HOWARD: [RECORDER MALFUNCTION]-- District in Omaha, and I serve as Chair of this committee, I'd like to invite the members of the committee to introduce themselves, starting on my right with Senator Murman.

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

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

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

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

HOWARD: Also assisting the committee is our legal counsel, T.J. O'Neill, and our committee clerk, Sherry Shaver-- Shaffer. And our committee pages today are Nedhal and Angenita. A few notes about our policies and procedures. Please turn off or silence your cell phones. This afternoon, we'll be hearing four bills and we'll be taking them in a little bit of a different order. We're going to go LB875, LB1065, LB1059, and then LB815 at the end. OK. On each of the tables near the doors to the hearing room, you will find green testifier sheets. If you're planning to testify today, please fill one out and hand it to Sherry when you come up to testify. This will help us keep an accurate record of the hearing. If you are not testifying at the microphone, but want to go on record as having a position on a bill being heard today, there are white sign-in sheets at each entrance where you may leave your name and other pertinent information. Also, I would note, if you are not testifying but have written testimony to submit, the Legislature's policy is that all letters for the record must be received by the committee by 5:00 p.m. on the day prior to the hearing. Any handouts submitted by testifiers will be, will also be included as part of the record, as exhibits. We would ask, if you do have any handouts, that you please bring ten copies and give them to the page. We do use a light system for testifying. Each testifier will have five minutes to testify. When you begin, the light will be green. When the light turns yellow, that means you have one minute left. When the light turns red, it's time to end your testimony, and we'll ask you to wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone. Then

please spell both your first and last names. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters of the bill, then from those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given 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 will begin today's hearing with the gubernatorial appointment of Todd Hovey to the Board of Emergency Medical Services. Mr. Hovey is planning on calling in. So we'll just wait a moment for our technical support. Good afternoon, Mr. Hovey.

TODD HOVEY: Hello.

HOWARD: This is Senator Sara Howard with the Health and Human Services Committee. I'm going to introduce the members of the committee to you so you know who's with us. I've got Senator Dave Murman, Senator Lynne Walz, Senator John Arch, Senator Matt Williams, and Senator Machaela Cavanaugh with us today. We were hoping you could tell us a little bit about yourself and your interest in serving on the Board of Emergency Medical Services.

TODD HOVEY: OK. Well, I grew up in Trenton originally. I was-- became an EMT in 2009, EMS instructor in 2013, and then I got my RN license in 2015. I actually started here at the hospital in McCook in 2008. In 2009, I took over the Life Support Education program. So I teach CPR, advanced cardiac life support. I also bring in classes for nursing and emergency medical services. And then this last year, I took over the clinical educator position, so taking on new hires. I've been active, part of Trenton's ambulance, and I was part of McCook's ambulance and fire for several years. I still do trainings for Trenton, and I teach for the college here in McCook. My passion is, obviously, education, especially for EMS and nursing. I'm excited to be able to possibly be part of this for the fact that I like to stay on top of a lot of protocols and procedures. So--

HOWARD: Oh, that's wonderful. Thank you. Let's see if there are any questions from the committee.

TODD HOVEY: OK.

HOWARD: All right. Well, there are no questions from the committee, but I do have to say McCook has one of my favorite bakeries in the state out at Sehnert's. It's wonderful.

TODD HOVEY: Yeah.

HOWARD: And I'm very jealous that you get to go there whenever you want. Well, we very much appreciate your willingness to serve on the Board of Emergency Medical Services, and we appreciate you taking the time to call us today and speak with us about it.

TODD HOVEY: [INAUDIBLE], thank you.

HOWARD: All right. Thank you, Mr. Hovey. Have a great day.

TODD HOVEY: You, too. Bye.

HOWARD: All right. This will close the hearing for the gubernatorial appointment for Todd Hovey to the Board of Emergency Medical Services, and it will open the hearing for LB875, my bill to require a Medicaid state plan amendment for out, outpatient assisted therapy. And I'll pass it over to Senator Arch.

ARCH: Welcome, Senator Howard. And you may begin your introduction to LB875.

HOWARD: Thank you, Senator Arch. I do have some handouts-- Angenita, thank you-- that describe assisted outpatient therapy. So good afternoon, Senator Arch and members of the Health and Human Services Committee. My name is Senator Sara Howard, H-o-w-a-r-d, and I represent District 9 in midtown Omaha. Today I'm bringing before you LB875, a bill that would require the Department of Health and Human Services to cover assisted outpatient therapy, or AOT. As a note, when drafting this bill, we came across both the term "assisted outpatient therapy" and "outpatient assisted therapy," and the correct term is "assisted outpatient therapy," or AOT. And so the green copy of the bill will need to be amended to reflect that. I brought this bill on behalf of one of my constituents who you'll hear from today, Tim Heller, who is here to testify. Late last year I had an interim study on mental and behavioral health needs in the state of Nebraska. And this bill is what I decided to bring forward, as a result of that study. Assisted outpatient treatment, or AOT, is court-supervised treatment within the community. To be a candidate for AOT, a person must meet specific criteria, such as a prior history of repeated

hospital, hospitalizations or arrests. Formally known as involuntary outpatient treatment or outpatient commitment, AOT commits local mental health systems to serve participants at the same time it assists participants to strictly adhere to their treatment plans. Developed by patients with their healthcare providers, these plans are highly individual, but typically include case management, personal therapy, medication and other tools known to promote recovery. AOT participants receive due process, protections order and-- protections, and orders are made only after a hearing before a judge. The Department of Justice Office of Justice Programs and SAMHSA have deemed AOT to be an evidence-based practice, and its use has been endorsed by the American Psychiatric Association, American College of Emergency Physicians, International Association of Chiefs of Police, National Sheriffs' Association, and National Alliance on Mental Illness. The Treatment Advocacy Center reports that AOT reduces arrests and violence for the populations it serves, with a 44 percent decrease in harmful behaviors, two-thirds reduction in risk of arrest in any given month. Folks who participate are four times less likely to perpetrate serious violence, and they're half as likely to be victimized themselves. I've handed out a fact sheet on AOT that will provide additional information on the benefits of assisted outpatient therapy. And I appreciate your time and attention to this important matter. I'm happy to try to answer any questions you may have.

ARCH: Are there any questions from the committee? I just have one. Is, is, is AOT, is that, is that a particular type of therapy that is, that's being offered?

HOWARD: It's a pretty, it's, it's sort of a combination of a, of multiple things, right? It's case management. It's, it is one-on-one therapy; it can be. It can include medication assistance. So it's sort of like a wraparound that includes therapy, but it's called AOT; that's the term that is used for all of those services combined.

ARCH: And formerly known as involuntary outpatient therapy,--

HOWARD: Um-hum.

ARCH: --is that what you said?

HOWARD: Um-hum.

ARCH: OK. Well, be interested in hearing more from testifiers.

HOWARD: From my constituent, Mr. Heller.

ARCH: Yes.

HOWARD: I think he's very excited to speak with you today.

ARCH: Thank you, Senator Howard.

HOWARD: Thank you.

ARCH: And for the-- we're open now for proponents, so anybody who would like to speak in favor of the bill, please come up.

TIM HELLER: There's nine copies, and then I have a tenth over here; I'll give it to you after I'm done. My name is Tim Heller, T-i-m H-e-l-l-e-r, a resident of Senator Howard's district. I appreciate the time before you, senators. I'm here to take, talk to you about the catastrophe that is the Nebraska health, mental healthcare system. Approximately 16,000 Nebraskans signed up for--

ARCH: Did you, did you spell your name? Could you?

TIM HELLER: H-e-l-l-e-r.

ARCH: OK. Thank you.

TIM HELLER: Approximately 16,000 Nebraskans suffer from schizophrenia. Approximately 32,000 Nebraskans suffer from severe bipolar disorder. That is nearly 48,000 people in our state with severe mental illness. When the Treatment Advocacy Center grades the 50 states-- and you get a copy of this-- Nebraska gets a D. Nebraskans deserve better. My son deserves better. My 22-year-old son Devon [PHONETIC] is one of these. As a result of a traumatic brain injury and a drug overdose, Devon is schizoaffective. He is our son, and we love him and want the best for him. We are working with a variety of doctors to find the right balance for his medications and treatments to address his symptoms. It's a work in progress. He is currently EPC'd, or emergency protective custody at Immanuel right now, for the last two weeks, as the result of some issues. We're also working with Region 6, Nebraska's behavioral healthcare, to find solutions for him. At this point, Medicaid does not cover adult daycare, an important part of that process. Nebraska no longer has inpatient long-term care for mental illness, a result of a change about 30 years ago. We are actively working with available resources to get him the access to what he needs. My wife and I both have jobs, and that leaves him home

during the day, unattended. He experiences a variety of symptoms that detrimentally affect his ability to work and function in certain social systems, situations. Among these are: a lack of understanding of social boundaries and norms; no short-term memory; inappropriate laughter; auditory hallucinate, hallucinations; complete lack of self-control; excessive salivation due to medications; depression; paranoia; and noncompliance. Just this morning at the psychiatric ward at Immanuel Hospital, he-- where he's once again in EPC for my, for assaulting my wife and I, he called 911, saying his mother and I were trying to kill him. I just got word from my wife. She's out in a-- she wanted to be here, but she is in a care counseling appointment with him. And during that, he tried to call 911 again, to have the police come and rescue him. At times, when he is faced with confrontation, he becomes abusive and violent with his mother and I. I will not repeat the language that he uses here. Some nights we go to sleep wondering whether or not we will wake up with a knife in our chest. The alternative is to put him on the streets and make him homeless. The problem is that, due to his issues, particularly noncompliance, he has been kicked out and will continue to be kicked out of any homeless shelters. We've tried this. With our Nebraska weather, this amounts to a death sentence for anyone with SMI, severe mental illness. We could charge him with theft, battery, assault, and destruction of property. But what does that fix? We love him and want the best for him. Our prison and jail systems are overcrowded as it is, and to throw someone in jail is not the answer. It's costly and leads to overcrowding. And it's a leading cause-- and a leading cause of inmate death is suicide. Persons with severe mental illness are 70 percent-- I'm sorry. It's estimated that nearly 20 percent of Nebraska's inmate population suffer from severe mental illness. This has been confirmed to me by both police and folks at work in the corrections system. Persons with SMI, severe mental illness, are 70 percent more likely to end up incarcerated in Nebraska rather than receiving the care that they desperately need. Only 40 percent of those with SMI are presently served by the mental health courts. Our Corrections Department should not be our mental health solution in Nebraska. Nebraskans deserve better, and my son deserves better. Our mental healthcare system in Nebraska is broken. People with SMI are disproportionately impacted by agonizing wait times in emergency departments, a phenomenon known as boarding. These people experience longer waits than nonpsych-- psychiatric patients and more serious consequences. This makes recovery less achievable and their treatment more cloth, costly to the health system. This disparity in boarding is especially true for psychiatric patients who require inpatient care for their recovery.

Psychiatric patients who are admitted to the hospital for inpatient care or transferred to other inpatient facilities are likely, more likely to experience boarding and the longest placement for inpatient bed of any emergency department for inpatient. I noticed the light came up, and I'm going to go and kind of skip ahead here to recommendations. You should all have a copy of this. LB875-- for LB875 to have any measurable impact, we must establish AOT in Nebraska. To do so, we need to enact the following changes which are here in our Nebraska statutes: We need to amend Nebraska Statute 71-921(1) to authorize citizen right of petition for at least enumerated systems-- citizens, preferably any responsible adult for an emergency evaluation; Number two-- I'm at the same provision-- to authorize citizen right of petition for at least enumerated system, citizens, preferably any responsible adult for inpatient commitment; three, adopt a psychiatric deteriorate, deteriorations standard; four, also amend to authorize the right of petition, preferably any responsible adult for outpatient commitment; require a treatment plan be submitted to the court; to extend duration of initial outpatient order beyond 90 days-- that 90 day window is just ridiculous; and to extend the duration of all continued orders for outpatient treatment to or beyond 180 days. I'm happy to take any questions you may have.

ARCH: Thank you. Are there questions?

TIM HELLER: I believe these measures will save the court system and our corrections system. A lot of money involves the mental healthcare system.

ARCH: Senator Williams,

WILLIAMS: Thank you, Senator Arch. And thank you for being here and telling your story. Can you let us know if there are other states that have adopted some of these similar set of recommendations?

TIM HELLER: If you will open this particular packet that has the recommendations on it, you'll see both Wisconsin and, I believe, Michigan, states that have similar legislation and actually received a B from the Treatment Advocacy Center.

WILLIAMS: So those could be models that we could refer to and look at. Thank you.

ARCH: Other questions from the committee? I, I have one more. Would the-- is, is the goal of a-- I guess early on we talked about an 1115 waiver. Is that correct? No?

TIM HELLER: I'm not familiar with that.

ARCH: Is the goal to get AOT funded by Medicaid?

TIM HELLER: Currently, most treatment is already funded by Medicaid, not as much of a worry as I, as I have for anything else. The concern is that currently we don't have an AOT program in Nebraska. We have like a BMH, board of mental health. This puts some judicial backing behind it, where I think it's described here as black robe fear. Where is that? So that the, so that there is a-- for example, my son's situation. My wife is his legal guardian. He will dispute and argue things to the letter of the law, quite literally. He's very intelligent in spite of his mental illness.

ARCH: Hmm.

