*Indicates written testimony submitted prior to the public hearing per our COVID-19 response protocol

ARCH: Morning and welcome to the Health and Human Services Committee. My name is John Arch, I represent the 14th Legislative District in Sarpy County, and I serve as Chair of the HHS Committee. I'd like to invite the members of the committee to introduce themselves starting on my right with Senator Murman.

MURMAN: Good morning. I'm Senator Dave Murman from District 38, seven counties to the west, south and east of Kearney and Hastings.

WALZ: Good morning. My name is Lynne Walz, and I represent District 15, which is all of Dodge County.

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

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

B. HANSEN: Ben Hansen, District 16, Washington, Burt and Cuming Counties.

ARCH: Thank you. Also assisting the committee is one of our legal counsels, T.J. O'Neill, our committee clerk Geri Williams and our committee pages Payton and Sophie. A few notes about our policies and procedures. First, please turn off or silence your cell phones. This morning we will be hearing three bills and we'll be taking them in the order listed on the agenda outside the room. 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. For those of you who are planning to testify, you will find green testifier sheets on the table near the entrance of the hearing room. Please fill one out and hand it to one of the pages when you come up to testify. This will help us keep an accurate record of the hearing. We use a light system for testifying. Each testifier will have five minutes to testify. When you begin, the light will be green. When the light turns yellow, that means you have one minute left. When the light turns red, it is time to end your testimony. We will ask you to wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly

into the microphone and then please spell both your first and last name. Please also note that materials are provided to the committee electronically, so you may see committee members referencing their laptops and tablets during your testimony. If you are not testifying on the microphone today but want to go on record as having a position on the bill being heard today, we have implemented a uniform set of rules for public input, some old some new, across the committees of the Legislature. For the details on those policies, including submitting written testimony, please see the new public hearing protocols on the HHS Committee's Web page at nebraskalegislature.gov. Additionally, there is a white sign-in sheet at the entrance where you may leave your name and position on the bills before us today. For the safety of our committee members, staff, pages and the public, we ask those attending our hearings to abide by the following procedures. Due to social distancing requirements, seating in the hearing room is limited, so we ask that you only enter the hearing room when it is necessary for you to attend the bill hearing in progress. The bills will be taken up in the order posted outside the hearing room. The list will be updated after each hearing to identify which bill is currently being heard, and the committee will pause in between to allow the public to move in and out of the hearing room. We request that everyone utilize the identified entrance and exit doors and we request that you wear a face covering while in the hearing room. However, testifiers may remove their face covering during testimony to assist committee members and transcribers in clearly hearing and understanding the testimony. Pages will sanitize the front table and chair between testifiers. And this committee has a strict no props policy. With that, we will begin today's hearing with LB101 and welcome Senator Walz.

WALZ: Good morning, Chairman Arch and members of the Health and Human Services Committee. My name is Lynne Walz, L-y-n-n-e W-a-l-z, and I represent Legislative District 15. Today I would like to introduce to you LB100. This is the latest effort to ensure Nebraskans continue to be able to access health services in our Medicaid managed care system. Last year, the Nebraska Legislature unanimously passed LB956, which, which required the three managed care companies contracting with the state to communicate and work with health care providers when MCOs make changes to contracts that have a substantial financial impact on the delivery of health care services. Protecting access to health care

for those in our Medicaid system is something this committee has worked very hard to maintain.

ARCH: Excuse me.

WALZ: Oh.

ARCH: Senator, could I interrupt you for a second?

WALZ: Sure.

ARCH: You are introducing LB100. You have you have two bills here, LB101 and LB100. We have LB101 ahead of you.

WALZ: Oh, I'm sorry.

ARCH: Is that OK?

WALZ: Yeah. No, I'll start over.

ARCH: OK.

WALZ: I apologize.

ARCH: OK, thank you.

WALZ: I just was going in--

ARCH: Right.

WALZ: -- numerical order.

ARCH: Well, you're next as well on the other bill so.

WALZ: All right. I apologize.

ARCH: That's OK.

WALZ: Well, good morning, Chairman Arch and members of the Health and Human Services Committee. My name is Senator Lynne Walz, L-y-n-n-e W-a-l-z, and I proudly represent Legislative District 15. I'm here today to introduce LB101. LB101 is an extremely simple bill that changes the date from July 1, 2021, to July 1, 2023, as the first possible date that the Department of Health and Human Services could

move long-term services and supports into a managed care situation. The intent of LB101 is to maintain the current fee for service reimbursement method that all long-term services and supports are covered, covered under and have been for decades. Heritage Health, Health was launched in 2017 and moved the general Medicaid population into managed care with three MCOs: UnitedHealthcare, Nebraska Total Care and WellCare of Nebraska. Long-term services and supports were unchanged. In 2019, this committee prioritized LB468 and advanced it to the full Legislature, 7-0. The bill was passed 43-1 and signed by the Governor later that session. LB468 delayed the implementation of managed long, long-term care services and supports until July 1, 2021. This bill delays any implementation for an additional two years. Stakeholders were told that before managed care could be considered, the department and the managed care organizations would spend considerable time working with them to ensure their comfort level and address their significant concerns. To date, there has been little, if any, outreach by the department or the MCOs towards the long-term care and assisted living facility organizations and other advocacy groups in this regard. There will be testimony following me that will describe the reasons why stakeholders are worried about a looming managed care situation for long-term services and supports. The highlights of their testimony include delayed or denied reimbursement claims that caused major financial distresses, additional financial distress due to COVID on a revenue and expense side, and current reimbursement rates that are far less than the cost of care. Moving long-term care into Heritage Health any time in the near future would be devastating to the industry in general and would inevitably cause many of the facilities to close their doors forever. Many facilities operate on a tight budget with little or no room for dropped payments. In the case payment was delayed to a facility, it would affect their ability to pay staff and cover operating expenses. We passed LB468 in 2019 and within just that same year, 14 nursing homes were closed in Nebraska. And with significant impacts of the pandemic last year, nursing homes are facing even more difficulties than ever before. I hope the committee will support our efforts to fight for their improvement and to fight for their stabilization. I would be happy to answer any questions you may have.

ARCH: Thank you, Senator Walz. Are there questions from the committee? I have one. I would, I would anticipate there will be testifiers on

this bill as well that could help us understand why there have been no conversations. Because I do recall--

WALZ: I would hope so, yes.

ARCH: -- when we passed the bill that was the expectation, that it was to give them time to have those conversations.

WALZ: Exactly.

ARCH: OK.

WALZ: Yeah. Thank you, Senator Arch.

ARCH: Thank you. Now offer the opportunity for anybody who would like to speak in favor of the bill. Proponents. They want to clean the table here. Just a second. Welcome to the HHS Committee.

JINA RAGLAND: Good morning Chair-- Chair Arch and members of the Health and Human Services Committee. My name is Jina Ragland, that's J-i-n-a R-a-g-l-a-n-d, I'm here today testifying in support of LB101 on behalf of AARP Nebraska. Between 2015 and 2050, the age 85-plus population in Nebraska is protected-- projected to nearly triple. People age 85-plus are more, most likely to need assistance with activities of daily living, such as bathing, eating, transferring and toileting. Everyone faces a risk, but not a certainty, of needing some kind of long-term supports and services as we age. According to the AARP 2017 LTSS report, 52 percent of people turning 65 today will develop a severe disability that will require long-term services at some point, 19 percent are expected to have needs that last a year and 14 are expected-- 14 percent are expected to have needs that extend beyond five years. On average, someone, someone turning 65 today will incur $138,000 in future long-term service costs in his or her lifetime. The risks and costs continue to increase as we age, especially as someone reaches 85 and older. The silver tsunami is upon us, and with that comes the need to ensure our long-term care services and support systems is prepared to meet these demographic challenges and that any changes to the system like implementing managed care can be accomplished without disruption to care. Just so we're clear, AARP does not completely oppose the implementation of managed care for long-term supports and services. But we believe at this present time in Nebraska, we're not ready. It needs to be done cautiously and with

specific attention to network access, payment reimbursement, transparency, oversight, consumer choice and direct input from consumers, caregivers and providers. As one of our state's most vulnerable, we have to raise caution and ensure that rolling out the program is done in an effective manner, and that we protect and ensure adequate access to services and programs that are in place. Nothing has proven the need for the above to be more important than all that is involved with the COVID-19 pandemic. During this pandemic, nursing homes and other residential care facilities have faced unprecedented challenges. It is undeniable that these residents have borne the brunt of this terrible disease. Adding another major change to this population and to the entire system could be further devastating, if not done properly. We've been following the implementation of Medicaid managed care since its debut in January of 2017. Our concern has always been, and will continue to be, the need to ensure adequate access to providers and services across the state for consumers utilizing such programs, and especially for those most vulnerable. We recently had the privilege to meet with Director Bagley and continue to be encouraged by his leadership and willingness to continue open conversations and addressing the ongoing issues as these programs are rolled out. It is a must to ensure our most vulnerable are protected. Progress has and continues to be made with the Medicaid managed care. We appreciate and recognize the department's work in addressing many of the issues that have been previously presented. But we continue to hear from provider groups, families and others that issues are still relevant and that many are still struggling to overall to make the program work. We're fortunate that many providers who have or continue struggling with the program continue to provide and maintain services and relationships to Medicaid consumers. LTSS managed care takes on an entirely new meaning in our state. It is critical that necessary services focus on our most vulnerable residents, not just on managing the costs of care. Medicaid managed LTSS provides many opportunities and challenges in care delivery and financing. The opportunities can include the use of care coordinators and better outcomes of care, including unnecessary hospital admissions. The fixed payments to managed care organizations make costs more predictable for state government, however, sometimes those fixed payments may also create incentives to restrict, limit or deny access to necessary services for people who have costly health care and long-term care needs. Over the last five years, more than 33 facilities have closed their doors in Nebraska. Just like other services, long-term care costs continue to

rise while often just meeting the bottom line continues to decline. Some of these closures have occurred in small towns that have few or no options for relocation and are often many miles from another operating nursing home. Closures can take a significant physical and emotional toll on residents, some of which suffer what is known as transfer trauma or relocation stress syndrome. These conditions can cause displaced residents to become depressed, agitated, socially isolated, withdrawn, which in turn then leads, could lead to falls, weight loss or complacency about caring for themselves. We've heard from many families that have been through these kinds of situations. We support the concept of managed care, but continue to feel that more time and study, especially as we navigate COVID-19 and its detrimental effects as needed. Thank you to Senator Walz for introducing the legislation and for the opportunity to comment, and I'd be happy to ask-- answer any questions.

ARCH: Are there any questions from the committee? Seeing, seeing, none, thank you very much for your testimony. Next proponent.

LOIS JORDAN: Good morning, Chairperson Arch--

ARCH: Welcome.

LOIS JORDAN: -- and members of the Health and Human Services Committee. My name is Lois Jordan, spelled L-o-i-s J-o-r-d-a-n, I'm the president and CEO for Midwest Geriatrics. It's a management company for a nursing home and two assisted livings in Omaha. And I'm also the past president of LeadingAge and here as a representative for LeadingAge Nebraska. Thank you for the opportunity to testify in support of LB101. Midwest geriatrics provides long-term care services to 95 to 100 seniors in Nebraska, and more than 70 percent of those individuals are on Medicaid. With the shortfall in Medicaid reimbursement that fails to meet our actual costs, we operate with a very thin margin, if any margin at all, some years. Our ability to break even and not lose money is dependent on the payer sources our residents have, including private pay, VA, Medicaid or Medicare. Accordingly, any delays in payment by such payer sources results in a dramatic impact on our ability to meet operating expenses such as payroll, utilities and supplies. As you've heard today, in 2017, Nebraska Medicaid rolled out Heritage Health, Nebraska's new managed care delivery system. Services incorporated in this system are physical health, mental health and pharmacy services. Heritage Health

contracts with United Health Care, Total Care and Healthy Blue, which was formerly WellCare. Medicaid recipients are mandated to choose one of these, these three health plans, or it will be assigned for them in order for them to receive health services such as therapy services, medications and mental health care. Two years ago, when this bill was passed, delaying the implementation of managed care for Medicaid services, the Legislature and specifically this committee sent a clear message to Nebraska Medicaid and Heritage Health: Fix the issues providers are experiencing with the claims processing in the next two years. I'm here to testify today, those issues are not resolved for long-term care communities. We're still trying to get claims processed from two years ago. Currently, Nebraska Medicaid does not contract with Heritage Health for reimbursement of monthly room and board care to nursing homes or assisted living communities. Passage of LB101 would allow us to continue receiving reimbursement through Nebraska Medicaid rather than through the Heritage Health System. The reason this is so critically important for long-term care communities is as follows. Nebraska Medicaid directly reimburses long-term care in assisted living communities for Medicaid eligible residents. On a weekly basis, any room and board claims submitted to Medicaid by Friday of that week are generally paid by that following Wednesday. The predictable and reliable reimbursement from Nebraska Medicaid with the current system is what nursing homes rely on to keep their doors open. If the reimbursement process for such claims was outsourced to the currently contracted Heritage Health Insurance companies, based on our experience with their ineffective and inaccurate claims processing for the past three years, it would have significant detrimental impact on Nebraska providers. Heritage Health has had more than three years to iron out their processes, and yet under Heritage Health, we do not receive payments in the same time frame as Nebraska Medicaid, and it is having a detrimental effect on their ability to continue caring for Nebraska seniors who are Medicaid recipients. On a daily basis, our community spends significant time and staff resources addressing Heritage Health, claim denials, loss claims, claim overpayment or underpayment corrections that drag out for months. We have provided care to Medicaid recipients for more than 50 years. We know how to bill. Since Heritage Health started, we estimate that well over 75 percent of our claims are not processed properly and payment is delayed or withheld altogether. Caring for 70 percent of our population who are served by Heritage Health and having this type of delay and/or lack of payment creates significant concern for our

ability to continue to serve this population. When Heritage Health was rolled out in Nebraska, the plans were given the directive to reimburse for the 20 percent coinsurance for any Part B Medicare claim for therapy services in our community. However, effective July 1 of 2017, there was a change in the state's rate computation for any provider willing to accept a dual-eligible resident. A dual-eligible resident is a Medicare eligible beneficiary who qualifies for Medicaid to cover their Medicare supplement for the coinsurance and deductibles not covered by Medicare. There's now a complicated formula that compares the Medicare payment amount for each specific therapy billing code to the Nebraska Medicaid allowable payment amount for that same code. Communities who accept these dual-eligible residents and provide therapy services as part of their plan of care are now being reimbursed very little for any of the coinsurance or deductible adjudicated on the Medicare therapy claim. Time-consuming manual calculations are required to determine if a small payment or any payment by the Heritage Health Plan is correct. Many communities are writing off the difference without the manual calculation, due to the time it takes to evaluate the accuracy of the Heritage Health payment. The three insurance companies contracted have had tremendous difficulty in replicating accurate claim processing to properly reflect this complicated formula. Our billing staff have spent hours upon hours attempting to decipher inaccurate reimbursement statements with no one from Heritage Health personnel willing to delve deeper into the issue to resolve the inaccuracies and programing issues. In our community, we have increased our part-time biller to a full-time position just to help with this analysis.

ARCH: Since you have the red light, if I could ask you to to wrap up your, your testimony, please.

LOIS JORDAN: Certainly for the past three years since the adoption of this policy, Florence Home has had to write off $70,000 of unreimbursed Medicaid coinsurance related to those claims. Because of this inability to financially afford Medicare supplements, Medicaid recipients are not able to get a secondary insurance in organizations such as ours are having to write that amount off or absorb this loss. The gap between providers who are serving Medicaid and those that do not is widening. If we expand into managed care for additional provider service payments using business models like what we have with Heritage Health, Nebraskans will suffer, as nursing homes cannot physically operate in these conditions and continue to provide the

proper care, the services needed by Nebraska seniors. I'm here to testify in support of LB101. Thank you.

ARCH: Thank you. Are there questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here. You mentioned, and Senator Arch, I think, even asked this of Senator Walz, about the issues not being addressed over the last two years. Could you speak to that a little bit more? Have there been any conversations and have they just not been fruitful or have there been no conversations?

LOIS JORDAN: No. Every claim that we submit and is either processed incorrectly, we, we follow up. We have to. And we don't get resolution. You know, we're told they'll get back to us. We don't hear back. We might hear back later. Some of these claims we're still trying to process for two years now and we just don't get anywhere. And, and part of-- the majority of it is those 20 percent coinsurance and the ability to process those accurately. We just can't seem to communicate.

M. CAVANAUGH: And if we were to not extend this date, how would that impact you?

LOIS JORDAN: We'd continue to bill Nebraska Medicaid for room and board. The 20 percent coinsurance is still going to be an issue, that's still under Heritage Health. And so, you know, ideally that would need to get resolved, too, in order for us to continue serving this population. But if, on top of that, we aren't able to get room and board process properly, that's 70 percent of our income. We can't stay in business. We would close.

M. CAVANAUGH: Thank you.

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

LOIS JORDAN: Thank you.

ARCH: Next proponent for LB101. Morning, welcome.

ASHLEE HENDRICKSON: Morning, hi. Chairman Arch and members of the Health and Human Services Committee, my name is Ashlee Hendrickson,

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A-s-h-l-e-e H-e-n-d-r-i-c-k-s-o-n, and I'm the advocacy coordinator for the Nebraska Health Care Association. On behalf of our a hundred--423 nonprofit and proprietary skilled nursing facilities and assisted living communities across the state, I'm here to testify in support of LB101, a bill to delay the implementation of Medicaid managed care for long-term care services until July 1 of 2023. Nebraska's current statute does not permit implementation of managed long-term care until July 1 of this year, so today I'll share with you why our members believe this statute must be extended for an additional two years. During 2019, nursing facility providers, members of this committee and the Department of Health and Human Services worked to develop a new Medicaid payment methodology. And in July of 2020, the first phase of the new methodology was implemented, and in 2021 the state will implement the second phase. The plan moving forward is to continue to modify this nursing facility rate methodology with the goals of incentivizing efficiency, rewarding high-quality care and maintaining statewide access, especially for those individuals reliant on Medicaid. This process is far from complete, but there has been significant progress. Further delaying managed long-term care would allow this collaborative effort to continue. Additionally, NHCA, NHCA asks that managed long-term care be delayed until Nebraska's Heritage Health Program has demonstrated metrically that the following goals have been accomplished: The health outcomes for elder Nebraskans and individuals with multiple chronic illnesses have improved, the Medicaid managed care has been proven to be a cost-effective solution for Nebraska, and Medicaid managed care has the ability and capacity to pay for long-term care services in an accurate, complete and timely manner. Since January, 2017, our skilled nursing facility members have had experience with Nebraska's Medicaid managed care program in reimbursement for short-term skilled rehabilitative care and outpatient physical therapy services. And unfortunately, it's not gone well. Payments for these services are fairly simple, especially when compared to the complexity of a per diem payment for long-term nursing facility services, which vary by facility and then vary on a monthly basis depending on the medical needs of the individual resident. For more than a year, even with these simpler payments, our members have experienced numerous ongoing problems with accurate and timely payment and with prompt authorization of necessary services. Therefore, to ensure continued statewide access to nursing facility and assisted living services, NHCA respectfully asks that you advance LB101. We'd

like to thank Senator Walz for her continued leadership on this important legislation, and I'd be happy to answer any questions.

ARCH: Thank you. Are there questions from the committee? I have one.

ASHLEE HENDRICKSON: Yep.

ARCH: In your discussions with DHHS, have they indicated their intention to proceed with, with rolling this into managed care?

ASHLEE HENDRICKSON: Not directly to me. I'd have to check with the rest of my team to see.

ARCH: OK.

ASHLEE HENDRICKSON: But we can get back to you on that.

ARCH: All right. OK, thank you. Thank you for your testimony. Next proponent for LB101. Good morning. Welcome to--

KENT ROGERT: Good morning, Chairman Arch--

ARCH: -- HHS Committee.

KENT ROGERT: -- members of the HHS committee. My name is Kent Rogert, K-e-n-t R-o-g-e-r-t, and I'm here today representing LeadingAge Nebraska, which is an association of about 80 nonprofit nursing home assisted living and day services providers, and PHT Consulting and Billing. Ms. Darsey Hamm could not be here today, but she's also a member of LeadingAge. We want to thank Senator Walz for introducing the LB101. I'm just going to do a little bat cleanup and try to answer a few questions around here out. Senator Arch, we don't, we don't have the indication that they're seeking to move to managed care today on long-term services supports, but it's always looming. And what we-- when we passed LB468 two years ago, obviously we didn't know a pandemic was going to come and cause all things to probably halt in terms of moving forward with lots of things. That's probably why there hasn't been a ton of outreach. I don't think they're necessarily looking to get right in it. But that date will come and go after this legislative session without the passage of this bill. And they could all of a sudden decide in November of this year that they're going to start moving towards managed care. And from the testimony behind us in front of me, we're just not ready. I will say that it's odd to be

here, which in a situation that doesn't happen enough, we're going to say that the department is doing a great job of reimbursing us on a timely manner for room and board, which, as Ms. Jordan said, is 70 percent of our, our income. We bill for the claims on a Friday, we're paid, it shows up in our bank account on Wednesday. We know that it would be at least 30, probably 60 days to get that reimbursement through one of the Heritage Health plans. If it's not submitted absolutely perfectly and correctly, it is immediately flat out denied. There's no working on it. It's comes back. And so when you can get into this rolling process of where it-- and our, our facilities don't have resources to hire a team of people to submit all these claims. We just don't. We-- even if we did a year ago, we absolutely don't now. So as the, as the denials and the claims start to back up, all of a sudden you get into a situation where a claim may be a year old, then it's never going to be paid at all unless the, unless the plan says that it could be in their error. And we have to file and, you know, appeals and try to get these things-- and it continues to build up. And then you can, all of a sudden you can have claims that are not paid for two and three years. You know what the facilities that I represent do? They walk away from it. They take whatever money they've gotten and they have no resources to fight it and they just lose the money. And that is a terribly unfortunate situation because that's what causes us to have to be behind and close. We already know that we're about $40 per bed per day short on being reimbursed for the cost of care. And you add that into a longer period of time then we, we just aren't going to get it done. Ms. Hamm provided you with her testimony, which is almost exactly what it was two years ago. And she'll admit that she doesn't have a horse in the race, but her question is, why would you reward a company that's chronically behind in its billing processes with a bigger contract? So I, I'll answer any questions. I will point out that I believe that the date we have selected in the bill is, it aligns with the rebid of the entire Heritage Health program. I think they come up as the end in July of this year, at the end of their third. The department has an option-- opportunity to renew for two additional one-year pieces. That would take us to July of 2023, which is what LB101 puts us to. Yeah, I would say if the system isn't broken, I don't know what we're trying to fix, but managed care would definitely cause something to break. Answer any questions.

ARCH: Thank you. Questions? I have one.

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KENT ROGERT: Sure.

ARCH: So please help me understand the billing for room and board versus the billing through Heritage Health. Are these individuals that qualify for, for what I would call straight Medicaid versus Heritage Health or are these different services that are built differently?

KENT ROGERT: Different services. And most of I think what our facilities are billing for, and this gets me into the weeds of things that I don't pay attention a ton to, but pharmacy is a big thing that is all, it's undermanaged right now. And obviously in a nursing facility, there's a lot of pharmacy that happens. And that would be, that would be billed through one of the Heritage Health plans. Fee for service, which is what we currently run now, we basically bill on all the services that are provided on a specific fee that's set out through the Medicaid program and the department. And you manage, you put in today this particular resident got this much of her-- he, her stuff was these different 10 fees and it adds up to the room and board and those services. And those are the things that are currently being serviced through Medicaid rather than the health-- Heritage Health.

ARCH: Thank you. Seeing no other questions, thank you very much for your testimony.

KENT ROGERT: Thank you.

