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

WALZ: Hi, I'm Senator Walz and I represent Legislative District, which is all Dodge County.

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

ARCH: Also assisting the committee is one of our legal counsels, T.J. O'Neill; our committee clerk, Geri Williams; and our committee pages, Sophie and Claudia. A few notes about our policies and procedures. First, please turn off or silence your cell phones. This morning, we will be hearing two 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 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 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 and 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. If you are not testifying at the microphone, but want to go on record as having a position on a bill being heard today, please see the new public hearing protocols on the HHS Committee's webpage on 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. 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 agenda posted outside the door will be updated after each hearing to identify which bill is currently being heard. The committee will pause between each bill to allow time for the public to move in and out of 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. Pages will sanitize the front table and chair between testifiers. And this committee has a strict no props policy. And with that, we will begin today's hearing on LB413. And welcome, Senator Wishart.

WISHART: Well, good morning, Chairman Arch and members of the Health and Human Services Committee. My name is Anna Wishart, A-n-n-a W-i-s-h-a-r-t, and I represent the great 27th District here in west Lincoln. I'm here today to introduce LB413. LB413 would increase access to substance use disorder treatment both through medication and behavioral health. It does this by limiting restrictions such as prior authorization that Medicaid and the managed care organizations are able to place on this important treatment for people in our state diagnosed with mental illness and substance use disorder. According to the U.S. Substance Abuse and Mental Health Services Administration, over two million people in the United States suffer from a substance use disorder. However, more than 90 percent of these Americans who need treatment are not receiving it. A large part of addressing this issue can be done through enhanced efforts to increase treatment and prevention, which Nebraska has been a leader on. Thank you to this committee and a lot of work done by Senator Sara Howard. According to the Centers for Medicare and Medicaid Services, substance use disorder treatments reduce recidivism and drug courts. And there is strong evidence that utilizing substance use disorder treatments provides a substantial cost savings to state Medicaid programs. In fact, a 2020 study published in the Journal of American Medical Association found that while removal of prior authorization barriers to this lifesaving treatment resulted in a $50 increase in prescription drug expenditures per plan per year. It also resulted in a $480 decrease in total nondrug healthcare expenditures per plan per year. Removal of barriers resulted in a 28 percent decrease in substance use related inpatient

admissions and a 36 percent decrease in emergency room visits. The end effect is lower costs to the healthcare system, meaning lower costs for Nebraska citizens and better health outcomes. The study compared that data to what happens when there are barriers to substance use disorder treatment. When barriers are in place, there was $125 decrease in prescription drug expenditures, but a $12,000-- excuse me, a $1,200 increase in total nondrug healthcare expenditures. Additionally, these barriers caused a 10 percent increase in inpatient admissions and a 13 percent increase in emergency room visits. The data is clear, colleagues, removing barriers to this vital treatment saves money for our healthcare system. With a rising focus on substance use disorder and behavioral health treatments in recent years, LB413 would have a real impact on the health of Nebraskans dealing with this issue. On December 17, 2020, the CDC released a health advisory on the increase of overdoses seen during 2020. For June 2019 to May 2020, the most recent data available there was an 18 percent increase in overdose deaths, the largest 12-month increase ever recorded. From February 2020 to May 2020, the month-to-month increase in overdose deaths was again the most ever recorded by the CDC. Substance use disorder is something that cannot be solved by one magic approach. After years of working to lower the devastation seen by this disease, the numbers continue to increase. We must take a variety of approaches to address this issue. And LB413 is a commonsense measure backed by data that can play an important role in helping people get the treatment they need. And I did want to point out that, you know, if we went forward with LB413 and your committee decides if this is a priority this year, there are many other states that have similar policies in place. Currently, 21 states have a law similar to LB413, including Iowa, Missouri, Arkansas, and Illinois. And I would also be happy to get you that 2020 study so you can, you can see for yourself some of the facts and statistics that I used today in my testimony. With that, I'm happy to answer any questions. And I will advise the committee that I have some experts after me who can talk details about the specific types of treatment we're talking about today.

ARCH: Any questions this morning? I, I just have one. This is the Medicaid program and I'm assuming adults and children?

WISHART: I would imagine so, yes.

ARCH: Yeah. OK. All right. Thank you.

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WISHART: Thank you.

ARCH: Now invite the first proponent for LB413. Good morning.

