as of today, no changes have been made to our proposed regulations, and we believe this change rises to the level of a statutory solution. We appreciate your time and consideration on this issue, and I'm happy to answer any questions. I am especially equipped to answer questions regarding LMNT scope of practice, types of licensees who will be impacted, and any other questions you have in regard to LMNTs and nutrition as a healthcare profession.

HOWARD: Thank you. Senator Arch.

ARCH: Thank you. Thank you for coming today. I, I do have some questions. So my-- is it my understanding that there are times when you will fulfill a physician order?

LISA GRAFF: Absolutely.

ARCH: So no salt diet, no-- I mean, there, there's, there are those things that happen in hospitals where, where--

LISA GRAFF: Yes,--

ARCH: --a physician orders--

LISA GRAFF: --especially, especially in a hospital scenario where there are physicians on site. Where, where I see this most impacting LMNTs is those who practice in outpatient or private practice or in our more rural long-term care facilities, where they're not having that daily interaction with a physician to approve diet orders.

ARCH: So by inserting the word "approval" into regs, it, it's not requiring a supervisory agreement either, then.

LISA GRAFF: It's unclear.

ARCH: OK. Well that-- yeah, that would be unclear.

LISA GRAFF: Um-hum.

ARCH: I, I, I would agree with you. So there are times that you would, in consultation with a patient, do a-- in consultation with a patient and apparently in consultation with a physician, as well-- I don't know if you use the word prescribe-- but you would, you would, you would recommend a particular diet for the patient.

LISA GRAFF: Yeah. May I give an example? I worked in outpatient for about five years and I would-- the facility I worked for would not bill insurance, so I did not have to have like a faxed order or any of those things. I worked closely with a rheumatologist who would refer her patients to me, saying: I would like you to talk to them about inflammation. Well, you know, there's not really an anti-inflammatory diet, but she would send them to me. I would see them, talk to them, you know, based on their medical history about what I thought was appropriate and will be most impactful to them. And so that was in consultation with,--

ARCH: OK.

LISA GRAFF: --but she wasn't--:you know, I wasn't calling her and saying, is it okay if I talk to them about a low carb diet, you know. So there was no approval--

ARCH: Oh, OK.

LISA GRAFF: --in that scenario.

ARCH: All right. Thank you.

LISA GRAFF: Sure.

HOWARD: Senator Walz.

WALZ: Thank you. I was just curious, are-- is there any data or any reasons that backs up the need for the change? Like--

LISA GRAFF: Actually, CMS-- so Centers for Medicare and Medicaid Services authorizes dietitians, so registered dietitians, to write diet orders in any facility that takes or, you know, that abides by the CMS regulations. So the short answer is no. Every individual facility, like hospitals, write their own rules within their facility, whether or not they approve that. And you know, if you're in private practice, you are your own supervisor.

WALZ: All right. Thank you.

LISA GRAFF: Um-hum.

HOWARD: Senator Cavanaugh.

CAVANAUGH: Thank you for serving here today. So without the regs change, if I wanted to see an LMNT, I could just call someone who has a private practice. I wouldn't have to have a doctor refer it

LISA GRAFF: Correct.

CAVANAUGH: With this change, I-- a doctor would have to be involved?

LISA GRAFF: With this change-- my understanding of this change is, if you called me to come for some nutrition counseling, I would then need to reach out to your physician, probably, and see why you needed to come and what they thought I needed to talk to you about. And if you're a generally healthy individual, you know, they might not have a lot to say about that.

CAVANAUGH: And then, if you were to present me with a diet, would they have to approve that before you presented it to me?

LISA GRAFF: Like similar to what Senator Arch asked, it's unclear, but to be, to be on the safe side, I would say, probably, yes. So we're not. I mean, no one wants to violate their licensure.

CAVANAUGH: Right. Thank you.

LISA GRAFF: Yes.

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

LISA GRAFF: Thank you.

HOWARD: Our next proponent testifier for LB1044?

DAVID SLATTERY: Good afternoon, Chairman Howard, members of the Health and Human Services Committee. My name is David Slattery, S like in Sam-l-a-t-t-e-r-y, and I'm director of advocacy for the Nebraska Hospital Association. And I'm here to testify in support of LB1044, on behalf of the NHA. We would like to thank Senator Hansen for introducing this bill. The Nebraska Hospital Association has long been focused on promoting access to high quality healthcare. One of the ways we do that is by ensuring that healthcare professionals are practicing at the highest level of their training and experience. In some instances, we are coming before this committee to talk about possible expansion of scope of practice for some healthcare professionals. But today we are here requesting legislation be passed that will maintain the status quo and allow licensed medical nutrition therapists, LMNTs, to continue practicing in collaboration with physicians, as they presently do. This past October, Nebraska's-- Nebraska hospitals testified in opposition to the department's proposed rule change that would add new language requiring physician approval of therapeutic diet orders. This could potentially cause unnecessary delays in patient care. We are still unsure of the basis for the proposed rule change, and appreciate that this bill would stop that problematic provision from going into effect. Under our current law, the regulation LMNTs may prescribe a diet in collaboration with a physician. This, this is working well in a hospital setting, and we ask that this bill be advanced so that that can continue. Thank you for your consideration.

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

DAVID SLATTERY: Thank you.

HOWARD: --for your testimony today. Our next proponent testifier for LB1044? Seeing none, is there anyone wishing to testify in opposition? Seeing none-- seeing none, is there anyone wishing to testify in a

neutral capacity? Seeing none, Senator Hansen, you're welcome to close. While he's coming up, there are some letters in support, proponent letters: Paula Ritter-Gooder, representing herself; Christopher Young, Midwest Covenant Home; Heidi Wietjes, representing herself; Emily Estes, representing herself; Andrea Laughlin, representing herself; Amy Harshman, representing herself; Jessica Wegener, representing herself. No letters in opposition, no neutral letters. Welcome back, Senator Hansen.