***JAMES WATSON:** Chairman Arch and Members of the Committee, good afternoon. My name is James Watson, and I am the Executive Director of the Nebraska Association of Medicaid Health Plans (NAMHP). Those plans include Nebraska Total Care, UnitedHealthcare Community Plan and Healthy Blue Nebraska. Thank you for this opportunity to testify in a neutral capacity before your committee with respect to LB101. LB101 would extend the current provision which bars the addition of long-term care services and supports to the Medicaid managed care program until July 1, 2021. The extended date is proposed to be July 1, 2023. While NAMHP strongly supports adding long term care services and supports to the Medicaid managed care program, we also understand that any such addition needs sufficient time for all the stakeholders to prepare. The year 2020 saw us facing a deadly virus, and the nursing home industry has been particularly impacted. It therefore seems highly unlikely that a program to add long term care to Medicaid managed care is within reach by July 1, 2021. On the other hand,

nothing in LB101 prohibits the Medicaid and Long-Term Care division from planning and undertaking activities to prepare. Nebraska's Medicaid managed care industry intends to be exceptionally supportive in that regard. A start date of July 1, 2023 seems reasonable under the current circumstances.

ARCH: Next proponent for LB101. Seeing none, any opponents for LB101? Seeing none, anyone want to testify in the neutral? Well, that's loud. Wow. OK, anybody anybody want to testify in a neutral capacity for LB101? Seeing none, Senator Walz, you're welcome to close. And while you're coming up, I want to let you know that we did receive one written testimony for LB101, and it is from the Nebraska Association of Medicaid Health Plans and it is a neutral, it is a neutral capacity. And we had three proponents that submitted letters of support. No, no opponents and no neutral letters. So, Senator Walz, you're willing-- you're welcome to close.

WALZ: Thank you. And thank you for listening today and thank you for your patience on the first bill that I was trying to introduce. I would like to quickly remind the committee and the department that this issue deals with our most vulnerable population. They have been hit pretty hard by COVID and the last thing that we want them, want for them is to be blindsided by an ill-timed and hasty transition into Heritage Health. Until reimbursements are made accurately and timely and long-term health care facilities are stabilized, I believe that this legislation is necessary and will be necessary every couple of years until we are confident that a transition would not destabilize the entire system. I also wanted to bring up to the committee that we have considered additional stricter requirements for the department for when this transition does take place. Those would include a hearing before the Health and Human Services Committee and an appropriate transitional period of at least six months. Transition is so important. This issue directly affects the lives of our senior citizens who have worked hard their entire lives. They've provided for their families. They've paid their taxes. So we need to make sure that what we do is intentional. They deserve quality care in a safe environment as they live out the rest of their lives. And this plan, again, must be intentional and it must be thoughtful. And with that, I thank you for your time today and I'll try to answer any questions.

ARCH: Thank you, Senator. Are there any questions for Senator Walz? Seeing none, thank you very much. That closes the hearing for LB101.

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And we will now open the hearing for LB100. And Senator Walz, this is your bill as well. And so as soon as they change out the, the card here, Senator Walz, you're welcome to open on LB100.

WALZ: Again. Chairman Arch and members of the Health and Human Services Committee, my name is Lynne Walz, L-y-n-n-e W-a-l-z, and I represent District 15. Today, I would like to introduce to you LB100. This is the latest effort to ensure Nebraskans continue to be able to access health care services in our Medicaid managed care system. Last year, the Nebraska Legislature unanimously passed LB956, which required the three managed care companies contracting with the state to communicate and work with health care providers when MCOs make changes to contracts that have substantial financial impact on the delivery of their health care services. Protecting access to health care for those in our Medicaid system is something that this committee has worked hard to maintain. LB100 stops managed care companies that contract with the state of Nebraska to deliver Medicaid services from implementing a payment policy that severely alters the ability of three types of therapy providers: physical therapist, occupational therapist, and speech and language pathology providers. The policy is called a multiple provider payment reduction, or MPPR. The policy reduces rates paid to providers when multiple procedures are delivered to the patient on the same date of service. This bill focuses only on these three rehabilitative health care service, services because these were impacted by the implementation of this policy by one of the managed care companies. I anticipate there may be other providers that are concerned that such a policy may be implement, implemented for their types of services. We all know how low Medicaid rates are and that those low rates have a dramatic impact on the number of providers that can no longer afford to provide services in our Medicaid system. Can you imagine the impact on your small clinic after delivering one service and getting paid at the full right-- rate, then be paid significantly less for subsequent service? Perhaps a larger facility can sustain that business model longer, but at some point decisions must be made to cut those services. This is not a policy that can be sustained by providers and one that we cannot let contractors of the state implement. There are several providers coming up behind me that will go into more detail on how this policy works in practice and the impact it has on their patients. Thank you, and I will be available to answer any questions.

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ARCH: Thank you. Are there any questions at this point for Senator Walz? Seeing none, thank you. Now welcome the first proponent for LB100.

GRACE KNOTT: Good morning.

ARCH: Good morning. Welcome.

GRACE KNOTT: My name is Grace Knott, G-r-a-c-e, Knott, K-n-o-t-t. Senator Arch and members of the Health and Human Services Committee, my name is Grace Knott, but I currently am president of the American Physical Therapy Association of the-- and of the Nebraska chapter. Our chapter has over 1,400 PT, PTA and student members. I want to thank Senator Walz for introducing LB100 on behalf of all therapy providers. I'm here today in support of this bill. The association believes this bill will benefit Nebraskans by having a clean and concise method of payment for therapy services provided from all the current and future participants of Heritage Health. Currently, this is not true as one MCO within Heritage Health applies a payment policy for therapy services that result in 10 to 15 percent reduction of payment for therapy services compared to the Nebraska Medicaid fee schedule. This affects all rehab providers, as well as Nebraskans who have Medicaid for their health insurance. This will also have an impact as-- on more Nebraskans with the recent Medicaid expansion. At first glance, you might see this as only a provider problem, but it may have ramifications for accessibility for therapy services and lower socioeconomic regions of metropolitan and rural areas and finally, for our pediatric patients with developmental disabilities. In Nebraska, services provided to the Medicaid beneficiaries are paid based on Nebraska Medicaid fee schedule. This fee schedule is set at the lowest possible level, which in many instances are below the cost of providing the service. Therapy services are labor intensive and the majority of services are paid based on time actively treating a patient and not, unfortunately, on the skill and knowledge of that therapist. Any reduction of reimbursement affects our ability to pay rent for office treatment areas, pay supportive staff and to pay off the astronomical student loan debt that physical therapists and other rehab therapists occur as they pursue their calling. The physical therapy entry point is at the doctorate level. When private practice physical therapists investigate a location for their practice, they look at the local population and that they will be serving. As we well know that for physical therapy, since we see them on a regular basis

for a period of time, from two to three weeks to four to six weeks, maybe twice a week, five times a week, we know that it needs to be convenient. So distance from your house or from your work to the therapy clinic is crucial. If it is inconvenient or difficult or time consuming to attend a therapy session, the therapy prescription is not completed. With the knowledge that an MCO is paying below cost of delivering services, there is a high concentration in a particular area of Medicare beneficiaries, the private practice rehab provider will probably choose a different location. Therefore, a Medicaid beneficiary is left with driving longer distances to assess needed rehab services, therapy services are left to large state institutions and large hospital systems to assess therapy services. If a private practice therapist decides to locate their practice in an underserved area, they might limit the amount of Medicaid beneficiaries they treat at one time to keep their average reimbursement at a level that they may have an economically sustainable practice. This would delay the initiation of therapy services. Pediatric rehab practices are especially affected by declines in reimbursement for Medicaid beneficiaries that are below the Medicaid fee schedule. Over three quarters of Medicaid CHIP children with special health care needs live in families with incomes below the 200 percent federal poverty level, which right now is at $42,660 a year. So again, many of these Medicaid beneficiaries have to drive longer distances to obtain needed therapy services for their children. They have limited resources and must rely a lot of times on public transportation, cab services and other modes of transportation. With a lack of accessibility to needed medically necessary therapy services which delay the start of therapy or complete lack of therapy, what are the downstream costs to health care in the future? Looking at a study in 2017, those who refer to PT within 15 days of diagnosis have downstream costs that are $3,500 less than those who receive therapy 45 to 90 days after the onset of acute back pain. For patients undergoing hip arthroscopic surgery, for patients that had physical therapy first before opioid use, there were significant less downstream health care costs and less opioid use addiction if therapy was assessed timely. Chronic diseases are effectively managed by physical therapy and other rehab disciplines. And lack of function is directly a result of muscle weakness, joint influent inflexibility and poor endurance-- I'm in the red already, which can be treated effective, for effective plan of care here.

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ARCH: So since the red light has come on, I would ask that any, any concluding just--

GRACE KNOTT: Yes. Yes.

ARCH: -- concluding statement quickly.

GRACE KNOTT: I never get past the red here. You have it in the testimony. What I want to stress is that this is a flawed policy, the MPPR. It originally was implemented for surgical practices, which it makes sense that a surgeon is in the room, everything is sterilized for the hospital. The instruments are there. If you do one thing, a procedure to a shoulder and you do another thing for that shoulder, it makes sense that that second procedure should be paid less because the practice expense is less. But for physical therapists and all rehab professionals, our cost, it was already spread around three units of service or three different procedures. So it's been a flawed policy that my association has been vocal in trying to do advocacy since its inception by Medicare seven, eight years ago.

ARCH: Thank you.

GRACE KNOTT: And I thank you.

ARCH: Questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here. You stated that there's, there's only one MCO currently.

GRACE KNOTT: That's correct.

M. CAVANAUGH: So is it fair to assume that providers then will not want to take patients that are covered under that?

GRACE KNOTT: That's correct.

M. CAVANAUGH: OK, so we're, we're sort of creating a disparity amongst Heritage Health clients.

GRACE KNOTT: Right, they're not the same.

M. CAVANAUGH: OK, thank you.

ARCH: Senator Hansen.

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B. HANSEN: Thank you, Chairman Arch. Thanks for coming to testify. I think I've heard you testify many times before here in this committee and, yeah, it seems like you get halfway through and that red light comes on.

GRACE KNOTT: I'm a little too verbose.

B. HANSEN: Don't feel bad.

GRACE KNOTT: I need to work on that.

B. HANSEN: [INAUDIBLE] good. So essentially, it seems like, especially in your profession, we're paying for your expertise, right? It seems like we're, that's what we're paying for, to get the patient better, to improve health outcomes, to be efficient with our care. And that's what we're paying for. And so when you do three services, say 15 minutes each, you're doing-- your expertise is the same each one, right? I mean, there's nothing you're changing, you're not providing less service with the other two than you would with the first. And so it seems to me that it's hard for me to understand why we're not paying the same for each one. And so I think your argument seems valid when it comes to your-- but I want to make sure and reiterate and confirm with you that nothing is changing with each one of those services, right?

GRACE KNOTT: No.

B. HANSEN: Like you're doing the same pretty much there.

GRACE KNOTT: No.

B. HANSEN: OK, thank you.

GRACE KNOTT: And it was already how our relative value of each thing that we do was already spread across three units of service when they decided what each type of thing that we do has already said, well, is part of three. And so they reduce that amount anyhow.

B. HANSEN: Thank you.

ARCH: Thank you. Other questions? Senator Williams.

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WILLIAMS: Thank you, Chairman Arch. And I'm just reading through some testimony that we have been given to us that is in opposition to this legislation. And it seems to indicate that the billing process that you are talking about has been fixed and that's no longer going on. But from your standpoint, this is a current concern that is still happening today with one of the MCOs.

GRACE KNOTT: I will say that we have been advocating and it was United Healthcare community plan. And we have been advocating with them, have met with them multiple times over the last two years. In December of last year, of 2020, they did verbally tell us that they were looking at not implementing the MPPR anymore. We have not gotten that confirmed yet. We have decided to go ahead, and we feel this bill is still needed because we know new contracts come up and we don't want to have to fight again. I hate to say how many hours and meetings and my other members that are here can tell you we have met with United Healthcare multiple times and multiple hour-long meetings.

WILLIAMS: So there's been a lot of talk, but not implementation of that yet.

GRACE KNOTT: That's correct.

WILLIAMS: You have not seen billing changes.

GRACE KNOTT: That's correct.

WILLIAMS: Thank you.

ARCH: Thank you, Senator Williams. Other questions? Seeing none, thank you very much for your testimony.

GRACE KNOTT: Thank you.

ARCH: Next proponent for LB100. Thank you and welcome.

MARY WALSH-STERUP: Good morning. My name is Mary Walsh-Sterup, I'm testifying today-- Mary, M-a-r-y, Walsh, W-a-l-s-h-S-t-e-r-u-p. I'm testifying today in support of LB100 as a member of the Nebraska Occupational Therapy Association and on behalf of the Nebraska Speech-Language-Hearing Association. I'm currently a practicing occupational therapist here in the state of Nebraska and a partner at Central Nebraska Rehabilitation Services, a provider that provides PT,

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OT and speech services across Nebraska. First of all, Chairman and the rest of the committee, thank you for allowing me the opportunity to come here and speak to you today about the MPPR and its effect on our practices here in Nebraska. As Grace just indicated, the MPPR, we believe, is a flawed plan because of our therapy codes are based on 15-minute increments provided sequentially. Currently it is-- we have worked with one of the MCOs and currently they have suspended that practice. My concern as a practice owner is that if all three of these MCOs were able to provide the MPPR, we would no longer be able to treat Medicaid patients at our clinics. In recent years, the private practice session-- section of the APTA put out some cost analysis of what it costs a therapist to provide a visit. Visits are based on, most insurance companies say that four timed units and one untimed code is a very typical therapy visit. And so if you figure four timed units are about 15 minutes apiece, you can assume that the majority of therapy visits are 45 minutes to one hour in nature. The cost to provide those you can see in 2019 was $85.19. The actual, the PPS has indicated that that will probably increase this year by $5.22 due to the American Medical Association's application and study, looking at all the additional COVID measures that need to be put in place. So I actually took some actual claim examples to show what's going on. So if you look at a patient in example number one that had a post hand surgery and receiving occupational therapy, they had 49 minutes of direct one-on-one care with the therapist. If they were getting the state-approved rate, which is what I call straight Medicaid rates, they would receive $72.42 cents. One of the MCOs paid us $61.43, a reduction of $10.99 for that same 49 minutes. Another example would be a PT and speech claim. Here, the patient received 98 minutes of services and the state-approved rate would have been 123.54. And what we actually received after the NPR was applied was 99.90. You can see how, if you added this up over a period of time and over a day, how this would dramatically affect what is occurring. You can see on that example too realizing that statistically and research shows that the actual cost per visit is $85.19. In this example, they were receiving two services, so two visits. You can see how much, and just in general, Medicaid is already at the bottom dollar for us to be able to provide these services. I provided three additional examples. So when performing Medicaid visits, Medicaid already requires more paperwork, more administrative burden-- Medicaid already requires more paperwork, more administrative burden, more authorizations than any other payer out there, including Medicare. So when you add the MPPR on that, when

you're already getting the lower dollar rates, it makes it nonfeasible and makes this for a practice that we cannot, cannot sustain. I'm from a large provider. We will not be able to sustain this practice if all the MCOs-- and we were actually considering moving away from it. If you look at the Title 471 of the Nebraska administrative code, it gives specific guidelines that we as providers need to adhere to when providing Medicaid services, including that we are providing the least amount in the most cost-efficient manner to the therapist-- or to the patient. We as therapists believe that we provide this for the patient, and we were hoping that, you know, the rate is already low. We feel it's right at about our cost. We're happy to do that, but we can no longer sustain going below cost. I'm happy to answer any questions about that.

ARCH: Thank you. Are there questions from the committee? Seeing none, thank you very much for your testimony. Next proponent for LB100. Seeing none, anyone wish to testify in opposition to LB100? Welcome to the, to the HHS Committee. You may proceed.

JEREMY BRUNSSEN: Good morning, Chairman Arch 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 deputy director of finance and program integrity in the division of Medicaid and long-term care within the Department of Health and Human Services. I am here to testify in opposition to LB100, which prohibits certain billing practices under the Medical Assistance Act. LB100 seeks to prohibit what is known as multiple procedure payment reduction, or MPPR, which reduces certain payments for multiple services provided to the same patient on the same day. This bill seeks to ban this billing practice specifically for physical, occupational and speech therapy covered by Medicaid and Medicaid's managed care health plans. MPPR is considered by many to be an industry best practice for reimbursement. It's used in Medicare and in many commercial plans to account for the increased efficiency achieved when multiple procedures can be provided at the same encounter. While some of the state's managed care plans have implemented policies that include MPPR, the division is committing to work, to working with them to address concerns raised by the providers. The division is open to including stakeholder feedback in our policy decisions. However, adding statutory restrictions could make it more difficult to incorporate future feedback and can, can present potential conflicts with industry best practices or federal requirements, such as the National Correct Coding Initiative, which

may contain MPPR types of billing and coding requirements. Additionally, the division wants to be cautious about mandating how many payments are made by managed care plans, as the Centers for Medicare and Medicaid Services may view that as a directed payment, which could lead to additional oversight of payments and requirements on providers. To be clear, opposition to this bill is not based on a desire to continue or even necessarily support practices described. Rather, we do not believe it's necessary to place those in statute. This could remove a potentially effective fool-- effective tool from our bill for improving outcomes for consumers, consistency for providers and efficiency for taxpayers. For this reason, 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.

ARCH: Thank you. Are there any questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thanks for being here. It's nice to see you again.

JEREMY BRUNSSEN: Good to see you.

M. CAVANAUGH: OK, so the issue about efficiencies, we heard from earlier testifier Grace Knott about that that makes sense like when you're having surgery, which, you know, you have an anesthesiologist and all these in a sterilized room. And so if you can do more than one surgery, you don't need to pay the anesthesiologist twice to be there. But for physical therapy, these are specific therapies that are happening and you're not paying the provider for the work that they're doing. So and it's only one provider that's doing it, which really promotes a disparity in services. And so I guess I don't, I'm not quite understanding why the age-- DHHS is in opposition to this.

JEREMY BRUNSSEN: Sure. Thank you for your question. So what I would say is that I would agree that it's important when you're looking at how the agency reimburse providers and we look at it in totality, right? Not just the rate, but kind of the administrative policies around the rates. That's important consideration that should always be taken into account when looking at how our policies impact, you know, payment to services to our Medicaid beneficiaries. I agree with that statement. What I would say is that our position is that we would

disagree with the necessity to put it in statute from the perspective that, you know, we are willing to work with providers and hear their concerns. I know that I personally wasn't involved in the meetings between the association and providers in United, but I do know that there were several meetings referenced. And I think it's important to understand that we just, we believe we can manage that through our own policies, but that's our position.

M. CAVANAUGH: I have a follow up, if that's OK, Chairman Arch.

ARCH: Yes, please.

M. CAVANAUGH: So, OK, I appreciate that position, but so are you, are you saying that the department is willing to tell United Healthcare to discontinue this practice when it comes to physical therapy because it's creating a disparity in care for those patients that are covered under them versus the other MCOs?

JEREMY BRUNSSEN: So I don't believe it's going to be necessary for the department to direct United to no longer utilize the MPPR. It's my understanding that consistent with the prior testimony that United has made the policy decision, after hearing the concerns from the community and having conversations with us, you know, as part of that, that they're doing, basically unwinding that policy on their own behalf.

M. CAVANAUGH: Is there any documentation of that?

JEREMY BRUNSSEN: I don't know that I can produce any, but I'd be happy to share anything if I, you know, if I have anything.

M. CAVANAUGH: I think having documentation showing that that's the case would be very helpful.

JEREMY BRUNSSEN: Sure.

M. CAVANAUGH: Thank you.

JEREMY BRUNSSEN: Yeah, absolutely.

ARCH: Thank you. Other questions? Senator Williams.

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WILLIAMS: Thank you, Chairman Arch. And thank you, Mr. Brunssen, for being here. I think I'm the one committee member that's been here since Heritage Health was rolled out and have had all the discussions with the different issues that we've had. Could you help us as a committee understand what goes on between the three MCOs and HHS when we have disparities in payment like it appears we have here? This isn't the first time that we've seen those kind of things. And I think you understand from a provider standpoint when that person that has that need for a physical therapist walks in the front door, they don't know whether they're with WellCare. I mean, they know eventually, but they don't discriminate based on that, who walks in the door. Can you help us understand from DHHS's perspective how you do manage it so the providers have more consistency in knowing what the payments are going to be?

JEREMY BRUNSSEN: So I think it's a really complex answer. I'll try to do my best, to kind of summarize kind of the key concepts of how we manage the contract, I think is really where you're kind of asking about. So, you know, so obviously it starts really in the beginning when we release a request for proposal, we have certain requirements that we set forth within our contract from-- that touch on all aspects of monitoring and operating the Medicaid business through the managed care delivery system. So when potential partners bid, we have a chance to select bidders that we believe will be the best fit for the state and the program. But then once we're actually in operations, we actually review. We do have the opportunity to review policies. And this, I would believe would be a policy that would come through our team's office to review. So we do look at it from that perspective. With that said, though, we are also not in the business of necessarily telling them how to do every aspect of managed care. There are some efficiencies that are gained nationally by the managed care companies because they operate in Kansas and Iowa and other states as well. And so, you know, there might be a process that they do differently and it would be, you know, difficult to have different processes in place in every state that have good outcomes already established. We also, you know, they are allowed to pay differently and more than we can pay in the state plan as well, so they can provide other things that the state Medicaid can't-- plan can't provide through the state plan, through value added benefit. So there are always, you know, some differences within when you look at it from plan to plan. But when significant concerns arise, you know, I think that's where the

important feedback channel happens between the managed care companies, the actual providers in the department to, you know, when these issues are raised, we try to look at them and assess whether or not we believe, you know, the policy is something that is good for the state Medicaid program and have conversations from there depending on what, what the topic is.

WILLIAMS: Thank you.

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

JEREMY BRUNSSEN: Thank you.

***JAMES WATSON:** Good afternoon. My name is James Watson, and I am the Executive Director of the Nebraska Association of Medicaid Health Plans (NAMHP). Those plans include Nebraska Total Care, UnitedHealthcare Community Plan and Health Blue Nebraska. Thank you for this opportunity to testify before your committee. I am here to respectfully express the Association's opposition to Legislative Bill 100 (LB100). Therapy services are frequently performed together on the same date of service. Reimbursement for these procedures includes payment for practice expense services such as 1) greeting the patient, 2) cleaning the room and equipment, 3) providing education and instruction, 5) counseling and coordinating home care, 6) and post-therapy patient assistance. When the same provider or provider group practice provides multiple therapeutic services for the same patient, the practice expense procedures are not performed twice. Therefore, payment at 100% for the practice expense of secondary and subsequent therapeutic procedures would represent duplicative components of the primary procedure. When this occurs, full payment is made for the unit or procedure with the highest allowed amount and subsequent procedures/units are reduced by an established percent. With this testimony, I can confirm that none of the Medicaid health plans in Nebraska are applying such a reduction to therapy services provided by physical therapy, occupational therapy, or speech language pathology. Understanding that LB100 is the result of a past payment policy, which is no longer being utilized, the NAMHP expresses our concern to the HHS Committee around the practice of amending state law to remedy an issue that no longer exists. Instead, we support continued collaboration and open dialogue with our provider partners to identify concerns and discuss possible solutions to those concerns.

For that reason, the NAMHP therefore opposes LB100 and suggests that the Committee indefinitely postpone this legislation.

ARCH: Any other opponents for LB100? Seeing none, anyone wish to testify in the neutral capacity? Seeing none, Senator Walz, you're welcome to come up and close. And while you are coming, I will, as, as mentioned previously, we did receive one written testimony this morning that will be put on the committee statement, and it was from James Watson, the executive director of the Nebraska Association of Medicaid Health Plans. And it was, it was testimony in opposition. We also received several letters for proponents, one neutral, none opposed. Senator Walz, you're welcome to close.

WALZ: Well, thank you. Thank you for listening and thanks to those who came to testify today. I believe it is true that the managed care company that was using this has rescinded the policy, I believe. I think that that's positive and it's a clear acknowledgment that a mistake was made on their part by implementing the MPPR policy for therapy services. However, the issue here is whether or not they will choose down the road to implement this again in the future. With LB100, we want to ensure that there is protection in place for therapy services because Nebraskans must be able to adequately access rehabilitative services, whether caused by an injury or a mental or physical disability or as the result of aging. So with that, I would close my testimony or my, my closing, I guess, and ask if there's any other questions.