TIM HELLER: So unless he has rules that are enumerated, he has difficulty complying. Having a legal edict that says, OK, you have to do these things or you go back into the mental health ward, would help keep him and other people like him on the right track, where they have to, where they're ordered to comply. That's basically what AOT comes down to, is a court order to comply with your treatment and gives that. And that treatment could be a variety of different things, whether it's seeing a therapist, whether it's taking your medication, whether it's going in for adult day care, regular counseling appointments, meeting any of the different therapy requirements that are set forth by the psychiatrists and psychologists and counselors.

ARCH: OK.

TIM HELLER: So that's, that's the teeth we need for this to be effective. And that's why I brought those additional recommendations. I'd like to see the bill amended to include those recommendations.

ARCH: I see. All right. Thank you. Other questions? It was, it was not an 1115 waiver, but a state plan amendment that I was thinking of. All right. Thank you very much. Other proponents for the bill? Seeing none, are there any opponents for the bill? Welcome.

CARISA SCHWEITZER MASEK: Thank you. Good afternoon, Senator Arch 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. I'm the 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 LB875, which would require the Department of Health and Human Services to submit a state plan amendment or apply for a Medicaid waiver to cover outpatient assisted therapy for eligible recipients. The previous proponent mentioned something about looking for amendments to the bill, and this testimony is specific to the green copy. So assisted outpatient therapy is, Senator Howard explained, is not a specific mental health treatment that can-- it is a group of treatments. And because it's not a specific mental health treatment that can be defined as a service, covering it in a state plan or a waiver would probably not get approval from CMS. Assisted outpatient treatment means anything that is medically prescribed by mental health treatment that a patient receives while living in the community, under the law, authorizing a court or tribunal to order such treatment. Medicaid already pays for court-ordered treatment for eligible recipients living in the community, as long as it is a Medicaid-covered service that is medically necessary and provided by a Medicaid-enrolled provider. An application to the Centers for Medicare and Medicaid Services is not likely to be approved and would not add coverage that does not already exist. If the intent of the bill is to further empower courts or the mental health boards to order community-based treatment for persons with severe mental illness, the bill doesn't quite meet those needs. Thank you for the opportunity to testify today and I'd be happy to answer any questions.

ARCH: Thank you. Does the committee have any questions? Senator Williams.

WILLIAMS: Thank you, Vice Chairman Arch. And thank you, again, for being here. If, if the bill in front of us did address, did empower the courts and the mental health boards to order community-based treatment for persons,--

CARISA SCHWEITZER MASEK: Um-hum.

WILLIAMS: --what would be your reaction to that legislation?

CARISA SCHWEITZER MASEK: From a Medicaid--

WILLIAMS: I know that's an open question.

CARISA SCHWEITZER MASEK: Yeah, open question. From a Medicaid and department perspective, Medicaid does cover medically necessary services, and some of those are defined in Chapter 71 that was referenced. Outpatient treatment is defined, which is a treatment ordered by a mental health board, directing a subject to comply with specified outpatient treatment requirements, including, but not limited to: taking prescribed medications; reporting to a mental health professional or treatment facility for treatment or for monitoring the subject's condition; or participating in individual or group therapy, educational rehab, residential, or vocational programs. So by looking at both of those chapters together, the Medical Assistance Act and then the Chapter 71, there is support and a basis for an assisted outpatient treatment program in Nebraska.

WILLIAMS: Thank you.

ARCH: Other questions? I have one. In the fiscal note, and this-- you don't have to-- this, this is not a question about the dollars, but it, it refers to assisted outpatient therapy or treatment, formerly known as involuntary outpatient commitment.

CARISA SCHWEITZER MASEK: Um-hum.

ARCH: Formerly known as, does that mean that that-- does that no longer exist? There is no such thing as involuntary outpatient commitment?

CARISA SCHWEITZER MASEK: It means, in the literature and within the health profession, the language has transitioned a bit to call it assisted outpatient therapy--

ARCH: OK.

CARISA SCHWEITZER MASEK: --instead of the previous language.

ARCH: OK, it's a new, it's a new name, but new-- but it's, it is, it is the involuntary--

CARISA SCHWEITZER MASEK: Principles are the same.

ARCH: --outpatient commitment. All right. Thank you. Any other questions from the committee? Seeing none, thank you very much. Any other opponents to the bill? Seeing none, Senator Howard, if you'd like to close--

HOWARD: Do you want to do neutral?

ARCH: Oh, that'd be a good thing. Is there anyone that would like to testify in a neutral capacity? Seeing none-- and while you're coming up, I would mention--

HOWARD: There are no letters.

ARCH: --that there are no letters for submission.

HOWARD: Excellent. Thank you, colleagues. Thank you for your time and attention to this matter. I always try to listen to my constituents when they say there's a concrete concern, and try to bring things that respond to those concerns. This is obviously a jumping-off point for larger conversations about emergency protective custody and what sort of treatment options or wraparound options we need to consider for individuals with mental health needs that are, that are greater than what we can handle. And so I really do appreciate you taking the time to hear this bill today.

ARCH: Thank you. Are there any other questions for Senator Howard? Seeing none, thank you very much. And this will close the hearing for LB875.

HOWARD: All right. This will open the hearing for LB1065, Senator Halloran's bill to change provisions regarding pharmacies, pharmacists, and pharmacy personnel. Welcome, Senator Halloran.

HALLORAN: Good afternoon, Chairperson Howard and members of the Health and Human Service Committee. For the record, my name is Senator Steve Halloran. S-t-e-v-e H-a-l-l-o-r-a-n, and I represent the 33rd Legislative District. I think this is my first time in front of Health and Human Services; this is an honor.

HOWARD: Welcome. I hope you have a good experience.

HALLORAN: And Drew, my LA, just told me as I got up, he said: Stand tall, so you can see me [LAUGHTER]. I'm here today to introduce LB1065 to the committee for your consideration. I intend to keep my remarks brief this afternoon and allow more time for individuals that will follow me. LB1065 would revise the Pharmacy Practice Act, with the goal of permitting pharmacists to better utilize their expertise and time to focus more on patient-centered services and less on administrative tasks. It would permit pharmacy technicians to perform additional administrative nondiscretionary duties under pharmacist

supervision. It would also allow a pharmacist to supervise more technicians than existing statute allows. Increasingly, evidence supports that patients benefit when pharmacists are more involved in their care. To best assist patients, pharmacists need more flexibility. Presently, under the Nebraska law, a pharmacist can only supervise up to three technicians. As introduced, LB1065 would remove that restriction. It would also expand the authorized duties for pharmacy technicians to include: 1) validation of acts, tasks, and functions of another pharmacy technician in a pharmacy licensed by the Department of Health and Human Services, under the supervision of a pharmacist; 2) in-- transferring noncontrolled prescription to another pharmacist, pharmacy intern, or pharmacy technician for a refill; 3) consulting with a prescriber to clarify a prescription question that does not require the clinical judgment of a pharmacist; and 4) a practitioner or their agent could communicate a prescription to a pharmacy technician. I was asked to consider this issue by the Nebraska Retail Federation on behalf of their pharmacy members, with the goal of initiating a serious conversation with those who may oppose some portion of the bill. It is my understanding that some of those discussions have already begun. Hopefully I, hopefully all involved can work together over the interim to come to an agreement on a comprehensive bill that can be introduced next session. I'm happy to take your questions, with the understanding that there will be testifiers following me who can best answer questions about specifics. Thank you.

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

WILLIAMS: Thank you, Chairwoman Howard. And thank you, Senator Halloran. And these may not be questions for you, but to some of those that will be coming behind you. I'm going to need some help understanding what clinical judgment means, what that would be defined as in here, and some examples of that. Also, in your testimony, you mentioned the, the increase from three to unlimited supervision. And I would like to have some discussion on that, of what the, what a right number might be in there if there is a right number. If you have any response, that'd be great.

HALLORAN: Those are good questions. The first one is-- I'm going to allow someone behind me. It's kind of a subjective-- I think it's probably going to be kind of a subjective answer, as may be your second question. I think the point-- to me, the point is not micromanaging. It could be different for every pharmacy. What the

right number is, to your, to your question, I don't know that we can prescribe. I'm not coining that phrase because we're talking about pharmacies. I'm not sure that we can prescribe my legislation, the exact number or even the limit of the number. But that, but the experienced people behind me can answer that question better for you.

WILLIAMS: Thank you.

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

HALLORAN: I will absolutely do that.

HOWARD: Thank you. All right. This will-- we'd like to invite our first proponent testifier up for LB1065. Good afternoon.

JOEL KURZMAN: Good afternoon. Joel Kurzman, J-o-e-l Kurzman, K-u-r-z-m-a-n. Good afternoon, Chairwoman Howard and members of the committee. My name is Joel Kurzman and I'm a director of state government affairs for the National Association of Chain Drug Stores. Thank you for the opportunity to speak with you today. And thank you, Senator Halloran, for your leadership in sponsoring this important and forward-facing legislation. In Nebraska, NACDS represents nearly 250 pharmacies, employing approximately 1,250 pharmacists and thousands of other Nebraskans, contributing millions of tax dollars to the economy. Our health system nationally is facing a variety of challenges, including an aging population with an increased chronic disease prevalence and increasing medication use. And this is happening at the same time as we see a worsening physician shortage. As you know, Nebraska is not immune to these challenges. Since 2013, diabetes in adults in Nebraska has increased by 20 percent, and over 19,000 Nebraskans live in areas designated as health professional shortage areas. Community pharmacists are increasingly being called upon to leverage their accessibility and to deploy their clinical expertise to care for patients, complementing the work of other health professions. This is especially important in rural areas where pharmacists may be the only healthcare professional within a reasonable distance. However, the extent to which a pharmacist can engage in direct patient care and clinical activity depends heavily upon whether nonjudgmental tasks can be delegated to technicians. And this is the crux of LB1065. Freeing up the pharmacist does not increase prescription volume or workload but, instead, better balances responsibilities across the pharmacy team, leveraging the unique skills and qualifications of all members. Research published in 2017 found at least 17 states allow technicians to accept verbal prescriptions called in by a prescriber

or a prescriber's agent, or transfer a prescription order from one pharmacy to another. The authors concluded that these tasks can be performed safely and accurately by appropriately trained technicians. They also noted that the delegation of verbal orders and prescription transfers removes undue strain on pharmacists, and frees up pharmacists' time for clinical care. LB1065 would also permit technicians to check the work of other technicians, using technology solutions like barcoding. Pilot programs in Iowa, Wisconsin, and Tennessee consistently document that technicians can safely verify medication products billed by other technicians. These pilots demonstrated that when technicians perform more administrative duties, pharmacists can spend more time providing clinical care to patients. Especially given the training requirements already in place in Nebraska, expanded duties are a win-win-win for patients to receive more access to clinical care, for pharmacists to provide the clinical care they were trained to provide, and for technicians to have an opportunity to advance their career. LB1065 also eliminates the pharmacist-to-technician ratio. These arbitrarily set ratios prevent pharmacies from maximizing the use of technicians to provide broader patient care services. Eliminating the ratio will enable pharmacy owners and pharmacists to best determine proper staffing requirements to fulfill the basic, the specific patient needs at their pharmacies. The National Association of Boards of Pharmacy, NABP, has supported the complete elimination of such a ratio since 1999. And perhaps this is why 22 states and the District of Columbia have opted against using an arbitrary ratio. In close, in closing, NACDS is excited about the opportunity of LB1065 to improve the ability for pharmacies to serve their communities, namely by leveraging the skills of pharmacy technicians. So we thank the committee for its time and consideration of the bill, and the opportunities it provides to better serve patients here in Nebraska. And I would be happy to field any questions that you may have.

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

ARCH: Thank you. Could you educate me on the-- it, on, on how the pharmacy tech is trained? What's the background necessary? What are the qualifications for a pharmacy tech?

JOEL KURZMAN: So in the state of Nebraska, we do have some regional folks who would be able to tell you their experience with employing technicians here in the state of Nebraska. I do know that there is a requirement for them to be PTCB certified, which-- and that is several

years old in the state of Nebraska. And so we know that there is a baseline of training of each and every technician employed in pharmacies in Nebraska, certainly capable of handling the nonjudgmental tasks that we envision with this bill. For in, more in-depth information, I would refer to our in-state members operating in the state of Nebraska.

ARCH: All right. Thank you.

JOEL KURZMAN: Um-hum.

HOWARD: Other questions? Senator Walz.

WALZ: Thank you, Chairwoman Howard. And thanks for coming today. I am looking for, maybe, some ideas on what nonjudgmental tasks are.

JOEL KURZMAN: Yes. Well, nonjudgmental tasks, you know, calling to clarify a prescription, you know, at a-- you know, calling a doctor's office and just clarifying. I'd say reading anything off a computer screen. But again, we do have a pharmacist upcoming who'd be able to give you an answer to that, as well as the question to the, to Senator Halloran about, you know, clinical judgment. I do think we can answer that in a subsequent testifier, by in a subsequent testifier.

WALZ: OK. And I also had another question. Maybe it's for the next person. You mentioned something about taking orders that were called into the pharmacy from the prescriber. I just want some clarification on that.

JOEL KURZMAN: Yeah, that can also be provided.

WALZ: All right. Thank you.

JOEL KURZMAN: Um-hum.

HOWARD: Thank you. Other questions? Seeing none, thank you for visiting with us today.

JOEL KURZMAN: Thank you again.