B. HANSEN: Thank you. Just want to run through a couple of questions that some of the committee members had that, I think, were already answered, I think, by Mrs. Graff. But one of the ones-- I think Senator Arch asked-- was, does approval mean that you then have to get almost like a prescriptive reason for, you know, providing diet consultation? And just like she said, it seems like it is unclear, like they-- it seemed like they didn't, they didn't know, when I was talking to the people involved with LMNTs; it was a little unclear. And just like she said, you'd rather be safe than sorry, and not want to violate your, your licensure. And so they would almost have to get, get approval, almost a prescriptive approval, which then totally goes against what they've been doing before. And it seems like a huge extra hurdle to try to provide diet consultation to, especially those in rural areas and long-term healthcare facilities. Senator Walz asked, you know, is, is there like-- that was one of the questions I had, is-- why are we doing this? It seems like that's a huge unknown, as well. So it seems like there's a lot of unknowns. There's like there's no-- nobody can really figure out why the reason for this was. And so sometimes it's best just to kind of go back to the way they've been doing before, which seems the most reasonable approach to me, to make sure we're providing adequate healthcare and advice to those, not just in urban areas, but in rural areas, as well. So if I could at least try to shed some light on some of those questions. With that, I will take any questions if you guys have any.

HOWARD: Are there any other questions for Senator Hansen? All right. Seeing none,--

B. HANSEN: Thank you very much.

HOWARD: Thank you, Senator Hansen. This will close the hearing for LB1044, and we will open the hearing for LB838, Senator Arch's bill to provide an exemption from licensure, under the Medicine and Surgery Practice Act. 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 am here this afternoon to introduce LB838, and this is my last bill for the year. I brought this bill at the request of the Nebraska Medical Association. Its intent is to clarify that a physician can, in these very important words: assign tasks to an uncredentialed person as long as those tasks are appropriate to the skill and training of that person. I'm offering an amendment to address concerns raised by the Nebraska Nurses Association, which provides further clarification that those tasks are limited to the routine care, activities, and procedures that are part of that person's routine function. I'm aware there is some history associated with this bill. The issue began when the licensure division at DHHS took the formal position that only registered nurses could delegate tasks to uncredentialed healthcare staff. The problem revolves around the term "delegate" and what that word means with respect to the healthcare industry. Currently, the term "delegate" lies exclusively within the Nurse Practice Act, and it means to actually transfer the authority and responsibility of nursing duties to another individual. This has led to confusion among physicians, and concern that having uncredentialed persons on their staff could increase liability. So if it's only in the nurse, if it's only in that nurse section, then the physician assigning, as well, is problematic. The National Council of State Boards of Nursing did issue guidelines for nursing delegation, which speaks to the difference between the terms "assignment" and "delegation." And it was based on those guidelines that this bill was drafted. LB838 purposely uses the term "assign" as opposed to "delegate" and, with the amendment, defines what assignment of tasks means, which is routine functions. So again, LB838 clarifies that a physician can assign routine tasks to an uncredentialed person, not delegate nursing interventions. I'm going to be very brief, stop here to let other testifiers go into more details about the necessity of this bill. But I think it does clear up any underlying confusion, with respect to the assignment of tasks to uncredentialed individuals. I do want to thank the groups that have been involved with this bill for being proactive and working together to find a solution. And I encourage the committee to advance LB838 to General File to clear up some confusion. I'd be happy to answer any questions, if you have any.

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

ARCH: I will.

HOWARD: Thank you. Our first proponent testifier for LB838? Good afternoon.

MICHAEL ISRAEL: Good afternoon, Chairman Howard and members of the Health and Human Services Committee. My name is Dr. Michael Israel, M-i-c-h-a-e-l I-s-r-a-e-l, testifying in support of Senator Arch's LB838, on behalf of the Nebraska Medical Association. I received my medical degree from the University of Missouri-Kansas City School of Medicine in 2011, and then went into Family Medicine Residency Program here at Lincoln-- Lincoln Medical Education Partnership-- graduating in 2014. After residency, I started working with Bluestem Health, a federally qualified health center in Lincoln, formerly People's Health Center, as a family practice physician, and then in 2018, was promoted to the chief medical officer. Bluestem Health served more than 19,000 unduplicated patients in 2019, and employs approximately 19 medical assistants across our clinics. Our medical assistants are important members of our integrated health teams, providing daily support to patients on behalf of their physician, nurse practitioner, and physician assistant. The medical assistants get weight and height while rooming the patient, take vitals-- like blood pressure, pulse, temp-- and obtain information from the patient for that visit. LB838 provides much needed clarification in statute for physician groups and health clinics across the state who employ uncredentialed staff members as part of their team. Physicians, as the leader of the healthcare delivery team, undoubtedly should have the authority to assign tasks to members of their team, so long as those tasks are within the person's routine functions and are appropriate to their skills and training. It is the physician's responsibility to ensure office protocols are in place for establishing guardrails and limitations for uncredentialed staff members. This protects patient safety by limiting the tasks these persons are able to complete in a clinic setting, and keeps these persons from performing tasks that a license is required for. It is also best practice for a physician to establish competency checks for their uncredentialed staff members on the task they are routinely assigned. This, again, helps to provide oversight for the sake of patient safety by ensuring uncredentialed staff members are properly trained in the performance of these routine functions. The tasks in a physician or clinic office that staff members are able to complete can vary widely, and are the tasks that make clinics run more efficiently, for both support staff, as well as the patient. For example, administrative tasks typically include

greeting and rooming patients, maintaining patient records, and providing patients with general appointment instructions, including arranging for hospital admissions. Whereas tasks to support the physician or other providers include entering patient intake data, entering scribing information into the medical record that either the provider or the patient provide during the visit. These staff members also assist in transcribing exact prescriber instructions into the electronic medical record, providing patients and caregivers with preprinted instructions from the provider, and setup, removal, and cleaning of instruments for clinical procedures or lab work. In essence, these staff members play a vital role in the operation of a clinic setting. Medical assistants are critical to the operations of the federally qualified health centers, and it is important to maintain their ability to work with physicians and perform assigned tasks to keep the clinics open to serve the patients. Without the clarification that LB838 provides, ambiguity will remain in the state over a physician's authority and ability to efficiently run their offices and provide the best possible care for their patients. As Senator Arch mentioned, the current view from DHHS is that physicians do not have this ability to manage members of their staff. Physicians are typically very-- are risk-adverse individuals. It is important for them to clearly know that they, as well as their clinics, are in compliance with Nebraska law. For these reasons, the Nebraska Medical Association requests the committee's support of LB838, and urges its passage this year, to remove the uncertainty for our member physicians. Thank you.