ARCH: Are there any other questions for Senator Walz? Seeing none, thank you very much. And this will close the hearing for LB100. The next and last bill we'll be hearing this morning is LB437, introduced by Senator Ben Hansen. Senator Hansen, you're welcome to open.

B. HANSEN: Thank you, Chairman Arch. So I get up on the microphone, everybody leaves. I see how it goes. All right. Good morning, Chairman Arch and the rest of the Health and Human Services Committee. My name is Senator Ben Hansen, that's B-e-n H-a-n-s-e-n, and I represent District 16, which includes Washington, Burt and Cuming Counties. Some might call it the best district in the state of Nebraska, but I'll leave it up to you. LB437 will have a direct impact on protecting some of Nebraska's most vulnerable population by addressing public assistance and Medicaid fraud. Back in 2004, the Nebraska Legislature updated the False medical-- Medicaid Claims Act with the assistance of

then Nebraska Attorney General Jon Bruning, who assisted in helping pass LB1084, which established the Medicaid fraud unit. By modifying three aspects pertaining to the current status of Nebraska's False Medicaid Claims Act, we will help protect some of Nebraska's most susceptible citizens. So I'm just briefly going to introduce the changes here because there's three fundamental changes here. Kind of lay the foundation and the groundwork here, because I'm sure there will be testimony after me that might kind of describe these more in greater detail. So the first modification allows the Nebraska Attorney General to investigate and prosecute Medicaid fraud cases outside the purview of institutional settings like retirement communities. The second modification allows the Nebraska Attorney General to access any records of a Medicaid-funded facility. Additionally, this particular change makes Nebraska's law consistent with the federal government and aligns us with every other state with similar, similar requirements. The third modification restructures the penalties for public assistance fraud to an increased penalty structure, aligning it with the state's theft laws. These modifications would be a major step forward in our continued efforts to combat Medicaid fraud and patient abuse and neglect and save our state millions of dollars in fraud. So this does conclude, conclude my opening statement. And I do have Mark Collins, the Assistant Attorney General and director of Medicaid Fraud and Patient Abuse Unit for the Nebraska Attorney General's Office testifying after me, and he may be more able to answer any specific questions you have. Thank you for your attention and I am open to any questions. I'll answer them the best that I can.

ARCH: Thank you, Senator Hansen. Are there questions? Senator Cavanaugh?

M. CAVANAUGH: Thank you, Chairman Arch. Thank you, Senator Hansen. I don't know, this is probably not a question you can really answer because you're not on the Referencing Committee, but it just seems odd to me that this was a referenced to our committee because of the criminal codes in here.

B. HANSEN: You're right. I'm not on the Reference Committee, so--

M. CAVANAUGH: I just--

B. HANSEN: -- I will leave it up to them in their pur-- purview.

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M. CAVANAUGH: Yeah, that just kind of struck me. I apologize. And it looks like, how is this reported? Or maybe this is for the next testifier. Like, how do people, how do we find out about this fraud and how--

B. HANSEN: I could probably answer that, but it would probably be better if the testifier after me answered that.

M. CAVANAUGH: OK, thank you.

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

B. HANSEN: Thank you.

ARCH: First proponent for LB437, welcome to come up. Welcome to the HHS Committee.

MARK COLLINS: Thank you, Mr. Chairman. Good morning, I'm-- excuse me. Good morning, I'm Mark Collins, M-a-r-k C-o-l-l-i-n-s, Assistant Attorney General and director of the Medicaid Fraud and Patient Abuse Unit in the Nebraska Attorney General's Office. The Medicaid fraud unit is a federally mandated law enforcement entity, and our primary responsibilities are the investigation and prosecution of fraud committed by providers of Medicaid services and the prosecution of abuse, neglect and exploitation of residents of Medicaid-funded facilities such as nursing homes. Our unit was created by the Legislature back in 2004. It has both civil and criminal jurisdiction. We've investigated about 2,300 cases, obtained 126 criminal convictions, recovered over $93 million in civil settlements and judgments, and obtained court orders for an additional $17 million in criminal restitution. LB437, which we support, makes three modifications to the statute, statutes pertaining to Medicaid provider fraud and our ability to protect some of Nebraska's most vulnerable citizens. First, it allows us to prosecute cases of abuse, neglect and exploitation of Medicaid recipients who do not reside in an institutional setting. This new authority was passed by the Congress in the COVID-19 relief bill that was signed by the President in just this month, January of 2021. Many Medicaid recipients receive health care services that are designed to allow them to remain in their home. But while they remain there, they are still vulnerable, vulnerable to acts of abuse, neglect and exploitation in their homes. Medicaid fraud

units have the knowledge, skill and experience to pursue these matters and are now federally permitted to pursue them. And Section 2 of LB437 authorizes us to investigate these in-home cases. Second, LB437 amends Nebraska Statute 68-945. When Medicaid fraud units were created by Congress in the mid 1970s, one of the missions that we were given was to investigate and prosecute cases of abuse, neglect and exploitation of residents in Medicaid-funded facilities. And that mandate extended to all residents of those facilities, regardless of whether or not they were on Medicaid. But 68-945 currently prohibits us from reviewing or obtaining information concerning a non-Medicaid resident of a health care facility without that patient's consent or a court order. A review of the legislative history behind the enactment of this passage doesn't show us the reason for this prohibition and no other state in the country has this provision in their law. So LB437 fixes this anomaly and allows us to access the record, the records of any resident that lives in a Medicaid-funded facility such as a nursing home when we're investigating abuse, neglect or exploitation cases, regardless of whether the victim is a Medicaid recipient. Federal regulations on this subject are clear. That is what we are supposed to do. It says that we must review complaints alleging abuse and neglect of patients or residents of health care facilities receiving payments under Medicaid. And it doesn't make a delineation between whether they're private pay or on Medicaid. This restriction currently in our state statute hampers our ability to protect non-Medicaid residents for several reasons. First, the victim may not be able to consent to the release of their records due to their infirmity. The victim's power of attorney may be a suspect in our crime, and requesting consent from them could tip them off to our investigation, which is especially important in cases where we're, where we're investigating financial exploitation. Obtaining a court order to receive, receive, review or obtain records can waste valuable time in an investigation, especially where there's a sexual assault or physical injury. So LB437 treats all residents and patients the same. It makes our law consistent with Congress's intent and aligns our law with the similar provisions found in 49 other states. And finally, LB437 amends Statute 68-1017, which is the primary criminal law that we use to prosecute providers who defraud our state's Medicaid program. Those amendments would harmonize its penalties with the theft provisions, revisions that were made in LB605 back in 2015, matching the penalties imposed with the state's theft laws. One of the helpful features in 68-1017 is that it has a five-year statute of limitation

rather than the three-year limitation period that's standard for most penalties. But as 68-1017 is currently written, any fraud in any amount over $1,500, whether it's $1,501 or a million dollars, is only a Class IV felony, carrying a maximum two years imprisonment and a ten thousand dollar fine. And probation is the presumptive sentence, frauds of less than fifteen hundred dollars or misdemeanors. Defendants charged under our theft statutes face higher penalties of theft of five thousand dollars or more is a Class IIA felony, with up to 20 years in prison. Theft of $1,500 but less than $5,000 is a Class IV felony with two years imprisonment. So our prosecutors sometimes will use the theft statutes to convict an errant Medicaid service provider, but we can only do so if we become aware of the crime, get our investigation complete, file charges within the three-year time period. And that can be tough to do when you're talking about a white-collar crime that occurs over several years. So LB437 corrects this anomaly by harmonizing the penalties under 68-1017 with the theft provisions made in LB605. Now 68-1017 does apply to both public assistance recipients as well as providers. And some could argue that increasing the penalty for large-scale fraudsters will subject these Medicaid or public assistance recipients to harsher penalties for minor crimes. While the penalties for large theft will increase, the penalties for thefts under $1,500 will remain a misdemeanor. And additionally, prosecutors always have the discretion to downgrade a criminal charge when it's appropriate, but they can't upgrade a charge any higher than what the Legislature allows. And so with that, if I can briefly conclude, Mr. Chairman.

ARCH: Please.

MARK COLLINS: What LB437 does is to strengthen our ability to protect our most vulnerable citizens in Nebraska, strengthens our ability to pursue those who would defraud our Medicaid program. So the Attorney General respectfully requests that this bill be advanced to the General File. I thank you for your consideration. I have-- I'm available to answer your questions. The written testimony that I've provided also has an appendix to it that contains the section of the new federal law that allows us to do in-home investigations. The, there's a copy of the federal regulation that says that we're supposed to investigate cases involving all residents who are abused or neglected in Medicaid facilities, regardless of how they're paid. There's a copy of the theft statute, the copy of 68-1017, and there's a copy of a letter sent by 49 attorneys general to the Congress that

outlines why in-home investigations should be done by Medicaid fraud units. Thank you for your time.

ARCH: Thank you. Thank you for your testimony. Questions? Senator Walz.

WALZ: I have a question. Thank you. Thanks for coming today. And I'm just asking this because I don't understand the process. So I'm wondering what the process is in place currently for you to go out and investigate abuse and neglect cases. Do you physic-- does your office physically go to the facility and conduct an investigation or do you rely on other entities to do that? How does that work?

MARK COLLINS: We go out.

WALZ: You go out.

MARK COLLINS: Our unit is made up of auditors, investigators and attorneys. So it's not just a bunch of lawyers. Our investigators, we have three who are law enforcement certified officers and another one who is a civil sworn-- or a nonsworn investigator. They have specific training in resident abuse cases. We generally get those cases from adult protective services is how we find out about them at first, because of mandatory reporting. We work with APS and we go into those facilities and do investigations. We also cooperate with local law enforcement if they're investigating the case or if it's a large law enforcement agency such as Omaha Police or Lincoln Police. If they want to do the investigation, we will assist them with it.

WALZ: OK, and is that work also done in conjunction with DHHS?

MARK COLLINS: With Adult Protective Services, yes.

WALZ: OK.

MARK COLLINS: Yeah, oftentimes we would go at their request or with them when we would go-- excuse me, when we would go into a facility.

WALZ: All right. Thank you.

MARK COLLINS: Sure.

ARCH: Other questions? Senator Williams.

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WILLIAMS: Thank you, Chairman Arch. And thank you for being here. Some would suggest that the, what we are looking here in Medicaid fraud is a rather small area and that there are other ways that that fraud is currently being detected. What would you, would your response to that kind of a question?

MARK COLLINS: No one else at the state government level investigates Medicaid fraud specifically and exclusively. The only agencies that do that are the Medicaid fraud control units in each of the 50 states and three of the territories. The fed-- we work with the federal government, with the U.S. Department of Health and Human Services and their special agents in their Office of Inspector General. But they do Medicaid, not only Medicaid, but they do Medicare and other federal health care programs. The reason that Medicaid fraud control units were started back in the 1970s when Congress said we need to do this, is because there was no one else that was looking after state and federal funds used in the Medicaid program to detect and prosecute fraud.

WILLIAMS: Thank you.

MARK COLLINS: Sure.

ARCH: Other questions? I have, I have one question. I was-- as I was reading this, I guess my assumption was always that your focus has been on institutions not as-- not on, not on individuals outside of the institution. This would broaden that where you could go outside of the institution. When you-- your experience, and I know you won't have the exact numbers, but how many of your cases that you actually took to prosecution were institutions versus individuals in the institutions?

MARK COLLINS: Usually with institutional cases we exercise civil jurisdiction and rather than criminal jurisdiction. When you're, when in the criminal realm, it can be tough to prove corporate liability for a crime. But we would look to see if there are individual people working within the facility who committed a crime, especially with abuse and neglect. Now, sometimes it can be systemic. And there are a few cases out there federally that I'm aware of where a health care system was, was prosecuted. But for the most part, those big systems are, are pursued civilly because that's, that's just you go how the-- you go where the evidence leads you and you base your decisions on

what the evidence shows. And it can be tough to prosecute a case corporately in those, in those instances.

ARCH: Do you, do you prosecute civilly for individuals?

MARK COLLINS: Yes.

ARCH: That's another option that you have. It could be criminal, it could be civil.

MARK COLLINS: It depends on what-- you go where the evidence takes you. And if there's evidence of a crime that we can prove beyond a reasonable doubt to a jury of 12 people who would unanimously convict, if we can meet all those criteria, then we might go with a criminal case. If we can't do that, then we would look at a case civilly. Can we prove by a preponderance of the evidence to the satisfaction of a majority of jurors, 10, that a a cause of action is there for a violation of Nebraska's False Claims Act, which is found at 68-945 and thereafter? So that's the civil law that we would look at. If the evidence is sufficient to go with a criminal case, we'd do that. If it doesn't, then we would look at a civil remedy. And if there's not enough to go with a civil remedy, then we might look at an administrative remedy.

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

MARK COLLINS: Thank you.

ARCH: Are there others, other opponents-- excuse me, proponents to LB437?

SPIKE EICKHOLT: I snapped up when you said that first.

ARCH: Are you a proponent or opponent?

SPIKE EICKHOLT: Opponent.

ARCH: OK. Are there any other proponents that would like to testify? Seeing none, are there any opponents that would like to testify? Welcome.

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SPIKE EICKHOLT: Thank you. Thank you, Chairman Arch and members of the committee. My name is Spike Eickholt, S-p-i-k-e, last name is E-i-c-k-h-o-l-t. I'm appearing on behalf of the ACLU of Nebraska and the Nebraska Criminal Defense Attorneys Association in opposition of at least a portion of the bill. As-- and I explained to Senator Ben Hansen earlier this week that we would be opposing this bill. As Senator Ben Hansen explained, this bill does three things. And the first part, our associations, our-- the people I represent don't take any position on that, and that is LB437 allows the Attorney General to investigate and prosecute cases of abuse, neglect or exploitation of recipients of Medicaid who do not reside in the institutional setting. We don't have a problem with that. We do have some concerns with the second suggestion that is on page 7 of the bill, lines 11 through 13, that strikes that requirement that for a non-Medicaid patient that their account or records of non-Medicaid patient needs to be-- can only be reviewed by the Attorney General with that patient's consent or a court order. I understand, I think, what Mr. Collins is saying, the difficulty when you have somebody who may be a victim in that situation of being exploited, and I understand perhaps in those situations that person doesn't have the mental capacity to consent. But I think just removal, that blanket removal of that privacy protection is a little too far. And I caution the committee very strongly to not do that. I think that language is there for a reason. We may be an anomaly compared to other states, I'm not sure, but it's there for a reason. If the patient doesn't want to consent and the Attorney General has a suspicion that something is going on, they can get a court order pursuant to a search warrant to get it without anyone knowing. And if they have at least a likelihood, they could likely get a showing to a judge and grant that order and get that approval. But the other component of the bill that we do have a problem with is the increase in penalties that are proposed by this bill. As Senator Machaela Cavanaugh asked earlier, I think why this bill didn't go to Health-- or to Judiciary Committee or another committee. It actually was introduced last year, LB793, by Senator Slama and it had this identical proposed increase in penalties. That bill was referenced to the Judiciary Committee, it was not advanced. We have, I would submit, a prison and jail overcrowding problem. We have, I would editorialize, enough penalties, enough crimes, enough felony offenses. If you look at pages 8 and 9 of the bill, Mr. Collins and Mr.-- Senator Ben Hansen talked about Medicaid fraud and so on. But the proposed increase in penalties applies to all public

assistance that's referenced in this statute. That would include SNAP benefits, that would include Medicaid assistance, that would include other benefits administered by the Department of Health and Human Services. And it would align those penalties based on the amount of money that was involved in the fraud or the deception. The penalty for $5,000 or more under the general theft statute is up to 20 years imprisonment. As Mr. Collins indicated, and I would highlight to everybody, there is nothing stopping the prosecution, the Attorney General or the state from charging somebody with Medicaid fraud or SNAP benefit fraud or unemployment benefit fraud and a concurrent charge of theft by deception. They do it on a regular basis. I've had many cases. I've even argued unsuccessfully in court many times the state should not be able to do that because the Legislature has says the lesser penalty should apply. In other words, if you align the penalties consistent with the general theft statute, then prosecutors are going to have two hammers to hit people with. And I will tell you, zero to 20 years, even if it's a nonviolent offense, judges in this state will send people to prison for a while. Now, maybe, you know, Senator Morfeld was talking yesterday, it was something that I watched, there's a distinction between people as a state that we are angry with and people who we are afraid of and whether it really makes sense to incarcerate people who we are angry with. And the public should be angry if somebody rips off the state and gets benefits where they're not entitled to. And if they take $6,000, $7,000 from the state, we can be angry, but it doesn't really make a lot of sense to incarcerate them for five, 10 years at $41,000 a year, again, at state costs. There's got to be some proportionality. There's got to be some moderation, I would submit, the criminal penalties that are imposed. And on this bill, we would argue it's just too excessive. Other than that, that's the only comments that I have and I'll take any questions the committee has.

ARCH: Thank you. Are there any questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thanks for being here. When we go talk about the concern over the blanket removal of privacy, is, is there language that you could bring to us that would help address that that's also still allow for that type of investigation?

SPIKE EICKHOLT: One thing you could look at, if you look on page 7, lines, maybe 11 or 12, it says the accounts or records. So it seems to me that would be everything related to the patient, not just the

medical stuff, right, or not just the financial stuff, but their medical records, maybe even personal records and visiting logs or whatever. I mean, you've just, it's just everything, particularly since you used both the terms "the accounts" and "the records." Presumably those two things mean something different.

M. CAVANAUGH: So--

SPIKE EICKHOLT: So maybe narrowing that to some sort of, if it's a financial fraud, maybe the financial accounts may be reviewed by the Attorney General. I mean, once it's out there, it's out there for really any purpose.

M. CAVANAUGH: So there, in your, in your mind, there is an opportunity to, to create a change that meets the goal but doesn't remove the blanket privacy?

SPIKE EICKHOLT: I think so.

M. CAVANAUGH: OK.

SPIKE EICKHOLT: And I would just submit that it is an inconvenience for the prosecutor to have an investigator swear to an affidavit explaining the factual reasons why they're looking at a particular case or cases and present that to a judge. But it's certainly not impossible. It happens on a regular basis. In other words, you can get a search warrant, that's what they mean by court order, to allow the Attorney General or an investigator to go back and look at some of these records. And I think it's just logical that if the Attorney General is looking at a particular case, it's because they already have some kind of information or indication something's going on already. So I don't-- and I don't know that they, and maybe they've got instances that they can show this committee where they are unable to get a warrant and something happened. I think it's really just a matter of convenience. And I don't think that should necessarily trump privacy.

M. CAVANAUGH: And I made the mistake of not asking this question. So I'm going to ask it and I doubt you'll be able to answer it, but perhaps we can get the information of how many cases are of fraud are investigated each year.

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SPIKE EICKHOLT: I know that there's a number of unemployment cases that I've been appointed to and had over the years. [INAUDIBLE] cases.

M. CAVANAUGH: Specific--

SPIKE EICKHOLT: As far as Medicaid, institutional fraud, I'm not sure.

M. CAVANAUGH: Yeah.

SPIKE EICKHOLT: I mean, there's relatively few, I'm guessing, I'm going to speculate, for institutional fraud, but the cost could be significant. And I would just say that and this is maybe me editorializing, it's easier for the reason Mr. Collins explained, when you've got a corporate structure and you've got different people involved, it's difficult to find accountability for the purpose of getting a criminal conviction. It's relatively easy to get a criminal conviction for a lot of recipients. You're typically dealing with marginal people who are unsophisticated, who just either through oversight or just greed get more than they necessarily deserve to. And usually there's a paper trail and it's easy to prosecute those people.

M. CAVANAUGH: Thank you.

***JAMES GODDARD:** Dear Chairman Arch and Members of the Health and Human Services Committee, my name is James Goddard, and I am the Senior Director of Programs at Nebraska Appleseed. Nebraska Appleseed is a nonprofit legal advocacy organization that fights for justice and opportunity for all Nebraskans. Nebraska Appleseed has a long track record of advocating for effective administration of Nebraska's public assistance programs and for the rights of the individuals and families that utilize these important programs. We submit this testimony today in opposition to LB437. First, this bill represents a heavy-handed approach to addressing a relatively small problem that is already being addressed in other ways. While we must ensure effective administration of Nebraska's public assistance programs, fraud in programs like Medicaid and the Supplemental Nutrition Assistance Program (SNAP) are rare, and sufficient mechanisms exist to prevent and root out any fraud in the system without creating excessive penalties. The vast majority of Medicaid providers do not participate in fraud and abuse; in fact, in Fiscal Year 2019, Nebraska's Medicaid Fraud Control Unit had 104 investigations, six indictments, and three convictions for fraud and abuse/neglect and six civil judgments and

settlements. A number of safeguards exist, along with the Medicaid Fraud Control Unit and including Medicaid managed care contractual oversight, to protect against Medicaid fraud. SNAP fraud is also rare, and numerous areas of oversight exist to protect against both retailer and enrollee fraud.4 Moreover, the penalties proposed under Neb. Rev. Stat. § 68-1017 would be excessive. The potential penalty for offenses under Neb. Rev. Stat. § 68-1017(1) involving an aggregate value of $500 or less is elevated from a Class IV misdemeanor to a Class II misdemeanor, meaning the maximum punishment would be changed from a sentence of no imprisonment and a $500 fine to a maximum of six months imprisonment or a $1,000 fine or both. Additionally, for offenses involving an aggregate value of more than $500 but less than $1,500, the proposed sentence would change from a Class III misdemeanor, with a maximum sentence of three months imprisonment or a $500 fine or both, to a Class I misdemeanor, with a maximum sentence of not more than one year in prison or a $1,000 fine or both. This bill also adds an additional Class IIA felony sentencing level for offenses involving an aggregate value of $5,000 or more, which carries a maximum sentence of twenty years imprisonment. As stated, these proposed changes are excessive penalties. Furthermore, if the intent behind this proposed legislation is to redefine and penalize fraud by Medicaid providers, a more surgical approach could be taken that does not generally subject low-income patients and enrollees in public assistance programs to extreme penalties. This could include modifications to the language in Neb. Rev. Stat. § 68-1017(1) to create separate penalties for enrollees who commit the described offenses and for providers or retailers. Finally, we have no opposition to the proposed changes under the bill to better monitor abuse, neglect or exploitation of Medicaid recipients, but this legislation goes well beyond that singular goal. In conclusion, we respectfully request that this committee not advance LB437.

ARCH: Thank you. Are there other questions? Seeing none, thank you for your testimony. Are there other opponents to LB437? Seeing none, are there any, is there anyone who wants to testify in a neutral capacity? Seeing none, Senator Hansen, you're welcome to close. And while you're coming up, I would note that we did not receive any letters either for, against or neutral. However, we did receive one written testimony from James Goddard, senior director of programs at Nebraska Appleseed. And it was it was testimony of opposition.

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B. HANSEN: OK, thank you for listening to all of this and answering good questions. I'd at least like to thank Mr. Collins for coming up here, because I think he is kind of the voice of the taxpayer, you know, when it comes to fraud and protecting taxpayer money and also the voice of those who maybe can't speak, who are being abused and, you know, either physically or financially. I appreciate all the work that he does to make sure that they're being protected as well. One of the questions I think I can respond to that Mr. [INAUDIBLE] had earlier was about-- see if I can find it. He was asking about page 7, lines 11 through 13, about the ability to review non-Medicaid patient files. He didn't know if we were a kind of anomaly. And we are, we're the only state in the United States that, that doesn't allow us to review non-Medicaid patient files. And actually, the federal regs require it and we can be found out of compliance. So far, they haven't dinged as yet. But this is one of the changes that is kind of fundamental because we're the only state right now that doesn't allow us to look at non-Medicaid files. So I at least want to respond to that, because I know he had a question about that. And as, I mean, one of the questions somebody else had so. With that, I will again do my best to answer any questions that you guys might have otherwise, I'll conclude.

ARCH: Are there any questions for Senator Hansen? Senator Cavanaugh.