ALENA BALASANOVA: Good morning, Chairman Arch and members of the Health and Human Services Committee. My name is Alena Balasanova, that's A-l-e-n-a B-a-l-a-s-a-n-o-v-a, and I'm a board certified addiction psychiatrist practicing actively in Omaha. I'm not representing the University of Nebraska or Nebraska Medicine in this testimony. I am here today on behalf of the Nebraska Medical Association and the Nebraska Psychiatric Society in strong support of LB413. As the voice of Nebraska's physician workforce, we recognize and embrace our responsibility to advocate for our patients' ability to access the standard of care in addiction treatment. Substance use disorder is a chronic brain disease with potential for relapse and remission. Due to the nature of the disease, the window for engaging a patient in treatment is often small. And when we catch folks in that "intervenable" moment, as I like to call it, it's important we jump on that opportunity to provide them with care and, most importantly, to reduce their risk of overdose death. The current policy in Nebraska of requiring prior authorization for generic medications for addiction treatment is preventing patients from receiving the care they desperately need. In my practice, I can think of many patient stories and they all play out similarly. One patient I recall was a gentleman in his 50s who had been injecting heroin into his veins for ten years after first becoming addicted to opioid pain medicine following a back injury. He had come to our clinic to address his opioid use disorder in hopes of receiving medication that could help. We identified the patient was in the beginning stages of opioid withdrawal and we immediately stabilized him on buprenorphine/naloxone right in the clinic using the medication we stock exactly for this purpose. As most facilities, we stock the generic and least expensive formulation of this product. Once the patient was stabilized on his first-line treatment, I prescribed a small supply of buprenorphine/naloxone tablets for the patient to pick up at his pharmacy to take home until coming in to see me the following week. This is always where the problems begin. When he arrived at the pharmacy, the patient was told his insurance required a prior authorization for them to be able to fill his medication. Concerned about going into withdrawal, he contacted the drug clinic and we scrambled to fill out and submit the requested paperwork for the prior auth. Several phone calls and faxes later, we still didn't have an answer. The following day, we received

a denial notice that the patient needed to first try the more expensive brand name medicine before being considered for the generic one I had prescribed and the one had already been stabilized on. Because that was not a safe option for this patient, I wrote an appeal letter to the insurance company and let the patient know that we were doing everything we could to get him the medication that he needed as soon as possible. By that point, it was Friday and the patient was experiencing withdrawal. We didn't hear back from the insurance company until the following week when we received another denial notice. Unfortunately, by that point, I suspect the patient had returned to using heroin because he did not return to our clinic again. I have often wondered about what happened to that patient, and I pray that he is alive today because his risk of overdose was very high. As physicians, we take an oath to serve in the best interests of our patients. The unintended consequences of the current practice of prior authorization for generic medications for addiction treatment can be deadly. Twenty-one states and the District of Columbia have enacted laws that limit insurers from imposing prior authorization on SUD service or medication. Since 2019 alone, 15 jurisdictions have enacted such laws. This includes many of our Midwestern neighbors, like Missouri, Iowa, going all the way down to Arkansas. Many national commercial insurers have also eliminated prior authorization for MAT. Unfortunately, less than 10 percent of people with SUD receive treatment and only a fraction of treatment facilities offer medications for addiction, which is a first-line treatment for SUD. Time and time again, we've seen evidence that medication helps reduce illicit drug use and overdose deaths, improves retention and treatment, and reduces HIV transmission. In particular, patients on Medicaid who receive medication have been shown to have a 50 percent lower risk of relapse, and their healthcare expenses are hundreds of dollars lower than if treated without medication. In closing, I'd like to reiterate that we at the Nebraska Medical Association and Nebraska Psychiatric Society are in strong support of LB413 and the safe, effective patient care it will provide for Nebraskans. Thank you for your time, and I'm happy to answer any questions you may have.

ARCH: Thank you for your testimony. Are there questions this morning? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thanks for being here. Just want to make sure I heard correctly, you prescribed the generic and it was rejected because they needed to take the expensive drug first.

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ALENA BALASANOVA: Correct.

M. CAVANAUGH: OK, just-- I wasn't--

ALENA BALASANOVA: That is the current policy.

M. CAVANAUGH: OK, just thought that I maybe misheard. Thank you.

ARCH: Other questions? Yes, that is-- the default is brand name in our, in our-- both our psychotropic as well as substance abuse formula, is that not correct?

ALENA BALASANOVA: I believe so.

ARCH: Yeah. Could you, could-- help me understand where are the substance use treatment programs in Nebraska? Who, who, who operates those currently?

ALENA BALASANOVA: Well, there's a variety. The nice thing about opioid use disorder treatment is that actually any physician who has the DATA 2000 Waiver can prescribe buprenorphine/naloxone. So you don't have to be a special program. You can just go to your regular doctor and actually receive this kind of treatment. In terms of like intensive rehabilitation programs, there are several. You know, there's CenterPointe is one that I'm familiar with in both Lincoln and Omaha that does prescribe this medication as well.