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

WILLIAMS: Thank you, Chairwoman Howard. And thank you, Doctor, for being here. You used the term "skills and training" in judging when you're delegating authority-- if that's the right term-- to a medical assistant

MICHAEL ISRAEL: Assign them.

WILLIAMS: How, how, how do you monitor what those skills are and how do you ensure that there's training?

MICHAEL ISRAEL: As we mentioned, with the competency tasks that we need to-- we have to set up our protocols to make sure that they are competent in what we are assigning them to do. So it is part of the physician's responsibility to be able to do that.

WILLIAMS: So you actually set up-- you used the term "competency tests," also. Do you do that now?

MICHAEL ISRAEL: We currently have protocols in place where we audit, on a regular basis, what is going on with-- or how the things that we have assigned to our medical assistance.

WILLIAMS: So if you have a medical assistant and one of their jobs is to be sure that the instruments are sterilized correctly-- I think you used that in your example--

MICHAEL ISRAEL: Yes, sir.

ARCH: You have competent, a competency test to be sure that they know how to do that?

MICHAEL ISRAEL: There is a training, and then we make sure that they do-- they are able to do that prior to being able to do it on their own. And then we audit it very, very periodically.

WILLIAMS: Thank you.

HOWARD: Other questions? Can you give me an idea of some of the tasks, because it sounds like some of these are administrative and then some of them are medical? So can you sort of walk me through the difference-- or maybe some of the different tasks and give me examples?

MICHAEL ISRAEL: Sure. So the medical assistant will room our patients for us. They'll take their vitals. They'll enter it into the electronic record. They will then notify us of what the patient said, stated, so that we can be prepared when we go into the room, and then that helps kind of give us an idea for-- that, that's crucial for me. When I go into an exam room, if I don't know what I'm seeing a patient for, you know, it can be very open-ended. It can-- which is OK, but you want to know, OK, they're here for this. So that way it gives me an opportunity to review previous charts for that specific example. So it saves time, so I'm not in the room flustered, looking through everything, trying to figure out, OK, this, this, this. So I have a clearer presentation to the patient. So they take the vitals, they do that. Again, they sterilize equipment when tasked to do so.

HOWARD: Are-- and medical assistants-- so really, when you think about this, this is just about medical assistants? Or, or--

MICHAEL ISRAEL: Yes.

HOWARD: --for your administrative staff and medical assistants?

MICHAEL ISRAEL: Yes.

HOWARD: All right. OK. And all of these people are protected under HIPAA already? Like they're part of--

MICHAEL ISRAEL: I, I would believe so, yes.

HOWARD: They have to follow HIPAA?

MICHAEL ISRAEL: I'll have to-- I'll let-- I'll have to clarify, but I believe-- yeah. Oh, absolutely. No, I don't have to, I know that, yes. I'm sorry. I'm so nervous, guys. I apologize [LAUGHTER].

WILLIAMS: You know what we feel like when we come to the doctor [LAUGHTER].

MICHAEL ISRAEL: Yeah. They--

HOWARD: You're doing great.

MICHAEL ISRAEL: Yes, of course, we have to be HIPAA compliant, absolutely.

HOWARD: OK. Nope, you're doing great. I think I just, I just want to make sure that, for me, I understand what the sort of unlicensed individuals would be doing, but in--

MICHAEL ISRAEL: Um-hum.

HOWARD: --sort of in your view. And so those are the questions that I'm asking. So are there any other questions for Dr. Israel? All right. Seeing none, thank you for visiting with us today.

MICHAEL ISRAEL: Thank you.

HOWARD: Good afternoon.

RITA WEBER: Hi. Senator Howard, members of the Health and Human Services Committee, I'm going to read from script. If I go off script, I could be 10 minutes. My name is Rita Weber, R-i-t-a W-e-b-e-r, and I'm speaking on behalf of the Nebraska Nurses Association today, in support of LB838. Nebraska Nurses Association is the voice of

registered nurses in Nebraska, and patient safety and improved health is a priority for our association. NNA seeks to support the delivery of safe, cost-effective care for Nebraskans in all settings. NNA is aware of the critical nature of the shortage of licensed nurses in some areas in Nebraska, and the increased utilization of unlicensed personnel to meet patient needs. NNA supports the appropriate assignment and direction of routine care activities and tasks. Those tasks would be ones that are part of a routine function of an unlicensed assistive personnel. There are noncomplex tasks that do not require the unlicensed person to exercise independent judgment. They utilize a standard and unchanging procedure. The outcomes are predictable and pose minimal potential risk. These criteria actually were taken from Nebraska Administrative Code, Section 172, Chapter 29-005, use of unlicensed personnel by chiropractic physicians. When I started looking into this, and our legislative committee was looking into this, I did a search of some of the Nebraska administrative codes to see if we actually had some clear definitions out there, in, in code, of how we use unlicensed assistive personnel. And I included a copy of that administrative code as a handout for all of you. And I found this wonderful one right in our own Nebraska Administrative Code. So I thought, well, it's a good place to start. We recommend using the verbiage in this section and developing rules and regulations for implementation of this statute, if LB838 passes; and you have a copy of that. NNA sees that assignment and direction in this way can help physicians provide care for the basic functions, in a safe way. We're comfortable that this statute will not give authority for anyone to practice a profession that they're not licensed to practice, at the direction of a physician. It doesn't give authority for others to practice nursing that are not lawfully authorized to practice nursing, without appropriate licensure, or to misconstrue to the public that there's a nurse present if, in fact, there is not. The Nurse Practice Act protects the title "nurse" by law. NNA would like to see the rules and regulations for this statute clearly establish the responsibility for training, competency assessment, supervision, and evaluation of outcomes rests with the assigning physician. Physicians and employers should have to maintain records of those competencies for unlicensed staff in the proposed assignment model. With the shortage of nurses and other licensed and even unlicensed personnel in our state, this seems to be an appropriate time for medicine to clearly define the nature of their practice relationship with unlicensed assistive personnel. With well over 30,000 licensed nurses in Nebraska, the Nebraska Nurses Association is eager to participate in shaping the activities that

best utilize the skills of all providers in meeting the healthcare needs of Nebraskans. Thank you.

HOWARD: Thank you. Are there questions?