M. CAVANAUGH: Thank you. The fraud question of how many instances they investigate, maybe that's something we can get for the committee.

B. HANSEN: I will have a follow-up of that, actually. Yeah.

M. CAVANAUGH: Thank you.

ARCH: Any other questions? Senator Day.

DAY: Thank you, Chair Arch. I can see the importance and the significance of this bill, like you said, in making sure that we're protecting people from abuse and, and people who are vulnerable and things like that. But I also understand some of the concerns in terms of the excessive consequences and putting people in jail for long periods of time because we're angry with them and the disproportionate cost to the state in the long run of incarcerating people. Is that something that you would be willing to amend or is that kind of-- would you be willing to amend the bill to address that concern?

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B. HANSEN: That is something I would probably have to follow up with the Attorney General's Office--

DAY: OK.

B. HANSEN: -- and see if we can kind of come in collaboration with others who might have a concern like that and see if that is something we can work on. Right now, I'm unsure I, if I can answer that.

DAY: OK, OK. Thank you, Senator.

B. HANSEN: Thank you.

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

B. HANSEN: Thank you.

ARCH: This will conclude the testimony and the bill, LB437. And we'll conclude our hearings for the morning and we will gather together at 1:00 for a briefing at 1:30 for continuing bill hearings.

[BREAK]

ARCH: [RECORDER MALFUNCTION] we have so-- so questions from the senators? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here and welcome.

KEVIN BAGLEY: Thank you.

M. CAVANAUGH: It's nice to see you again. OK, so I have-- I do have a few questions and if anybody else wants me to take a break, please let me know. This is a question that I've asked throughout this entire process. How are we collecting this information about community engagement and personal responsibility? Who is tasked with that reporting?

KEVIN BAGLEY: Yeah, that's a great question, Senator, and I'll say that we're still finalizing some of that development, but we anticipate that we'll be getting reports from providers when, when a-- an appointment is missed, for example, that they'll be able to actually send us information in the form of something similar to a

claim that indicates to us that, that someone missed their appointment. We'll be able to store that information and go back and reference it as part of our, our semiannual review.

M. CAVANAUGH: So is that information-- is there any, I guess, allocation of funds for the administrative burden of providers tracking that and reporting it?

KEVIN BAGLEY: We don't anticipate that it will be a tremendous burden for providers.

M. CAVANAUGH: We've heard from providers that they don't want to do that, so they seem to think it is.

KEVIN BAGLEY: So I'd be happy to take that back and include that in some additional discussion with provider groups because I-- we certainly don't want it to be burdensome and so that's something I'm, I'm happy to take back and, and look into that feedback.

M. CAVANAUGH: Thank you. I have additional questions, but if anything else--

ARCH: Other questions? Just try and rotate here.

M. CAVANAUGH: Oh, go ahead.

ARCH: Senator Walz.

WALZ: I'll give you a break, Machaela-- Senator Cavanaugh. I, I am just really curious about the mental health aspect of the program. As we know, mental health can be a really debilitating issue for so many people and I'm just wondering-- I, I know that, you know, they're exempt from the demonstration. They--

KEVIN BAGLEY: From, from those community engagement requirements?

WALZ: Yes, but I'm wondering is there a way or are they being connected at that point or at any point in getting into the program, are they being connected with mental health resources so, you know, in time they'll be able to participate in community engagement? How, how are we making sure that people with the debilitating mental health issues are, are being connected with the resources that they need, I guess?

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KEVIN BAGLEY: That's a great question and I guess I'll, I'll preface it by saying I don't think I have a holistic and, and complete answer to how we would manage that, but I will say one of the things we have a regular discussion with our managed care plans regarding is what that utilization looks like for this group. I think we recognize broadly and, and we've seen nationally that this group is, in particular, users of that service who, who are in particularly high need of it, I guess, if that's the right way to put it. This is a-- mental health is a service that is frequently utilized by this population and so we want to make sure that we're doing it effectively, that we have access to care. So access to care, utilization, and even looking at things down in the weeds, like the average amount of time it takes for any kind of a prior authorization or even medication utilization, are things that we look at with our plans. I think there's more that can be done on that front. I don't think I'm ready to say what that will look like at this point. I think we're still learning what works best for this population in terms of managing their care.

WALZ: OK, thank you.

ARCH: Senator Murman.

MURMAN: Yes, thanks for coming in. The 80-hour requirement is-- for phase three is in what time period?

KEVIN BAGLEY: So that will, that will fall in April of 2022.

MURMAN: OK, so 80 hours over--

KEVIN BAGLEY: Over a month.

MURMAN: --that much time? OK, over a month. And you did say that working qualifies as the 80 hours?

KEVIN BAGLEY: Absolutely, yes. Employment would be included as well as education, apprenticeships, and, and similar-type activities.

MURMAN: OK, so, so volunteer work would qualify also?

KEVIN BAGLEY: It would.

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MURMAN: OK and it seems like the employment part of it would be easy to document. The other part would be a little more challenging, I suppose, but do you, do you have a plan for that then?

KEVIN BAGLEY: Yeah, that, that is definitely something, again, I think we're still working on as we have additional lead time to make that happen, but we anticipate that that we'll have a base-- I, I want to say simple and standard way for that information to be provided. It may be that we have to look at a couple of different sources for that information, but to the extent that we're asking especially members for that information, I think we want to have it be simple and standardized to the extent that we are able.

MURMAN: OK, thank you.

ARCH: Other questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. I'm looking at the three slides for the year one HHA phase two demonstration.

KEVIN BAGLEY: OK.

M. CAVANAUGH: So you've already answered the question about the health screenings, I, I suppose. It says personal responsibility activities include maintaining employer-sponsored health coverage. Well, this population inherently is lacking employment-- employer-sponsored health coverage, so I guess can you explain that because I'm confused as to how, how that would work.

KEVIN BAGLEY: Sure. No, that is, that is a great question. I, I can say in a lot of cases, certainly folks in this population may not have access to employer-sponsored health coverage. And if that's the case, we don't anticipate that they would maintain it because it doesn't exist. We, we have found that there are a number of individuals who do and that significantly reduces the burden on the Medicaid costs when they have that employer-sponsored health coverage. So that's something that we find is a really effective way to make sure that they have adequate access to services--

M. CAVANAUGH: So--

KEVIN BAGLEY: --without necessarily increasing their costs.

M. CAVANAUGH: --if they had employer-sponsored health coverage, then they wouldn't be in the expansion population.

KEVIN BAGLEY: They could actually. It's-- that expansion population is really based on their medically adjusted gross income.

M. CAVANAUGH: So if they can't afford their employer-sponsored health program, then will they be penalized because of that under this?

KEVIN BAGLEY: I may have to get back to you on the details of that, Senator, I'm, I'm not entirely clear on the mechanisms here in the state of Nebraska on, on how that would work, but I'd be happy to do that.

M. CAVANAUGH: Yeah because my employer-sponsored health coverage is more than my salary, so I don't take advantage of the state's health coverage because it's more than the $1,000 a month that the state pays me, so I'd be interested to know. I think that's-- that would be a, a big burden for, for some individuals. On the, on the next page, it says that DHHS will conduct benefit tier reviews for each participant every six months. That seems very costly for the state to take that on and then it, it looks like there's two different tiers of if you are compliant with what the state wants you to be doing, you, you-- or if you are not compliant, then you are penalized for six months for wellness checks and you're penalized for interestingly worded two consecutive six-month periods, which by my math, is a year.

KEVIN BAGLEY: Yes.

M. CAVANAUGH: So you have to sit out for a year before you can qualify or apply to move to the other tier?

KEVIN BAGLEY: Yes, that's correct. That's the way that the waiver is, is currently written.

M. CAVANAUGH: And again, this seems pretty costly to the state of Nebraska.

KEVIN BAGLEY: You know, I, I think we tried to strike a balance here where we'd be able to allow individuals as much opportunity as we could to move into that higher tier without necessarily creating a really enormous administrative burden. I think where we've, we've

settled with this actually mitigates a lot of that, that issue for us while also kind of encouraging effective utilization of the services.

M. CAVANAUGH: A suggestion before I ask my next question--

KEVIN BAGLEY: Sure.

M. CAVANAUGH: --would be to eliminate the 1115 waiver and put everybody in the prime and that would eliminate a lot of administrative costs for, for the state, which is what the voters intended, but let's move on to the next page.

ARCH: Unfortunately, we have run out of time.

M. CAVANAUGH: Oh.

ARCH: So we need to, we need to move on--

M. CAVANAUGH: Can--

ARCH: --to our hearings.

M. CAVANAUGH: --can I ask--

ARCH: Well, I--

M. CAVANAUGH: Really, it's just one more question.

ARCH: OK, OK, because I, because I think we'll also be submitting additional questions, but please.

M. CAVANAUGH: At the bottom of the last page, it's updated state regulations. If you could follow up with the committee as to what those are that are needed before this can be implemented, phase two, that was it.

ARCH: OK.

M. CAVANAUGH: Thank you.

KEVIN BAGLEY: All right. Thank you, Senator.

ARCH: Thank you.

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KEVIN BAGLEY: Thank you.

ARCH: Director, thank you very much for your briefing today and as I mentioned, I think we'll probably-- I know I had a number of questions as well, so we'll probably submit some additional questions to you and, and appreciate you letting us know and educating us some more, so, so--

KEVIN BAGLEY: Yeah.

ARCH: --very nice for you to come to the committee.

KEVIN BAGLEY: Thank you.

ARCH: And I know we have a gubernatorial appointment later on that we'll also address with you, but for now, thank you very much and this will end the briefing for the day.

KEVIN BAGLEY: Thank you.

ARCH: Good afternoon and welcome to the Health and Human Services Committee. My name is John Arch. I represent the 14th Legislative District in Sarpy County and I serve as Chair of the HHS Committee. I'd like to invite the members of the committee to introduce themselves, starting on my, on my right with Senator Day.

DAY: I am Jen Day and I represent District 49, which is northwestern Sarpy County.

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

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

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

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

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ARCH: Also assisting the committee is one of our legal counsels, T.J. O'Neill, and our committee clerk, Geri Williams, and our committee pages, Kate and Rebecca. A few notes about our policies and procedures. First, please turn off or silence your cell phones. This afternoon, we'll be hearing three bills. We'll be taking them in the order listed on the agenda outside the room. 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 and 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. For those of you who are planning to testify, you'll find green testifier sheets on the table near the entrance of the hearing room. Please fill one out, hand it to the-- one of the pages when you come up to testify. This will help us keep an accurate record of the hearing. We use a light system for testifying. Each testifier will have five minutes to testify. When you begin, the light will be green. When the light turns yellow, that means you have one minute left. When the light turns red, it is time to end your testimony. We'll ask you to wrap up your final thoughts. And when you come up to testify, please begin by stating your name clearly into the microphone and then please spell both your first and last name. Due to social-distancing requirements, seating in the hearing room is limited. We ask that you only enter the hearing room when it is necessary for you to attend the bill hearing in progress. The bills will be taken up in the order posted outside the hearing room. We request that you wear a face covering while in the hearing room. Testifiers may remove their face covering during testimony to assist committee members and transcribers in clearly hearing and understanding the testimony and pages will sanitize the front table and chair between testifiers. This committee has a strict no-props policy. With that, we will begin today's hearing with LB15. Welcome, Senator Blood.

BLOOD: Well, thank you, Senator Arch, and good afternoon to Chair Arch and the entire Health and Human Services Committee. My name is Senator Carol Blood. That is spelled C-a-r-o-l B-l-o-o-d and I represent District 3, which is western Bellevue and southeastern Papillion, Nebraska. Thank you for the opportunity to present to you today LB15, my Occupational Therapy Interstate Compact. So today states are facing issues that are not confined to geographical boundaries or jurisdictional lines. As we become more integrated socially,

culturally, and economically, the volume of these issues will only increase. Interstate compacts prove to be an apt mechanism for developing state-based solutions to superstate, superstate problems while preserving the states' authority and their freedoms. This is why, since 2017, interstate compacts have become so very popular in our country. Now there are two types of licensure contract-- compacts. There's the expedited licensure model and the mutual recognition model. As I noted at yesterday's hearing on LB14, the Interstate Medical Licensure Compact is the only expedited compact. All of the other compacts being utilize-- being adopted utilize the mutual recognition model where a practitioner's home-state license is mutually recognized by the compact states. They do this by obtaining what is known as a privilege to practice, which is equivalent to a license. Also yesterday, I gave you a comprehensive comparison fact sheet that was created by the National Center for Interstate Compacts that CSG titled "Interstate Licensure Compacts and Universal License Recognition Laws" that clearly points out that compacts and universal recognition statutes can coexist without conflict or redundancy as long as provisions to exclude interstate compacts are inserted into the universal recognition bills. When you enhance the ability of practitioners to engage in interstate practice, it requires more than a one-size-fits-all approach. We must account for industry-tailored reciprocity mechanisms like this compact and our other interstate compacts as we also craft our universal recognition laws. In fact, it's really irresponsible not to do so. This particular compact is for occupational therapists. According to the American Occupational Therapy Association, occupational therapy is the only profession that helps people across their lifespan to do the things they want and need to do through the therapeutic use of daily activities. Occupational therapy practitioners enable people of all ages to live life to its fullest by helping them promote health and to prevent or live better with injury, illness, or disability. Common accu-- occupational therapy interventions include helping children with disabilities to participate fully in school and social situations, helping people recovering from injury to regain skills, and providing support for older adults experiencing physical and cognitive changes after life-altering illnesses such as strokes or loss of limbs. Occupational therapy services typically include an individualized evaluation during which the client and his or her family and occupational therapists determine that person's goals, then a customized intervention to improve the person's ability to perform daily activities and to reach

those goals, and then an outcomes evaluation to ensure that the goals are being met and to make necessary changes to that intervention plan. Occupational therapy practitioners have a very holistic perspective in which the focus is on adapting the environment and task to fit that particular person and the person is an integral part of the therapy team, which is a little different than a lot of things that we've experienced. It's an evidence-based practice that is deeply rooted in science. The demand for occupational therapists is rising, with a-- job growth expected to increase 27 percent from 2014 through 2024, according to the U.S. Bureau of Labor Statistics. The aging population is definitely driving those numbers, but it is not the only cost. More than half of occupational therapists work in hospitals and occupational therapy offices, where they provide reability-- rehabilitation services to the elderly suffering from stroke, arthritis, Alzheimer's, and other long-term disabilities, according to the most recent data from the Bureau of Labor. There has been an increased need for occupational therapists and occupational therapy assistants over the last decade and one reason for this demand is because hospitals recognize that occupational therapy has a role in lowering readmission rates. In a study of Johns Hopkins University, researchers found that occupational therapy was the only spending category that had a statistically significant impact on hospital readmissions for heart failure, pneumonia, and acute myocardial infarction. So data shows us that there are many benefits that are not always obvious to those of us with general knowledge of the sector, myself included. This Occupational Therapy Interstate Licensing Compact would allow licensed occupational therapists and occupational therapy assistants to practice across state lines and participate in telehealth. It improves consumer access to occupational therapy. It enhances mobility of occupational therapy practitioners, for example, spouses of relocating military families and, and also staff with travel therapy, travel therapy companies. It improves the continuity of care. It addresses competition, competition issues that have been raised by the FTC, as was the instance with Delaware and the, the telehealth issue. It preserves and strengthens the state licensure system and enhances the exchange of license, investigative, and disciplinary information between member states. An interstate licensing compact would not change state occupational therapy practice acts or the scope of practice. I'm going to repeat that. It isn't going to change the scope of practice. As a friendly reminder, universal recognition does not reduce barriers for in-state

practitioners aiming to practice in multiple states, nor does it allow military spouses to retain a single-home state license for the duration of the service member's active duty, regardless of relocations, without submitting a separate application to each state's license board or other paperwork that would be involved, nor does it allow practitioners to work in multiple states, both in person and via telehealth or telework, without again submitting paperwork to a variety of different sources depending on the state. Noll-- nor will it bring together a coalition of states to establish uniform and enforceable interstate license standards that are narrowly tailored to the public protection requirements of a specific profession. Nor can it enhance public protection by creating a multi-state database of license information to facilitate, facilitate collaboration on license verification and investigations of potential misconduct. So currently the mutual recognition model compacts that exist or are in process of bringing states on for eventual implementation are for counseling, occupational therapy, nursing, physical therapy, EMS, psychology, and speech-language pathology and audiology, as you heard yesterday. They are all similar in form and function and yesterday you were provided a map that clearly shows the state-by-state progress and today, I've shared with you a comprehensive look at the difference between interstate licensure compacts and universal license recognition laws. Now it should be noted that so far, ten states have pending legislation on this particular compact and as with the others, more will quickly come on board that will eventually be neighboring states. Senator Williams, the states that currently have pending legislation are Utah, Texas, Missouri, Ohio, Virginia, Maryland, South Carolina, Georgia, New Hampshire, and Maine so far. There are more jumping in and you will shortly see these numbers start to grow as they rush to bring all available interstate compacts to their constituents. And it is a race. I can tell you that every conference that I've gone to on this, the competition is intense, so it would be nice for us to, to be ahead of the pack. So in closing, you will note in your letters of support that there is a very enthusiastic and supportive community here in Nebraska. You've received a long list of letters of support requesting to be included in the record because like all of the health sectors that I've worked with on these interstate compacts, they are excited for the potential that this will bring to their profession. So with that, I would be happy to answer any questions you may have. But as always, I believe I have a few experts that are also available and better qualified to usually answer those questions than I. But it is

my hope that you will please "exec" on these and my other compacts and help me move them out onto the floor for debate. With Space Command still in play, bills such as this that embrace our military families can only benefit our cause to make that happen. I'll also add that I included a copy of an amendment we'd like the committee to adopt. I do apologize that I wasn't able to get this to the committee council quicker, but we received it just ahead of the hearing as well and I do know that the language in the amendment is harmonizing and making sure that we're in compliance with both compact law and state law. There's also an addition, as there was yesterday, of immunity language that the trial attorneys and the compact administrators worked out. This is the same kind of language that we've included in all of my compact bills over the years. I've also included a letter from Paul Dongilli Jr., who is the president and CEO of Madonna Rehabilitation Hospitals, that we received yesterday afternoon, too late for the deadline to get them into the clerk. And I really hope this is the last speech like this that I have to give, but with the confusion of the new policies this week, I'm hoping we can also get this letter entered into the record as well. With that, I will close--

ARCH: Thank you.

BLOOD: --and open for any questions.

ARCH: Any questions for Senator Blood? I have, I have one.

BLOOD: Yes, sir.

ARCH: I don't know if I missed it or not.

BLOOD: Yes, sir.

ARCH: This is the question you get every time, every time with a compact. How many states have signed onto this compact?

BLOOD: There are ten that have it in process right now, up in front of them, so--

ARCH: OK.

BLOOD: --this is a new compact--

ARCH: This is new, OK.

*Indicates written testimony submitted prior to the public hearing per our COVID-19 response protocol

BLOOD: --but like all compacts, as soon as they're released, the states line up and they want to be the first state and they want to move it forward.

ARCH: All right. OK, thank you. Any other questions for Senator Blood? Will you stay for close?

BLOOD: I certainly will.

ARCH: OK, thank you very much.

BLOOD: Thank you, sir.

ARCH: I'll elect to welcome the first proponent for LB15. Welcome to the HHS Committee.

MELISSA KIMMERLING: Thank you. Good afternoon, Senator Arch and members of the Department of Health and Human Services Committee. My name is Dr. Melissa Kimmerling and I am a licensed occupational therapist in the state of Nebraska and I'm here to speak in favor of LB15, adopt the Occupational Therapy Interstate Compact. I'm the vice president of policy and advocacy for the Nebraska Occupational Therapy Association and I'm speaking on behalf of my association as well. I'm here today to express the association's support for LB15 and to pry-- provide information on the profession of occupational therapy as a whole. I will say Senator Blood did an excellent job talking to you about occupational therapy, but it is very common to be a misunderstood profession so I will give you some more information as well. We are a science-driven, evidence-based profession focused on helping people across the lifespan do the things they want and need to do through the therapeutic use of daily activities and we call those occupations. Occupational therapy practitioners enable people of all ages to live life to its fullest by helping them promote health and to prevent or live better with injury, illness, or disability. We work in schools, outpatient clinics, hospitals, inpatient rehabilitation facilities, skilled nursing facilities, and community-based settings. I provided you with a brochure about what occupational therapy is and also some statistics on where occupational therapists work and the number of licensed occupational therapists in each state. As Senator Blood indicated, LB15 uses a mutual recognition model of interstate practice, whereby a compact member state agrees to recognize valid licenses issued by other member states. This approach is made possible

by the fact that core licensure requirements for occupational therapists and occupational therapy assistants are virtually the same across all 50 states. For this compact, the practitioner must first be licensed in their home state and in good standing before they are allowed to practice in a compact member state using compact privilege. This compact has multiple benefits, but I will focus on the benefits for occupational therapists in telehealth and in rural settings. I provided for you also a copy of written testimony from a peer, Melissa Anderson, who works in telehealth and submitted this to me this morning. She works with clients who have experienced traumatic brain injury, spinal cord injury, stroke, and with chronic pain. According to current state licensure laws, practitioners like Dr. Anderson must be licensed in the state which they are in and the state in which their client is in as well and Melissa is currently licensed in 34 states, taking on the financial and logistical burden of all 34 of those states in order to provide her telehealth practice. For rehabilitation facilities in Nebraska, the ability to follow the client post-discharge to ensure that they are able to carry over the techniques and strategies they learned during their inpatient stay, it's paramount to preventing a costly rehospitalization or a reinjury. With telehealth becoming even more common and hopefully allowable long term, more practitioners will embrace the opportunity to ensure this carryover post-discharge regardless of where the client calls home. The compact would therefore, therefore improve the continuity of care for the citizens of Nebraska and for citizens in other member states who have completed their course of rehabilitation in Nebraska. Nebraska is also a state with many border towns and communities in which clients come across the border to receive their care. In many situations, an OT may need to be licensed in more than one state solely to work for the same company. For example, the company I work for has locations in Nebraska and Iowa and requires licensure in both states for me to have one job. In conclusion, LB15 will support military families, improve access to and continuity of care for citizens of Nebraska, and increase license portability for occupational therapy practitioners in Nebraska while maintaining the current licensure system. Additionally, by ensuring the sharing of investigative and disciplinary information among member states, it will allow member state regulatory entities to better protect the public. So it appears that there are many benefits and not many drawbacks at all for the state and we hope that you will consider

adopting the Occupational Therapy Interstate Compact. With that, are there any questions?

ARCH: Thank you. Are there questions from the senators? Seeing none, thank you very much for your testimony.

MELISSA KIMMERLING: Thank you, thank you.

ARCH: The next proponent for LB15. Welcome to the HHS Committee.

CHERYL FRICKEL: Thank you. Thank you for having me. My name is Cheryl Frickel, C-h-e-r-y-l, last name is F-r-i-c-k-e-l, and I am also Dr. Frickel, occupational therapy therapist at Madonna Rehab, but however, today I'm here as Nebraska Occupational Therapy Association. I'm testifying in support of bill number-- LB15. I would like to express my appreciation for your consideration of the Occupational Therapy Licensure Compact, the OT Compact. This measure is a joint initiative of the American Occupational Therapy Association and the National Board for Certification in Occupational Therapy. Occupational therapists and occupational therapy assistants are virtually, virtually the same across the 50 states. To utilize the compact, an OT or OTA must have a license and good standing in their home state, primary residence, and the home state must be a member of the OT Compact. When the licensee wants to work in another member state for-- the licensee obtains a compact privilege from the OT compact commission. The state may charge a fee for granting the compact and we do not anticipate substantial additional costs for states participating in the compact. The compact will not take over state regulatory authority or state licensing systems. Again, I would like to state out how the state may charge a fee for granting the compact, so this is something that the state can determine. There may be a cost for additional software required to connect the compact's interstate licensure data system, as well as costs associated with the attendance for your state's chosen commissioner to the annual in-person OT compact commission meeting once the compact is enacted in ten states. There will also be a potential increase in the number of licensees in Nebraska, as practitioners who reside in, but are currently not licensed in Nebraska because they work elsewhere, they may choose to obtain the license in Nebraska in order to access the compact as required through their primary state residence. The OT compact has many benefits for Nebraska. However, I want to focus on a key point. It will improve portability for military spouses and facilitated

alternate delivery methods such as telehealth, resulting in increased patient care and safety and reducing rehospitalization, in turn reducing the cost for the state. According to the Department of Defense, military families move every three years on average. The compact helps milli-- military spouses relocate and begin work without delay by reducing the amount of time needed to gain authorization to practice in a new state and decrease administration, administration costs-- excuse me. It takes only a few minutes to obtain the compact privilege from the commissioners website. As a member of the co-- of the compact, Nebraska may become a more attractive option to call home for military family with an OT or an OTA. Overall, the OT compact will support military families, improve access to and the continuity of care for Nebraska residents, and increase license portability for OT professionals based in Nebraska while maintaining this current state licensure. Are there any questions that--

ARCH: Thank you.