HOWARD: Our next proponent testifier for LB1065? Good afternoon.

ANNIE CALDER: Thank you, Chairwoman Howard and members of the Health and Human Services Committee, for allowing me to testify today. My name is Annie Calder, A-n-n-i-e C-a-l-d-e-r. I'm a market health and

wellness director for Walmart and a pharmacist in Nebraska. In my 14 years of pharmacy experience, I have worked in various retail settings. I have worked in urban locations in Omaha, Lincoln, and Grand Island. I have also worked in more rural locations such as York, Seward, Crete, and Hastings. During my time on the bench, I relied on the support and expertise of pharmacy technicians and supervised a wide range of staff members to provide care and services to our community members. I am here to speak today in support of LB1065, introduced by Senator Halloran. LB1065 would modernize pharmacy practice and allow for maximized use of pharmacy resources and services by: first, allowing pharmacies to eliminate the current pharmacist-to-technician ratio; 2) expanding the ability of pharmacy technicians to transfer and accept verbal prescriptions; and 3) using technology to check the work of other technicians. This bill has been carefully crafted to help close critical patient care gaps in Nebraska, without sacrificing patient safety, and will help empower pharmacy technicians to grow in their experience and career. Further, allowing pharmacy technicians to transfer prescriptions and use technology to check the work of other technicians would help advance their own experience in careers. In a cross-sectional survey on pharmacy technicians' attitudes in the United States, community pharmacy technicians reported positive attitudes and relatively high levels of involvement, self-sufficiency in, and positive attitudes towards many administrative tasks. According to the American Society of Health-System Pharmacists, pharmacy technicians have a 13 percent turnover rate. ASHP suggests that expanding professional opportunities for pharmacy technicians can help elevate their roles, increase retention rates, and add values to pharmacy. In my experience as a district manager with rural communities, it could take months to find an interested applicant, let alone an already trained technician. The administrative tasks of filling a prescription then fall on the pharmacists, who then are still required to perform at the top of their license. LB1065 would help maximize the use and value of pharmacy technicians without sacrificing patient safety. Limiting the number of pharmacy technicians through a ratio has not been shown to contribute to improve patient safety. One pilot study of community pharmacies in Iowa found that pharmacy technicians are as accurate as pharmacists when performing final product verification. Meanwhile, pharmacists' time spent performing patient care services increased by approximately 19 percent with the availability of pharmacy technicians. With this increased capacity, pharmacists were able to spend more time doing clinical services like medication reviews, medication- synchronized appointments with patients, and medication

therapy management. Most importantly, the bill includes a list of functions and tasks which may only be performed by a licensed pharmacist. For example, the bill specifies that pharmacy technicians shall only perform tasks which do not require the professional judgment of a pharmacist, prohibiting them from providing patient counseling, performing any evaluation or necessary clarification of a medical order, interpreting or evaluating data within a patient's record, and drug product selection with regard to an individual, individual medical order. I support LB1065 because it will maximize our time spent on patient care by expanding the role of pharmacy technicians, who will perform more administrative tasks without sacrificing patient safety. Passing LB1065 would have a positive impact on the health and wellness of Nebraskans. By improving the scope of duties for pharmacy technicians, we will be able to provide better patient care for the people of Nebraska at pharmacies, which is one of the most accessible locations for healthcare. Thank you for your time.

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

WILLIAMS: Thank you, Senator Howard. First question-- I know that we have a pharmacy tech in the audience. Do you know if he is going to testify?

_____: There's a pharmacist.

ANNIE CALDER: We have a pharmacist. I'm also a pharmacist. But, yes, we do have a--

WILLIAMS: A pharmacy tech, I asked.

ANNIE CALDER: I do not know about that.

WILLIAMS: OK. You're a pharmacist.

ANNIE CALDER: That's correct.

WILLIAMS: And in your various positions, did you manage any pharmacy techs?

ANNIE CALDER: Yes, I did.

WILLIAMS: How many, normally, did you manage?

ANNIE CALDER: Depending on the scope--

WILLIAMS: Don't say more than three.

ANNIE CALDER: No, that's correct [LAUGHTER]. Depending on the store, how busy we were, I would have a staff of anywhere from three. To my more rural store or urban stores, I had a staff of 15, including pharmacy sales associates.

WILLIAMS: What, what do you think? How many could you supervise well, as one pharmacist? Pharmacy techs, not your other people.

ANNIE CALDER: Sure. It depends on how busy your store is, and if you have other pharmacists scheduled with you. On any given day, I would say four or five.

WILLIAMS: OK. We also had the question, Senator Walz asked the question about nonjudgmental tasks.

ANNIE CALDER: Sure.

WILLIAMS: Can you give us some examples of those type of things?

ANNIE CALDER: In regards to actually looking at a physical hard copy of a prescription, sometimes there can be some information missing from that prescription. An example would be a date on a prescription. That would be a nonjudgmental thing that a parent, a technician could call and clarify on, also could clarify milligrams, or strength of a medication; that would be nonjudgmental. Other tasks, if you're talking about transferring your prescription, sometimes there would be refill information. That's, that's pretty nonjudgmental. That's straightforward information that a technician should be able to handle.

WILLIAMS: Thank you.

HOWARD: Senator Arch.

ARCH: Thank you. One of the, one of the items in your testimony refers to the acceptance of verbal prescriptions, which I would call verbal orders.

ANNIE CALDER: Sure.

ARCH: So a physician would call in or perhaps a nurse would call in. Am I correct?

ANNIE CALDER: Currently, any member or any staff member at a doctor's office can call in a prescription. So it could be a secretary, it could be a doctor, it could be a nurse. They don't have to have any medical--

ARCH: OK. So the physician then would, would make the order, put it into the record.

ANNIE CALDER: Um-hum.

ARCH: Another staff member would read that order from, from the record.

ANNIE CALDER: Correct.

ARCH: Is there any, is there any process of confirmation of those orders?

ANNIE CALDER: Speaking on behalf of what-- my location where I work at, technicians do the manual order entry of all the prescriptions they type in the prescription. That prescription then goes to a pharmacist to check. All right. So we do multiple pharmacists checking on a prescription. And it would be at that time where the pharmacist would make the clinical judgment if this is the correct therapy on the correct dosing for that patient, based on what the medication is.

ARCH: So if the pharmacist then would-- if a question arose, the pharmacist then could confirm,--

ANNIE CALDER: Correct.

ARCH: --would call the office and say: Did you mean 5 or .5?

ANNIE CALDER: Yes.

ARCH: Right. OK. Thank you.

HOWARD: Senator Walz.

WALZ: Thank you, Chairman Howard. And thank you. We all know that follow-up with the patient is really important, so--

ANNIE CALDER: Sure.

WALZ: --in, in that case, who would be responsible for following up after a prescription has been given, three or four days later, to find out how things are going? Would that be, well, one of these tasks of a pharmacist tech or would it--

ANNIE CALDER: I think it could go either way. I think the initial phone call could be technician driven. And then, based on how that conversation would go, that conversation could then be directed towards the pharmacist.

WALZ: OK. All right. Thank you.

ANNIE CALDER: Um-hum.

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

ANNIE CALDER: Thank you.

HOWARD: Our next proponent testifier for LB1065?

MAX OWENS: All right. Thank you, Chairwoman Howard and members of this committee, for allowing me to testify today. My name is Max Owens. I'm a pharmacist here for Walgreens in Lincoln. I grew up in western--

HOWARD: Could you spell your name for us?

MAX OWENS: Oh, yes. I'm sorry. It's M-a-x O-w-e-n-s. Again, my name is Max Owens, and I am a pharmacist here for Walgreens in Lincoln. I grew up in western Nebraska and graduated from Creighton with my doctorate of pharmacy in 2016. The reason I chose to be a pharmacist, and the main goal I have every day I step into my pharmacy, is to provide the best patient care I can to the patients that are in front of me. The, the, the mentioned, the mentioned tasks that technicians would alleviate from the pharmacist, so those being nonclinical, I just wanted to provide a perspective from Walgreens, as far as how that goes. The last speaker spoke. So what we do, and to address your question further, three days after your prescription is picked up, the, the current categories that we call on are blood pressure, cholesterol, and diabetes. So once a patient picks up that medication and the system recognizes that as new, the pharmacist at Walgreens calls the patient, and says: Hey, how are you doing on that medication? Do you have any questions, concerns? And that's the time

that we take with them to make sure everything is going OK. And I have a personal example of a time when that's really been successful and potentially prevented or helped alleviate patient harm. So a patient was new to Walgreens. They had transferred to us. They were taking a cholesterol medication. Upon talking to them, they had actually started a new cholesterol medication. I didn't know this at the beginning of the conversation, but I just kind of talked about, you know, this is what you can anticipate, as far as side effects that are potentially-- that could come up while you're on this medication. He said: Well, you know, it's funny 'cause about two months ago I started this medication and I was experiencing that exact same thing. I said: Well, what are you taking? You know, I don't have any of your prescriptions on your file. He said: Well, I'm taking this for cholesterol. So the doctor had called in a new cholesterol medication. He had no idea that they weren't supposed to be taken together. So he was potentially going to continue to take two cholesterol medications, which can cause damage to muscles, lots of bad effects. So that's one example I can allude to and provide. The other thing that I really enjoy about my profession is being able to immunize, and that is one clinical activity that technicians are not able to do. It does take a lot of time, especially-- we talk to patients at Walgreens, go over their past immunizations, see what ones they would be recommended to receive when they're there. So it really opens up a window to have a communication with patients and to really promote healthcare, you know, outside of their doctor's office where pharmacists are very accessible to answer clinical questions in that way. And that's why I really see this as a good opportunity, as a pharmacist, to utilize technicians to perform nonclinical activities, so transferring prescriptions, taking new prescription orders. It really would save a lot of time 'cause you can have three phone calls at one time from a, you know, another pharmacy transferring, especially at the beginning of the year when people's plans change. And it really does take a lot of time to read over, you know, something that you're looking at on a screen that you could train or trust anyone to do. And as far as trusting goes, it's really at the discretion of the pharmacist, anything that happens in the pharmacy. So your license is what keeps the pharmacy open. So even in my situation where I work for Walgreens, if I'm not comfortable with the tech, you know, say they're new, they're just learning, that there's something I'm not comfortable with them doing, I'm not going to let them do that 'cause I don't want to put my patients at risk, you know, I don't want to put my license at risk. So I think that kind of helps to maybe alleviate some of the current concerns people would have. You know, it's not a mandatory

thing that, you know, every single technician would be performing these functions. You know, they would have to show some sort of competency. You know, you'd have to trust them, as a pharmacist, because it's your say, you know, everything that goes on in the pharmacy. And with that, I will conclude my statement and answer any questions.

HOWARD: Thank you. Are there questions? Seeing none, thank you for visiting with us today.

MAX OWENS: OK. Thank you.

HOWARD: Our next proponent testifier for LB1065. Good afternoon.

LORI WALMSLEY: Good afternoon. Senator Howard, my name is-- and members of the committee-- my name, my name, my name is Lori Walmsley, L-o-r-i W-a-l-m-s-l-e-y, and I'm a director of pharmacy affairs on behalf of Walgreens. And I'm here to testify today in strong support of LB1065. To keep my testimony brief, I'd like to address some of the questions, if that's OK, to kind of clear up some of the things that you guys had to this point. Based on our experience in other states, what we envision at Walgreens, as tasks that would require clinical judgment, are some of the things that my other pharmacist colleagues have alluded to-- I am a pharmacist, as well-- are things like drug utilization review, so determining whether or not there are prescription interactions, whether or not the prescription is the appropriate strength for the for the appropriate condition, those types of things, looking for interactions, looking for drug, drug allergies, those types of, types of items, as well as things like clinical review, so ensuring that the prescription is accurate versus what the prescriber intended, so not the actual tablet in the bottle, but whether or not the prescription is written as the prescriber intended. And this would clear-- both of those things would clear up a lot of the concerns around the questions related to: How do you confirm a new prescription if it's called in by somebody else? A lot of that confirmation can be done through the clinical, but clinical review and the drug utilization review, to ensure that that's really appropriate for that particular patient, based on their medical history. Lastly, and probably one of the most important things that pharmacists do to help prevent prescription errors, is consulting with patients. That's something that takes quite a bit of time, whether it's the follow-up calls that you alluded to, Senator Walz, or talking to patients as they're, as they're in stores, something that takes quite a bit of time and, depending on the patient population, can take

even more. So that's not something we would want delegated to, to a technician. We would want to make sure that a licensed, trained professional is able to continue to do those things. So those would be the items that I would say would be the things that are really under clinical judgment. In terms of nonjudgmental tasks, what we're looking at is the items that are specifically laid out in the bill. There are things that have been considered in other states. The things that were included here are things that are fairly widely accepted across the country: calling-- taking new verbal orders; taking refills over the phone; transferring prescriptions; and then checking, checking whether or not the tablets in the bottle match, versus the intended product. Those are the things that we would consider nonjudgmental for the purposes of this bill here today. To address around training-- so the requirements in Nebraska for a technician are that they have to be licensed by the state board of pharmacy. And within their requirement, they are required to be certified within one year of becoming a technician. So in order to obtain national certification, there are two different exams. There's the ExCPT exam and the PTCB exam. Both of them have a number of our requirements around how long they are required to be a technician, the amount of experience. So there's technical school programs that are out there through community colleges, those kinds of things, as well as employer-based training programs. So, for example, at Walgreens we employ and-- we're, we have a nationally accredited training program through the, through ASHP, so it's a very lengthy process, in addition to all of our normal trainings, policy and procedure-type trainings. And all of the additional duties, there is additional training that goes into those to make sure the technicians are properly able to do those. I'll pause there and see what other questions. But in summary, we're in strong support.