RITA WEBER: Thank you.

HOWARD: Ms. Weber, just so I'm clear-- I, I'm looking at the administrative code that you shared with us, and I was looking at 29-005.01E on the first page. And so that one says that a chiropractor-- which we've got one here just in case we have questions specific to that--

RITA WEBER: I knew that.

HOWARD: --may assign or direct unlicensed persons to perform selective tasks or treatments that reoccur frequently, do not require independent judgment, do not require the performance of a complex task, the results of the tasks are predictable and potential risk is minimal, minimal, and utilize standard and unchanging procedure.

RITA WEBER: Um-hum.

HOWARD: This is very clear to me.

RITA WEBER: Yes.

HOWARD: When you read LB838, do you feel that there's-- that a similar amount of clarity in the language in the bill, versus what's in this administrative code?

RITA WEBER: My understanding is that, when you pass a bill and, and that brief comment would go into the uniform credentialing clauses in statute, that there would have to be, then, an administrative code that would be the rules and regulations to implement it. So my hope was that, if the bill passes, so that that one paragraph would then go under the uniform credentialing statute, that this language would then be put in an administrative code to better help define it,

HOWARD: Oh, OK.

RITA WEBER: So, so, so I don't-- so it, it's a guessing game, you know, it's a gamble that says if we put that in statute, will it be

clarified to this extent in the administrative code? We don't know, but we're recommending it and hope that it would be.

HOWARD: OK. Thank you. All right. Other questions?

RITA WEBER: But we do have a good example of how, what it could read like, that you wouldn't have to start from scratch,--

HOWARD: Absolutely.

RITA WEBER: --because chiropractors have already done this work [LAUGHTER]. That's right. And they're some of my favorite healthcare professionals anyway, so--

HOWARD: With that, you're just buttering us up right now.

RITA WEBER: --[INAUDIBLE] didn't work for us.

HOWARD: All right.

B. HANSEN: Does my vote kind of break this up?

RITA WEBER: There you go. See?

HOWARD: OK.

RITA WEBER: Thank you.

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

RITA WEBER: Thank you.

HOWARD: --visiting with us today. All right. Our next proponent testifier for LB838? Good afternoon.

ABBIE FOUGERON: Good afternoon. My name is Abbie Fougeron, A-b-b-i-e F-o-u-g-e-r-o-n. I'm here on behalf of the NMA, in support of LB838. I'm the administrator for Nebraska Pulmonary Specialties, LLC. I have been in the administrator role with Nebraska Pulmonary Specialties for nearly 10 years. Prior to that, I worked in administration at Memorial Sloan Kettering Cancer Center, Center in New York City for five years, overseeing operations and practice workflows for over 10 different oncology specialties. As an administrator, I establish job descriptions, assist with recruiting, hiring, training, evaluate and monitor competencies, provide annual employee performance appraisals, and ensure compliance within the organization. Compliance management

includes adherence to and training of all staff in OSHA regulations, HIPAA, and mitigation of risk and malpractice, ensuring that the practice is operating within legal and appropriate clinical boundaries. In early 2012, Nebraska Pulmonary Specialties had 34 total employees, 5 of which were LPNs, and 4 medical assistants to serve 8 physicians and 3 midlevel providers in Lincoln. Today we have 8 LPNs, licensed practical nurses, and 12 medical assistants to serve 13 physicians and 12 midlevel providers in Lincoln and in Omaha. My LPNs can delegate tasks to the MAs or assign tasks to the MAs, but our physicians are not allowed to assign any tasks to the MAs. We've had ads open for available medical assistant and/or LPN positions in our office for over 18 months straight, and are in a state of continuous recruitment, as it seems we are also in a state of continuous growth and expansion. We utilize medical assistants in multiple areas, including the clinical medical records and scheduling departments. The bulk of our medical assistants are hired into the clinical department areas. The medical assistants' daily functions include: rooming patients for visits, discharging patients, helping the clinical team to schedule procedures at facilities. Medical assistants clean and stock exam rooms, ensuring they are ready for the next patient visit. The medical assistants organize our medical supply closet, unpack sample inhalers, arranging them in the medication room in advance of the clinic day. Medical assistants gather patient vitals and gather patient history. The medical assistants help the scheduled team-- scheduling team to work in add-on patient visits or urgent patients to the physician in midlevel clinic schedules. At the end of the patient visits, the medical assistants schedule procedures at the hospital facilities, including bronchoscopies, blood draws, or sleep studies. They send referral orders to the appropriate places, facilities or other physician offices. During the clinic visits, medical assistants will assist patients in our office in walking oximetry. This includes walking next to the patient to avoid falls, ensuring that the oxygen tank-- if one is being used-- remains connected and functioning throughout the test, and then the medical assistants will communicate to the providers, once the test is complete. The providers will review the information recorded from the test, and then the provider will assess the patient for their treatment-- advise for their treatment from there. Medic, medical assistants also help the clinical team prepare for clinic by reviewing the charts, obtaining the correct medical record information, and inserting it to our EHR in the appropriate place. Medical assistants return patient calls about appointment questions or upcoming, upcoming test questions, escalating to the physician and midlevel providers, as needed, for evaluation or

for any treatment decision questions. Medical assistants do not make any treatment recommendations to patients. Medical assistants submit prior authorizations, requests for various medications, procedures, diagnostic tests, and sleep studies. The medical assistants use completed encounter notes from providers in order to complete those authorization tasks. Note: The medical assistants are unlicensed. They cannot perform tasks beyond their training. Diagnosing would be under the practice of medicine and inappropriate for an LPN, let alone an MA, to do. In our office, medical assistants will receive organizational and job-specific training upon hire. Each medical assistant will undergo overall office orientation, observing in each department within the office. Then the medical assistant is assigned to a clinical team pod. The pod consists of LPNs, physicians, midlevel providers. The MA will take direction, guidance, and training from the LPNs directly. Once trained, the medical assistant, like the other staff, are autonomous within the bounds of their role. They follow a certain set of daily and weekly tasks. During the clinic, they will pay attention to their pod schedule and assist the LPNs with the tasks mentioned above. Without medical assistants, our office could not function at its current level or volume. We would have to reduce the number of available appointments offered as we would not be able to support the clinic throughput. As a result of lowered outpatient clinic volumes, we'd likely need to reduce the number of physicians. The ripple effect on this is massive. In addition to pulmonary and sleep medicine, our physicians are also critical care board-certified and currently contracted to oversee the intensive care units at all acute care facilities in Lincoln, Nebraska. If we were forced to reduce the physician levels as a result of a constricted outpatient practice, our abilities to support the ICU units would appropriately diminish, negatively impacting care and level of quality at the facilities here in Lincoln. For all these reasons stated, I strongly encourage the committee to vote in favor of this bill, LB838. Thank you. I'm open to any questions.