CHERYL FRICKEL: --you guys have on the compact or [INAUDIBLE]?

ARCH: Is there any questions from the senators? Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and thank you for being here. I just want to ask one general question that I think you could address so that we are clear on this. And Senator Blood mentioned that nothing in what we're doing here is changing scope of practice--

CHERYL FRICKEL: Correct.

WILLIAMS: --but you could have situations where you have a slightly different scope of practice in different states that are part of the compact, correct?

CHERYL FRICKEL: That is a question I'd want to get clarification from American Occupational Therapy Association--

WILLIAMS: OK.

CHERYL FRICKEL: --if you don't mind, that I could send that to Senator Blood.

WILLIAMS: Because then my question is-- and, and I'm sure Senator Blood can cover this in her closing-- to be sure that we, we maintain

the ability of each state to have their own hands-on scope of practice and that continues on.

CHERYL FRICKEL: Overall, on-- if you look at our umbrella, we're all under the American Occupational Therapy Association and that scope of practice, to my knowledge, is the same based on each state. However, I do just want to double-check all of--

WILLIAMS: Sure.

CHERYL FRICKEL: --and make sure we're getting every single detail for you as well, so-- but it should not change state to state for scope of practice.

WILLIAMS: Thank you.

CHERYL FRICKEL: Um-hum.

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

CHERYL FRICKEL: Thank you.

ARCH: Are there other proponents for LB15? Welcome to the committee.

EMILY RUMERY: Thank you. Thank you for having me. Good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Dr. Emily Rumery, that's E-m-i-l-y, last name is R-u-m-e-r-y, and I'm here today on behalf of the Nebraska Occupational Therapy Association, as well as occupational therapists like myself who provide telehealth services within our state. I'm testifying in support of LB15 and to express the impact that this legislation would have on the ability to successfully provide rehab services via telehealth. The COVID-19 pandemic has caused our healthcare providers and clients to recognize the distinct benefits that telehealth offers for patient access, utilization, convenience, compliance, and optimal participation in their healthcare services. As a provider of telehealth services, I'm grateful for the proposed legislation on a state and national level this year that's currently aiming to address the expansion and permanence of this service delivery model. However, the rapid adoption of telehealth during the pandemic also uncovered the significant red tape and regulatory barriers to providing these services. LB15, the Occupational Therapy Practice Interstate Compact,

would decrease one of these barriers by improving licensure portability and allowing increased ability for providers to offer services to clients outside of our state. My employer, Madonna Rehabilitation Hospitals, has been rapidly scaling our virtual services and telehealth programs in this past year. While we have been successful in offering our services to clients who reside within our state, we have not yet scaled our service delivery to out-of-state clients. In my role as virtual services coordinator, I spent a significant number of weeks in collaboration with our administrative and legal teams to develop the necessary infrastructure, including financial support, compliance, and a policy and logistical system for managing and organizing multiple licenses from multiple providers, all of which is necessary, simply to provide the services that we already offer to a client who might reside just outside of our state borders. While this is a priority and a possibility for a large institution like Madonna, this is impossible for a small clinic to manage. Even with widespread acknowledgment of the need for telehealth expansion, this simply will not be successful without using some of the regulatory and operational burden. Licensure compact such as this one will decrease one of those major barriers. Madonna offers care for clients with specialty rehab needs, such as complex medical conditions, traumatic brain injury, spinal cord injury, and stroke. Research has shown that clients with these conditions often require follow-up care and continued rehab even after discharge from the post-acute setting. We are privileged to have a state-of-the-art facility with expert clinicians right here within our state to provide care for our residents, as well as many who travel from outside of our state to receive this expert care. Telehealth ensures that we're able to offer this continuity of care to patients who need it. Ultimately, this would allow for decreased rehospitalization rates and healthcare costs for clients over the long term. An additional example is for clients who reside in rural areas, a significant portion of our state. These clients may face additional barriers to receiving their follow-up care, including travel and transportation to expert clinicians in urban locations that might be a significant distance from their homes. These clients may be able to receive their needed services via telehealth, thus eliminating barriers to access. Telehealth services could be provided by clinicians within our state or those outside of our state who become licensed in Nebraska through use of this compact act. This ultimately increases opportunity and access to expert care for our Nebraska residents, while also

increasing potential revenue through compact fees for providers of telehealth who might not otherwise choose to become licensed in Nebraska. The compact would therefore improve the continuity, continuity of care for the citizens of Nebraska, as well as for citizens and other compact member states who may have completed their rehab in Nebraska or who may benefit from access to services by our expert clinicians. Thank you for your time. Do you have any questions?

ARCH: Are there any questions from the senators? Seeing none, thank you very much.

EMILY RUMERY: Thank you.

***MATT SCHAEFER:** Chairman Arch and members of the committee, my name is Matt Schaefer and I am appearing today in support of LB15 on behalf of Madonna Rehabilitation Hospital. Madonna Rehabilitation Hospitals leads the nation in providing medical and physical rehabilitation for adults and children. Approximately 20% of patients cared for by Madonna come from outside of Lancaster and Douglas counties, with most coming from four bordering states: South Dakota, Iowa, Missouri and Kansas. Serving patients from multiple states presents many challenges. Some Madonna therapists currently must meet and maintain varying licensure requirements in more than one state. This is necessary in order to provide such services as an assessment of a patient's home environment and recommendations for modifications. Research has shown that patients with the complex conditions addressed at Madonna often require follow-up care and continued rehabilitation, even after discharge from the post-acute hospital setting. However, we know that many of our patients are unable to participate in follow-up care due to barriers with travel, transportation, or caregiver support. Others do not have local access to clinicians who specialize in their complex needs. Telehealth offers an opportunity to increase access, utilization, and continuity of care for patients who would benefit from our services. Adoption of the compact by Nebraska and other states would allow Madonna Occupational Therapists to provide inpatient follow-up or outpatient services, either in person or via telehealth, to their patients who live in other states. This will eliminate the necessity for therapists to meet two separate licensing requirements.

***BECKY WISELL:** Good afternoon, Chairperson Arch and members of the Health and Human Services Committee. My name is Becky Wisell

*Indicates written testimony submitted prior to the public hearing per our COVID-19 response protocol

(B-E-C-K-Y W-I-S-E-L-L), and I am the Interim Deputy Director for Licensure and Environmental Health for the Division of Public Health within the Department of Health and Human Services (DHHS). Please enter this written neutral testimony into the official record for LB15. This bill will create an Occupational Therapy Practice Interstate Compact, expanding opportunities for Occupational Therapists licensed in states with compact privileges to receive licensure and practice in the State of Nebraska. DHHS sees the benefit in improving public access to occupational therapy services. Occupational therapy provides support to many Nebraskans to maximize independent function, prevent further disability, and achieve and maintain health and productivity. DHHS also recognizes that ease of license transfers across state lines will attract additional residents to the State and ensure a regular career pipeline of Occupational Therapists in Nebraska. This is especially important for rural and frontier areas of the state where there is a continuing shortage of health care professionals and specialists, such as Occupational Therapists. However, DHHS would recommend Committee members consider other routes to increase the pipeline and attractiveness of practicing in Nebraska, not only for Occupational Therapists but for many health professions. Overall occupational licensing reform may be necessary and achievable to meet the aims of this legislation without the need to enter into a compact. Thank you for the opportunity to testify. I greatly appreciate the opportunity to share the above information.

***MEG MIKOLAJCZYK:** Dear Chairperson Arch and members of the Health and Human Services Committee, my name is Meg Mikolajczyk, and I am the Deputy Director and Legal Counsel for Planned Parenthood North Central States in Nebraska. Central to our mission at Planned Parenthood is the conviction that all people deserve to live in communities where sexual and reproductive rights are recognized for what they are--basic human rights. All people, regardless of their race or ethnic background, deserve to lead safe, healthy, and meaningful lives. In order for this to become our reality, we must take action to address the shockingly of high rates of black maternal mortality in our country. In recent years, there has been a greater focus on implicit bias within the healthcare space, specifically in relation to prenatal and maternal health care. As of 2019, approximately 700 women die every year from pregnancy and birth in the US, and an additional 50,000 experience a pregnancy complication so severe that they nearly die. Black women in the United States are three to four times more

likely to experience a pregnancy-related death than white women. Those deaths are also more likely to have been preventable. Importantly, Black women's heightened risk of pregnancy-related death spans income and education levels, suggesting that deeper societal factors, including racism in the health care system, are root causes of this crisis. Because of this, the American College of Obstetrics and Gynecology (ACOG) has expressed that reducing racial and ethnic disparities in health care should be a priority for all obstetrician-gynecologists and other women's health care providers. LB416 would take steps to address this public health crisis. LB416 would require implicit bias trainings annually for health care providers to qualify for licensure in the state, but does not clarify the content of such trainings. The call to require implicit bias trainings for medical providers is a direct result of the harmful historical context of reproductive oppression and discrimination of black women. As part of the annual training, Planned Parenthood hopes that this fraught history will be given context and explored. Additionally, Planned Parenthood would recommend the annual training curricula be evidence based and acknowledge valid medical mistrust in black communities, which only perpetuates and further exacerbates maternal health disparities amongst black women. Planned Parenthood deeply appreciates the attention LB416 Sec. 4(2) places upon health care providers treating people experiencing pregnancy, and the need to affirmatively address the unacceptable prevalence of racial and ethnic disparities in our healthcare system, and their effect on health outcomes for our citizens. We know that screenings for specific health conditions should already be included in routine prenatal care, so we are also hopeful that the implementation of LB416 could include intentional efforts to increase health literacy of black women. Black women should be provided with quality information and education around maternal health outcomes, which currently is not happening consistently due to the unacknowledged or uninvestigated implicit bias of medical providers. This will better enable and empower patients to advocate for themselves and their health care needs. Accountability by the medical profession will be key. Planned Parenthood is supportive of the implicit bias trainings being an annual requirement and hope that this is the first step for the medical community around addressing the history and systems of racism and oppression that have persisted in delivering services to people of color, particularly black women. If providers are consistently being exposed to this information, hopefully, Nebraska health systems will move towards a

more person-centered way of providing care that fully meets the needs of all women of color. In addition to implicit bias training requirements, LB416 would improve care for low income and minorities in our state, who statistically have the worst health outcomes during pregnancy, by covering pregnancy-related costs until twelve months post-partum and improving coverage for doula services in our state. Research compiled by Forward Together and Southern Birth Justice Initiative shows that people with doula support are two times less likely to experience birth complications and four times less likely to have a low-birth-weight baby. Doulas can make sure that their clients' voices are heard and that medical information is communicated directly to clients, so that clients understand and can make their own best choices for themselves and their babies. Because of this, Planned Parenthood agrees that encouraging and reimbursing for doula utilization is a critical way that we can address racial disparities in maternal and newborn health in our state. Ensuring that this includes community-based doula care is vital, as clients often benefit the most from doulas who come from their communities and who share cultural values and lived experiences. As a public health organization, Planned Parenthood continues to learn invaluable lessons from the wisdom of our reproductive justice partners about equity in reproductive health care, including the importance to listening to and honoring leaders in the reproductive justice movement, because health, rights, and availability of healthcare services are meaningless if you do not have access to them. This listening and learning is key to both our growth as an organization and more broadly could benefit Nebraska as a state. In the same way that we support the voices of our coalition partners in this state, we hope that those eff~ctuating LB416, such as the Nebraska Perinatal Quality Improvement Collaborative, value diverse perspectives from folks on the ground, from different backgrounds, with expertise in these spaces. To that end, Planned Parenthood would also endorse the testimony and any proposed additions or recommendations that our partners in this space and experts in the field would add to this important topic, owning Planned Parenthood's complicated history around racial health disparities and knowing that to continue to do better we need to listen and respond to the needs of those impacted-- in this case, Black women. Thank you to Senator Cavanaugh for her efforts on this topic and for her introduction of this important legislation. We respectfully ask the Committee to advance the bill to General File for broader consideration and debate.

*Indicates written testimony submitted prior to the public hearing per our COVID-19 response protocol

***CHRIS JONES:** Dear Chairperson Arch and Members of the Health and Human Services Committee: My name is Chris Jones and I am the Community Impact & Strategic Initiatives Director with the Nebraska Children's Home Society- a statewide licensed and accredited child-placing and child-caring nonprofit agency. On behalf of Nebraska Children's Home Society (NCHS), we respectfully ask for your support of LB416. Nebraska Children's Home Society (NCHS) has 127 years of experience in putting put children's needs first through an array of statewide services designed to build strong, supportive families and nurture children. Our core services include adoption, foster care, and family support. Pregnancy Services, which provides education and support on the options of parenting and adoption, certified lactation support, self-sufficiency and home-visitation are a few of the services within family support. Our home visitation services include Healthy Families America and the Teen and Young Parent Program. These services equip new and young parents with the education, support and resources to promote safe, healthy, thriving families. We utilize evidence-based models to deliver services such as Healthy Families America, and Growing Great Kids and the Mothers & Babies ® curriculum, to provide prevention interventions with proven success records. Family Support services focus on connecting mothers and children to medical homes, nutrition, behavioral health services, food security and other resources as needed. While our organization provides services across the state of Nebraska, almost 57% of families served are from the greater Omaha metropolitan area, predominantly in North and South Omaha. We serve children, parents and caregivers from single teen mothers to grandparents raising grandchildren. The average age of an NCHS pregnancy client is 23 years old. In fiscal year 2020, program participants were 19% African American, 55% White, and 4% Hispanic. Participation in family support/parenting and pregnancy services by minority parents has grown by 12% since 2013. The overwhelming majority of families served by NCHS live below 200% of the federal poverty level. Among those providing income data, 29% of program participants made less than $10,000 and 32% made between $10,000 and $20,000 annually. According to the Centers for Disease Control and Prevention, Nebraska's infant mortality rate is 6.2 per 1,000 children, compared to the national average of 5.9. NCHS supports the thoughtful provision of implicit bias training under the Uniform Credential Act laid out in LB416. Extending Medicaid coverage to postpartum women from 60 days to twelve months would greatly benefit mothers, infants and families in Nebraska. In our experience, many

mothers' Medicaid eligibility ends at six or eight weeks. In that time, some barely get a postpartum check-up completed. The bill also includes lactation services and coverage for doula services. Many mothers and infants would greatly benefit from the extra support, both technical (i.e., breathing, positioning) and emotional. We know, postpartum depression is a major source of stress for mothers which has a roll down effect on babies. Extending post-partum support and Medicaid for 12 months would allow for the mothers to get the help they need and ultimately be able to better care for their child. LB416 would improve our state's approach to prevention and early intervention for mothers and infants by addressing implicit bias in the professionals responsible for treating and referring pregnant and postpartum women for supports, and by including a broader array of supports to mothers and babies under medical assistance. We support legislation that promotes: thriving and resilient children, youth and young adults; supported and safe families of all configurations; and children in forever families. We support LB416 and ask that you do as well. I welcome additional conversations with you and your staff. My contact information can be found below.

ARCH: Are there other proponents for LB15? Seeing none, are there any opponents for LB15? Seeing none, are there any-- is there anyone that would like to testify in a neutral capacity for LB15? Seeing none, Senator Blood, as you're coming up to close, I, I would mention that we did receive two written testimonies this morning. One is from Becky Wisell from the Department of Health and Human Services, testified in a neutral capacity, and Matt Schaefer on behalf of Madonna Rehabilitation Hospital, as a proponent of LB15. And with that, Senator Blood, you may close.

BLOOD: And we had no additional letters of support, Senator?

ARCH: I do not believe there were letters-- Oh, thank you very much. There were a few. There were 40 proponents letters of record, one neutral, none opposed.

BLOOD: Thank you, Senator.

ARCH: Thanks for prompting that, Senator Blood.

BLOOD: I'm, I'm sorry to prompt you, I-- but I-- they were so enthusiastic. I want to make sure they were mentioned.

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ARCH: Yes.

BLOOD: Senator Williams, I believe you'll find your answer on page 4, line 15 and page 9, line 4, I think-- first paragraph. So it's really important to point out it doesn't change our scope of practice, that when they're in our state, they follow our rules without exception and all of our compacts say that. So you'll note that I'm very enthusiastic about the interstate compacts. CSG will tell you that I'm the person on the phone always asking what the progress is on the most recent compact because it offer, offers so many opportunity for our military families. And as I spoke yesterday a little bit about, that the Pentagon has invested greatly in these interstate compacts because this is what they believe is the solution for our military spouses who have to move every two years to a different location. And the states that have military bases understand that and that's why they, without any hesitation, jump into the interstate compacts and try and bring them into their states. Now we know with the pandemic that there are a lot of people that are having long-term issues for those that have suffered severely from the virus and because of that, we're finding that people in physical therapy, occupational therapy, and other areas of, of our medical community are overworked and we don't have enough people. We have more cows in Nebraska than people and unless we have a really huge population increase really soon and then we can wait 20 years, I don't think we're going to see that change. And so we have to have some flexibility within our medical community that allows not only for people to practice here when we need them, but to give those that practice here the ability to generate additional income by practicing across state lines outside of just the military spouses. Why would we not want to allow them that opportunity to generate, legally, additional income to make their lives better here in Nebraska? And if we make their lives better, are they going to stay here? Most likely. And what we're finding with things like interstate compacts is that if I'm a military person and I'm close to retirement and my spouse is happy and in a career that they like and generating good income, I'm more likely to stay here with my family than move to another state. So there really are no downsides to interstate compacts. It is a nice compliment to a-- the type of licenses that we already do and honor here in Nebraska. You'll find it touches many people, I bet, right in this room. I know for Senator Hansen, who is a chiropractor, that there are many people that will get adjusted before they go to occupational physical therapy because they can perform

better and vice versa. They send people back and forth. I know for me, with my son, with his brain tumors, he had to learn how to do a lot of things as simple as writing his own name with a pencil and that was occupational therapy, having to redo things that he lost because of his brain tumors. And so we need to make sure that we can do everything possible and it's affordable to embrace these communities. And so with that, I hope you guys are as enthusiastic as I am about interstate compacts because I promise you, this is not my last one and there are more to come next year and it's for the greater good of everybody here in the United States and Nebraska.

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

BLOOD: Thank you for your time.

ARCH: This will close the hearing on LB15 and we will now open the hearing on LB416 and Senator Cavanaugh, you may open.

M. CAVANAUGH: Thank you, Chairman Arch and members of the Health and Human Services Committee. I am Machaela Cavanaugh, M-a-c-h-a-e-l-a C-a-v-a-n-a-u-g-h, representing District 6, west-central Omaha in Douglas County, and I'm here to introduce LB416 today. And I'd like to note that this is my first bill introduction of this year, so I'm excited that's in front of the best committee in the Legislature, for the record. According to the U.S. Centers for Disease Control and Prevention, black women die of pregnancy-related causes at a rate three times higher than that of white women in the United States. Other women of color, including Native American women, die at a rate of two to three times more than white women. Research indicates that as many as two-thirds of these deaths are preventable. Pregnancy-related deaths occur up to one year postpartum; 11.7 percent of those deaths occur in the 40-- up to 43 to 365 days postpartum. During that time, the most common causes of pregnancy-related deaths in the U.S., cardiovascular conditions accounting for more than one in three pregnancy-related deaths. Every woman experience-- every year, women experience significant short and long-term consequences to their health related to labor and delivery complications. These complications are referred to as severe maternal morbidity and include damage to the heart and other cardiovascular damage, eclampsia, sepsis, or hysterectomy, to name a few. Data from 2017 shows over 25,000 hospital deliveries with a severe maternal more-- morbid,

morbid-- maternal morbidities-- sorry-- in the United States. Again, 25,000 severe maternal morbidities a year. The five most common complications were disseminated into the following conditions: intravascular coagulation, which is a clotting and bleeding disorder, hysterectomy, acute kidney failure, sepsis or severe infection, and adult respiratory distress syndrome. When those with blood transfusions are included, the number of hospital deliveries with severe maternal morbidity more than doubles. LB416 works to address and improve maternal and infant health outcomes for women in Nebraska through several mechanisms. This bill requires annual implicit bias training for all healthcare professionals through their continuing education hours. It tasks the Nebraska Perinatal Quality Improvement Program with developing a program regard-- regarding health screenings that can address conditions identified as contributing to the increase in maternal deaths and morbidity and to the disparities in health outcomes of poor women of color. This program would then become a curriculum for training to healthcare providers. The Nebraska Department of Health and Human Services would be required to apply for a Medicaid waiver to extend Medicaid coverage for up-- for eligible women for the current three months postpartum care to up to 12 months of postpartum care. States having expanded this Medicaid coverage postpartum for women include Georgia, which expanded the coverage to six months with state funds applying for waiver. Illinois has applied for the waiver to expand to one year. Missouri and Indiana submitted a waiver application to care, care for up to a year for women in need of substance use and mental health services. California uses state dollars to extend postpartum coverage for maternal mental health conditions. Texas provides a limited package of postpartum services for one year for women of reproductive age enrolled in the state's health-- Texas women program. Bills to expend math-- Medicaid coverage to one year for postpartum women are introduced in the United States Congress last fall and are expected to be reintroduced this year. Additionally, LB416 will require Nebraska Medicaid to pay for doula services. Doula services have been shown to reduce the cost of birthing and improve outcomes for mothers and infants. Doulas provide education and support to the mother during pregnancy, birth, and postpartum. LB416 charges the current Women's Health Initiative with creating and administrating a grant program to fund local programs that work to improve maternal health outcomes and to reduce or eliminate health disparities for women and children of color. Lastly, LB416 creates the Maternal Health Care Cash Fund under the Health Care

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Cash Fund. The Maternal Health Care Cash Fund will be used to direct funding to several maternal health initiatives, including funding of $23 million to Nebraska Medicaid to coverage twelve months pro-- postpartum until the federal waiver is approved, funding of $150,000 annually to the Perinatal Quality Improvement Collaborative for training of providers, funding of $800 to the Nebraska Medicaid for a one-time software change to the eligibility, eligibility system, funding of $2 million to the Women's Health Initiative Fund to grant-- fund the grant program for local maternal health programs, funding of $150,000 annually to fund the position of a data abstractor on the Maternal Death Review Committee. The Maternal Health Care Cash Fund monies could come from an increase in tobacco tax, which is another one of my bills. That bill also directs revenue into the Health Care Cash Fund itself. Much research has been done nationally to identify the reasons for the raising maternal mortality and morbidity in the United States. Each of the mechanisms in LB416 has been recommended to address maternal health. However, only one mechanism addresses one piece of the puzzle. We need systemic change in multiple ways to address the causes of maternal mortality, mortality and morbidity. The mechanisms in LB416 are recommended by multiple research and governmental entities and are being implemented in other states. This bill contains a lot of information and a lot of moving parts in order to address the various ways in which maternal mortality and morbidities are happening. I have supporting reports and documentation that I will provide to the committee. I believe they've already been handed out. Nebraska has the opportunity to address this very serious health crisis for women. Implementation of these solutions can not only save lives, but create a healthier and more welcoming state for young families. I do have a language change that has been requested by the Nebraska Perinatal Quality Improvement Collaborative in AM53, which also I believe has been handed out and I-- that I ask for you to consider. I'm happy to work with you on advancing the health of pregnant women and postpartum women in Nebraska and I ask for your support of LB416. Thank you.