HOWARD: Thank you. Are there questions? All right.

LORI WALMSLEY: Thank you.

HOWARD: Seeing none, thank you. Our next proponent testifier for LB1065? Good afternoon.

JIM OTTO: Good afternoon. Senator Howard, members of the committee, my name is Jim Otto. That's J-i-m O-t-t-o. I'm president of the Nebraska Retail Federation, and I'm here today to testify in favor of LB1065 on behalf of the federation and, also, to thank Senator Halloran for introducing it. As you heard, there's an increased demand on pharmacists' time to share their knowledge with patients. I can

actually speak from personal experience that local pharmacists have been very helpful to me. And baby boomers like me, relying more and more on the expertise of their local pharmacist, is a factor that contributes to this. We do suggest that expanding the authority of pharmacists to supervise more than three pharmacy technicians and allowing those pharmacy technicians to perform additional administrative, nondiscretionary duties, under pharmacist supervision, is prudent. The number of technicians and the tasks they are authorized to perform can best be determined by serious discussions with all involved. I believe the opposition testimony we will hear today will be valuable information to assist in reaching a consensus. And I would only add an answer to Senator Williams' question that, in every situation, the number could be different. And so I think a bunch of-- or a group of pharmacists and people involved in it probably need to have a discussion. And I'd also like to point out, it doesn't require them to supervise. It's up, still up to the pharmacist if they think they can only-- for example, presently, under the rule of three, if a pharmacist felt like they could only supervise two, that's fine. And it's up to the pharmacist. So with that, I thank you, and I would attempt to answer questions.

HOWARD: Thank you. Are there questions? All right. Seeing none, thank you for your testimony today. Our next proponent testifier for LB1065? All right. Seeing none, is anyone wishing to testify in opposition to LB1065? Good afternoon.

ROBERT HALLSTROM: Madam Chair-- thank you, Madam Chair. Members of the committee, my name is Robert J. Hallstrom, H-a-l-l-s-t-r-o-m. I appear before you today as a registered lobbyist for the Nebraska Pharmacists Association, to testify in opposition to LB1065. Joni Cover, who you normally see before this committee, is traveling out of state and sends her regrets. I certainly hope having me testimony, testify on her behalf was not among those regrets [LAUGHTER]. We have appreciated the opportunity, since Senator Halloran introduced the bill, to visit with him to express our concerns, and look forward to working with him and the other interested parties, going forward. Despite our opposition, we want to make it clear that we understand that pharmacy techs play a vital role in pharmacy in all practice settings, and they serve an extremely beneficial purpose. However, notwithstanding, we do have some significant concerns with LB1065. When we first caught wind that this type of proposal was going to be brought forward, we reacted proactively, conducted a survey of our membership, and that survey results generally reflected opposition to the elimination of the

pharmacist, the pharmacist-technician ratio, opposition to allowing pharmacy techs to receive new prescriptions, and opposition to tech-check-tech in a community pharmacy setting. There was some level of support, with specific caveats, allowing a pharmacy technician to clarify a prescription and some level of support for authorizing transfer of a prescription, but only by facilitating effects back to the prescriber. By way of background, we do have a pharmacy technician registry with the Nebraska Department of Health and Human Services that was adopted in 2007. In 2017, we enhanced the educational requirements for pharmacy technicians, and we think that that's probably something, if we're going to look at expanding the scope of practice, so to speak, for pharmacy technicians, that we have a better level of training and educational experience. I think Mr. Kurzman used the term "appropriately trained," so that may be something that we'll have to, to visit about. I appreciate Mr. Otto's suggestions that there may be some valuable testimony in the things that we have to say. There are limitations on pharmacy technicians' scope of practice and the types of activities that they may entertain, in terms of not requiring the professional judgment. I did find it interesting that Ms. Calder indicated, when she was describing certain types of activities, that they were pretty nonjudgmental. I think those are the types of things that, over the course of the summer, and in the interim, in working on this, that we can identify those types of things. With regard to the elimination of the three, three limit, I've been around long enough. I know that it was very contentious when we went to three technicians that could be overseen by a pharmacist. So I look forward to those types of discussions. I think the Pharmacy Association, in general, appreciates the fact that allowing the pharmacists to open up their expertise, to provide better pharmacy service, is important. But they are also concerned about the elimination of pharmacists for economic reasons, where they can use pharmacy techs, a less expensive fashion. So with that, again, we will look forward to working with Senator Halloran and other interested parties over the interim. I'd be happy to address any questions that the committee might have.

HOWARD: Thank you. Are there questions? Seeing none, thank you for visiting with us today.

ROBERT HALLSTROM: Thank you.

HOWARD: Our next opponent testifier for LB1065? Anyone else wishing to testify in opposition? Is there anyone wishing to testify in a neutral

capacity? All right. Seeing none, Senator Halloran, you're welcome to close. While he's coming up, we have one letter in support: Laura Ebke, from the Platte Institute; two letters in opposition: Dr. Todd Hlavaty, the Nebraska Medical Association; and Dr. Gary Anthone, the Department of Health and Human Services, Division of Public Health-- no letters in the neutral capacity. Welcome back, Senator Halloran.

HALLORAN: Well, thank you, Chairman Howard, and thank you to the Health and Human Services Committee for your time, and to all those testified. It does sound like there's some, quite a bit of positive direction from all the players, to do some more investigation of this over the interim. It's-- when someone mentioned-- it was brought up about the question about the nonjudgmental. My wife talks to me a lot about being nonjudgmental, so I kind of can relate to some of that. I do think, though, that the, the subject matter is, is very important. I think it's[-- anything we can do to enhance the time the pharmacist spends with the patient one-on-one, mano-a-mano, with their direct concerns about the medicines and pharmaceuticals they're taking, versus doing very clinical work, I think can make for-- not only more efficiency for the pharmacy, but better quality care for the for the patients. So I look forward to working with these folks over the interim.

HOWARD: Thank you. Are there any final questions for Senator Halloran? All right. Seeing none, thank you for visiting us, Senator Halloran.

HALLORAN: Oh, thank you.

HOWARD: All right. This will close the hearing for LB1065. We will open the hearing for LB1059, Senator Howard-- my bill to change provisions relating to healthcare facility licensure.

ARCH: Welcome, Senator Howard, and you may open on LB1059.

HOWARD: All right, thank you. Good afternoon, Vice Chair Arch and members of the Health and Human Services Committee. My name is Senator Sara Howard, H-o-w-a-r-d, and I represent District 9 in midtown Omaha. Today I present to you LB1059, as amended by AM2511. LB1059 was originally put in as a shell bill for the committee to consider. If there were any big issues that came up during the course of our hearings that we felt as though we needed to have a broader conversation on. And so I have submitted AM2511 to replace the original shell-- bill. In October 2018, the Department of Health and Human Services changed their drug testing policy, in child abuse and

neglect cases, where substance use is an issue. Under the new policy, drug testing occurs if it is recommended as part of the substance use treatment a parent is receiving, and is arranged by the treatment provider. Drug testing may also occur if court-ordered by the court. Several groups, particularly the county attorneys, have expressed concerns about this change in policy. Last fall, this committee held a hearing on LR134, an interim, an interim study by Senator Slama, to examine this issue. And in the context of other child welfare bills heard this session, the county attorneys continued to raise concerns about the drug testing policy. As a result, I've offered AM2511 to provide an avenue for additional discussion on this issue. AM2511 amends the Child Protection and Family Safety Act. Section 1 adds the definition of alcohol and drug testing to mean the use of biological sources such as hair, urine, and saliva to identify the concentration or presence of specific substances or their metabolites. Section 3(1) adds a new legislative, adds a new legislative intent language regarding the role of alcohol and drugs in child abuse and neglect cases, the effect of alcohol and drugs on a parent or caretaker's judgment and ability to provide consistent care, supervision, and protection, and the use of alcohol and drug testing as an effective and necessary tool to provide evidence of, or to rule out, substance use as-- abuse, as part of an investigation or assessment of a child's safety or risk, and to monitor substance use and ensure treatment compliance. Section 3(2) would require alcohol and drug testing to be a service available for all court/noncourt-involved traditional response or alternative response cases in our child welfare system. Alcohol and drug testing is required to be one component of initial assessment and ongoing case management, to identify or eliminate substance abuse as a contributing factor to child abuse and neglect, in cases in which drug or alcohol use or exposure is suspected. Section 3(3) requires the Department of Health and Human Services to promulgate rules and regs consistent with this section and revoke any contrary rules by July 1, 2020. With that, I'm happy to try to answer any questions you may have.

ARCH: Are there questions from the committee for Senator Howard? See any? Thank you.

HOWARD: Thank you.

ARCH: We open it now to proponents of the bill.

CHRIS TURNER: Good afternoon, Vice Chair Arch and members of the Human Services Committee. My name is Chris Turner, C-h-r-i-s T-u-r-n-e-r. I

am chief deputy of the Lancaster County Attorney's Office's Juvenile Division, and I'm here today testifying on behalf of the Nebraska County Attorneys Association, in strong support of LB1059 and AM2511. Our association wants to thank Senator Howard for her leadership on this issue and for bringing AM2511 forward. As county attorneys, we were shocked in 2018, when the Department of Health and Human Services and their Child Welfare Division began reversing course on their longstanding policy of appropriately utilizing drug testing in child welfare cases. As county attorneys, we have an obligation to ensure protection and safety of children; we're passionate about that responsibility. And we, along with other members in the child welfare arena, including HHS, including law enforcement, and, when necessary, the court system, have taken this issue with drug testing very seriously. The County Attorneys Association supports AM2511 because we recognize the current threat being posed to the protection and safety of drug-endangered children due to the department's drug testing policy that was implemented in October of 2018, as described by Senator Howard. We recognize, as county attorneys, the terrible situation that department policymakers have put their own frontline staff in by asking them to conduct an initial assessment into allegations of children being drug-endangered due to their caregivers' use of substances, such as methamphetamine or cocaine. And those parlicy, policymakers have now refused to allow those workers to utilize drug testing as part of those assessments. We recognize the situation the department policymakers have put their frontline staff in by asking them to ensure child and-- child safety and to assist caregiver recovery from substance abuse disorders, but then removing from them an important tool, such as drug testing, that they could utilize to accomplish their mission. Despite efforts made by prosecutors, defense attorneys, guardian ad litems that serve as attorneys on behalf of children, child advocacy groups, and judges, we have been unable to get the department to reconsider their policy. There's been no positive movement since it was enacted. The legislative response in AM2511 is now necessary so that the department will have to return to appropriately assessing and responding to the safety of children who are drug-endangered. As described previously, the prior-- to October of 2018, there was a drug testing policy in place. That drug testing policy really serves, I think, as the basis for the language that's now included in AM2511. Previously, the department recognized, in that prior policy, quote: The Division of Child and Family Services recognizes that alcohol and other drugs are often contributing factors in child abuse and neglect, and that effective drug testing is often necessary to ensure treatment

compliance and manage safety risk concerns. That is true. That is best practice in child welfare, and AM2511 adopts that same language. The pre-2018 policy required a department worker first to identify a clear purpose for using drug testing, and identify that it would be common and appropriate to use in certain situations. That's what the old policy said. I'll give you some examples. One, to provide evidence of, or rule out, substance abuse as part of a child abuse or neglect investigation and to determine whether substance abuse is associated with child safety or risk. AM2511 adopts that same language. That would be an example where a call comes into the hotline, a worker is assigned to that call, and it has to do with allegations that maybe a parent is, is abusing substances such as methamphetamine. A worker could go out if there was some indication that that allegation was warranted. Maybe there are some physical indicators, behavioral indicators by the parent. There could be a request for a parent to voluntarily submit to a drug test that could confirm or, maybe, help deny those suspicions. That doesn't happen under the new policy any longer. One of the prior recommended uses, or commonly appropriate uses for drug testing pre 2018, was to monitor whether a parent was using substances during an open court or open noncourt case-- also, to provide positive reinforcement and to monitor parents, particularly in early recovery. Again, AM2511 adopts that same purpose and that same goal. One example of that situation would be a parent who is engaged in substance abuse treatment, to have them tested regularly to ensure that they're at the appropriate level of treatment. If they were having that objective drug test and finding that they were remaining positive, they may have a recommendation to increase their level of treatment to, perhaps, something like intensive outpatient treatment or maybe even inpatient treatment. One thing I would point out is that the department often cites to, as a basis of their new policy, a U.S. Department of Health Human Services child welfare report. When they cite to that report, they do not cite to it completely. They leave out very specific and very important positions that contradict their policy, and so sometimes they will cite a language that says drug testing alone cannot be a sufficient basis for making child welfare decisions-- and I'm paraphrasing-- but what they don't then tell you about or what they will not cite is that that same document says that drug testing is an important addition to child safety, it is important to ensure absence from drugs, and it is important to ensure, as a combination of other tools, child welfare and child safety. And I see that I'm out of time, but I'd be happy to answer any questions that you all may have.

ARCH: Thank you. Are there questions from the committee? I don't see any. I guess I have, I have-- oh, Senator Williams.