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

WILLIAMS: Thank you, Chairwoman Howard. And thank you for being here. So if I'm understanding this correctly, under your current practice and other people's practice, an LPN could actually assign tasks to a medical assistant.

ABBIE FOUGERON: It's not-- they just take-- the medical assistants take direction from the LPNs. The LPNs are the one getting dele-- being delegated from the other providers.

WILLIAMS: Can you help me understand the difference between--

ABBIE FOUGERON: Um-hum.

WILLIAMS: --assigning tasks and taking direction?

ABBIE FOUGERON: I think those verbs are probably-- or those actions are quite similar, but I do know that the medical assistant's scope does not include, as the level or degree of the nursing practice. And so--

WILLIAMS: Right.

ABBIE FOUGERON: --the medical assistant's is a little bit more administrative in nature. It does not follow the same guidelines.

WILLIAMS: I understand.

ABBIE FOUGERON: Yeah.

WILLIAMS: It's all within their skill and--

ABBIE FOUGERON: Right. Right.

WILLIAMS: --training, and whatever that is.

ABBIE FOUGERON: Um-hum.

WILLIAMS: The second piece, then, is that the the practitioner there, though,--

ABBIE FOUGERON: Right.

WILLIAMS: --can't give that--

ABBIE FOUGERON: Correct.

WILLIAMS: --same direction.

ABBIE FOUGERON: Um-hum.

WILLIAMS: Can you give me an example or two of when a physician might want to give instruction?

ABBIE FOUGERON: For example, in our clinic right now, we've been able to successfully recruit more medical assistants than LPNs. In that sense, if a physician comes out of a room and says, I need this person to have a walking test or I need, you know, this patient to be set up for a test on such and such a day at whatever facility, the physician would then have to wait for an LPN to become available, to delegate that information or to assign that information to an LPN, who then would instruct the MA on what to do. It creates--

WILLIAMS: Instead of going straight to the--

ABBIE FOUGERON: Correct.

WILLIAMS: --medical assistant with that.

ABBIE FOUGERON: --creates inefficiencies. Um-hum.

WILLIAMS: Can you think of any-- what is the rationale behind that current rule? Hard to think of that.

ABBIE FOUGERON: It's, it's very difficult, yeah. It's--

WILLIAMS: Thank you.

ABBIE FOUGERON: Um-hum. You're welcome.

HOWARD: Other questions? And you may not know this. I don't know this.

ABBIE FOUGERON: Um-hum.

HOWARD: Medical assistants, they're defined in statute already?

ABBIE FOUGERON: I don't believe so. They're unlicensed and so they're not. It would be in any unlicensed professional.

HOWARD: OK. And your, your thoughts on LB838 is that it's just about medical assistants? Or is it more than that?

ABBIE FOUGERON: I think it could probably be applied to more than that for our practice or a lot of private practices that operate similar to ours. And the biggest key issue right now, in terms of operations, is medical assistants.

HOWARD: When we say more than that, who would that be?

ABBIE FOUGERON: I think-- honestly, I don't know. I would need to ask for a better opinion from a practice administrator. I don't know if they offer unlicensed personnel in other surgical practices or something like that, to that nature. But I'm not-- I probably can't speak to that one very well,

HOWARD: Thank you.

ABBIE FOUGERON: You're welcome.

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

ABBIE FOUGERON: Thank you.

HOWARD: Our next proponent testifier for LB838? Seeing none, is there anyone wishing to testify in opposition? Seeing none, is there anyone wishing to testify in a neutral capacity? All right. Seeing none, Senator Arch, you are welcome to close. While he's coming up, there are three letters in support: Andy Hale and David Slattery, from the Nebraska Hospital Association; Nicole Fox, from the Platte Institute; Donald Balasa, the American Association of Medical Assistants. No letters in opposition, no neutral letters.

ARCH: Thank you. I, I think what you've seen here today is, is a request from physicians and nurses for our assistance in clarifying some language so that they know clearly what they, what they can and cannot do. And I think that's a, that's a bit unclear right now in our, in our statutes. There is a, there was-- Dr. Israel actually mentioned one thing when he, when he was testifying that, that jogged my memory, and that, that has to do with a CMS regulation. The, the introduction of electronic medical records in a lot of offices, put physicians in a difficult position where, where they were either going to slow down their practice by inputting all of this data on their own, or they were going to have to employ a scribe. And CMS made it very clear that, that if you employ a scribe, this cannot be a clinician, cannot be an RN, cannot be a licensed professional that would, that would sit in the room at a laptop and input data as the physician dictated to the-- or the practitioner, the independent practitioner would dictate to the scribe. That, that is because the CMS made it very clear, we do not want anyone sitting there at that computer inputting that, exercising independent clinical judgment.

That's the role of the physician or that independent practitioner, so cannot be licensed, cannot be a, cannot be a clinician. So here we have a physician assigning a task to a nonclinician sitting in the office, and the task being: Input this data according to my, according to my direction. And I, and I see this is very similar to what we're, what we're talking about with MAs, with medical assistants. How can we clarify our language, And the physicians, the nurses spent a lot of time working through language that they found acceptable, that avoided that delegation and moved to assignment, and came to some language that they think would clarify, both for themselves as well as for the department, when it came to the enforcement of this. So with that, I will, I would close. I would encourage you to take a serious look at LB838. And I would be happy to answer any questions you might have.

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

WILLIAMS: Thank you, Senator Howard. And thank you again, Senator Arch. There's been a consistent line of questioning today about, is this just talking about medical assistants.

ARCH: Right.

WILLIAMS: And as I sit back and think about who all is in that doctor's office and around there, you've got other people besides the providers, the nurses and medical assistants.

ARCH: Um-hum.