ARCH: Thank you, Senator Cavanaugh. Questions for Senator Cavanaugh? Seeing none, thank you for your opening and we will now ask if there is any proponents for LB416?

ANN ANDERSON BERRY: Good afternoon, Chair Arch and members of the Health and Human Services Committee. I am Dr. Ann Anderson Berry. For the record, A-n-n A-n-d-e-r-s-o-n B-e-r-r-y. I'm a faculty of UNMC.

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I'm the medical director of the Nebraska Perinatal Quality Improvement Collaborative, otherwise known as NPQIC. However, I am not speaking as a representative of the university today. I am here speaking as an individual and on behalf of the Nebraska Perinatal Quality Improvement Collaborative. I am here testifying with regards to LB416. As you are likely aware, maternal mortality is rising in the United States, more than doubling in 30 years from 7.2 deaths per 100,000 births in 1987 to 17.3 deaths per 100,000 births in 2017. There are disparities in health outcomes for mothers and newborns. According to the recent surgeon general's call to action to improve maternal health, black women die of pregnancy-related causes as a-- at a rate of about three times higher and American Indian Alaska native women at a rate of about two times higher than white women. According to the Centers for Disease Control and Prevention data, infants born to these women die at a higher rate, about two times higher than infants born to white women. The Nebraska Perinatal Quality Improvement Collaborative works to reduce disparities in maternal and neonatal mortality and morbidity outcomes in our state through improvement science. This well-established process involves the identification of opportunity for improvement by analysis of data, implementation of evidence-based practices that are likely to result in improvement, and then evaluation and adoption of strategies until sustained improvement is achieved. NPQIC works with all delivery hospitals in the state of Nebraska, as-- and-- as NPQIC-member hospitals. These member hospitals actively participate in quality improvement initiatives. Our plan is to expand the scope of this work and we would recommend that the state target specific resources towards these efforts, as outlined in the Surgeon General's report for a state healthcare provider and health system recommendations. Included in this plan is an outline as a roadmap for the U.S. to decrease maternal mortality by 50 percent in the next five years. Nebraska can work alongside other states to improve and implement these interventions and NPQIC is ideally situated as an organization with a diverse board of directors, a statewide footprint, and, and close working relationship with DHHS. NPQIC's past successes in statewide implementation of initiatives for at-risk populations speaks to our ability to contribute to the success of these new initiatives. This proposed initiative will allow us to address perinatal issues that develop long before the hospital admission for delivery fee-- for deliveries, decreasing both untoward outcomes such as death and morbidities for the maternal and neonatal populations, as well as decreasing the costs associated with these

expensive outcomes. The state is a necessary public health partner if we are to ensure safety for Nebraska families. In conclusion, the funding proposed in LR416 [SIC] would allow NPQIC to work with DHHS to implement critical programs across Nebraska to decrease disparate perinatal outcomes for Nebraska mothers and infants. Specifically, NPQIC would focus targeted quality improvement methodology on the following items from the Surgeon General's report: ensure quality preventative healthcare for all women, children, and families; address disparities such as racial, socioeconomic, geographic, and age and provide culturally appropriate, appropriate care and clinical practices; facilitate timely recognition and intervention of early warning signs during and up to one year after pregnancy; improve healthcare services during the postpartum period and beyond; participate in quality improvement and safety initiatives to improve care. Nebraska's mothers and babies need the work not only of our perinatal collaborative, but of all stakeholders, including local, state, and national governing bodies. With our statewide presence and our highly skilled volunteers, we have the potential to provide an even greater impact in close partnership with DHHS and the state of Nebraska. Working together, Nebraska's perinatal collaborative will continue to work so that Nebraska will be a state where great life starts with healthy moms and healthy babies. Although I specifically addressed the NPQIC portion of this bill, I'd be happy to take other questions, as I consider myself well versed from a day-to-day basis in those imp-- imp-- implications as well. Thank you.

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

B. HANSEN: More just from a medical perspective and I-- unless I missed it or I didn't, I didn't see it in your testimony, with the implicit bias training, do you, do you think that medically it would have a positive outcome when it comes to addressing neonatal disparities?

ANN ANDERSON BERRY: Yes, it has been shown to improve interactions with healthcare providers for those providers that have taken that implicit bias training. I think that there is good evidence. I didn't specifically talk about that in my testimony, I focused on NPQIC. But in the other work that I do, particularly with disparities in healthcare situations, implicit bias training has been shown to be very helpful in interactions and patient outcomes. The training is available for free. There's good modules, say the Harvard website is

one of the best ones and it's literally, you know, a free web address and you go through the training and then it has modules to talk about your outcomes. So it not only does some training, you know, it also actually assesses your propensity for implicit bias and then lets you reflect on that. So I think that there are resources that would be low cost that could be implemented.

B. HANSEN: OK, and this may be something I could ask Senator Cavanaugh too-- as well, but you've taken some of these classes before?

ANN ANDERSON BERRY: I have. I've taken multiple classes through my leadership training, through my healthcare positions and, you know, they can be completed in as little as 15 or 20 minutes, some of them. Some of them are much more time intensive. I work with healthcare providers who have never heard the words implicit bias and, you know, if we're going to make a change, they need to be educated.

B. HANSEN: OK and do you know how much, like, one of these classes would cost? Because as a healthcare provider myself, I would be affected by this. I'm kind of curious--

ANN ANDERSON BERRY: Yeah.

B. HANSEN: OK, what's the outcome we're going to have for--

ANN ANDERSON BERRY: You can log on for free.

B. HANSEN: OK.

ANN ANDERSON BERRY: Anybody can log on for free to the Harvard website and it's one of the best in the country. So the, the courses I've taken in academic leadership and medicine, they start with that free course pretty much unanimously. It's considered the gold standard and there is no cost.

B. HANSEN: OK and just more from a personal and not so much a professional question--

ANN ANDERSON BERRY: Uh-huh.

B. HANSEN: --do they usually ever discuss, like, proper access to, like, reproductive health at all, like-- and, you know, the differences among different cultures, the need for, you know--

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ANN ANDERSON BERRY: Not so--

B. HANSEN: [INAUDIBLE]

ANN ANDERSON BERRY: --much in the implicit bias training. It really-- it, it's associative training and it looks at reaction times and it helps you associate, like, good and bad words with different pictures of different people and there's implicit bias training for race, for age, for gender. So we all have a lot of implicit biases that we aren't aware of and the Harvard course addresses a multitude of those and, and it's all for free.

B. HANSEN: OK, I--

ANN ANDERSON BERRY: Yeah.

B. HANSEN: --I appreciate it. I don't, I don't mean to kind of--

ANN ANDERSON BERRY: No--

B. HANSEN: --berate you with questions here--

ANN ANDERSON BERRY: --that's--

B. HANSEN: --but I think I like the-- I feel like I know what implicit bias trip-- courses would be like, but I wanted to talk to someone who's actually taken them so I can--

ANN ANDERSON BERRY: Sure, yeah.

B. HANSEN: --expand my knowledge on it so I appreciate you sharing that with me.

ANN ANDERSON BERRY: I appreciate the questions. I drove down here to talk with you all, not to just read them from a piece of paper.

B. HANSEN: Thank you.

ANN ANDERSON BERRY: So I'm happy to talk with you about anything you'd like.

B. HANSEN: Thanks.

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

ANN ANDERSON BERRY: OK, thank you for your time.

ARCH: Is there someone else that would like to speak as a proponent of LB416?

SCOUT RICHTERS: Good afternoon.

ARCH: Good afternoon.

SCOUT RICHTERS: My name is Scout Richters, S-c-o-u-t R-i-c-h-t-e-r-s. I'm here on behalf of the ACLU of Nebraska in support of LB416. The ACLU works to ensure that everyone can make the best decision for themselves with regard to whether and when to have children. However, we know that the decision to have a child in the United States can be dangerous, particularly for women of color. The United States is actually the only developed nation that has a maternal mortality rate that is rising. Between 1991 and 2014, the rate more than doubled from 10.3 maternal deaths per 100,000 live births to 23.8 deaths per 100,000 in 2014. And as the testifier before me noted, the racial disparities in these rates cannot be ignored and, and I think we must acknowledge that the reason for this disparity is biases and discrimination based on race, based on gender, and then also the intersection of race and gender on a variety of levels, including personal biases of individuals, but also historical and systematic racism built into the healthcare systems themselves. And I say this because while the antibias training outlined in LB416 would certainly do work to dismantle implicit biases on the personal level of those in the healthcare field and it's certainly a good start, there's, you know, room for other measures to really address the full scope of the problem. And then I also wanted to express our full support for requiring Medicaid coverage for doulas, as we know that support from a doula has all kinds of benefits, including individualized support and cost savings. And then additionally, ensuring women have medical coverage for a year after giving birth ensures that women can actually get the care they need. We know that ACOG now recommends postpartum health coverage that is not just a single visit, but for 12 weeks of ongoing support. And as a mom, I can tell you that-- firsthand that some of the most important care that I received was post labor. And my experience is not unique given the prevalence of things like

postpartum depression and other challenges that have-- that come with what has been called the fourth trimester. So for those reasons, the ACLU of Nebraska thanks Senator Cavanaugh for bringing this bill and I would be happy to answer any questions.

ARCH: Thank you.

SCOUT RICHTERS: Thank you.

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

SCOUT RICHTERS: Thank you.

ARCH: Is there someone else that would like to speak in favor of LB416? Welcome.

TIFFANY SEIBERT JOEKEL: Thank you. Chairperson Arch, members of the HHS Committee. My name is Tiffany Seibert Joekel, T-i-f-f-a-n-y S-e-i-b-e-r-t J-o-e-k-e-l, and I'm here to testify in support of LB416 on behalf of the Women's Fund of Omaha. I want to echo what other testifiers have said. We have an increase in maternal mortality that is disturbing and those rates are even higher among black, indigenous, and women of color. And I also want to specifically name that there is nothing inherently dangerous about being a black woman and being pregnant or being a native woman and being pregnant. There's nothing biologically dangerous about that that justifies the disparities. It is social and economic risk factors and institutionalized bias and racism that research shows are contributing to those deaths and so there are measures in LB416 that I think are really important and we continue conversation with the medical community about how we can begin to address and untangle some of those things to ensure healthy moms and healthy babies in our state. Specifically, the postpartum coverage in Medicaid extending postpartum coverage from 60 days to, to the full postpartum period of a year will save lives. The more recent data I could find from the Nebraska Maternal Death Review found that almost 40 percent of pregnancy-associated deaths in Nebraska occurred in the late postpartum period, so 40-- 42 days to a year. Other states, in their maternal death reviews, have found significantly higher numbers. Specifically, Illinois found that 51 percent of maternal deaths occurred after 60 days postpartum, 56 percent in Texas, and 62 percent in West Virginia. What's important to know about

pregnancy-related death is largely, it's preventable. The CDC names access to clinical care, inappropriate or delayed treatment, lack of continuity of care, and case coordination or management as contributing factors to these pregnancy-related deaths. So the extended coverage, postpartum coverage in Medicaid to 12 months in LB416 would mitigate delays in treatment. It would support continuity of care and continuity of providers and fundamentally save lives during this very vulnerable period. It also has a potential to reduce costs in Medicaid. Overall, there's some research to suggest that women who-- or parents-- people-- birthing people who become eligible for Medicaid through their pregnancy do and may return to Medicaid, especially in expansion states. So there's an opportunity to ensure continuity of care, ensure that chronic conditions are managed appropriately so that we're not dropping people off the program and then putting them back on where their conditions are more expensive to treat. There's also the opportunity to provide very strong preconception healthcare in that period following childbirth. There is research to suggest we can have healthier babies and healthier moms if we can lengthen the duration between pregnancies and ensure health is good in between pregnancies. There's also an opportunity to provide family planning, preventing unintended pregnancies so families can choose when and, and if they like to have another child. Preventing unintended pregnancies has tremendous cost savings for the Medicaid program. We save in prenatal costs, the cost of birth, and then remember that when a child is born on Medicaid, when their mother-- the birth is covered by Medicaid, that child is automatically eligible for Medicaid for the first year of their life. So by helping families choose when and, and to safely space their pregnancies, there's potential cost savings for the Medicaid program. Additionally, there is cost effectiveness research to support access to a doula, which is a nonmedical support person through the birth. Doula presence has shown to reduce C-sections, which reduce hospital costs and recovery time and has been shown to, to provide savings in Medicaid programs specifically across the country. So I would just name that normally, I would do my very best to have better experts up here to talk to you about these issues. I am a mom. I've given birth twice. I've had a doula. I can talk to you about those things, but due to COVID and the restrictions, we at the Women's Fund are being very serious about not asking people to come down here and take that risk. So I'm sorry you got me and you'll probably see me a few times this session. But with that, we'd urge your, your serious consideration of provisions in

LB416 and to keep this conversation going and I'd be happy to answer any questions.

ARCH: Thank you. Questions? I have one.

TIFFANY SEIBERT JOEKEL: Yes.

ARCH: And maybe this isn't a question for you, but I'll, I'll, I'll ask you, do you think that Medicaid expansion is going to have a positive impact on some of these women, that that then would qualify and then could continue their coverage well after delivery?

TIFFANY SEIBERT JOEKEL: Yeah, Senator, I think that is a central question to this piece, right? So we cover-- so Medicaid expansion will cover up to 138 percent of the federal poverty level-- which anticipating this question, I wrote down the numbers as roughly $23,000 a year for a, for a single mom-- single parent and the child. We cover parents-- pregnant parents up to 194 percent in an effort to recognize the priority of prenatal care and its cost savings in the long term and so that's about $33,000 a year for a family of-- a single mom and a child. So what we're talking about here, anybody who is near that 138 percent, they can maintain coverage through Medicaid expansion. It's the folks that are going to be above that, between the 138 percent and 194 percent that are going to be impacted by this policy primarily and those are folks who are really living on the margins of affordability. So at 30-- so, so yes, Medicaid expansion will make a difference for certain, providing continuity of care for low-income folks. It's the people in the middle at $33,000 with one young child. Daycare costs $11,000 a year, so we're knocking that out of your ability to pay. Those folks are going to be really cost sensitive so they could potentially access health insurance on the exchange with the subsidy. But even a significant cost of, you know, a couple hundred bucks a month is going to be difficult to weather. There's also the question of continuity of care and provider. So if we change from Medicaid to a different plan, especially if I have a chronic condition, is that the most cost effective and most-- best way to manage my health and, and prevent these poor maternal outcomes? So, yes, it will have an impact, but this is still needed.

ARCH: OK, thank you. I have one other question.

TIFFANY SEIBERT JOEKEL: Yes.

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ARCH: The disproportionate impact, impact on women of color, is that also correlated to low income?

TIFFANY SEIBERT JOEKEL: Certainly, there's no doubt about that--

ARCH: OK.

TIFFANY SEIBERT JOEKEL: --I mean, the, the connection, but there has been research specifically for black mothers that finds regardless of education, regardless of income and other related factors, birth outcomes are still worse than white women, so there's something else--

ARCH: OK.

TIFFANY SEIBERT JOEKEL: --going on and it's pretty clearly implicit or explicit bias.

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

TIFFANY SEIBERT JOEKEL: Thank you very much.

ARCH: Is there anyone else that would like to speak in favor of LB416?

DEANNA STEWART: Thank you, Chairman Arch and members of the committee. My name is Deanna Stewart, D-e-a-n-n-a, Stewart, S-t-e-w-a-r-t. I'm here as a patient advocate and founding president of Save the Mommies here in Lincoln, Nebraska. I came across Senator Cavanaugh's bill and I am-- just want to express my gratitude for her presenting this bill and that this conversation is taking place finally. I'm a 13-year survivor of peripartum cardiomyopathy, which is pregnancy-related heart failure. My son was born December 31, 2007. Exactly two weeks postpartum on January 14, 2008, I went into complete heart failure in the middle of the night. This did not happen in my first pregnancy. William [PHONETIC] was my second. I did not hear of PPCM, which is peripartum cardiomyopathy. I'll probably refer to it as PPCM throughout my testimony because it's easier to say. Looking back at what I've learned over the years, I noticed that I had symptoms within the first three months. Typically they say that you do not receive the symptoms until six months and then postpartum. During my first three months, I noticed that I was extremely fatigued. I was to the point where I could not steer my car so I called into work and I said I need to go to the doctor, I think I have mono, even though, you know, I'm

married and everything, but that's, that's how fatigued I was because I thought I had that. So I went to the doctor and we took the test. The test was negative. I explained how fatigued I was. She put me on bed rest for a couple of days and then I was to go back to work. So I did that. The rest seemed to help, but the problem continued. I was tired. What increased over the months was exhaustion. I was lightheaded and dizzy, which is another symptom of PPCM. I remember standing talking to a coworker throughout the pregnancy. We would just be having water cooler talk, you know, and I would start blacking out and I'd have to, I'd have to cut our conversation short and say I need to go sit down because I feel like I'm going to just pass out. I'd go to church. I'd get through half the song and I'd feel like I was going to pass out so then I had to sit down. This continued through the whole pregnancy. The pregnancy also brought a sense of doom or death was imminent. This is common with women with PPCM, just the feeling of something's going to happen, something is imminent, me or my baby or-- we're going to die. So this continued throughout the pregnancy to where I even canceled a trip to Houston for my cousin's wedding because I thought getting on the plane, that's it, that's, that's how we're going to go. That's how strong this feeling was. So also during the pregnancy, I couldn't walk very well because I had inner thigh tendonitis. It was a inflammation of my inner thighs. I believe it was brought on by the pregnancy because my heart was not actively working correctly. I believe my heart was failing while I was in pregnancy-- is why I, I was experiencing these symptoms. They said it would not probably resolve itself after-- until after I had William [PHONETIC]. I had William [PHONETIC] and I thought having him would relieve that sense of doom-- we both made it, we're both fine-- and it didn't. Two weeks postpartum, I found out why I had that sense of doom. I thought I was going to die. Since then, I-- the story is long, so I know I don't have enough time, but it took two and a half years to recover. I missed the first three months of my son's life. I represent the PPCM community around the country. I'm based out of Nebraska, but we do-- I do support everybody throughout the country and the maternal health movement and I just celebrated my 13th "heartiversary" on 1/14. I am due for an echocardiogram every three years. And I know I'm forgetting a lot of things. There's just so much about peripartum and the maternal health death rate.

ARCH: Thank, thank you, though, for coming and, and sharing your story with us.

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DEANNA STEWART: Yeah.

ARCH: Do we have any questions? Seeing none, again, thank you for coming--

DEANNA STEWART: Thank you.

ARCH: --very much. Are there other proponents for LB416? Seeing none, are their opponents for LB416? Welcome to the HHS Committee.

JEREMY BRUNSSEN: Good afternoon, Chairperson-- Chairman Arch 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 a deputy director for the Division of Medicaid and Long-Term Care within the Department of Health and Human Services. I am here to testify in opposition to LB416, which would change provisions surrounding Medicaid eligibility for pregnant women, require payment of doula services directly to beneficiaries, and change credentialing requirements for providers. Before I continue and I-- continue, I would like to note that my testimony today will be largely similar to the testimony Medicaid offered last year for LB1170 in 2020. Section, Section 6 of LB416 seeks to extend Medicaid eligibility for pregnant women from the current 60-day postpartum period to 12 months via an 1115 section-- oh, Section 1115 demonstration waiver. The approval of an 1115 demonstration waiver by the Centers for Medicare and Medicaid Services, or CMS, requires that the state show budget neutrality. So in other words, we would need to show that implementing this waiver would not lead to any additional expenses for the federal government. Given that the broad expansion of eligibility and service coverage afforded through the bill, we believe it, it would be difficult or unable, unable to show budget neutrality and therefore unable to leverage federal funds to pay for it. The department also has concerns related to paying for the services of a doula as written in the bill. The language in Section, Section 8 directs DHHS to re-- to "reimburse a recipient of medical assistance for the services of a doula." Such reimbursement shall be met-- shall be paid by the state funds-- base-- paid by state funds-- excuse me, end quote. Implementing this type of payment would create significant challenges for the department. Medicaid does not have systems or procedures in place to reimburse benefit beneficiaries directly for services. Making any payments to participants directly increases the risk of fraud, waste, and abuse and additionally, Nebraska does not currently license or certify

doulas. As such, payments could be made for services that do not meet minimum standards of quality and even for services that never took place. Additionally, LB416 requires a wide range of licensed medical practitioners to complete implicit bias training approved by DHHS each year. While the department shares the priority of eliminating implicit bias in healthcare, as written, this bill would be particularly burdensome for providers and DHHS. Making these trainings a one-time requirement rather than an annual requirement would give healthcare providers the flexibility to improve workplace culture in a way that works best. In addition, removing language requiring training as a condition of licensure renewals would remove the challenges for state employees reviewing provider training records during periodic license renewals. Finally, I'd like to address the largest component of the fiscal note, which I alluded to previously in my testimony. Section 7 of the bill extends medical assistance coverage as noted of postpartum coverage, coverage to 12 months versus the existing 60-day period after birth. In state fiscal year 2019, medical assistance coverage for 2,370 women ended immediately following the 60-day period after birth. There were 2,284 women whose medical assistance coverage ended at some point between 61 days and 11 months after birth. The average cost of coverage for these persons is around $600 a month, so the estimated cost, based on the 2,370 women who would lose that coverage that we would then pay for ten months at $600 dollars a month, would be around $14.2 million. And then for the 2,284 individuals who lost that coverage sometime between 61 days and 11 months at $600 dollars for around six or seven months would be about $9 million for a total estimate in that fiscal note of around $23.2 million per year. This amount is included as General Funds and we'd be managed under the Maternal Health Care Cash Fund. Due to the significant issues we have noted here related to Medicaid and professional licensure, we respectfully oppose this legislation. Thank you for the opportunity to testify. I'd be happy to answer any questions.

ARCH: Thank you. Are there questions from the senators? Seeing none-- oh, I'm sorry. Senator Williams.

WILLIAMS: Slow on the trigger there. Thank you, Chairman Arch, and thank you, Mr. Brunssen, for being here. So there's, there's several pro-- provisions, as I see it in this bill: the doula training, the expansion of, of Medicaid for the longer period of time, but then there's the implicit bias training. And, and you, sir, are suggesting in, in your testimony-- I want to be sure I'm catching this

correctly-- that as written there are problems with this, but you are suggesting that if this training were maybe a, a-- required one-time training or something different with that language, that's something that would not be objectionable?

JEREMY BRUNSSEN: So I will carefully make my statements, as I am not obviously part of the public health department, but that's my understanding. It's not so much an opposition to providing that. It's more kind of the frequency and, and that aspect of it. I think people do see the value in training opportunities in that space.

WILLIAMS: Thank you.

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

JEREMY BRUNSSEN: Thank you.

ARCH: Thank you for your testimony. Are there other opponents of LB416 that would like to speak? Seeing none, would anybody like to speak in a neutral capacity for LB416? Seeing none, Senator Cavanaugh, you may come up to close. I-- while you're coming up, I would note that we received, in written testimony this, this morning, two proponents from Planned Parenthood North Central States and from the Nebraska Children's Home Society. We also received letters of record; 8 proponents, zero neutral, zero opposed. You may close.

M. CAVANAUGH: Thank you, Chairman Arch and members of the committee and thank you to those that came today to testify on this. This is a commitment. This is a commitment by the state of Nebraska, by us as legislators to take seriously this health crisis for women and children in this state. It's going to cost a lot of money. It's going to take time and it's going to take dedication. That does not mean that we shouldn't do it. Hard things can be important, but they can also be accomplished and women dying and babies dying is not acceptable. I appreciate the department's concerns and I think that there are things that we can work on together, but doing nothing is not acceptable. Implicit bias training is by far the lowest-hanging fruit that we can address in this. We know that there are institutionalized systems of racism. We hear it all the time about different industries across this country. It's not that anyone wants to hurt a woman of color, but we just aren't training in an appropriate way. Women of color are not believed in the doctor's

office as much as white women are. Their pain is not viewed the same and that is something that we can address and can help solve some of these very serious medical situations. Once a year-- or once ever is not enough for that kind of training to do-- undo decades, if not centuries of, of, of systems being put in place. So I am happy to work on all kinds of parts of this. I do believe that annual training should happen as part of the continuing education that medical providers have to already do and we have a wonderful perinatal collaborative that can take this on and help us move that forward. Again, I know this is expensive. I know it's hard and I know it's going to take a long time and a big commitment from the state, but if we're serious about making this a healthy state for families, for children, and for women, this is important. And I appreciate the committee's-- taking the time to hear testimony today and I'll take any questions if you have them.