WILLIAMS: I was just going to-- and thank you, Vice Chairman Arch. And thank you, Mr. Turner, for being here. Were there additional examples in your testimony that you didn't get to, that you wanted to share with us?

CHRIS TURNER: As far as examples, I would say-- I say this on behalf of a multidisciplinary team that gets to review noncourt involved cases. So their cases have been investigated. The department has determined that there is a sufficient risk to the children that some services are necessary. We get to review those cases. And one thing that our team, which includes those child advocates-- what we see are workers coming to us saying: Well, I can't drug test, that's our policy now. And, you know, those workers would like to be able to drug test. And there's even been-- you know, this, this issue made the news, and there was a lot of reporting on this issue back in, kind of, May of 2019. And if you look back to those records, there's caseworkers telling the news agencies, like KETV: I resigned because I couldn't keep kids safe with that policy. And we hear that same feedback from some of our caseworkers, with their frustration. And they want to do a good job and they're there to do a good job. But this policy handcuffs them, prevents them from doing it.

WILLIAMS: So your testimony would be with it, without this, we are not protecting child safety.

CHRIS TURNER: Absolutely. And I think my testimony would be supported by a lot of others in the child welfare area.

WILLIAMS: Thank you.

ARCH: Other questions? I, I have one. I don't know if you-- do have the bill in front of you?

CHRIS TURNER: I do.

ARCH: Could I ask you a question about, on page four, lines 17-22. It seems to be kind of the heart of the language here. It talks about alcohol and drug testing will be a "service available." And then, and then in line 19, it says "alcohol and drug testing shall be one component." Is there anything in this language that requires drug testing of, of every individual? Or is this, is the intention of this

language to be optional, that, that, or-- and of course, the policy would have to be developed-- but, but the intention would be that it would be optional, it would be a tool that, that could be used, or required of everybody?

CHRIS TURNER: Not required of everybody. I think the language is written, written in a way in line 22, that it "shall be one component" of the initial assessment and ongoing, specifically for drug or alcohol use or exposure being suspected. And I think I can see the, the-- maybe kind of the--what you're considering. It's not in order to mandate that every parent has to submit to testing on a certain basis. Certainly the child protection workers that we train, that we rely upon to implement and ensure safety. We just want to give them back the tool that they need, and that they're telling us they need, to ensure safety and have it as one option in front of them that they could utilize to ensure safety, and also just ensure and support the parents' recovery themselves.

ARCH: Thank you. Any other questions? Seeing none, thank you very much for your testimony.

CHRIS TURNER: Thank you very much.

ARCH: Other proponents for LB1059? Welcome.

IVY SVOBODA: Thank you. Good afternoon, Senator Arch and Health and Human Services Committee. My name is Ivy Svoboda, I-v-y S-v-o-b-o-d-a, and I'm the executive director of the Nebraska Alliance of Child Advocacy Centers, the membership organization for our state's seven child advocacy centers, or CACs, and I'm in support of LB1059 and AM2511. I testified before this committee, last October, about the significant decline in testing children for exposure to substances in our state's-- since the department's policy in 2018, where they changed the drug and alcohol testing. In 2018, DHHS stopped ordering tests of children for exposure unless there was a court order requiring them to do so. You're receiving a copy of the fact sheet that I had distributed then. The change in DHHS practice occurred in the spring of 2018 and then was formally finalized with a new drug testing memo issued that fall. The data on the fact sheet shows that there is a change, that the change in policy reduced the number of tests, but has not necessarily improved the accuracy or appropriateness of children tested. Since your October hearing, when this committee was briefed about the impact of the current drug testing policy, there has been no movement or meetings to reconsider

the policy that the CACs had been included in or made aware of. Child advocacy centers remain concerned about the current DHHS policy on drug testing. Our members believe that it does not serve children's best interests for several reasons. First, the policy treats testing of children exposure to substances in exactly the same manner as the testing of parents for substance use. This is not sound policy. The reasoning behind testing children is different than the reasoning behind the testing adults, and the policy should reflect the differences. Medical literature is sparse on the full impact of drug exposure for children, though there are indications that exposure can impact children's long-term health and development. Furthermore, specialized medical providers who work at our child advocacy centers consider positive hair and nail tests indicative that a child has experienced neglect. Neglect is clearly shown to have an impact on child development, physical and mental health. I distributed a summary of these points and the appropriate use of interpretation of positive drug testing results from the medical director at the Lincoln Child Advocacy Center. Because testing can essentially prove neglect, testing is especially important for young children who are reportedly drug endangered, but who cannot be interviewed and therefore provide information about the environment that they live in. One example of when testing for exposure is recommended: a parent admits to some sort of drug use, but contends that they are always away from the children and only use when the children are in the care of others. Testing children for exposure can confirm or deny this. Sometimes when a parent tests positive, it can be an important tool to help the caregiver to seek treatment. In addition, our CAC membership is concerned that currently there is not enough multidisciplinary team collaboration around drug endangered children, and that cases are not being appropriately detected and responded to. This is, in part, due to continued fallout and entrenched conflict over DHHS's drug testing policy, making testing extremely rare, and even when it would be helpful to DHHS staff, as Mr. Turner mentioned, other multidisciplinary team members, and, most importantly, children and caretakers. Best practice recommendations, from both SAMHSA and the Department of Justice Task Force on Drug Endangered Children, stress the importance of agency communication and cross-agency protocol for consistent response in these type of cases, for a response that ensures safety and fairness, and promotes healing for our children and families. Our hope is that AM2511, if enacted, would take away some of the cumbersome restrictions on drug and alcohol testing so that this continues to be one investigative tool available, and teams responding can better coordinate and collaborate in these cases. We thank Senator

Howard, for putting forth this measure, and we hope the committee considers advancement and lends legislative assistance to help ensure a full array of tools are available in investigations of child abuse and neglect.

ARCH: Thank you. Thank you for your testimony. Are there questions from the committee?

WALZ: I-- go ahead.

ARCH: Senator Murman.

MURMAN: Thank you, Senator Arch. And thanks a lot for testifying. I may have missed it, but what if the parents refuse to be drug tested?

IVY SVOBODA: Ours is about the testing of children.

MURMAN: OK.

IVY SVOBODA: So if they refuse-- well, is this part of the investigation?

MURMAN: Um-hum.

IVY SVOBODA: Then that's determined by the, those that are in custody of the children.

MURMAN: OK. So that--

IVY SVOBODA: So the--

MURMAN: --would be--

IVY SVOBODA: --department would take custody,--

MURMAN: --a factor,--

IVY SVOBODA: --and then they would, yeah.

MURMAN: --if they did refuse. OK. Thank you.

ARCH: Thank you. Senator Walz.

WALZ: I was just-- I, I don't remember. Can you remind me why that was changed in 2018, what the reason was?

IVY SVOBODA: I'm not exactly-- it would be conjecture for me to say. That'd be a question for the department,--

WALZ: OK.

IVY SVOBODA: --why they decided to change it.

WALZ: All right. Thanks.

IVY SVOBODA: Um-hum.

ARCH: All right, just one last question.

IVY SVOBODA: Um-hum.

ARCH: So your testimony was specific to children.

IVY SVOBODA: Yes.

ARCH: The bill does include testing of adults, though, as well.

IVY SVOBODA: Yes.

WALZ: OK.

ARCH: Thank you. Other proponents of LB1059? Welcome.

JOE KOHOUT: Vice Chairman Arch and members of the Health and Human Services Committee, my name is Joe Kohout, K-o-h-o-u-t. I'm registered as a lobbyist, appearing today on behalf of our client, Nebraska CASA, Court Appointed Special Advocates. We appear in support of both LB1059, but also AM2511. And you have received, as part of the record, a letter from Lancaster County CASA, I believe. We, as the state organization, fully endorse that letter. But more importantly, I think-- when I was speaking to our executive director, I said: OK, give me an example. What have our volunteers-- because of, if the committee recalls, our, our folks are all volunteers who are out working in cases where they're acting in the best interests of children who are in abuse and neglect cases. And she related a story of a, of a situation in central Nebraska where one of our volunteers had, in fact, worked, had, had two small children that she was caring for. And the mother had an addiction issue that was preventing her from providing a home where abuse and neglect, where the children wouldn't be neglected. And so the judge had ordered this particular volunteer to oversee those children. The mother went through

reunification, met the standards of the court, went through the unification, reunification process. And shortly thereafter, the CASA volunteer showed up to check on the children. And the mother was high, so high that she couldn't stand up. So in that particular case, CASA believes that this testing is absolutely imperative to making sure that we're putting children in those, in those positions back into safe homes. So with that, I will try to end my testimony and answer any questions you may have.

ARCH: Are there any questions from the committee? Seeing none, thank you--

JOE KOHOUT: Thank you.

ARCH: --for your testimony. Other proponents for LB1059? Seeing none, are there opponents to LB1059?

JANINE FROMM: Hello.

ARCH: Welcome.

JANINE FROMM: Good afternoon. Members of the Health and Human Services Committee, my name is Dr. Janine Fromm, J-a-n-i-n-e F-r-o-m-m, and I am the executive medical officer for the Nebraska Department of Health and Human Services. I'm here to testify in opposition to AM2511, which was filed on February 20th and is referenced in the intent statement. AM2511 would require the department to utilize alcohol and drug testing for all court, noncourt involved traditional response or alternative response cases in which drug or alcohol use or exposure is suspected. As DHHS has previously testified, the Division of Children and Family Services, CFS, updated its drug testing protocol for children and families involved in the state's child welfare system on October 1, 2018. After a review of our prior policy, it was determined that CFS's drug testing protocols needed to be revised in order to enhance the parents' protective capacities and allow parents to safely raise their children in their family home. The agency's prior policy, and what would occur under AM2511, is repetitive drug testing of parents, using taxpayer dollars. The department sought to develop a policy that aligns with national best practices. CFS continues to use drug testing as one part of working with families when it is recommended by a treatment provider or when it is ordered by a judge. And our policy currently allows for that drug testing. AM2511 would require drug and alcohol testing during the initial assessment phase of working with families. The initial effect, assessment phase is a

largely voluntary process. Families often choose to allow the caseworker into their home, but this amendment would require the caseworker to request far more from the family. The caseworker cannot require a parent to submit to a test. The caseworker can only ask a parent to voluntarily submit to such testing. It's effectively a mandated search of a person. Some might suggest that this presents constitutional issues. It's one thing for a person conducting the initial assessment to enter into someone's home to determine if a child is safe. But it's another thing for the initial assessment worker to inform the parent that they must submit to a drug and/or alcohol test. In addition, in order for the Alternative Response program or any child welfare case management to be effective, there's a required level of trust necessary between the caseworker and the parent. As written, this amendment would require a caseworker to request a drug or alcohol test from any parent who indicates that he or she uses, not abuses, or has exposure to alcohol or drugs. This could detrimentally impact the relationship caseworkers work so hard to build with families in what is already a very trying time. As executive medical officer, a behavioral health clinician, and a medical doctor, I'm concerned about the assumptions that drive a drug-testing mandate for families involved in child welfare cases. A drug test alone cannot determine the existence or absence of a substance use disorder, nor can a simple drug test assess the impact, if any, assess-- the substance use has or the risk to the child. A positive drug test should never be immediately equated with child maltreatment or the need to remove a child from their home, just as a negative drug test does not mean the child is necessarily safe and cared for. Detection of a substance in a drug screen does not always mean impairment. Medically, there are so many variables that can affect drug screens. Detection of drugs is dependent on the type of specimen, the amount and frequency and time of drug use, the person's metabolic rate, BMI, age, health, and drug tolerance. There are currently no federal guidelines for any biological specimen other than urine; and urine has some real limitations. The department strongly opposes AM2511, and would ask the committee not to adopt the amendment. Thank you for the opportunity to testify before you today, and I'm happy to answer any questions you might have.

ARCH: Thank you, Dr. Fromm.

JANINE FROMM: Sure.

ARCH: Are there any questions from the committee?

WILLIAMS: Go ahead.

MURMAN: Thank you.

ARCH: Senator Murman.

MURMAN: Thank you for testifying.

JANINE FROMM: Sure.

MURMAN: If, if the initial assessment was a court-ordered assessment, would that make any difference in your testimony?

JANINE FROMM: If it was court ordered that a drug screen be done, drug?

MURMAN: Yeah.

JANINE FROMM: Yes, then that would be done. We, we will still do drug screening with court orders, and, and also drug screening if they're in treatment, they-- they will have drug screening.

MURMAN: OK. To clarify a little more, would the initial assessment be a court-ordered welfare check? Or is there a difference between a court-ordered welfare check and a court-ordered drug assessment?

JANINE FROMM: If a judge orders a drug test to be done, that if-- we can have that done. And we, we still pay for that, we still do those.

MURMAN: OK. And that wouldn't always be done with a judge's-- if a judge just ordered like a welfare check on the--

JANINE FROMM: Correct.

MURMAN: --home, that wouldn't necessarily--

JANINE FROMM: Would not be necessarily--

MURMAN: --be in a court.

JANINE FROMM: --done. Correct.

MURMAN: That'd be a-- yeah, a drug test. OK, thanks.

ARCH: Thank you. Did you have a question?

WALZ: Yeah. Thank you.

ARCH: OK. Senator Walz.

WALZ: Thank you. Thanks for coming today.

JANINE FROMM: Sure.