WILLIAMS: And are we thinking about those other people, the cleaning staff that comes in, maybe later in the day or at night, those kind of people? Would they be covered by this also? Or the better question is, should they be covered by this?

ARCH: I'm, I am unclear on that. I, I, I want to research that before I respond to that. I think that the intention is that we're talking about people involved with a patient in some, in some fashion-- rooming a patient, you know,--

WILLIAMS: But those other people that are there--

ARCH: --that, that type of thing.

WILLIAMS: --are also unlicensed--

ARCH: They are.

WILLIAMS: --employees, and [INAUDIBLE].

ARCH: Absolutely. And I did mention, and I did mention another one, the scribe that could be in the room with the electronic--

WILLIAMS: Yeah.

ARCH: medical record, as well.

WILLIAMS: OK. Thank you.

HOWARD: And I, I actually have a very similar sort of line of questioning because, if this is about medical assistants, why not just say it's about medical assistants and really clarify that?

ARCH: Um-hum.

HOWARD: Or if it's about medical assistants and the people who are working the front desk and managing the billing or something like that? But do you know? So we sort of heard that physicians can't assign tasks to a medical assistant. But then is it your understanding that they're not able to assign tasks to anyone else in the clinical setting, whether that's a front desk person, an electronic health records, a billing manager, a janitor? They're not able to assign tasks to any of them?

ARCH: Yeah, OK. So again, again, it's-- are you talking about in a, in a clinical situation, or are you, are you saying, please pick up the trash?

HOWARD: Well, I think that's what I'm struggling with. So we heard some testimony that says they can't assign to anyone. And, and that doesn't seem accurate.

ARCH: Um-hum.

HOWARD: Right? I'm certain they can.

ARCH: Right.

HOWARD: But, but I just don't understand.

ARCH: Well--

HOWARD: It sounds like medical assistants they can't assign to, but they can assign to a front desk worker. That's-- I think that's what I'm struggling with.

ARCH: And I think, and I think we can even clarify that further, that we can make, make sure that we're-- I mean, again, the effort here is to get clarifying language, so maybe we need to sharpen it one more step and make sure that we have exactly what, what we need to say.

HOWARD: Yeah, I absolutely agree with you--

ARCH: Yeah.

HOWARD: --because I think the word "persons" is very broad,--

ARCH: Yeah.

HOWARD: --and that it's anybody.

ARCH: Yeah.

HOWARD: OK. All right. Any final questions for Senator Arch?

ARCH: I, I-- in response, again, to that last question, if I might, you know, the, the, this is, this is something that has just kind of percolated for a while, this language. And how do we say it and how best? And we've probably taken it further in this step, with the nurses and the physicians getting together and coming to an agreement. And if, in an amendment we can make that even sharper, we would certainly, we would certainly want to do that, because it's one of those things that we need to provide some direction. So thank you.

HOWARD: Absolutely. All right. Seeing no other questions, thank you, Senator Arch. This will close the hearing for LB838, and the committee will take a brief, five-minute break.

[BREAK]

HOWARD: [RECORDER MALFUNCTION]--but if you have any outside conversations that you take them outside. All right. And this will open the hearing for LB1182, Senator Wayne's bill to provide for notice of new drug or biologics license applications and for a study of drug costs. Welcome, Senator Wayne.

WAYNE: Good afternoon, Chairwoman Hunt and members of the Health and Human Service--

HOWARD: Hunt?

WAYNE: Hunt-- Howard [LAUGHTER].

HOWARD: Whoa.

WAYNE: I--

CAVANAUGH: Wow.

WILLIAMS: Off to a good start.

WAYNE: I was-- who'd I, who'd I confuse you with last time? Ah, OK. Well--

HOWARD: That's all right. Crawford. You confused me with--

WAYNE: Used Crawford, yes.

HOWARD: Crawford, yeah.

WAYNE: I waive my opening [LAUGHTER]. Well, we will shorten this up quite a bit now. Justin Wayne, J-u-s-t-i-n W-a-y-n-e, and I am sorry, Chairwoman Howard. LB1182 actually is a growing trend across the state. And for me, how I came to it is very simple. This year, for my diabetes medicine, they-- my insurance said I can go to a three-month cycle only through direct mail, or I can go to Wal, Walgreens and only do a month for this price, and if I go somewhere else, I can get another price. And then I got on GoodRx to try to figure out what was the better price. And I just thought we should have some transparency in prescriptions and, and figure out why is there so many different prices. From that, we started doing research, and we started looking at the rising healthcare costs across the country, particularly around prescriptions. And we came to a bill in Connecticut that was passed, a prescription drug transparency bill, and that's basically the genesis of this bill. I'm going to apologize to Jake ahead of time. He wrote out a great opening, but I recognize this is later in the session, and I have talked to, today, numerous people who were going to testify, hopefully maybe not all testify. Well, we are going to try to get together over the summer and work on it. But this bill basically does three things. It requires manufacturers to report to the Department of Health and Human Services within 60 days after a sponsor of a drug

receives an action date from the Food and Drug Administration. It also requires that March 1, 2021, and annually thereafter, the director of Medicaid and Long-Term Care and the director of Public Health at DHHS prepare a list of the top ten prescription drugs that they determine are critical to public health, and have been subject to questionable price increases, and have become a substantial cost to the state, and have, basically, these drugs come with forms and do some research. And it provides them a way to conduct the study on the impact of future expenditures around the state. What Connecticut has done is, basically, try to create some transparency for the consumer, and we will work with these individuals over the summer to try to come up with some kind of transparency law that, instead of having to get on GoodRx and search everything, and call your insurance company and figure out how to lower your prices, there should be a mechanism, in this day and age, to be able to just log in and figure it out, really, really simply. And so that's what we're trying to do, and we are going to work with the parties to do that. So we'll have the bill back next year.

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

WALZ: Thank you, Chairwoman Howard.

WAYNE: I'm going to be hearing that for the rest of the session.

WALZ: Hey, I'm just curious. So what, what would that look like?