ARCH: OK. All right, thank you. Thank you very much for your testimony. Next proponent for LB413.

***DAVID SLATTERY:** Chairman Arch and members of the Health and Human Services Committee. I am David Slattery, Director of Advocacy for the Nebraska Hospital Association (NHA). I am expressing the NHA's SUPPORT for LB413 introduced by Senator Anna Wishart. LB413 requires that medical assistance shall include coverage for health care and related services as required under Title XIX of the federal Social Security Act, including medications for substance use disorder treatment. Based on the increasing long term mental health concerns, the NHA would like to see expanded coverage for all mental health disorders, whether it is coverage for medication or access to mental health care. Behavioral health continues to be an under-resourced service. The NHA was disappointed that rate increases for inpatient hospital providers and Psychiatric Residential Treatment Facilities (PRTF)were excluded from

Senator Bolz's LB1100 last year. That bill would have reimbursed those providers a 15% increase or more for rates paid by the Division of Behavioral Health for behavioral health and mental health services. Roughly 6% of children in the United States, ages 6 through 17, are living with serious emotional or behavioral difficulties, including children with autism, severe anxiety, depression and trauma-related mental health conditions. In Nebraska, 25% of high school students reported feeling depressed within the last year, and about 15% of high school students reported they considered suicide. The COVID-19 pandemic created and will continue to create long term mental health disorders. Statistics show that the pandemic increased suicides, drug use, alcohol use, and other harmful behavior. Many of these substance use abusers end up in either our emergency departments or in police custody. The NHA wants to thank Senator Wishart for introducing this legislation and we ask the Committee to advance the bill. Thank you for your consideration.

***BOB HALLSSTROM:** Senator Arch, members of the Health and Human Services Committee, my name is Robert J Hallstrom and I submit this testimony as registered lobbyist for the Nebraska Pharmacists Association. The Nebraska Pharmacists Association represents pharmacists, interns, and technicians in all areas of practice in Nebraska. The mainstay of substance use disorder is outpatient treatment with counseling and medication therapy. The Nebraska Pharmacists Association supports LB413 as it will increase access and treatment options for patients with substance use disorder and reduce treatment delays. For these reasons, the NPA would respectfully request that the Committee advance LB413 for further consideration by the full legislature.

***DAVID MIERS:** Dear Members of the Health and Human Services Committee: My name is Dr. David Miers, PhD., LIPC, Vice President of Acute Care Services for the Nebraska Association of Behavioral Healthcare Organizations (NABHO). I am writing this testimony in support of Senator Wishart's bill LB413. NABHO agrees that all current and new formulations and medications approved by the federal Food and Drug Administration for the treatment of opioid-use disorder be covered by Medicaid and Heritage Health. In mid-August 2020, the Centers for Disease Control and Prevention (CDC) published the results of a survey conducted in late June of 2020 that revealed just how serious the psychological and emotional impact of the Coronavirus pandemic is for Americans from all walks of life. The survey showed that reports of

anxiety disorder symptoms were about three times those reported in the second quarter of 2019 (25.5% versus 8.1%), and depressive disorder was about four times that reported in Q2 2019 (24.3% versus 6.5%). CDC also said 13.3% of respondents reported starting or increasing substance abuse (including drugs and alcohol). In addition, Public health officials across the country reported spikes in drug overdose deaths during the COVID-19 pandemic, with more than 30 states reporting increases in opioid-involved overdose deaths. Additional therapeutic approaches to assist individuals who need treatment are needed such as Medication Assisted Treatment. The National Council for Behavioral Health Care Organizations affirms that Medication Assisted Treatment (MAT) bridges the biological and behavioral components of addiction. Research indicates that a combination of medication and behavioral therapies can successfully treat substance use disorders and help sustain recovery. MAT utilizes a multitude of different medication options that can be tailored to fit the unique needs of the patient. MAT is evidence-based and is the recommended course of treatment for opioid addiction. American Academy of Addiction Psychiatry, American Medical Association, The National Institute on Drug Abuse, Substance Abuse and Mental Health Services Administration, National Institute on Alcohol Abuse and Alcoholism, Centers for Disease Control and Prevention, and other agencies emphasize MAT as first line treatment. LB413 gives a clear message to insurers and third party payers that in Nebraska we expect Medication Assisted Treatment to be readily available for substance use clients without burdensome authorization processes or restriction of which medication our providers may prescribe due to coverage limitations. This bill will improve access to an important element of care for these clients. NABHO supports expanding coverage of substance use treatment options so that substance use and mental health are covered equally by Medicaid and Heritage Health across all ages and all levels of care for all Nebraskans. Thank you for all that you do for our great state.