WALZ: I-- in your testimony, you said that it would be required. I'm trying to find where you said that-- but that it would be required.

JANINE FROMM: Correct.

WALZ: A caseworker--

JANINE FROMM: There's--

WALZ: --would be required to request a drug. And I'm not[-- I guess maybe I'm looking at it differently. I'm not seeing where it says that the caseworker is required--

JANINE FROMM: In which drug or alcohol use or exposure is suspected.

WALZ: Drug and alcohol testing shall be one component of initial assessment, but it doesn't say that it's the only-- that it's required. Or maybe I'm--

JANINE FROMM: Well, it is part of the initial assessment when it's suspected, and you would require that to be done.

WALZ: OK. OK.

JANINE FROMM: Right? Is that not?

WALZ: I don't know if I'm-- you know, I must be [INAUDIBLE].

JANINE FROMM: That's the way I read it.

ARCH: OK.

WALZ: I'll ask Senator Howard.

ARCH: OK. Any follow-up questions? All right. Senator Williams,

WILLIAMS: Thank you, Senator Arch. And thank you, Dr. Fromm, for being here. And if I understood your, your initial comments right, you felt that the change that was made in 2018 was based on nationwide best

practices. My question follows along the practical aspect. You, you've heard the testimony of Mr. Turner and Mr. Kohout about specific examples and, specifically, the one where the CASA worker goes into the home and the mom who has young children there is clearly impaired. What choices does that caseworker or that CASA worker have, at that point, without us doing something or DHHS doing something?

JANINE FROMM: Sure. If the mom is clearly impaired and the children are at risk, they get taken out of the home, regardless of what a drug test would show you. Right?

WILLIAMS: OK.

JANINE FROMM: There's a clear impairment there and a clear risk to the children. It, it, it's-- again, it doesn't, it doesn't mean that we do nothing.

WILLIAMS: OK. So the-- is, is there more than just best practices to the rationale of the change that took place?

JANINE FROMM: Yes. Drug testing leads to more out-of-home placements, kids being taken away from their parents. Families and parents find it adversarial, not collaborative, to have bodily fluids taken by a social worker. If we want to go in there and build the family, help them, actually work with them on getting proper treatment and getting support so that they can parent their children, to be the best practices are-- is considered to work with them collaboratively, collaboratively and not punitively. I think we see that with our Family First Prevention Act. We want to try to keep the kids in the home. You know, the war on drugs is probably really our longest war that we have fought. We have data now. We know that kids that are taken out of the home are traumatized, no matter how, how bad the parents are. They want to be with the parents-- that you do better long-term if you put services into the home for the parents and build that family, so that they can take better care of their children and have the children stay in the home. You know, this is coming from, from years of data. So there's a real shift, a shift away from going in punitively, asking for bodily fluids, and reacting to that, to really doing a full assessment, working with the family collaboratively, getting those families treatment so that those kids can, can be taken care of in the home.

WILLIAMS: Thank you, Doctor.

JANINE FROMM: Sure.

ARCH: Thank you. Are there any other questions? Senator Walz.

WALZ: I have a quick follow-up on that. Going back to the CASA worker, you mentioned that in that case that the children could be taken out of the home immediately. I guess my question is, then-- and you, and the worker definitely knew that there was something going on. How do you go back? And if you can't take the drug test, then how do you go back? And how do you go back and clarify that that person-- not clarify, that's not the word I'm trying to find-- but how do you go back and clarify that person was using drugs? If-- how much time is there between the time you take the kids out and the time you have the ability to go back and clarify that, I guess? I don't know what--

JANINE FROMM: Get them into appropriate treatment? Get them in front of the judge? I'm not sure what--

WALZ: Substantiate that they were using drugs, substantiate that they were, that they were using drugs that day. How do you substantiate that if you cannot take the drug test at that point?

JANINE FROMM: I will, I will let Child and Family Services answer that. My medical opinion would be, at some point you can do drug testing if that is a concern. Right? You could do a hair sample. That will show you that they're, they are using meth later on, if a court orders that, if that's needed. The question is, does that caseworker, does a social worker have the ability or have, have the right to take bodily fluids right then?

WALZ: Um-hum.

JANINE FROMM: Is that the best thing for them? If the kids are at risk, the kids are out of the house,--

WALZ: Um-hum.

JANINE FROMM: --whether there's drugs or not.

WALZ: OK.

ARCH: Thank you. Other questions? Seeing none, thank you--

JANINE FROMM: Thank you very much.

ARCH: --very much for your testimony. Other opponents to LB1059? Seeing none, are there any individuals that would like to testify in a neutral position to LB1059? Seeing none, Senator Howard, you're welcome to close. And while you're coming up, we do have some letters-- proponents: Sandra, Sandra Markley, Office of County Attorneys, from Sarpy County; Karin Walton, self, who is an attorney; Amy West, self; Dawn Rockey, CASA for Lancaster County; Brent Kelly, Holt County Attorney; Jaymee Lavender-- Levander, criminal investigator, Columbus Police Department; Andrea Phillips, National Association of Social Workers. There were no opponent letters. And in the neutral: Sarah Helvey, from Nebraska Appleseed; and Lana Temple-Plotz, from Children and Family Coalition of Nebraska. Senator Howard.

HOWARD: Thank you, Senator Arch. Thank you for paying attention to AM2511 and considering this carefully. I, I-- to, to your point, Senator Walz, it's very hard for a caseworker to prove risk if they're not able to test. And while Dr. Fromm says: Well, they could take a hair sample at that moment, but if they're not able to take a urine sample, they're also not allowed to take a hair sample, and then maintain the fidelity for it to be utilized for a test at that moment. And so I think the drug testing policy, while there, there's a piece of it that's a best practice, I think there also still needs to be the opportunity for a worker on the ground to be able to call for a test when they do feel as though there's a risk. And right now, under the current policy, without a court order, you're not able to get that drug test done. And so this is an issue that I think will keep coming back until the Legislature truly is able to grapple with it with the department. And this is just part of that ongoing conversation. So I appreciate your attention to this issue.

ARCH: Any questions for Senator Howard? I, I guess I have one more, given, given your history and knowledge of this topic.

HOWARD: Hmm.

ARCH: Did-- when, when that policy-- before the policy changed in 2018,--

HOWARD: Um-hum.

ARCH: --was it an automatic decision to remove a child if that drug test came back positive? Does it-- it doesn't require the, the removal

if there's a positive drug test-- is that-- was that correct, prior to 2018?

HOWARD: Yeah.

ARCH: So there was still discretion--

HOWARD: Um-hum.

ARCH: --on the part of the department, whether or not to remove.

HOWARD: Right. And sort of-- and I was speaking about, with Mr. Turner earlier, about this. Our, our, sort of, mores and expectations around drug use have really changed, in the sense that it used to be, if there was marijuana, you would do a removal, right And now that's less of a concern. What we're really dealing with are things like meth and nonprescription opioid use, heroin and cocaine. And so a positive drug test isn't necessarily an indicator that you would need to do a removal. But it is helpful when you're trying to decide what type of services that family might need. And so without a drug test, how do you know that they need a substance use treatment plan or treatment opportunity? I think it really sort of handicaps the worker when they're trying to figure out what services they need and, also, make that judgment call about whether or not they need to recommend a removal.

ARCH: All right. Thank you. Any other questions? Seeing none, thank you.

HOWARD: Thank you.

ARCH: And that will close the hearing for LB1059.

HOWARD: My last bill-- ever.

ARCH: Congratulations.

HOWARD: Yeah, I did it. And we're going to take a five-minute break.

ARCH: Great. We'll take a five-minute break before resuming.

[BREAK]

HOWARD: We will open the hearing for LB815, Senator Morfeld's bill to prohibit certain, certain Section 1115 waivers under the Medical Assistance Act. Welcome, Senator Morfeld.

MORFELD: Thank you, Chairwoman Howard. Members of the Health and Human Services Committee, my name is Adam Morfeld; that's A-d-a-m M-o-r-f as in Frank-e-l-d, representing the fighting 46th Legislative District, here today to introduce LB815. LB815 prohibits the Department of Health and Human Services from pursuing, applying for, or implementing any Section 1115 waiver projects to expand eligibility to the Medicaid expansion population. As you all know, in November of 2018, Nebraskans overwhelmingly voted to support expanding Medicaid to 90,000 of our fellow citizens. Voters believed it was important to provide healthcare access to their hardworking friends and neighbors, many of those whose stories I have shared with this committee on the floor and here in, in committee, as well. However, in April 2019, the department announced that it would take until October 2020 to implement a complicated Section 1115 waiver plan called the Heritage Health Adult Program. This optional program involves two tiers of benefits, work and wellness requirements, and a waiver of retroactive coverage, none of which were contemplated by the ballot initiative. This past winter, there were state and federal comment periods on the proposed waiver, and the response from the public and the health policy experts was overwhelmingly negative, with hundreds of comments submitted in opposition. Concerns were raised regarding the barriers to coverage presented by work and wellness requirements. Commenters also stressed the importance of dental care, vision care, and over-the-counter drugs to staying healthy and being able to work. Additionally, there was no shortage of comments on the administrative burdens that will result in this program, which is based on layers and layers of red tape that is unnecessary. As I've stated to this committee before, a Section 1115 waiver is not what voters intended, and it's not required for the state to expand Medicaid. I would know; I helped lead the initiative. It is an option that the department is pursuing that makes it overly burdensome and complex for those who just want to see a doctor, and I think it's also in violation of the law. LB815 would prohibit the department from pursuing, applying for, or implementing any experimental pilot or demonstration project, under Section 1115, to expand eligibility for the Medicaid expansion population. Instead, the department would need to move forward with the state plan amendments to expand Medicaid, as contemplated by the ballot initiative, without tiers, without work requirements, without administrative burdens and unnecessary red tape, which costs millions of dollars, which the

administration also used as an excuse to oppose the original initiative. Also, it's important to note that this bill does not prohibit the use of other Section 1115 waivers as they apply to other Medicaid eligibility categories. The bill specifies that the prohibition applies to using a waiver to expand eligibility for medical assistance persons eligible under the section, referring to Section 68-992, which is a statute that voters passed to adopt Medicaid expansion. The intent of the bill is not to prohibit all Section 1115 waivers in all circumstances, but rather to ensure that the intent of the voters who passed Medicaid expansion on the ballot is fulfilled, and to avoid harm presented by the Heritage Health Adult Program. I would urge your favorable consideration of this bill and be happy to answer any questions that you may have.

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

MORFELD: I'm going to stay, but I may have to step out for--

HOWARD: Yeah.

MORFELD: --a Judiciary Committee group photo that--

HOWARD: Yep.

MORFELD: --our chairman is very insistent on.

HOWARD: Got to get--

MORFELD: Yeah.

HOWARD: --that photo op.

MORFELD: Yeah.

HOWARD: All right.

MORFELD: Yeah.

HOWARD: We'd like to invite our first proponent testifier up for LB815.

JEANNETTE JONES-VAZANSKY: Good afternoon.

HOWARD: Good afternoon.

JEANNETTE JONES-VAZANSKY: Do you want me to start or wait until she passes out?

HOWARD: You can start.

JEANNETTE JONES-VAZANSKY: OK.

HOWARD: We'll get them.

JEANNETTE JONES-VAZANSKY: So good afternoon. My name is Jeannette Jones-Vazansky, J-e-a-n-n-e-t-t e J-o-n-e-s-- hyphen-- V as in Victor-a-z as in zebra-a-n-s-k-y. Dear Senator Sara Howard and members of the Health and Human Services Committee, I'm here today on behalf of my sorority's chapter, the Lincoln Alumnae, Alumnae Chapter of Delta Sigma Theta Sorority, Incorporated. We support LB815 to prohibit Medicaid expansion waivers, on the ground that the waivers will prevent the department from providing healthcare to Nebraskans in need. In addition, the waiver program, as we see it, includes numerous barriers, including tiered benefits and work requirements, to providing healthcare. Founded in 1913, as a historically black sorority, we have, for 107 years, taken an active interest in the political, social, economic, and legislative affairs of these United States of America. We are committed to ensuring that laws have a positive impact on society. Back in 2014, our national headquarters charged us with two tasks that we believe are important to promoting public health, even now, six years later: 1) to continue educating the public about the Affordable Care Act; and 2) advocating for Medicaid expansion. We continue this advocacy today as part of one of our five programmatic thrusts, physical and mental health-- health, excuse me. In implementing this bill, the state will help address health and, and-- oh-- and not-- if implementing this bill, the state will not help address health disparities affecting all Nebraskans, including African-Americans. When we did research, we found, for instance, in 2011, about 20 percent-- and this is a nationwide figure-- of African-Americans were uninsured. Furthermore, at least 59 percent of uninsured African-Americans with income, incomes below the Medicaid expansion limit resided in states not expanding Medicaid. As Senator Morfeld said, Nebraskans voted overwhelmingly in 2018, to expand Medicaid in the state. And one of the reasons why we're concerned is because African-Americans, our primary focus group, are at risk of facing coverage gaps due to states like Nebraska, who are not expanding Medicaid or are putting barriers to that expansion. While the numbers have improved in 2020, in terms of black people's access to healthcare, there is still a substantial racial gap in access to

affordable healthcare. And that is, of course, not the only group that is affected. So passing LB815 is an opportunity to assure healthcare access to thousands of Nebraskans without burdening them with excessive requirements to receive coverage, and paperwork, as Senator Morfeld said. This will keep our community strong, healthy citizens who are able to contribute to the community, or how we build a better Nebraska. We conclude with the words of Senator Nordquist from some time ago, "Access to quality, affordable healthcare should be a priority for all of us who represent the 'good life' in Nebraska." And we ask that you vote yes on LB815. Thank you.