ARCH: Are there questions for Senator Cavanaugh? Senator Murman.

MURMAN: Thank you, Chairman Arch. This question is pretty much related to a question I think Senator Arch kind of alluded to earlier and it probably would have been a good question to ask Dr. Berry in her testimony, but I'm wondering if, if you've seen any statistics on-- I suspect that the, the biggest disparity here is because of income and if there's result-- or studies that have compared, like, different income levels, say black women in a certain income level to white women in the same income level, you know, the death rates or--

M. CAVANAUGH: So black--

MURMAN: --hospitalization--

M. CAVANAUGH: --black women, despite their income or education-- they can have a Ph.D. and make two $250,000 a year-- their health outcomes are disproportionately worse than white women of anything, of any background. So that why, that's why the bias piece is so important because women of color are just-- doesn't-- it doesn't matter what their income is or what their education is. The implicit bias that exists in society is really what's impacting their outcomes, but additionally, we in Nebraska have a problem with health outcomes for all women. We have a high maternal mortality rate in this state.

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MURMAN: Yeah, I totally agree with you. Healthcare after birth is very important and, and probably more than 60 days. But, you know, we hear a lot that there is disparities and I'm not disputing whether there is or not, but I just haven't seen studies and I know it would be more difficult to, to obtain because, well, when you go to the doctor, you-- I think you typically check what race you are, but I don't think you have to check any boxes about your income level, so I think it'd be more difficult to find, but I just haven't seen those studies, so that's the reason I'm asking.

M. CAVANAUGH: Yeah, I-- I'm-- I can check. I'm sure that studies do exist. I will say that it's-- and, and, and it's so much more than just the healthcare provider, the-- those long-term effects for women of color. It's the-- that toxic stress that you as a woman of color just automatically live with. One of the women that I met with in, in developing this legislation talked about a study of women in Africa giving birth versus women in the U.S. giving birth. Black women, their health outcomes were much better in Africa because they didn't have that toxic stress from that implicit bias that women in America live with just inherently. And so it really-- addressing the toxic stresses is the, the low-hanging fruit for improving outcomes for women of color.

MURMAN: Thank you.

M. CAVANAUGH: Yeah.

ARCH: Senator Walz.

WALZ: Thank you. Thank you, Senator Cavanaugh, for bringing this important bill. You know, I always like to look at the local nonprofit organizations because I think that they do a super job. They're effective and they're very efficient with their resources. So I'm just curious, do you know if there's any current effort to collaborate with local nonprofits so they can educate and maybe support this need or has there been in the past? I just--

M. CAVANAUGH: Well--

WALZ: --they're so good at what they do.

M. CAVANAUGH: --I, I suppose it depends on what part of the need we're talking about. There's lots of organizations that provide supports to

women that help with-- we have the federally qualified health centers that can help with formula and food and clothing, baby clothing, and car seats and all of those, those things. There are obviously organizations that do a great job addressing the needs, the, like, the tangible needs. But it's a little bit different when we're talking about the less tangible and we're talking about the training that's happening with our medical professionals. And, and it's not that our medical professionals aren't being trained well. It's just that they're not being trained fully to do the whole-- you know, address all of the needs of the patient and this implicit, implicit bias is really a big part of addressing the whole patient.

WALZ: Um-hum.

M. CAVANAUGH: So again, the Perinatal Collaborative, which is part of our university, is really-- and, and because of the-- they're part of the university because they're part of the medical center and they have a relationship with the Legislature and they have a relationship with the university system, that they are really a great home for a lot of this work.

WALZ: All right. That, that helps me. Thank you.

ARCH: Thank you. Any other questions for Senator Cavanaugh? I, I would just make one comment at the end and that is-- that this is, this is obviously an area of education. There's a lot of questions that, that came up regarding the connection to poverty, the connection to ethnicity or, or race or, or all of that and, and so if there is additional educational material, I think we would welcome that.

M. CAVANAUGH: So I will give a little plug/shout-out to Voices for Children, their annual Kids Count Report that I'm sure we'll be getting soon. It-- that's a, a good resource on a lot of these sort of data questions, but another issue is-- and as Senator Murman sort of alluded to, the collection of the data, we don't have an integrated data system in Nebraska for this sort of thing. I would love to see us have a, an early childhood integrated data system that would track a lot of this, but, but that is part of the hurdle and so we have to rely on a nonprofit organization like Voices for Children to really pull multiple sources of data from different state agencies and, and other entities and synthesize that. And we're very lucky that they do that for us, but that is something that we as a legislature should

probably discuss. It would be expensive, but, you know, most things are.

ARCH: Well, thank you. Thank you for your testimony and this will conclude LB416 and the committee is going to take a approximately ten-minute break and we will regather at 3:10.

[BREAK]

ARCH: And we will open the hearing now on LB19.

TYLER MAHOOD: All right. Good afternoon, Chairman Arch and members of the Health and Human Services. My name is Tyler Mahood. That's spelled M-a-h-o-o-d and I am Senator Kolterman's legislative aide. Unfortunately, as you are aware, due to COVID protocols, Senator Kolterman is unable to attend so I am introducing this bill on his behalf. Senator Kolterman introduced LB19 on behalf of the Board of Cosmetology, Electrology, Esthetics, Nail Technology and Body Art, a board whose members are appointed by the Governor and confirmed by the Legislature. LB19 is an extension of the efforts Health and Human Services Committee and the Legislature has taken over the past few years in updating the statutes that govern these professions. First and foremost, LB19 updates the definition of manicuring to include the practice of performing on the natural nails of a person and provides a clear-cut definition of the practice of pedicuring. Before LB19, the act of pedicuring fell under the definition of manicuring, but the practice itself was never defined in statute. LB19 does not create a new license or a separate license, but creates one comprehensive license that combines all nail services. And as of today, we are the only state in the Union that does not license the practice of natural nails. Since there are many individuals in this state who perform services on the natural nail, we retained the grandfathering clause that was first placed in LB607 from last year. So if an applicant can pass the examination and provide documentation showing that they have worked at least 300 hours over the last five years providing these services, those individuals will be allowed to test and, and receive a license. And since we are-- and because we are allowing-- that's just one license and we are allowing people to test if they have proved that they worked 300 hours over the fast-- last five years, they will be able to expand their clientele base, which I believe would-- which we believe would provide for greater economic mobility for these practitioners as they are able to interact with new patient-- not

patients-- new customers and provide additional services. We are also updating statutes regarding the terminology "tattooing" to align this definition with current industry standards, which includes the-- and so that will include the practice of permanent makeup, microderma pigmentation, micropigment implantation, microblading, and dermagraphics in the new definition. And as you saw in the letter that I distributed from the Board of Health, there has been some concern about the term "eyelid tattooing." I would like to add that this is not a new practice and it is legal under the current statute, but we are just simply updating the definition to meet industry standards. LB19 also places in the statute language that will allow for temporary body art facilities and temporary body artists. This is important as it will allow the state to host body art conventions at locations such as the Pinnacle Bank Arena or the CHI Health Center in Omaha. The temporary body art facility will be licensed and inspected by the, by the department and the license is only valid for up to 72 hours and shall expire at the conclusion of the event. The temporary body art-- artist license could allow this artist to offer services at the temporary body art facility or to be hosted in a facility licensed as a traditional body artist-- art facility. And an individual must be registered by the state before they can practice as a temporary body artist and the registration should-- is only valid for up to 14 consecutive days and it can be renewed up to two times per calendar year. Additionally, LB19 would allow nail technology salons licensed by the state to serve as a site for teaching of this practice to apprentices and we are providing for specific requirements that a nail technology salon must meet in order to qualify as an apprentice salon. We believe this provision decreases barriers to enter this profession for those who are unable to attend a traditional school. So if an individual who lived in Blair, Gothenburg, or Holdrege wanted to join this profession, they would no longer have to uproot their lives and move to a city to be trained that has-- or they would have-- they would no longer have to move to a city with a school to be trained. This would allow them to train in their local communities and we believe this will allow more people to enter the profession. Finally, LB19 allows for individuals wishing to practice this profession-- in the professions governed by the board to take the licensing examination in different states [SIC]. As we all know, Nebraska has seen an increase of individuals who do not speak English as their first language. These people want to practice in these fields and they have the sufficient skill and training to practice safely, but the

current language barrier prohibits them from doing so. The board believes that by allowing these immigrants, most commonly from Vietnam or Mexico, to take an examination in their first language, more individuals would then be able to join. As you may be aware, this exact leg-- legislation passed on final reading last August, but was vetoed by the Governor after the Legislature adjourned. Senator Kolterman still believes this bill has merit because this bill does provide for greater access for individual-- individuals to join the profession. Thus, it expands the earnings of-- capabilities for these practitioners and it still allows for the Department of Health and Human Services to inspect and regulate providers so our citizens know that they are receiving services from a well-trained individual in a sanitary environment. Testifiers from the board will follow me and will explain the need to update these statutes, to answer more specific questions on the legislation, and will be able to expand on the risk that our-- that is facing our citizens by not regulating natural nail services. And by doing so, they will provide numerous examples of life-changing injuries that have occurred to our citizens. With that, I want to thank you for your attention on this important issue. I will try to answer any questions, but like I said, experts will follow me.

ARCH: Thank you. Information for the committee as well, Senator Kolterman contacted me and wants to be able to close. So with the-- at the end of this hearing on this bill, he's going to be able to dial in and he will actually do the close for the bill, so he would be available over the phone at that point for questions from us directly if you want to hold those questions, but any, any, any questions? Senator Walz.

WALZ: I have a question and you should-- I think you can answer this, but I, I just don't recall the reason why the bill was vetoed. I-- was-- do you remember?

TYLER MAHOOD: I believe we have somebody from the department who is going to testify on behalf of that--

WALZ: OK.

TYLER MAHOOD: --but mainly how to deal with the natural nails provision and that was believed to be a barrier to entry in the practice.

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WALZ: OK.

TYLER MAHOOD: So I can get you the veto letter after the hearing.

WALZ: I can find it. I was just curious.

TYLER MAHOOD: OK.

WALZ: All right, thank you.

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

TYLER MAHOOD: Awesome, thank you.

ARCH: We now welcome first proponent for LB19.

PAM ROWLAND: If--

ARCH: Welcome--

PAM ROWLAND: --if I may, senators--

ARCH: --to the HHS Committee.

PAM ROWLAND: --I'd like to speak on behalf of the board, State Board Cosmetology, Electrology, Esthetics and that first and then stay in the chair so-- to avoid them cleaning it twice and then go on to my personal testimony--

ARCH: We can, we can do that.

PAM ROWLAND: --proponent. Is that acceptable?

ARCH: Yes.

PAM ROWLAND: And I am hearing impaired so if I could ask that the senators please speak up to their mike so I can hear you? What you're receiving now is just some letters from persons wanting their letter to be entered as testimony. The Nebraska Board of Cosmetology, Electrology, Esthetics and Nail Technology and Body Art is in support of LB19 as introduced this legislative session. The board discussed this proposal-- proposed legislation at our board meeting. It is the position of the board that natural nail services, manicures, pedicures

require licensure and oversight in the cosmetology, cosmetology industry for public health and safety.

ARCH: Could I stop you for just a second and ask you to state your name--

PAM ROWLAND: Oh.

ARCH: --and, and spell it?

PAM ROWLAND: My name is Pam, P-a-m, Rowland, R-o-w-l-a-n-d.

ARCH: Thank you.

PAM ROWLAND: Natural nail services, particularly pedicuring, by far, has the highest risk to public safety. Nail services use some of the most dangerous chemicals in the industry. Nebraska and natural nail care professionals deserve the protection of a licensure. With regards to the nail apprentice salon and the temporary body art establishment license, this is an effort to reduce barriers in our industry and merely a cleanup of current legislation. In an effort to be more uniform with other states, we support the legislative change to have the ability to examine in other languages. So that, that is a letter from the State Board of Cosmetology.

ARCH: She has some more papers as well.

_____: Oh, I'll double-check.

PAM ROWLAND: Thank you. Good afternoon, senators, Senator Arch, Committee Chair. My name is Pam Rowland, P-a-m R-o-w-l-a-n-d. Thank you for the opportunity to speak in support of LB19. I am a licensed nail technician and nail technology instructor practicing for over 24 years. Infection control is one of my many health and safety concerns. I have an exhibit from the CDC titled "Why We Legislate Cosmetology" that I'd like to share with you. This document for your review graphically explains the reasons for this legislation. The real risk associated with the transmission of pathogens within the salon have increased substantially due to antibiotic-resistant, resistant pathogens, pathogens new to our country, COVID. Lastly-- this is a huge for our state-- is limited government resources, which-- resources, which has led to reduced surveillance and accountability. What should scare you is MRSA. This harmful strain can kill a healthy

person in 48 hours. Allen Murphy [PHONETIC], president of Key Research-- you know the blue stuff, senators, that you see our combs and nippers in to protect you? He said, and I quote, of all the cosmetology-related fields, nail technology by far is the highest risk to the public. Nail technology is the most hazardous profession in cosmetology to public safety. Nebraska does not license natural nails, manicuring, and pedicuring, particularly the most hazardous, pedicures. We stand alone. Thirty-three states mandate more hours for nail technology and nail services than ours. Four states, last session, last year, increased their hours for nail technology. The State Board of Cosmetology really has no recourse or disciplinary action that be-- can be taken on a licensed or unlicensed profession or facility. So I do have a map of the states verifying the information that I a-- gave you and the-- a fact sheet on those states and if you need to verify that, that is from the National Interstate Council State Boards of Cosmetology.

ARCH: Please speak to the microphone so they can-- they'll be transcribing.

PAM ROWLAND: What you're seeing circulated is a map of the United States and the hours verifying what I've told you and that is recorded by the National Interstate Council of State Boards of Cosmetology. And then here's some other pictures if I could get a page one more time? A license allows an individual to engage in a specific scope of practice, for example, cosmetology or nail tech. A certificate is a title protection, for example, a mental health professional that specializes in family therapy. A registry is a list of persons who offer specified service or activity, for example, CNA, nurse aide, medication aid. All of these require hourly course of education. What makes our or my industry different is that every state across the U.S. uses a license for reciprocity. A certificate of registry will not be recognized mobility in-- from state to state. Say a registry individual moves from Nebraska to Missouri or Iowa. They would have to pay tuition, attend a school to get a license to practice in that state. If an individual is on a registry, how are we going to know where they work to do-- even do an inspect-- inspection? The apprentice salon opens up so many opportunities for education, especially in other cities and rural communities. Comprehensive education by an examination is a must for comp, comp-- competency to protect the public. LB19 does just that.

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ARCH: Ms. Rowland, I, I, I-- I'm sorry for interrupting you. We have a, we have a five-minute rule for testimony. Are you testifying at this point for the Board of Cosmetology--

PAM ROWLAND: No, personally--

ARCH: --or is this your personal?

PAM ROWLAND: --personally.

ARCH: This is your personal testimony?

PAM ROWLAND: Yes.

ARCH: OK, I believe, I believe the five minutes have expired, so I would ask that you complete your testimony quickly.

PAM ROWLAND: OK, I just have two more paragraphs.

ARCH: Great.

PAM ROWLAND: Thank you for allowing me to finish. Over the years, I've seen lawsuits from nail technology increase from 6 states to 16. States of California, Arizona, Virginia, Texas, and yes, Nebraska, are states that have had litigation in nail technology services. The state of Virginia had a lawsuit where a woman was awarded $1.3 million for injuries in a pedicure. It's been all over the national news, Dateline, etcetera. In closing, I have been asked by an attorney to be an extra-- expert witness in lawsuits in the state of Nebraska. This is-- there is now a third lawsuit. I can only say generically that the one lawsuit involved nail technology. The other, other lawsuit involved unlicensed nail services. The source of infection transmitted to both patrons had been verified by a medical professional traced to these services. The infection spread to the bone, leading to surgeries, numerous antibiotic therapies, hospitalization, amputation of the client's top inch of a wedding ring finger and the other client was the amputation of her leg-- in Nebraska. Is this not the definition of needless pain and suffering? Senators, in closing, again, I come from a family of public servants. My son and husband are both police officers. They're my heroes. They protect and serve us every single day. Is not your job essential-- essentially the same, public servants to protect your state, your constituents, and Nebraskans? I just implore you to do the right thing. Thank you.

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ARCH: Thank you for your testimony. Are there questions? Senator Hansen.

B. HANSEN: Thanks for coming to testify by the way.

PAM ROWLAND: You're welcome.

B. HANSEN: Just to make sure I get it right, so nail technicians right now are licensed or not licensed in the state of Nebraska?

PAM ROWLAND: Nail technicians-- nail technology, which allows people to apply artificial enhancements like acrylic and gel to the nail, is licensed. Natural nail manicuring and pedicuring in a tub that applies no product other than polish is natural nail care. That is exempt.

B. HANSEN: OK and that's what we're trying to change with this bill?

PAM ROWLAND: Correct.

B. HANSEN: OK and do you know-- you said there's two lawsuits?

PAM ROWLAND: There are three.

B. HANSEN: There are three? And were they all from licensed or nonlicensed or--

PAM ROWLAND: One, I don't know specifically. The next testifier would. The two that I've been contacted as an expert witness, one was nail technology services, the other was unlicensed practice. The one that I told you about that lost the tip, the one-inch tip of her finger, was from unlicensed manicuring service.

B. HANSEN: The one who lost her foot was from a licensed one?

PAM ROWLAND: The next testifier--

B. HANSEN: OK.

PAM ROWLAND: --will be telling you that.

B. HANSEN: Just curious and maybe if you can answer this one or maybe the next testifier too, do you know how many incidences of injury or illness come from the-- from people that are unlicensed in Nebraska

versus other states? Like, are we-- are they ordinary because we're not licensed or is it kind of similar to other states?

PAM ROWLAND: That is a very difficult question because we've asked the state department of licensure. We've also asked the department of investigations. Neither of those two entities do any tracking. There is no way for us to know unless it's brought before the board as a disciplinary action or litigation in civil suits, so I can't--

B. HANSEN: Yeah.

PAM ROWLAND: --really answer that.

B. HANSEN: That's, that's fine. I appreciate it. I'm just trying to figure out-- that helps me get-- justify then, like, if licensure equals safety or not because if it's-- if we're the same as every other state, I wouldn't see how a licensure would improve the safety and welfare of the system, so that's the reason I asked--

PAM ROWLAND: Yeah.

B. HANSEN: --so I was just curious. Thank you.

ARCH: Other questions? I do not see any questions, so thank you very much for your testimony.

PAM ROWLAND: Thank you.

ARCH: Next proponent for LB19.

HAROLD SIMS: Hello.

ARCH: Welcome to the committee.

HAROLD SIMS: Thank you so much. My name is Harold Sims, H-a-r-o-l-d. S-i-m-s for the last name and if you're ready, I can begin whenever you are.

ARCH: Please.

HAROLD SIMS: OK. Thank you for the opportunity to speak in support of LB19. I'm a salon owner and the nail tech representative on the Board of Cosmetology. Over the years, I've traveled and worked closely with industry insiders, owners, clients, and nail techs that all stand in

support of this bill. If it does not pass, as you know, Nebraska will be the only state without this type of legislation. I had the pleasure of working on this multifaceted bill and thank Senator Kolterman. As many of you know, we've been working on this bill for years and the support we garnered only grows. Over time, we've collected thousands of supporters, many of which have signed petitions and sent letters. You'll see a new petition in your packet. I also have a letter for the Nebraska Board of Health, who we know stands in support with us today, and then there's also a letter from a well-known podiatrist here in Nebraska who works with individuals who have had issues. Last year, this bill passed on the floor by a vast majority. We've done our due diligence by reaching across the aisle to create good legislation that lowers barriers, which can benefit many people. The people that benefit are the same voters that asked for this legislation in the last session and we urge you to listen to the people by voting in support. This whole thing began because of barriers to income and we took that to heart. We're offering unlicensed workers the opportunity to bypass the cost of schooling and the hours required so they can only take a test to obtain a license. Having a license will help them better market themselves and open doors to future employment, especially if they move to another state. Because Nebraska is not fully licensed, these individuals would struggle to gain reciprocity. During one of the worst financial times my business has suffered due to the lack of legislation, I lost two employees in the last year because our bill did not pass. An educator and potential student quit because they can no longer wait for our lawmakers to pass this legislation, which includes apprentice salons. I have lost thousands of dollars, which doesn't include the cost of my time and the printed materials of being here today, today. There's a section in LB19 for apprentice salons, which was left out previously. We want to eliminate that discrimination while creating new educational opportunities. We'll offer students a more realistic educational experience and this can benefit salon owners due to the lack of educational institutions. The Salon Owners Organizations of Nebraska is happy to hear LB19 stands to lower these barriers. With the lack of requirements in nail technology, clients come to my salon sharing their bad experiences, not including the multiple lawsuits in Nebraska. It's the state's responsibility to ensure there are high standards to protect your constituents. These voters should not be put at low-- put at risk because of low regulations. Additionally, many of them don't know there's a license, nor education required and they're shocked by this

information. One supporter is a woman named Niki Campbell of Plattsmouth who received an unlicensed pedicure and lost her leg. To answer your question, there is a stack of letters. The top one is about Niki Campbell's specific case. The last time I was here, a senator asked me what he thinks the consumer expects when having a nail service. Any time a consumer makes a purchase, they expect the government has taken on the burden of public safety. For comparison, when an electronic item is purchased, we expect oversight and quality assurance so the purchase is safe and won't cause harm. The same is expected in basically every single purchase made by a consumer. The only thing consumers universally want is to not be harmed by said purchase. Should bodily harm occur, those safeguards will protect them. Conversely, DHHS has no recourse or disciplinary action for an unlicensed person or facility. Natural nail licensure is imperative to monitor public safety. Unfortunately in Nebraska, the lack of legislation does not protect your voters. LB19 stands to eliminate a loophole to provide uniformity in law. Barbering nor cosmetology have mixed regulatory framework, so why would natural nails and pedicures, the most dangerous and litigated of all services, not be included under the nail tech license? The loophole and lack of oversight has created an opportunity for unlicensed people to work outside of their scope of practice. Many times, we find unlicensed individuals offering licensed services while using chemicals and tools only a licensed person can offer. This point alone punctuates the need for oversight and accountability for workers touching the public. Those that have lost their limbs and livelihood with this wish this would have been done sooner and they beg you to close the loophole. We're proud and thankful for the time we have with you today and hope you can work with us to elevate our industry standards. Thank you in advance for your support of LB19 and I am here for questions if you have any.

ARCH: Thank you for your testimony. Are there any questions? Senator Day.

DAY: Thank you, Chairman Arch and thank you, Mr. Sims, for being here today. I just want to clarify a couple of things. So essentially, what we're saying is that there's various areas in cosmetology that require licensure, you know, and certain standards of cleanliness that can be investigated by the Department of Health or whoever comes in and does that. But for some reason, natural nails weren't-- have never been included in that and we're looking to close that loophole and put

natural nails into the same standards that other areas in cosmetology are held to, is that what I'm--

HAROLD SIMS: Yes, you're correct.

DAY: OK.

HAROLD SIMS: So that's why we would say we're not creating a new license since the license is already there. We're just tying in and changing the description of what nail technology would be.

DAY: OK, OK and then I guess the other question I have is do you have any concerns that this would lead to a reduction in people offering those-- these services or practitioners or that people would, would move away from the industry because they have to be licensed? Do you have-- I mean, any concerns from that perspective?