***ANDREA SKOLKIN:** Good morning, Chairman Arch and Members of the Health and Human Services Committee, my name is Andrea Skolkin and I am the Chief Executive Officer of OneWorld Community Health Centers in Omaha. I am submitting this written testimony on behalf Health Center Association of Nebraska, representing the seven Nebraska Federally Qualified Health Centers. We are pleased to support of LB413, which would ensure access to substance abuse treatment and medications through the Medicaid program. We thank Senator Wishart for introducing

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this important legislation. Nebraska's Federally Qualified health Centers are an essential part of the healthcare safety net for low income Nebraskans. FQHCs provide primary medical, dental and behavioral health care, as well as enabling services like transportation and translation services, regardless of insurance status or ability to pay. Nearly 50% of health center patients are uninsured and uninsured and underinsured patients contribute to the cost of their care based on a sliding fee scale. In 2019, FQHCs provided substance abuse services on nearly 20,000 visits. Access to substance abuse services and medications is a critical need in our community. According to a December CDC report, nationwide there were over 81,000 overdose deaths in the 12 months leading up to May 2020. This is the largest number ever for a 12-month period and data indicate that the COVID-19 pandemic has only increased these numbers. Statewide in 2019, FQHCs had 10 providers with DATA waivers, allowing them to use Medication Assisted Therapy to treat opioid use disorders. Medication Assisted Therapy is a proven way to reduce deaths, and help patients recover to lead healthy, productive lives. Reducing barriers to accessing these services is essential to help stem the tide of the opioid epidemic. The Health Center Association of Nebraska strongly supports efforts to reduce barriers to accessing substance abuse treatment. Again, our sincere thank you to Senator Wishart and each of you for your continued engagement. We welcome the opportunity to work together td improve the lives and health of all Nebraskans.

ARCH: Is there anyone that would wish to testify in favor of LB413? Are there any opponents for LB413? Good morning.

CARISA SCHWEITZER MASEK: Good morning.

ARCH: You may begin.

CARISA SCHWEITZER MASEK: Good morning, Chairperson Arch and members of the Health and Human Services Committee. My name is Carisa Schweitzer Masek, C-a-r-i-s-a S-c-h-w-e-i-t-z-e-r M-a-s-e-k. I'm a pharmacist, deputy director in the Division of Medicaid and Long-Term Care with the Department of Health and Human Services here to testify in opposition to LB413, which requires coverage by Medicaid of all FDA-approved medications used for substance use disorders without pro-- while prohibiting step therapy, requires Medicaid's contracted managed care plans that would have a process for SUD treatment, and prohibits lifetime dollar limitations. Federal regulations already

require Medicaid programs to cover all rebatable FDA-approved drugs used for SUD. Additionally, on December 30, 2020, CMS issued mandatory guidance requiring all states to provide Medicaid coverage of buprenorphine, methadone, and naltrexone, drugs listed in this bill and any counseling services and behavioral therapy associated with these drugs. Federal requirements are part of the Substance Use-Disorder Prevention Act, known as the SUPPORT Act. Step therapy ensures state safe use of these medications that could cause harm, fatal outcomes, or addiction. To allow for this, federal guidance states, under the new mandatory benefit, various considerations affect which medication should be used for a particular patient. Many federal agencies oversee drugs in this bill, mainly the Substance Abuse and Mental Health Services Administration, known as SAMHSA, Drug Enforcement Agency, and the Department of Justice. As a result, federal requirements supersede many changes in this bill. These agencies decide who can prescribe these drugs and set patient limits. As an example, to prescribe buprenorphine, a physician must obtain a waiver from the DEA and there are federal limits on the maximum number of patients the doctor can treat with buprenorphine. This maximum number is not just Medicaid patients, but all patients treated by that physician. The majority of providers in Nebraska who have met the requirement can only treat 30 patients. The Medicaid program would not be able to control or change this federal requirement regardless of this legislation. Federal guidance around these drugs continue to change. On January 14, 2021, the federal Department of Health and Human Services announced it would exempt some physicians from needing the waiver to prescribe buprenorphine. That exemption has since been determined by SAMHSA to be premature and not implemented at this time. Nebraska Medicaid recently received approval from CMS for a substance use disorder program, which provides treatment, medication, counseling, vocational and educational assessments, along with other behavioral therapies, for opioid use treatment. Nebraska Medicaid is in the final stages of implementing this service, allowing the division to reimburse for services that CMS normally does not cover. This approval expands access to care by allowing Medicaid to pay for treatment in a facility that has more than 16 beds and no longer limits Nebraska Medicaid on the number of days that can be reimbursed. Normally, CMS limits the number of days of treatment to 15 days for SUD in these facilities for patients between the ages of 21 and 64. With reference to the process requirements of the bill, managed care plans are required by their contract to close any coverage gaps. The