HOWARD: Thank you. Are there questions? Seeing none, thank you for visiting with us.

JEANNETTE JONES-VAZANSKY: Thank you so much.

HOWARD: All right. Our next proponent testifier for LB815? Good afternoon.

TIFFANY FRIESEN MILONE: Good afternoon. Chairperson Howard, members of the committee, my name is Tiffany Friesen Milone, T-i-f-f-a-n-y F-r-i-e-s-e-n M-i-l-o-n-e. I'm policy director at OpenSky Policy Institute. We're here today in support of LB815, as we don't believe expansion should be delayed in order to undertake a demonstration that would provide less comprehensive health coverage to families while increasing bureaucracy and state spending. We instead support allowing the expansion population to enroll in the state's traditional Medicaid program, as outlined in the ballot initiative. The Department of Health and Human Services has estimated it will spend more than three times as much as an administrative cost to implement expansion with the demonstration than without it. And in 2017, the fiscal note, DHHS projected it would need around $1.8 million in FY20 to administer expansion without the demonstration, assuming enrollment starting January 2020. When DHHS announced the demonstration in April 2019, it said it would need an additional $4.2 million in FY20, with enrollment pushed to October, so significant increase, significant increase in both costs to the state and the amount of time those otherwise eligible will have to wait to get health coverage, during which time some may incur medical debt, and the state may forgo federal matching dollars. The agency's final application doesn't include administrative projections in the budget neutrality tables, but the estimates provided are, nonetheless, significantly higher than what was initially estimated for expansion. In the application. DHHS estimates total aggregated state and federal expenditures, which don't include

administrative costs, of $3.9 billion over the five-year demonstration period for the adult expansion population. Yet in September 2018, the agency estimated that the first five years of Medicaid expansion, as approved by voters, and including administrative expenses, would have a total cost of $2.4 billion. It's unclear why DHHS's estimates in the application are $1.5 billion higher under the proposed demonstration. Based on other states' experiences with similar Medicaid demonstrations, increased administrative costs likely aren't hypothetical. A Government Accountability Office report, released last fall, found taxpayers have already spent at least $408 million on similar programs in just five states, with $270 million spent in Kentucky alone. GAO emphasized that these estimates aren't inclusive of all costs, as most states only reported upfront expenses and not ongoing ones, like staff salaries and annual program evaluation, which is required by the federal government. Because of budget neutrality, estimates don't include any administrative costs. The full cost of the demonstration, at either the state or federal level, is unknown. In addition to the unit, community engagement requirements, Nebraska is proposing to waive retroactive eligibility for those gaining coverage through expansion, as well as many currently eligible for Medicaid. While DHHS projects savings from leaving this coverage, the state's projected per-member-per-month spending growth remains the same. That means the lower expenditures are the result of an anticipated drop in member months due to the change, which will likely shift millions of dollars of debt and uncompensated care to providers and raise medical debt burdens for beneficiaries. When Ohio was considering waiving retroactive eligibility in 2016, a consulting firm advised that hospitals could wind up with as much as $2.5 billion more in uncompensated care costs over the five year period. CMS ended up disapproving Ohio's waiver amendment application. To conclude, all these costs are significant and unnecessary. And so we support moving forward with expansion, as approved by voters, as soon as possible. With that, I'm happy to answer any questions.

HOWARD: Thank you. Are there questions? Seeing none, thank you for visiting with us today.

TIFFANY FRIESEN MILONE: Thanks.

HOWARD: Good afternoon.

ANDY HALE: Good afternoon. Chairwoman Howard and members of the HHS committee, my name is Andy Hale, A-n-d-y H-a-l-e, and I am vice president of advocacy at the Nebraska Hospital Association. And I'm

here to testify in support of LB815. The Medicaid population is a fluid population, with beneficiaries moving in and out of the program. Maintaining two separate benefits structures creates an administrative burden and complexity that really isn't necessary. One of our main concerns with that has to do with dental services not being included. Providing dental service is critical to both the prevention and treatment of chronic diseases. Studies have shown a strong association between oral health and illnesses, such as heart disease, diabetes, and cancer. Another issue is the process of eligibility checking every six months. Under this, eligibility beneficiaries may flip back and forth between prime and basic coverage every six months; and that's a burden. I'll tell a story that will probably make my lobbyists behind me cringe because every time I tell a personal story, she, she cringes a little bit. But I'm on my wife's insurance plan and we changed over and got a new insurance plan, a new card, last summer. And so my wife assured me to make sure we, we switch the cards out. And of course, I assured her I did-- and did not. Went to the clinic for a sinus infection and reached for the first card that I had, which was an old insurance card. And they accepted it and took it. And I've had insurance for 48 years of my life. And so even someone who's familiar with this area and arena can make mistakes. And so this is an issue that we think is difficult for those beneficiaries. Our last concern is the elimination of the three-month retroactive lookback period. And Tiffany, before in her prior, prior testimony, did a good job of laying out the concerns. But the elimination of this process would have significant impact on our facilities financially, as well as the beneficiaries and other providers. It will increase uncompensated care for costs for proprietors, providers and provide medical debt for beneficiaries. The last thing I would like to mention is I'd like to thank the state for working with the Hospital Association. We have six member hospitals with very diverse populations, working with Nebraska Medicaid and enrolling new Medicaid eligibility individuals within our hospitals. And so, starting last fall, we've had a pilot program. And those facilities are located in Lexington, in Crete, as well as Bryan Health, here in town, Nebraska Medicine in Columbus, and then CHI Health. So things have been working well, as far as that. We bring them into our facilities, and they're able to work with new enrollees, so trying to get a feel of what that process is going to look like. As we know, we only have 90 individuals. So we'd like to thank Senator Morfeld and his staff for introducing this legislation and ask the committee to advance LB815. And I'd be happy to answer any questions.

HOWARD: Thank you. Are there questions? Seeing none, thank you for visiting with us today.

ANDY HALE: Thank you.

HOWARD: Our next proponent testifier for LB815?

MARY SPURGEON: Good afternoon, senators. My name is Mary, M-a-r-y Spurgeon, S-p-u-r-g-e-o-n. Omaha Together One Community, or OTOC, is a broad-based organization of 20-plus congregations and other community organizations that work together for the common good. OTOC supports LB815. Initiative 427 was passed by a majority of Nebraskans. They envisioned the benefits that would accrue to the beneficiaries of Medicaid expansion and how these, those benefits would also ripple out to their communities. Members of OTOC institutions advocated for the passage of Initiative 427. We were well aware of the responsibility placed upon us by the tenets of our faith communities and as individuals. We sought to help those left behind in our current economy, mostly working Nebraskans, but unable to access or afford healthcare insurance coverage for themselves and their families. OTOC extends deepest gratitude to Senator Adam Morfeld for introducing LB815, in an effort to reduce harm that has occurred due to our state executive branch's action, which we believe to be in violation of the Constitution of Nebraska. OTOC laments the fact that LB815 is made necessary in order for legislation, passed by the people under Nebraska law, to be carried out as that law was written, including the following language, "(3) The Department of Health and Human Services shall take all actions necessary to mac, maximize federal financial participation in funding medical assistance pursuant to this section. (4) No greater or additional burdens or restrictions on eligibility, enrollment, benefits, or access to health care services shall be imposed on persons eligible for medical assistance pursuant to this section than on any other population eligible for medical assistance." OTOC observes, with profound sadness, dismay, and anger, that the executive branch of Nebraska state government has taken actions that are in violation of Article II of the Constitution of Nebraska, from Article II, Distribution of Power, Section 1. This has occurred through the submission of a delayed, costly and questionably lawful Medicaid expansion waiver. This waiver submission should not stand. Will you, the members of this committee, permit this infringement upon the most fundamentally empowering section of the Nebraska Constitution, the lawmaking powers of the people? Please assert the power of the Unicameral to correct the wrong that has been done to

Nebraska citizens through the ill-conceived state plan amendment that contravenes the clearly stated and duly passed Initiative 427 change to the Medical Assistance Act of Nebraska. George W. Norris, for whom the chamber in which you deliberate was named, was the champion of Nebraska's nonpartisan Unicameral form of government. OTOC urges each of you be filled to the brim with his sense of honor, integrity, conscience, and courage. Pass LB815 out of committee and champion it through passage in the Unicameral to achieve the stated will of Nebraskans in support of Medicaid expansion. Thank you all so much for all of your service.

HOWARD: Thank you. Are there questions? Seeing none, thank you for visiting with us today. Our next proponent testifier for LB815? Good afternoon.

ANDI CURRY GRUBB: Good afternoon. Thank you, Chairperson Howard and members of the Health and Human Services Committee. My name is Andi Curry Grubb; that's A-n-d-i C-u-r-r-y G-r-u-b-b, and I am the state executive director of Planned Parenthood North Central States in Nebraska. Planned Parenthood operates two health centers in Nebraska and serves as a leading women's healthcare provider, an advocate, and a trusted nonprofit source of primary and preventive care for women, men, and young people. Every year, our health centers provide affordable birth control, lifesaving cancer screenings, STI testing and treatment, abortion, and other essential care to more than 9,500 patients in Nebraska. PPNCS stands with our patients and the 356,891 Nebraskans who voted to expand Medicaid in 2018, without the work tiers or work requirements the 1115 wake, waiver seeks to impose. As an advocate for women and families, I know that Medicaid is critical to improving the health and well-being of women and families with low incomes, across Nebraska and the rest of the nation. Approximately one in five women of reproductive age use Medicaid. The program is the largest payer of reproductive healthcare coverage in the country, paying for 75 percent of family planning services. And for many women giving birth, Medicaid is the source of coverage for prenatal and delivery care. Recent data found that 31 percent of births in Nebraska are covered by Medicaid. Because women make up the majority of Medicaid enrollees, they will be disproportionately affected by Nebraska's proposal. Moreover, due to racism and other systemic barriers that have contributed to income inequality, women of color disproportionately comprise the Medicaid population, with 30 percent of African-American women and 24 percent of Hispanic women enrolled in the program, compared to only 14 percent of white women. We are deeply

concerned by several proposals in Nebraska's 1115 demonstration waiver request. While the stated goals of the request include promotion of economic stability and improving health outcomes, the result of these proposals will be the exact opposite, and the health of Nebraskans will suffer. These proposals contradict the objectives of Medicaid and do not serve a legitimate experimental purpose. The outcome is predictable. Women and families will lose access to affordable health insurance coverage and, as a result, the critical healthcare services. We have seen this repeatedly in other states that have adopted similar policies. Moreover, the proposed tiered system is confusing, complicated, and unnecessary to administer the Medicaid program. There is no evidence demonstrating these requirements improve health outcomes of participants, reduce unnecessary costs, or successfully transition individuals to employer-provided insurance, all of which are intended outcomes stated in the waiver application. In fact, there is ample evidence showing the exact opposite, that unrestricted access to comprehensive Medicaid coverage helps improve health outcomes. There are additional pieces in the document I submitted, regarding some of the harms of the proposed eligibility requirements but, for the sake of time, I'll let you read those on your own. For all of these reasons, both stated and in writing, PPNCS is grateful to the work of Senator Morfeld and proudly supports LB815, and asks this committee to advance LB815 out of committee to General File.

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

MURMAN: Thank you, Senator Howard. And thank you for testifying. Since you brought up racism in your testimony,--

ANDI CURRY GRUBB: Yeah.

MURMAN: --could you tell me the ratio of black babies aborted compared to blacks in the general population?

ANDI CURRY GRUBB: We don't necessarily have those statistics at hand. We voluntarily asked folks to submit information about their race. And if they don't, then, then we don't ask them to. So I also don't know that that's necessarily relevant to this particular discussion.

MURMAN: I think it is relevant. But thank you for your testimony.

ANDI CURRY GRUBB: Sure.

HOWARD: Other questions? All right. Seeing none, thank you for your testimony today. Our next proponent testifier for LB815? Good afternoon.