HAROLD SIMS: Sure, I'm just referring to some notes I have here.

DAY: Sure.

HAROLD SIMS: This bill would actually make it easier for any of those individuals that are currently working in the field-- this would make it easier for them to obtain a license. Without this bill, they would have to go back to school and pay all that money and probably potentially quit their jobs so they can go to school. So this actually makes it easier for them to obtain a license than it would without legislation like this.

DAY: OK.

HAROLD SIMS: Does that answer your question?

DAY: Yes, I--

HAROLD SIMS: OK.

DAY: --I think I understand that. And then also, too, it allows-- so someone, and I think it was Kolterman's legislative aide, had mentioned that people in more rural areas that don't have access to a, a standalone cosmetology school can be provided an option to get a license through apprenticeship. Is, is that--

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HAROLD SIMS: Correct.

DAY: OK.

HAROLD SIMS: Yep.

DAY: OK.

HAROLD SIMS: So the way it stands right now-- and this was-- we call it discrimination, but it was left out initially. You can have apprentice salons for cosmetology, for example. You cannot have those for nail technology.

DAY: OK.

HAROLD SIMS: So we're trying to eliminate that discrimination and then, like you said, in rural areas, because the nail technology schools are so few and far between, that would potentially be their only option.

DAY: OK.

HAROLD SIMS: So truthfully, right now, because of the lack of education, we are currently seeing the number of licensed nail technicians going down. We're hoping by passing this legislation, you'll actually see that go up.

DAY: OK, wonderful. Thank you so much.

HAROLD SIMS: No problem. Thank you, Ms. Day.

ARCH: Other questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and, and thank you for being here. So a, a person that is doing nails as a nail technician that has gone through the cosmetology training is exposed to training on the various diseases, the infections, and the use of chemicals, correct?

HAROLD SIMS: Correct.

WILLIAMS: A person that is offering a natural nail salon, do they have that same type of training?

HAROLD SIMS: Uh-uh, that would be up to the owner to decide if they offer any training whatsoever.

WILLIAMS: Based on your experience and, and doing this in your training, are they doing a very similar thing to the client, the, the service that they're providing, so there would just-- there would be as much risk to providing or to having an infection happen in a natural nail salon as there would be in a nail technician salon?

HAROLD SIMS: I would have to disagree with that. Though the steps of a pedicure might be the same, we're trimming the nails, we're filing away a calloused area, for example, those steps probably are the same, but how they're going about them, what tools they're using and potentially what chemicals they're using in conjunction with the sanitary practices could be worlds apart because of that lack of education. For example, with Niki Campbell, you'll notice in her letter, we talk about-- in my letter to the Board of Health, we talk about a particular foot file that gets used a lot in these unlicensed facilities. It's similar to a Credo blade, which is illegal in Nebraska. This would fall into that category. It looks like a cheese grater. So there are certain tools that are not only illegal, if you don't have the proper education, you probably don't know about that. But also they're, like I said, using those on people, which is what could cause infection once you have an open wound.

WILLIAMS: That's the question I was trying to ask, but there--

HAROLD SIMS: Oh, OK. I'm sorry if I misunderstood.

WILLIAMS: -- there is, there is potential and significant risk with the natural salon.

HAROLD SIMS: There is, yes, but your licensed--

WILLIAMS: And then to, to--

HAROLD SIMS: --individuals would know.

WILLIAMS: --go back to Senator Day's question, I think the term that, that I would use is anybody that is currently doing natural nails under this legislation would be grandfathered to basically walk in and get licensed by passing a test, is that correct?

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HAROLD SIMS: Correct, by proving the 300 hours and then by taking the exam. About two-thirds of that exam is going to be about anatomy of the nail, disease and disorders, as well as sanitation/disinfection. So it isn't a bunch of fluff in this exam. It's really the most important things and as long as they have that basic information, we agree that they should be able to work on the public. So I don't feel like we're asking for a lot in that exam.

WILLIAMS: Thank you.

HAROLD SIMS: Yeah.

ARCH: Thank you. Other questions? Senator Hansen.

B. HANSEN: So someone who hasn't-- I'm trying to get my, my, my language right-- because it's a natural nail salon. So they don't need any education right now? They can just open it up and call-- they don't need to be credentialed by any, by any means or anything like that?

HAROLD SIMS: The business itself doesn't even have to have a license with the state.

B. HANSEN: OK. I was just kind of curious, so-- OK, thanks.

ARCH: Other questions? I have, I have a few.

HAROLD SIMS: Oh sure.

ARCH: I've been storing them up here. So talk to me about cost. If this, if this bill were passed, the cost for somebody coming out of high school, what-- whatever age, say I want to, I want to do natural nail work. What would the cost be to get into and get the license and, and, and be ready to, to do that service?

HAROLD SIMS: So just the entire cost of schooling?

ARCH: Right, schooling, licensing, all, all those things.

HAROLD SIMS: Sure. It's probably going to be somewhere in the ballpark of $5,000.

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ARCH: OK, now if, if they are already working now and you say it can be grandfathered if you can prove 300 hours and pass the exam, cost to them to, to get licensed now?

HAROLD SIMS: I think it's $118. Yeah, it's $118 to obtain a license, correct.

ARCH: And that's the license cost?

HAROLD SIMS: Correct.

ARCH: Is there a cost to take the exam?

HAROLD SIMS: The cost to take the exam is about $100.

ARCH: So an additional-- about $218 or thereabouts?

HAROLD SIMS: Um-hum.

ARCH: OK. So if this were to pass, I guess-- help us understand enforcement as well. So a natural nail salon opens up. How does anybody know-- how-- what, what enforcement is there? You are licensed, you're not licensed, inspections-- how, how often do inspections occur now?

HAROLD SIMS: Well, it's hard to say, especially with COVID over the last year. Those were frozen.

ARCH: Yeah.

HAROLD SIMS: The number of inspectors we've had has fluctuated over the years as well. I wish I could answer how frequently those inspections are happening.

ARCH: Does it, does it require a regular inspection or are these just inspections based upon complaints?

HAROLD SIMS: No.

ARCH: When does, when does an inspector show up?

HAROLD SIMS: It could be at any point in time, yep. The inspectors, the one that would choose when or who they want to inspect, every-- it's supposed to be every two years--

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ARCH: OK.

HAROLD SIMS: --but it-- they could show up at any point in time.

ARCH: OK, so it could, it could increase the number of inspectors, obviously, if, if, if there was significantly more.

HAROLD SIMS: Yeah, I mean obviously the licenses would generate more income to be able to support those inspectors also.

ARCH: OK and the license is for the individual. It is not for the business itself.

HAROLD SIMS: Correct.

ARCH: Correct?

HAROLD SIMS: Correct. If the business is marketing licensed-only services, they should have either a cosmetology license or a nail technology salon license, but that doesn't always happen. The salon that Niki Campbell lost her leg at, they're offering waxing. That was not in, in the scope of practice whatsoever. So they didn't have a business license. They were offering services outside of their scope of practice. So you, you should have a license if you are doing anything except for manicures and pedicures. And as we know, with most kind of strip mall nail joints, if you will, they'll give you acrylic, shellac, basically anything you ask for.

ARCH: OK, all right. Thank you.

HAROLD SIMS: No problem.

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

HAROLD SIMS: Thank you very much.

ARCH: Other proponents for LB19.

SIOBHAN KOZISEK: Good afternoon, senators. My name is Siobhan Kozisek, its S-i-o-b-h-a-n, last name is Kozisek, K-o-z-i-s-e-k. I am a licensed esthetician here in the state of Nebraska. I also oversee the Nebraska Licensed Professionals Alliance and the Nebraska

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Professionals Against Domestic Violence and Human Trafficking. I'm here to speak in support of LB19. Governor Ricketts said in his veto letter that the bill would be burdensome on individuals who perform natural nail manicures and pedicures by imposing requirements that go well beyond the basic education and training in self-- in safe and-- safe health and sanitation practices. With this bill, we don't want to put people out of work, but we are concerned about worker success and safety. We are also concerned about the customer safety. Early on when this bill was being drafted, I addressed the concerns regarding those that are working in unlicensed positions at nail salons that may be victims of labor trafficking. I explained that there had to be a plan to be able to help them and take their skills to legitimize employment. By offering apprentice training and bilingual examination, those concerns were addressed. By encompassing these workers into nail technology license, it would also help the state to identify and aid workers who may be in labor trafficking situations and can help them find legitimate employment and a true living wage. It would also help the state's fight on human trafficking as far as labor. Licensed facilities with licensed professionals are subject to inspections. We want to allow these unlicensed workers the chance to obtain a license and success. Negligent, unlicensed nail services are dangerous, period. From the use of chemicals such as acetone to tools that can cut into the skin and communicable diseases, natural nail services are not harmless. If there's anything the COVID-19 pandemic has taught our industries, it's the importance of education and the effectiveness of a license, which helped to curb the spread. Nebraska was able to create and communicate and enforce effective, effective direct health measures for these licenses through the Department of Health and Human Services. Where these direct health measures could be ineffective could easily be where services that are not overseen by the department are performed, especially since those unlicensed workers are not required to have training on sanitation and disinfection in the field, such as natural nails and makeup artistry. To slow the spread, we had to go well beyond basic education and training in safe health sanitation practices.

ARCH: Thank you. Thanks for your testimony.

SIOBHAN KOZISEK: Short and sweet. Does anybody have any questions?

ARCH: Are there questions? Senator Day.

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DAY: Thank you, Chairman Arch. I just have a follow-up question. Well, first of all, thank you for being here, Ms. Kozisek--

SIOBHAN KOZISEK: Yes.

DAY: --and I appreciate your perspective from the-- mitigating issues with labor trafficking.

SIOBHAN KOZISEK: Um-hum.

DAY: --because that was not something I had considered when we looked at this bill originally--

SIOBHAN KOZISEK: Um-hum.

DAY: --so I appreciate you for mentioning that. Also, just a follow-up question to what I had asked Mr. Sims in terms of, you know, having a negative effect on practitioners.

SIOBHAN KOZISEK: Um-hum.

DAY: Do you think this could potentially have a negative effect on consumers in terms of extra cost or--

SIOBHAN KOZISEK: I mean, there-- the issue that I'm seeing as far as labor trafficking-- and I'd like to get into that for just a second-- is if you're paying $15 for a manicure, there is a problem.

DAY: Um-hum.

SIOBHAN KOZISEK: The overhead for a proper service and to pay an employee is more than $15 and a lot of these services that are going out there at these very reduced costs are a red flag and that, that's really where I can speak on that.

DAY: OK.

SIOBHAN KOZISEK: So as far as protecting the cost to the consumer, at what cost are we doing that? And that's what we also really need to look at.

DAY: Sure. Yeah, I agree. Thank you.

SIOBHAN KOZISEK: Um-hum.

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ARCH: Thank you. Other questions? Senator Hansen.

B. HANSEN: You mentioned something about unlicensed salons are not subject to inspection?

SIOBHAN KOZISEK: If, if your salon doesn't require to have a license by the state, there is no say on somebody going in there and taking a look at what's going on in there.

B. HANSEN: OK, so--

SIOBHAN KOZISEK: So if somebody were to just open up a natural nail shop--

B. HANSEN: Um-hum.

SIOBHAN KOZISEK: --they're not required to have a license by the state of Nebraska. Their workers are not required to be licensed. There's no oversight there--

B. HANSEN: OK, but--

SIOBHAN KOZISEK: --and in that--

B. HANSEN: --they can still be inspected, couldn't they, though, probably? Like, an inspector cannot walk into an unlicensed--

SIOBHAN KOZISEK: They wouldn't-- I mean, they could walk in there. It wouldn't mean that they may or may not be allowed in there. There would be some sort of a gray area, if you will.

B. HANSEN: That just it's kind of weird to me that just because they're--

SIOBHAN KOZISEK: If the owner were to say, yeah, I don't-- I'm not going to have you in here right now--

B. HANSEN: OK.

SIOBHAN KOZISEK: --what is the law if there's no license in place?

B. HANSEN: OK. That's what I'm unfamiliar with.

SIOBHAN KOZISEK: Yeah.

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B. HANSEN: I'm just kind of curious. Thank you.

SIOBHAN KOZISEK: Um-hum.

ARCH: Other questions? Seeing none, thank you very much for your testimony.

SIOBHAN KOZISEK: Thank you.

ARCH: Are there other proponents for LB16-- excuse me, LB19? Are-- anyone that would like to testify in opposition?

LAURA EBKE: Good afternoon, senators. Got a little glare coming off here. Chairman Arch, members of the committee, my name is Laura Ebke. That's L-a-u-r-a E-b-k-e. I am the senior fellow at the Platte Institute. In 2019, we testified in opposition to LB607, which is the same bill as LB19 as introduced. As you've heard, LB607 was advanced from the committee, ultimately passed by the Legislature, and vetoed by the Governor because it imposed new licensing requirements not justified by the risk it sought to mitigate for natural nail manicure and pedicures. I'm here to testify in opposition to LB19 as well. As in 2019, our opposition is related only to the bill's nail technology aspect, not to the various body our-- guest, guest body artist portions. As noted in the-- on the DHHS Cosmetology, Cosmetology and Esthetics website, the current status of the law is that quote, you do not need a Nebraska license to do manicure or pedicure of the natural nail, unquote. This bill raises the standard for simple manicures and pedicures and would require testing and likely educational hours if you were to pass the test. The added cost to become licensed will very probably result in one or, one or more of these things: reduced practitioners in the field of manicures and pedicures, increased costs to consumers, or previously served populations becoming unserved. The Occupational Board Reform Act, LB299 in 2018, established a framework whereby committees review all licenses on a five-year rotation. The Health and Human Services Committee did review nail technology and other cosmetology and esthetics licenses in the interim of 2020 and did not make any recommendations for any changes, nor has a 407 review been done that I can find. I met, at Senator Kolterman's request, to find common ground with him in the nail-- in nail technology industry at representatives last fall. I submitted a series of data-related questions seeking to figure out how significant or widespread the problem was with manicure and pedicure safety over the last five

years. The responses I received included two injury incidents-- it sounds like there-- perhaps there were three allegedly caused by manicures and pedicures. As, as I understand it, those cases are still being litigated, litigated. When I asked about how many total complaints there had been about improper practices or unclean or unsafe conditions, I was told that DHHS licensure division does not track that information, nor does it track complaints on licensed or unlicensed providers of nail services. The decision to regulate an occupation should be made based on real data concerning public safety, not on isolated anecdotes. The Platte Institute is concerned about creating licensing requirements that didn't exist previously or increasing licensing requirements without demonstrated need. We oppose this bill at least until a more detailed review of the data takes place. Given that the HHS committee churned out five years worth of 299 reviews in one year-- that was very impressive, folks-- we would encourage a deeper dive into this particular area in the next interim. Thank you and I'd be happy to take any questions.

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

LAURA EBKE: Thank you, Senator.

ARCH: Are there other opponents?

BECKY WISELL: Good afternoon, Chairperson Arch and members of the Health and Human Services Committee. My name is Becky Wisell, B-e-c-k-y W-i-s-e-l-l, and I am the interim deputy director of health licensure and environmental health at the Department of Health and Human Services' Division of Public Health. I am speaking today to oppose LB19 as introduced. LB19 includes a requirement that persons who have been providing manicuring or pedicuring services on natural nails pursuant to the exemptions from licensure set forth in Nebraska Revised Statute Section 38-1075 obtain a nail technology license in order to continue providing these services. To obtain a nail technology license, an applicant who has been providing these services on natural nails would have to successfully complete the written examination and a three-hour-- 300-hour nail technology program or document at least 300 hours of work experience manicuring and pedicuring within five years immediately prior to making an application. The department opposes this portion of the bill because it would impose new occupational licensing requirements and create a

regulatory burden for individuals who perform manicures and pedicures on natural nails without a demonstrated need to do so. At Senator Kolterman's request, a member of the Governor's staff met with Senator Kolterman on this bill in October 2020 to work on updated language from LB607 introduced last session, which the Governor vetoed. During the meeting, the Governor's staff reiterated the veto message, especially that the Governor would support a registration system rather than a separate licensure. Unfortunately, those recommendations are not reflected in this legislation. As a result, we respectfully oppose this legislation and request the committee not advance it further. Thank you for the opportunity to testify and I'm happy to answer any questions.

ARCH: Thank you for your testimony. Are there any questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and, and thank you for being here. Can you describe to me the-- from HHS's standpoint, the difference between what a registry would be and what licensure would be?

BECKY WISELL: Yes, under the Uniform Credentialing Act, we call it the UCA, there are definitions for the three levels of credentialing that we pursue. The least level is registration, which is defined as a list of persons who offer a specified service or activity. And then there is certification and that is the title protection that one of the, the prior persons testified about. And then the licensure is an authorization issued by the department to a person to engage in a profession or to a business, of course, to practice something that otherwise would be unlawful in the state if they did not have that authorization. So I would say typically licensure has more requirements to meet. Most of our registries are very basic requirements.

WILLIAMS: From a standpoint of public safety or examination of the two, what does the department of-- what does HHS do with those that are on a registry versus a licensure?

BECKY WISELL: Well, the registry identifies the people who are performing that service and so it allows us then, if there are reports that someone has done something improperly, we can investigate the matter. And typically with a registration, there is a process involved

for removing a person from a registry if they have performed acts that would be considered unprofessional.

WILLIAMS: Do you, do you track-- with, with the registry, again, as opposed to a license, is it annually updated? Does somebody apply each year to be on the registry versus a license that you update every year?

BECKY WISELL: It depends upon how the legislation is written. Some of our registries have a renewal similar to what a license would have, where on a regular basis the person would need to pay a fee and meet whatever requirements are necessary for renewal. And others, you're-- you remain on the registry until you're removed from the registry.

WILLIAMS: OK, what, what would you expect this type of registry to be? What were you suggesting here?

BECKY WISELL: I wasn't suggesting anything, but I think the Governor was looking at, at not as restrictive of regulation. One of the things that, that I see as a possible burden or barrier for a person who's been performing manicures or pedicures on natural nails and they're relying solely on their work experience to obtain the nanotechnologist license, they may not have the knowledge to successfully complete that examination so they wouldn't qualify for the license and so I'm seeing the, the examination as a barrier for them--

WILLIAMS: [INAUDIBLE]

BECKY WISELL: --without obtaining some type of additional education on the areas that were mentioned of the-- about the exam.

WILLIAMS: Do you know if there's any restrictions right now for a natural nail salon? Can that be home based as well as in the mall?

BECKY WISELL: I-- we don't regulate natural nails, so, I mean, I don't know that for certain, Senator.

WILLIAMS: So you, you wouldn't know that at all.

WILLIAMS: I, I don't believe that we would regulate anything to do with a, a business that only did natural nails.

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WILLIAMS: A question was asked earlier a little bit about complaints that may have come in and, you know, there's certainly those that have risen to the level that a lawsuit was filed, but that's-- as a lawyer, that's the rare case. There's lots of complaints that don't lead to lawsuits. Have you received complaints about natural nail salons?

BECKY WISELL: I don't know that without consulting with the investigations unit. I didn't bring that information today. But if we were to receive a complaint about someone who is not a credentialed person, who, who does not hold a credential of some type, whether that's a registration or a license, the means that's allowable to our department and the boards, the professional boards that we work with, is a cease and desist order. And that's something under the Uniform Credentialing Act where if there's evidence that someone has practiced a profession that requires a credential and did not have a credential to do so, an order for cease and desist of that practice can be issued.

WILLIAMS: So if, if, if I'm understanding what you just said, since there would-- is no licensing or registration right now, even if you received a complaint, you would be limited in what action Department of Health and Human Services could take?

BECKY WISELL: The limitation would be we have no credential to discipline--

WILLIAMS: Right.

BECKY WISELL: --and so the action that would be appropriate would be a cease and desist--

WILLIAMS: Right.

BECKY WISELL: --if that person was found to be performing a license or credentialed service.

WILLIAMS: Right, thank you.

BECKY WISELL: You're welcome.

ARCH: Other questions? I, I would have-- oh, Senator Day, please.

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DAY: Thank you, Chairman Arch. So I guess I, I'm trying to just get a little bit of perspective on this. So essentially 300 hours in an apprenticeship would equate to, if you're working 20 hours a week, four months worth of working, right? So to me, that doesn't seem like-- especially in comparison to, I think, what a hairstylist is required, 2,000-- 2,500 hours of school or, or something, I believe. So, you know, I definitely respect the perspective that we don't want to create a more burdensome licensure process where it's not necessary, but I'm wondering-- or, or at least where it's not warranted, I guess is maybe what you had mentioned or-- and, and what Dr. Ebke mentioned. And it-- I think we, we see examples of, like, a lost leg up here or a lost finger and so I, I'm wondering what would this-- how many complaints or examples of lost limbs or injure would we need to see before we felt that it was necessary for these people who are operating or providing these services to be licensed?

BECKY WISELL: I don't, I don't have a, an answer--

DAY: OK.

BECKY WISELL: --for that, Senator Day. I, I don't know how many incidents it would take before licensure would be an appropriate type of regulation for this group.

DAY: OK, thank you. I appreciate it.

ARCH: Other questions? I just have one. I don't mean to belabor the point. It, it-- without a registry, without licensure, it would be very difficult to know the scope of, of the problems that are being experienced in a natural nail salon, short of a lawsuit, short of some very large, disastrous event, loss of a limb that, that type of thing, would, would you, would you agree with that?

BECKY WISELL: It is difficult to identify and that's the beauty of a registry because then at least you do have a list of the persons who are performing the service. And if the legislation is written accordingly, you would have the ability to remove them from having that privilege if they were not performing according to rules.

ARCH: And, and a process for a customer to complain.

BECKY WISELL: Absolutely.

*Indicates written testimony submitted prior to the public hearing per our COVID-19 response protocol

ARCH: Right. OK, thank you. Any other questions?

BECKY WISELL: Customers can--

ARCH: Oh, I'm sorry.

BECKY WISELL: --complain about unlicensed activity as well. We, we get complaints all the time for a variety of things. Some things we have the authority to take action against and others we don't, but we receive all types of complaints.

ARCH: OK, good. That's helpful. Senator Walz.

WALZ: I just want to follow up on that. Thank you, Senator Arch. Thanks for being here today. So they, they would lose the ability to be on the registry, but that does not stop them from continuing to work, right?

BECKY WISELL: If a-- if the legislation were to create a registry that says you need to be a registered person on this registry in order to practice manicuring and pedicuring on natural nails, if that person were then removed from the registry, they could no longer practice that and provide that service.

WALZ: Legally.

BECKY WISELL: Legally, that's correct.

WALZ: Thank you.

BECKY WISELL: Um-hum.

ARCH: All right, seeing no other questions. Thank you very much.

BECKY WISELL: Thank you.

ARCH: Thanks for your testimony. Are there any other opponents that would like to speak about LB19? Are there any in a neutral capacity that would like to testify? OK, we're going to allow about a 45-second break here for Senator Kolterman to call in to do his close. We did not receive any written testimony this morning, but we did receive a letter of record that was submitted and it was a proponent on LB19. And so we'll pause here while Senator Kolterman calls in.

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_____: [INAUDIBLE]

ARCH: He's watching [INAUDIBLE]-- 45 seconds is a long time-- [INAUDIBLE]

_____: [INAUDIBLE]

ARCH: Right. He's calling my phone. Are you able to call in?

KOLTERMAN: I'm trying to call in. It's ringing, but I'm trying to call [INAUDIBLE]

ARCH: OK? He's trying to call in, but it's-- he said it's ringing.

_____: Did he call 2636?

ARCH: Yeah, that's-- yeah, that-- you called the number I, I gave you. He's gone.

_____: We have the dial tone, so we should be--

ARCH: Well, I apologize-- not-- he called and he got-- it, it was ringing, but it didn't come through.

_____: [INAUDIBLE]

ARCH: All right. OK, I apologize.

_____: [INAUDIBLE]

ARCH: I don't believe a staff can close on a bill. I believe that's the rules. That's what I was instructed anyway, so-- anyway, OK, this will close, close the hearing for LB19 and that will close the hearing [INAUDIBLE]. Thank you.