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December 30, 2020 federal guidance expects states to conduct provider outreach and enrollment to meet new requirements of medication assisted treatment, making the provision in the bill about covering out-of-network services unnecessary. Regarding the payment-related requirements of lifetime limits on coverage of cost-sharing requirements for SUD drugs, Medicaid would note that neither of these provisions are applicable to our program. There are no lifetime coverage limits for Medicaid services so long as the individual remains Medicaid eligible. Lifetime coverage limits are more typical to commercial insurance. Finally, Nebraska Medicaid has a strong continuum of care for SUD treatment currently in place. By implementing the SUPPORT Act and our SUD Demonstration Waiver, we are expanding this continuum of care further. We have been able to do this, in part, due to our comprehensive managed care system, as SUD treatment includes elements of physical health, behavioral health, and pharmacy services, all of which are included in managed care. In summary, LB413 duplicates some federal regulations around medications listed in this bill and is superseded by others. It also duplicates some current practices in the Medicaid program. For these reasons, we respectfully request the committee not advance this legislation. Thank you for the opportunity to testify today. I'd be 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. So from, from, from your perspective, with the changes that have come into play in December and early January, many of the provisions of this legislation you think are, are covered either federally or with the new guidelines?

CARISA SCHWEITZER MASEK: Correct.

WILLIAMS: One of the things that always gets us, that affects me, at least, when I sit here and hear stories, our first testifier talked about a person that had an opioid disorder and was denied the access to the drug that was prescribed. Does that particular circumstance that was described in her testimony, is that taken care of with the changes that have happened in December and January?

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CARISA SCHWEITZER MASEK: Very good question. In that circumstance, they spoke directly to a specific drug, Suboxone or buprenorphine/naloxone. With that drug, Medicaid has to look at, and across all drugs, we have to look at net cost. And there are federal rebates that are applied to certain drugs that make a significant difference in the cost of care to Medicaid patients. So what Medicaid does in order to help facilitate an understanding of providers of what can be covered without a PA and what requires PA, we publish a preferred drug list. So before the provider even prescribes the drug, they can look on that list and know if they need to submit a PA, and they can submit a prior auth at the same time that they write the prescription for the drug.

WILLIAMS: So if that circumstance were to happen today, the prescribing doctor would know which drugs needed a pre-authorization, which ones didn't, and would there, in your judgment, have been a, a drug that could have been prescribed for that situation, that would not have required a pre-authorization?

CARISA SCHWEITZER MASEK: Yes.

WILLIAMS: Thank you.

ARCH: Senator Cavanaugh.

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

CARISA SCHWEITZER MASEK: Thank you. Nice to see you.

M. CAVANAUGH: A lot of information in your testimony, so I'm trying to kind of catch up here. But one of the things you said sort of at the end is this bill, the federal regulations around this, it duplicates something like regulations and is superseded by others. Did you provide the information of what was superseded by other federal regulations to Senator Wishart?

CARISA SCHWEITZER MASEK: I don't believe that that was provided prior.

M. CAVANAUGH: Because that seems like an issue that can be resolved through an amendment. Did you have any communication with Senator Wishart's office about any of these things that could be fixed or addressed?

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CARISA SCHWEITZER MASEK: There was minimal communication just to let Senator Wishart know what the position of the department would be.

M. CAVANAUGH: OK. Well, it's, it's helpful to have that communication in advance so that these things can be addressed before the hearing because some of these things seem like sort of technical changes that likely could, could be addressed. So I think I'm not going to speak for Senator Wishart, but she's nodding in her head, I think she probably would appreciate that communication.

CARISA SCHWEITZER MASEK: We, we agree.

M. CAVANAUGH: And then to the, kind of following up on Senator Williams' question, that what we heard from, from the previous testifier was the issue of coverage. And this, as, as I read it, seeks to eliminate that pre-authorization step. What, what is the issue that the department has on eliminating the pre-authorization for Medicaid patients?