MOLLY McCLEERY: Good afternoon. Senator Howard, members of the committee, my name is Molly McCleery, M-o-l-l-y M-c-C-l-e-e-r-y, and I'm the director of the Health Care Access Program at Nebraska Appleseed. Nedhal is passing out quite a large pamphlet from me-- or packet of information. I will walk through my written testimony, but I also wanted to include a letter from an individual in Omaha who is in the coverage gap, who wanted to share his story, who is unable to be here today. And then I also included two analyses of the waiver that I will mention in my testimony. Nebraska Appleseed is a nonprofit legal advocacy organization that fights for justice and opportunity for all Nebraskans, and we support LB815. Under the voter passed initiative, as Senator Morfeld mentioned in his opening, the waiver program is not required for our state to expand Medicaid. It is an option that our state is pursuing, and it is clear, from the overwhelming opposition during the state and federal comment periods this past winter, that there are serious concerns with this proposal. And those concerns come from folks who would be eligible for the program providers, stakeholders, and health policy experts. You've heard from testifiers before me around the issues with the administrative complications with this program and the numerous barriers to coverage. In analyzing the Heritage Health Adult program, in comparison with other states' waiver programs, Families USA described Nebraska's waiver requirements as, "different in that they're the most extensive and administratively burdensome to date." The two packets of information from Families USA, that I've included with my testimony, compare Nebraska's waiver plan in terms of the requirements on providers and patients, and then, also, on the state administrative burdens that are presented by the waiver in comparison with other states. I think the number of checkmarks in the Nebraska column is pretty telling in comparison to what other states have proposed. And from the department's own estimates, over a third of enrollees will lose benefits that are important, including dental care, vision care, and over-the-counter drugs, due to the program's requirements. I've had conversations with individuals who utilize Medicaid, this week, and individuals in the coverage gap. And I can say, from their experiences, that dental and vision are key benefits in terms of being able to work and to support one's family. Over-the-counter pain relievers are key for individuals, as well, both to manage pain, but then also to treat heart ailments that individuals may have. These are services that are important to

maintaining overall health and to the ability to be working and involved in the community, which are the stated goals of this waiver program. Moreover, the agency note describes the risk of litigation, if not moving forward with this waiver. However, similar proposals in other states have faced legal challenges for not comporting with the purposes of the Medicaid program, including Arkansas' program that was blocked by a federal appeals court just this month. There have been three states that have seen their similar programs struck down by federal courts, and there are two other cases that are pending, as well. Work requirements are contrary to the purpose of the Medicaid program and legally suspect. The purpose of Medicaid is to provide medical assistance to individuals whose income and resources are insufficient to afford medical services. Reducing services to those who do not fulfill work requirement conflicts with Medicaid's purpose. The majority of Nebraskans who are in the coverage gap are already working, but in low wage jobs that don't provide insert insurance. However, due to potentially challenging reporting requirements, we are concerned about individuals erroneously losing benefits. This is something that is seen in other states that are further along in their waiver program, is that individuals are working, but, due to the complexity of reporting those hours and the challenges in providing that data, they end up losing coverage. The Medicaid program itself, including dental vision and over-the-counter drug benefits, support work by providing the coverage workers in low wage jobs need to stay healthy and to support themselves and their families. Again, a Section 1115 demonstration project is not something that our state needs to do to expand Medicaid under the statute that was passed by voters. And accordingly, we asked the committee to support LB815. With that, I'm happy to take any questions.

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

MOLLY McCLEERY: Thank you.

HOWARD: --visiting with us today. Our next proponent testifier for LB815? Seeing none, is there anyone wishing to testify in opposition? Good afternoon.

JEREMY BRUNSSEN: Good afternoon, Chairwoman, 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 am the interim director of the Division of Medicaid and Long-Term care within the Department of Health and Human Services. I am here to testify in opposition to

LB815, which prohibits the Department of Health and Human Services from utilizing a Section 1115 demonstration waiver for the purpose of expanding Medicaid eligibility. Section 1115 demonstration waivers are waivers granted by the federal government that allow states to waive provisions of federal Medicaid law for the purpose of demonstrating an innovative new way to better fulfill the main objectives of Medicaid, namely serving the health and wellness needs of those eligible for the program. As we shared with the committee in the past, our 1115 waiver is central Nebraska, central to Nebraska's planned Medicaid expansion program. Medicaid submitted our application for an 1115 waiver to the federal government on December 12, 2019. It is currently pending with the federal government, and we anticipate approval in early April. All of the work done on expansion has been to build the program detailed in our 1115 waiver application. If this bill were to go into law, we would need to significantly change our course, our approach to Medicaid expansion. This would involve undoing or redoing a fair deal of work the department has already completed, and could delay the beginning of the benefits many Nebraskans need. This bill will likely delay our technology build. A notable amount of coding has been done to implement our current plan and would need to be removed and redone, should this bill pass. In addition, regulations drafted for a new expansion program would need to be rewritten, training for staff would need to be redesigned, and business processes, such as eligibility determinations which are currently being rebuilt, would need to be paused and rebuilt again. This bill would impact our external partners, as well. The Heritage Health plans are currently updating their systems and processes to support the new expansion population. Fundamentally changing the structure of the current plans, the current plan brings risks to their systems, not accurately being updated in time for the expansion program to launch. In summary, LB815 would discard the months of progress we have made toward expanding Medicaid and likely to delay the launch of the program. We respectfully request that the committee oppose this legislation. Thank you for the opportunity to testify, and I'd be happy to answer any questions you have.

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

WILLIAMS: Thank you, Chairwoman Howard. And thank you, Mr. Brunssen, for being here. We've had a number of discussions about the issue of timing with-- first of all, getting the 1115 waiver and then the

implementation date. Are you still confident, like you have been in the past, about the implementation date of October 1?

JEREMY BRUNSSEN: Yes, very, very confident about where we are, where we are at on all aspects of our work to expand Medicaid.

WILLIAMS: Can you talk about the 1115 waiver process and the timing of that-- in that process, also?

JEREMY BRUNSSEN: Sure. So I think it's, it's been a, a process where we've worked proactively with our federal partners as we drafted the application, to ensure that, as we submit it, we've already removed any major concerns that they've communicated as we've shared drafts. So we, as, as noted, we submitted in December. The federal government comment period has closed. We've already received some questions from CMS and follow-up to that. We've responded to those questions. And all of our con, conversations with them indicate that they are confident that they're on the path to approve our waiver in April, as we had been communicating with them prior to submission.

WILLIAMS: And if that is approved in April, again, going back to the first question, the implementation process is underway. The MCOs are in their process of doing their job to be ready for an October 1. And as I remember, we had a hearing on setting that date, actually, in statute. And you came in either neutral--

JEREMY BRUNSSEN: Neutral.

HOWARD: Neutral.

WILLIAMS: --or supportive. You weren't opposed to it, though, at least. So--

JEREMY BRUNSSEN: Correct.

WILLIAMS: Has, has anything changed with that?

JEREMY BRUNSSEN: No, sir.

WILLIAMS: OK. Thank you.

HOWARD: And just to be clear, when in April do you expect to hear back?

JEREMY BRUNSSEN: So our target date is April 1st. It's obviously subject to the actual date that we receive notification. But all of our conversations, that we continue to have on a regular basis, would indicate that we're on, on pace for that.

HOWARD: And then I had heard that, on the federal level, they were allowing some states to take their 1115s and turn them into block grants. Is Nebraska pursuing that?

JEREMY BRUNSSEN: So yeah, there was a, really a very targeted 1115 demonstration waiver guidance that was provided to states. But Nebraska is not going down that path. It really was a framework that was being created to kind of create some more process around a specific target, targeted population. So that's not what Nebraska is doing. Ours is more like the waivers that many other states have sought, and they're specific to the state. In our case, ours is very specific to Nebraska.

HOWARD: Perfect. Thank you. All right. Other questions? Seeing none, thank you for visiting with us today.

JEREMY BRUNSSEN: Thank you.

HOWARD: Our next opponent testifier for LB815? Seeing none, is there anyone wishing to testify in a neutral capacity?

EDISON McDONALD: Hello.

HOWARD: Good afternoon.

EDISON McDONALD: Hi. My name is Edison McDonald, E-d-i-s-o-n M-c-D-o-n-a-l-d, representing The ARC of Nebraska, coming today in a neutral position. I just wanted to talk a little bit about state plans versus waivers, and about, kind of, the uses of those and what makes sense as I think we move forward on this and other projects; really taking a little bit of a glance at that is important. So in order for states to make changes to their Medicaid programs, you have the state plan amendment that can apply to anything, including eligibility benefits, provider payments. There's no cost neutrality requirement, it's permanent, so it doesn't expire, there are no waiting lists. Whereas a waiver, you have Medicaid benefits and often include, includes additional LTSS, cost neutrality is required, waiting lists are allowed and typical, they're time-limited and must be renewed regularly, and statewideness and comparability are waived. So special

benefit pop, benefits for populations can happen. The other handout there we handed out, kind of walks through a variety of waiver options, including an 1115 waiver. Ultimately, 1115 waivers are intended to be experimental, to go and provide for an opportunity to try something out, figure out something, and really find a way to go and move forward, and should come to a termination, which was not the intent of Medicaid expansion. An 1115 waiver is the broadest type of waiver available under Medicaid. Officially, these waivers are to be used for states to create demonstration projects intended to improve Medicaid or CHIP programs. They must include a formal evaluation of impact. Under an 1115, states may propose to waive many of the key provisions of the Medicaid statute, including, but not limited to, which individuals are covered, which benefits must be provided, how much individuals may be charged for premiums and copayments, and how providers will be paid. An 1115 waiver can be very broad or very narrow, depending on the state's goals. All 1115 waivers are currently required to be budget neutral, meaning the state will receive no more federal funding than it would have received without the waiver. States submit its 1115 waiver requests to CMS for review and approval. They are typically approved for an initial five-year period and can then be extended another three years, if requested and approved. Federal transparency rules, which require public input at the state level and again during the CMS review, apply to all new 1115 waivers and renewals of existing waivers. And ultimately, I think that it's clear there, there are some problems, and especially for our population. These problems could extend to lack of certainty, lack of being able to plan for the future and services or benefits. And for us, really, our concern is the entire breadth of the system. Medicaid is intended to be a system that covers both the scope of age and the breadth of disability. For folks who would qualify under this pathway, there are folks who are sitting at the lower level of disability, and so, really, figuring out how we can go and balance that and create that comprehensive system, I think, ultimately, an 1115 waiver may not necessarily be the best approach. 1115 waivers, really, we want to find some way that we can go and prove those results and look forward. And in testing those results, we'd really like to see some data, particularly from the state, around how that impacts populations with-- of individuals with disabilities. So thank you very much.

HOWARD: Thank you. Are there questions? Seeing none, thank you for visiting with us today. Is there anyone else wishing to testify in a neutral capacity? Seeing none, Senator Morfeld, you're welcome to close. While he's coming up, we do have a lot of proponent letters, so

bear with me: Mary Sullivan, National Association of Social Workers, Nebraska Chapter; John Dunn, representing himself; Sheena Helgenberger, representing herself; Dede McFayden-Donahue, representing herself; Christine McManaman, representing herself; Anica and Jeff Brown, representing themselves; Marcia Anderson, representing herself; Janet Price, representing herself; Jane Teply, representing herself; Jody Detwieler, representing herself; April Jorgensen, representing herself; Mary McKeighan, representing herself; Linda Kastning, representing herself; Laura Madeline Almond, representing herself; Arthur Zygielbaum, representing himself; Ash, Ashley Frevert, representing the Community Action of Nebraska, Nebraska's nine Community Action agencies; Carol LaCroix, representing herself; Todd Stubbendieck, rep, representing AARP Nebraska; Mary Beth Tuttle, representing herself; Joan Stahly Rouse, representing herself; Julia Feder, representing herself; Amy Behnke, representing the Health Care Association of Nebraska; Jordan Rasmussen, from the Center for Rural Affairs; Julia Isaacs Tse, Voices for Children in Nebraska; Marge Schlitt, representing herself; Barbara Straus, representing herself. No letters in opposition, no neutral letters. Welcome back, Senator Morfeld.

MORFELD: Thank you, members of the committee. And for the record, the Judiciary Committee still has not taken its group photo. Senator Chambers is spending 20 minutes closing on the bill that's not his [LAUGHTER]. And so it is his last hearing, and he, he deserves deference. So in any case, I just-- a few things I wanted to say. Thank you for listening to this today. I do-- this is not a priority bill, I understand, but I do think it is an important bill. I think it's important that the will of the voters be upheld and not be subverted by these 1115 waivers, particularly in this instance. I will say that, even though I disagree with Mr. Brunssen, I do appreciate him more than his predecessor in that I actually understand what he's talking about, and he clearly conveys the department's position. And that's not an insult or anything like that. That's-- I, I had a really hard time working with the last individual because I didn't fully understand what they were saying when they were saying it. And so I appreciate them being clear in their opposition and understanding where they're coming from. That being said, I will say that their opposition falls a little bit on deaf ears in my, in my case, because they should have never done any of this in the first place, and they know it. The will of the voters was clear to expand Medicaid, to maximize federal benefits under Medicaid expansion. And their scheme clearly violates that spirit, and it also makes it so that people

otherwise have less benefits than what they'd be entitled to pursuant to the initiative. So I respectfully disagree with what they've done, and I also think they've wasted a lot of taxpayer dollars. And that's particularly concerning to me because the main thrust of the Governor's opposition and the department's opposition, in the past, is how much money this would cost and how expensive it would be to implement. And so for them to go and then make it even more expensive and to make it more complicated to implement is really disingenuous. So that's all I have to say about the matter, but I'm happy to answer any questions.

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

WILLIAMS: Senator Morfeld.

MORFELD: Senator Williams.

WILLIAMS: Thank you for being here. And you recognize that this is the last bill that we are hearing this year in HHS. And on Monday, you had LB1196--

MORFELD: Um-hum.

WILLIAMS: --as the last bill in the Banking Committee that Senator Howard and I-- so--

MORFELD: I'm sensing a trend here.

WILLIAMS: Are you trying to set a new record for being the last bills?

MORFELD: I, I think we saved the best for last. And so this is--

WILLIAMS: Whatever [LAUGHTER].

MORFELD: That's-- OK.

WILLIAMS: Thank you, Senator Morfeld.

MORFELD: Thank you, Senator Williams.

HOWARD: Thank you, Senator Morfeld. Seeing no further questions, this will close the hearing for LB815 and end my hearings forever.

MORFELD: Thank you for all your service, Senator Howard.