WAYNE: So, so in Connecticut, there's actually a list that the department puts out of trans-- of all their-- not all, but major prescription drugs and prices and their increases and, actually, reasons behind those. So some of the time, the consumer is just left in the dark. And we're trying to, trying to figure it out and try to figure out, maybe, and actually make choices with our doctors on maybe there are some alternatives or some generics. And right now, we're just kind of in the dark. You know, the doctor prescribes something, and we just go to the store. And when they run it, you're like, oh, that's $45. Well, I didn't have that with me; I'll come back tomorrow. I mean-- and so we're trying to figure out how to give that, that transparency. So I don't have a clear picture. There are some issues with the Connecticut law that I think we can address, but we're trying to figure out that piece, what it would look like. For me it would be-- actually it'd be almost like the GoodRx app. But I think it's,

it's a little-- it should be dumbed down a little bit and a little more clear.

WALZ: Um-hum.

WAYNE: And I get that there's insurance companies and contracts and those kind of things. But we have to get a handle, especially around our Medicaid and long-term, these drug costs. And we need to be more transparent to the consumer.

WALZ: Yeah.

HOWARD: Senator Arch.

ARCH: Thank you. So this is not, this is not the question, why are drug prices so high, but rather, it's a question of transparency to the consumer. Am I, am I correct?

WAYNE: It's two parts. The, the second part or the latter part of why-- for the transparency to consumer, yes. But it also gives, I think, this committee, going forward, and the body going forward, some information on why some of these drugs are going up. Typically, we only hear-- like we heard-- this committee heard about insulin, or the Banking Committee heard about insulin. This committee heard about EpiPens. The body doesn't really know why things are happening until a bill is brought forth. And then you have people come in and say: Well, it's the manufacturers or it's the PPMs [PHONETIC]. And what we're trying to do is create some kind of guidance for the committee to make decisions on these drug prices that are going up. Is there something else we can do, alternatively, at the same time, provide some transparency to consumers? But the complexity of it, we just couldn't get it all worked out yet this year.

ARCH: And I would say summer may not be long enough.

WAYNE: Connecticut has a pretty good idea of how, how to do it, at least from the department's perspective, on the question of why prices are going up. It's the consumer piece that may be a little harder. But I think it's a, it's a, it's a growing trend around the country to try to deal with this one Medicaid population, long-term population, and the consumers. I think we can get there, I do. But I'll invite you to those meetings since, since you're interested.

ARCH: Thank you.

HOWARD: Are there questions? All right. Seeing none, will you be staying to close?

WAYNE: It depends on quick testimony. Otherwise, I'll waive.

HOWARD: All right. We'd like to invite our first proponent testifier up for LB1182. Seeing none, is there anyone wishing to testify in opposition?

KATELIN LUCARIELLO: Good afternoon, Chairwoman. Thank you for having me here today. I have seen a couple of your faces twice this week, so it's good to be here again. My name is Katelin Lucariello, K-a-t-e-l-i-n L-u-c-a-r-i-e-l-l-o; it's a long one. I am the director of state policy for the Pharmaceutical Research and Manufacturers of America, or PhRMA, and I'm here today in respectful opposition of LB1182. PhRMA is committed to working with lawmakers, patients, and other healthcare stakeholders to develop use-- legislation that provides useful information about medicine costs that ultimately helps patients make more informed decisions about their care, but also lowers the cost for-- to consumers. We believe that these are also the goals of LB1182, but we disagree on whether the bill accomplishes these goals. I'd like to explain some of our concerns with the bill, and then I'm happy to answer any questions. Our first concern is the lack of confidentiality provisions surrounding the information required to be reported on pipeline drugs. We're in a new era of biopharmaceutical innovation. There's nearly 7,000 medicines in development right now. Seventy-four percent of those are first in class, so that means the first drug that has that mechanism of action. Medicines are being developed for dozens of therapeutic areas, as you can imagine, with 7,000 medicines in development. There's medicines being developed for cancer, for cardiovascular disease, Alzheimer's, Parkinson's, as we speak. While we're excited about these new advancements, we want to ensure that there's sufficient confidentiality perfect-- protections around the reporting of information on pipeline medicines, so that we can also ensure that there's effective market competition for these medicines. Second, by only requiring reporting on drug costs by manufacturers, the bill is ignoring a significant portion of the supply chain that also has a role in prescription drug costs. There's a variety of stakeholders involved in determining what a consumer ultimately pays for a medicine. Insurer's, PBMs, and wholesalers all play, all impact what a patient pays, at the end of the day, at the pharmacy. Over the last decade, stakeholders in the supply chain have become, begun to play an

ever increasing role in the price of prescription drugs. In 2018, nearly half of brand medicine spending was collected by other stakeholders in the supply chain, not by the manufacturers that make that drug. That number is up from 33 percent in just the five years prior. While other stakeholders in the supply chain are consuming a greater piece of the drug spending pie, the amount retained by biopharmaceutical companies has actually remained flat over the past several years and in line with inflation. In Nebraska, Medicaid specifically, retail brand spending as a percent of the Medicaid budget has fallen from 5 percent in 2015 to 4.3 percent in 2018. Those are the most recent numbers that I have available. Our next issue of concern is that, by focusing on drug prices, the bill really ignores the ways that medicines improve lives and ultimately do save the health system money. Prescription medicines have recently transformed the trajectory of many debilitating diseases, including AIDS, cancer, and hepatitis C. On the note of hepatitis C, recent therapeutic advances have led to a cure for that disease and help patients avoid more serious complications like liver cancer, liver failure, and death. In 2022, it's estimated that 330 Medicaid enrollees will have been cured of hepatitis C, and this will lead to a savings to the Medicaid system of $12 billion. Medicines can also reduce the need for expensive healthcare services, as I just alluded to, the emergency room admissions, hospital stays, surgeries, and long-term care. Better use of medicines could eliminate $213 billion in healthcare costs annually, which is 8 percent of the nation's spending. So in closing, if our goal is to provide useful information on drug prices that ultimately lowers the price that patients pay for drugs, we should promote legislation that addresses the misaligned incentives in the supply chain, makes changes to benefit designs that make medicines more affordable for patients. And the bill-- there are bills that are running right now in Nebraska that I believe address some of these issues, LB1196 being one of them, which would provide patients immediate relief from out-of-pocket costs for medicines. For these reasons, I urge you to vote no on LB1182. I do not think it will provide an accurate picture of drug prices for the state or, ultimately, lower prices for consumers. Thank you very much, and I'm happy to take questions.