CARISA SCHWEITZER MASEK: So in order to provide coverage for the largest number of patients and manage the expenditure for Medicaid patients, there are prior authorization or step therapy methods that are utilized, not just Medicaid, but across all insurance plans to, number one, ensure safety. Some of these drugs, not only are risky, they lead to some respiratory depression, which you can see at high doses. Some of these drugs also have an addiction potential. They just do. They are used for substance use disorder, but they also have an addiction potential.

M. CAVANAUGH: So is the-- are the people that are evaluating the pre-authorization? Are they medical experts in that field? Because the people prescribing them are.

CARISA SCHWEITZER MASEK: Yes.

M. CAVANAUGH: So what is the credentials of those that are reviewing the authorization request?

CARISA SCHWEITZER MASEK: Yeah, good question. The prior authorization criteria are set by medical professionals.

M. CAVANAUGH: OK, so there's-- but who-- who's reviewing that? Are medical professionals reviewing?

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CARISA SCHWEITZER MASEK: So when the initial prior auth comes through, it is reviewed by a nonmedical professional against the medical professional criteria to make sure that it matches or meets that criteria. And then if there is a denial, then the prescriber can speak to a medical professional to explain why they--

M. CAVANAUGH: But--

CARISA SCHWEITZER MASEK: --want to go against [INAUDIBLE].

M. CAVANAUGH: Isn't the prescriber a medical professional that would know what those criteria are? And we're questioning their judgment by requiring a pre-authorization to be reviewed by a nonmedical professional? I, I-- it seems-- I'm sorry, I, I just feel like we're adding layered steps here to get to the same point.

CARISA SCHWEITZER MASEK: Yeah, the clinical criteria that's required for a prior authorization is defined by medical professionals and it's published and readily available for prescribers so they can reference that clinical requirement. And then if in their judgment, they decide that that clinical requirement does not meet the needs of their patient, they can prescribe what they feel is best and at the same time, submit a prior auth.

M. CAVANAUGH: Thank you.

ARCH: Other questions? Senator Walz.

WALZ: Thank you. I'm just going to follow up on Senator Cavanaugh and Senator Williams' questions. How long should it take for them to get the prior authorization?

CARISA SCHWEITZER MASEK: Twenty-four to 48 hours.

WALZ: OK. Twenty-- twenty-four to 48 hours?

CARISA SCHWEITZER MASEK: Um-hum.

WALZ: All right, thank you.

ARCH: Any other questions? I, I have one. Back to the prior authorization just for a second. Seems to be our focus. What, what

requires prior authorization? Do all prescriptions require prior authorization? What, what requires prior auth?

CARISA SCHWEITZER MASEK: No, sir. All prescriptions do not require prior authorization.

ARCH: OK.

CARISA SCHWEITZER MASEK: Prior authorization is leveraged in two ways, and it does make it very, very complex when you have a broad bill in this manner. And even just focusing on the SUD drugs, they're-- that is a, a wide variety of drugs. And there are prior authorizations sometimes where it's the generic instead of the preferred because it's a cost difference. There might be times where it's the preferred over the generic because of federal rebates that actually-- or the brand over generic because the federal rebates actually provide the Medicaid program the opportunity to put the brand on the preferred which other insurance companies cannot do. And sometimes prior authorizations are used for safety issues. There are drug limitations, maximum dose limitations, age limitations, contraindications, addiction potential of these drugs. Prior auths are used for all of those purposes.

ARCH: And the physician, the prescribing physician, knows what requires prior authorization and what does not?

CARISA SCHWEITZER MASEK: Yes, Nebraska Medicaid publishes our preferred drug lists with the prior authorization criteria.

ARCH: OK. Thank you.

CARISA SCHWEITZER MASEK: Um-hum.

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

CARISA SCHWEITZER MASEK: Thank you.

***JAMES WATSON:** Chairman Arch and Members of the Committee, Good Morning. 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 before your committee. I am here to respectfully express the

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Association's opposition to Legislative Bill 413 (LB413) as a measure which would conflict with the existing contractual provisions between Medicaid and Long-Term Care ("MLTC") and the Managed Care Organizations ("MCOs") serving Medicaid clients. MLTC has been delivering Medicaid services through a managed care delivery system since 1996. Currently a statewide program, the Heritage Health written contracts with the MCOs consist of over 2000 pages of detailed requirements and oversight. LB413 is primarily directed at two areas that are covered in those contracts i.e., medications for substance use disorder treatment and the adequacy of provider networks to treat substance use disorder. Regarding medications, MCOs serving Medicaid are contractually obligated to follow the Nebraska Medicaid Preferred Drug List ("PDL"). MLTC manages the opioid dependance drugs within the PDL as a managed drug class, including any permissible quantity limits and prior authorization requirements. MLTC, in conjunction with its Pharmacy and Therapeutics Committee comprised of Nebraska pharmacy providers, governs content of the PDL. Currently, the years proven therapy of choice is brand name Suboxone. This is available on the PDL. Other non-preferred therapies are also available using the prior authorization process. In contrast, §3(6)e) of LB413 decrees that step therapy or other utilization management strategies are prohibited if such interferes with a prescribed course of treatment by a "licensed physician or other health care provider". NAMHP believes this is a drafting error since the legal requirement is for the prescriber to be an X-waivered provider. Additionally, this section also includes services provided in conjunction with SUD treatment which is overbroad. Prior authorization for behavioral health services is not intended to limit care but instead can be helpful to consumers, helping to provide safe and appropriate care outside of medication. Examples would include Electroconvulsive therapy and Ketamine. To be clear, prior authorization requirements help to manage costs and contribute to optimal resource stewardship. Moreover, the prior authorization process can provide confirmation that only safe, effective, and appropriate treatment will be provided to the patient, based on scientific evidence. This function of the prior authorization process is especially critical in areas where providers prescribe buprenorphine quantities beyond the FDA maximum to patients who then sell the medications to others. Prohibiting a managed care organization from recommending step-therapy or other DUR strategies eliminates the MCO from managing patient safety. Each MCO has safety edits in place to ensure that the patient's care is appropriate.

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Additionally, processes are in place to collaborate with the behavioral health provider to ensure the course is appropriate. A second concern that LB413 seeks to address is that of network adequacy and SUD treatment providers. Section 3(3) requires that an MCO make other provider arrangements if a buprenorphine waivered provider or SUD treatment program is not available without unreasonable travel or delay. In contrast, the contract between the MLTC and the MCOs stipulates that the MCO must contract with an adequate number of behavioral health providers to meet the needs of its members and provide a choice of providers according to distance requirements for urban, rural and frontier counties. If the requirements cannot be met, the agreement directs the MCO to utilize telehealth options, which NAMHP suggests is a better solution. There are 120 waivered prescribers in Nebraska, with the majority in Omaha and Lincoln. It is better to resort to a known adequacy solution already found in the MCO contract than to require what is a more general rule set forth in LB413. In summary, NAMHP believes the current MCO contracts with MLTC already provide a pathway to resolve any issues regarding prescribed medications to treat SUD, as well addressing any issues regarding network adequacy with waivered prescribers. LB413 would only serve to create avoidable conflict between the MLTC/MCO structure which will not serve Medicaid clients in the end.

ARCH: Other opponents for LB413? Seeing none, is there anyone that would like to testify in a neutral capacity for LB413? Seeing none, Senator Wishart, you are welcome to close. And while you're coming up, I would note that we had, we had five written testimonies submitted this morning regarding LB413: one was from David Slattery on behalf of Nebraska Hospital Association, a proponent; Bob Hallstrom on behalf of the Nebraska Pharmacists Association, a proponent; David Miers, Nebraska Association of Behavioral Health Organizations, proponent; Andrea Skolkin, Health Center Association of Nebraska, proponent; James Watson, Nebraska Association of Medicaid Health Plans, opponent. And we had no letters of record.

WISHART: OK, well, thank you so much, Chairman Arch and, and members of the committee. I-- if you will recall, I think it was last year, I worked on kind of similar legislation when it deals with people getting efficient access to the medications that they need. In this case, lifesaving medications. And the issue came to me because there are people where the system is just not working. And so there needs to be a way to make sure that it is. I worked with the director of Health

and Human Services. We, we figured out a compromise. I'm, I'm happy to do that again. For me, the main thing is I understand that managed care has a lot of beneficial services for people with substance use disorder. But when I hear a person who is in desperate need of help and has taken that step to meet with a medical provider, which is a very important step, and they are not able in a timely fashion to get that person the specific medication that they need. And I understand there's a preferred drug list, but individuals have different individual needs. And this physician needed to get this patient this medication, and it took a week to get him that. That's, that's a problem. I understand Health and Human Services, and don't envy you for the complexity of healthcare systems. But from an outsider's perspective, as a senator, the basic fundamental responsibility is that people get the timely care that they need so that we reduce the fallout that occurs when that doesn't happen. So I really do want to move forward with this bill, work with the department, work with other stakeholders to try to find a way that we can create a more effective system for substance use disorder. Twenty-one other states and growing have, have moved down that route. I hope we do, too. And I'll take any follow-up questions.