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

WILLIAMS: Thank you, Chairwoman Howard, and thank you for being here again this week. We continue to look at the same issues.

KATELIN LUCARIELLO: Um-hum.

WILLIAMS: And one of my concerns is that we never address the underlying cost.

KATELIN LUCARIELLO: Um-hum.

WILLIAMS: We're always trying to figure out, sometimes in this committee, but more-- even more often in the committee you testified on, in, earlier this week in Banking and Insurance, of who's going to pay it.

KATELIN LUCARIELLO: Um-hum.

WILLIAMS: Are you and your group willing to sit down with Senator Wayne and others to try to look at, not just the transparency, but so that those of us that are not involved like you are, can understand some of the things: the supply train-- chain that you're talking about and how we-- all the parts of that are moving? Because until I think all the right parties sit around the table together, we're going to still just talk and talk, and not do. So I-- are you willing to work on those kinds of changes for Nebraska?

KATELIN LUCARIELLO: Absolutely. We would love to come to the table to talk about some of the changes that we could make to address misaligned incentives, to promote meaningful transparency across the supply chain, and to, ultimately, make sure that certain things like rebates and help are being passed through to patients to lower costs, and that health insurance design is ultimately helping patients pay for their drugs and not cost shifting onto the patients. We're 100 percent here to be at the table with you.

WILLIAMS: Thank you.

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

KATELIN LUCARIELLO: Thank you very much. Oh, and I'm sorry. I have a handout, if that's OK.

HOWARD: Sure.

KATELIN LUCARIELLO: It's a-- our statement, as well as a visual of the supply chain so that you can see the dynamics that are going on there,

and then the numbers that I talked about on Medicaid spending so that you have them.

HOWARD: Thank you. Just give it to our page.

KATELIN LUCARIELLO: Thank you. Thank you all again.

HOWARD: I would like to invite our next opponent testifier up. Good afternoon.

CARISA SCHWEITZER MASEK: Good afternoon. Good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. My name is Carisa Schweitzer Masek, C-a-r-i-s-a S-c-h-w-e-i-t-z-e-r M-a-s-e-k, and I am deputy director for population health for the Division of Medicaid and Long-Term Care within the Department of Health and Human Services. I'm here to testify in opposition to LB1182, which provides new administrative duties for the duty, for the department surrounding new or otherwise high-cost drugs. The department does not have concerns with certain aspects of the bill. We agree with Senator Wayne that studying drugs, particularly new drugs that will have a significant impact on the department, makes sense. DHHS would likely not face difficulties in meeting the associated reporting requirements of this bill that are associated with looking at the high-cost drugs. However, the department does have concerns regarding our, regarding our ability to comply with the mandates for drug manufacturers and the requirements it places on the state to monitor manufacturer compliance. Though we appreciate the intent of these provisions, the bill lacks an enforcement mechanism, and administrative costs associated with enforcing the provisions will make-- will be much greater than the return. LB1182 requires drug manufacturers to notify the state whenever they manufacture a new drug. Failure to do so will result in a $7,500 penalty per drug for the manufacturer. It would only require a minimal amount of staff time to receive these notifications, but verifying manufacturer failure to notify the state does come with a notable fiscal impact. Charging these companies a penalty comes with noticing and hearing requirements. Ultimately, these penalties are a small amount of money for the state, and an even smaller amount for the drug companies being penalized. It's unlikely this bill would have an effect on their operations. Similarly, it's unclear whether these provisions can be enforced for any drug manufacturer not based in Nebraska. Nebraska Medicaid will still be required to cover any new drugs that are included in the federal drug rebate program, regardless of the bill at hand. In summary, though, we share the bill's goals of keeping drug costs low. This is not the most

effective way to approach this issue. We respectfully oppose this legislation. Thank you for the opportunity to testify today, and I am happy to answer any questions.

HOWARD: Thank you. Are there questions? I, I want to ask--

CARISA SCHWEITZER MASEK: Yeah.

HOWARD: You, you started out by saying they don't have, you don't have a concern in terms, of of looking at the drugs that currently are high-cost--

CARISA SCHWEITZER MASEK: Um-hum.

HOWARD: --drugs to the state. So, so is that something that you'd be willing to report on?

CARISA SCHWEITZER MASEK: I think, as the bill states and as Senator Wayne mentioned, he'd be willing to work with individuals in the department to figure out, this summer, what we can do with this bill to make the most sense for the committee and for the states, we would be happy to hold those conversations.

HOWARD: OK, great. Thank you. All right. Any other questions? All right. Seeing none, thank you for visiting with us today. Our next opponent testifier for LB1182? Seeing none, is there anyone wishing to testify in a neutral capacity? Seeing none, Senator Wayne, welcome back. And we do have some letters-- no letters in support, two letters in opposition: Brett Michelin, the Association for Accessible Medicines; and Rob Owen from Bio Nebraska-- no letters in the neutral capacity.

WAYNE: I will be brief as this is my last bill this year. And being that through my course of four years, I've introduced about 13 percent of our total bills in the body, I have a problem when our department keeps coming in opposing bills, particularly on administrative costs, when they give us a fiscal note to pay for the cost. I'm going to leave it there. I'll answer any questions. I'm showing self-restraint today.

HOWARD: Thank you.

WAYNE: And I'm not mad at anybody; it's just that I've seen it time and time again, and I just don't get it. They give us a fiscal note to pay for it, but they say they're opposed to it. Anyway--

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

CAVANAUGH: Thank you, Chairwoman Howard. Thank you, Senator Wayne, for being here. Very important question. Will Jake be available to, one-on-one, give your opening to us tomorrow on the floor?

WAYNE: Yes. It's very detailed; it's four paragraphs. It's pretty long, single-spaced. It was, it was a really good opening, and I'm, I'm really upset I didn't get to share it with you.

CAVANAUGH: I would like to have it read to me instead of just reading it myself, is what I'm getting at, so--

WAYNE: OK. That's, that's fine.

CAVANAUGH: And you, you waxed on about it, so that-- thank you, Senator Wayne.

WAYNE: Thank you.

HOWARD: All right. Any final questions for Senator Wayne? Seeing none, thank you, Senator Wayne.

WAYNE: Thank you.

HOWARD: This will close the hearing for LB1182 and close our hearings for the day.