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

M. CAVANAUGH: Thank you. Thank you, Senator Wishart, for this bill. So the managed care-- I, I heard Senator Arch mention that they sent a letter in opposition and it, it sounds like some of the stuff with the department is some technical language that you've kind of indicated if you want to "reindicate" that you are interested in working on, but the managed care seems to oppose this. And it, it seems they work for us. Right?

WISHART: You know, last year it took me several years to get the other piece of legislation across the finish line for a constituent of mine in terms of mental illness medication. And at first managed care entities came in opposed and we sat down and, and we worked and negotiated. Your legal counsel was very helpful on that as well. And so I anticipate to circle back around with them. This is the first that I have heard from them being in opposition. But they, they-- it has been a delight to work with them in the past on this. And so I hope moving forward we'll find a solution.

M. CAVANAUGH: Terrific. Thank you.

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ARCH: Thank you. Any other questions? Seeing none, thank you very much. This will close the hearing on LB413. And I will turn the hearing to Senator Williams.

WILLIAMS: Good morning again. Our next bill is LB400 to change requirements related to coverage of telehealth by insurers and Medicaid. And it's a bill brought to us by Chairman Arch. Chairman Arch, you're welcome to open.

ARCH: Thank you. And good morning, Senator Williams, members of the Health and Human Services Committee. For the record, my name is John Arch, J-o-h-n A-r-c-h, and I represent the 14th Legislative District in Sarpy County, and I am here today to open on LB400. LB400 is a result of a comprehensive interim study I introduced regarding the role of telehealth during the COVID-19 pandemic. That study was the subject of a virtual public hearing in front of this committee on December 15. My primary objective with the study was to identify the practices and regulations that have been adjusted during the public health emergency in order to effectively meet healthcare needs. As part of the study, my office conducted two different surveys, one focused on the utilization of telehealth, and the other focused on regulations. Of course, at the onset of the pandemic, we saw that the utilization of telehealth services increased dramatically. That survey, which involved commercial insurer carriers, the state of Nebraska, University of Nebraska and the Medicaid program showed claims for telehealth visits for a three-month period in 2020 jumped by the thousands when compared to the same three-month period in 2019. For example, in March, April, May of 2019, the University of Nebraska Health Plan recorded 139 telehealth visits. In 2020, the same period of time, that number rose to 10,351 visits, which equates, do the math, a 7,447 percent increase in telehealth utilization. While more healthcare services are again being delivered in person, providers and patients have embraced telehealth. The benefits of telehealth and the role of telehealth and the practice of telemedicine can, can play in delivering healthcare services have been recognized and telehealth will be a part of our healthcare system going forward. As I said, the second part of the study centered on regulations, and my ultimate goal of the study was to identify the regulations that have been waived in response to COVID and those that should remain suspended into the future. We asked a varied group of stakeholders to identify regulations that presented barriers to utilizing telehealth, and the response was great. There are a lot of people interested in this

issue. We received feedback from 23 different associations and their members, including the insurance industry, the MCOs, hospitals, health centers, physicians, behavioral health providers, speech language therapists, occupational therapists, and pharmacists. Most of the restrictive regulations, unfortunately, exist at the federal level. Since the onset of the pandemic, the federal government has adopted 135 temporary changes with respect to telehealth services. However, I found relatively few adjustments were made with respect to Nebraska's telehealth regulations. Medicaid did adjust some billing codes to allow for the reimbursement of additional services, including dental triage, physical, occupational, and speech therapies in behavioral health. But overall, the amendments we have adopted over the years since the enactment of the Nebraska Telehealth Act put the state in a great position to quickly shift to delivering healthcare services via telehealth. So the number of regulations in our state compared to other states on telehealth, we didn't find that many. I asked on a number of occasions to the Department of Health and Human Services if the federal government allows us to do it, do we allow it? Are we more restrictive? And the answer kept coming back, if they allow it, we, we allow it. So as I said, the second start-- the second part, oh, I'm sorry, there were a few areas that were identified that can be changed and those are addressed in this bill, LB400. First, the bill will, will amend the Telehealth Act, which dictates telehealth parameters for the Medicaid program. Currently, the act requires a provider to give a patient certain written information prior to an initial telehealth consultation and requires the patient to provide a written statement prior to the consultation, that he or she understands the information the provider has provided. LB400 would allow for a patient to have the option to give verbal consent in lieu of the written consent during the telehealth-- that first telehealth consultation. If verbal consent is given, the, the signed statement from the patient must be collected within ten days. So it still requires the collection of that written confirmation, but not before the visit can occur. The bill would allow the patient to sign the consent statement via electronic signature. LB400 would also eliminate a requirement that insurers demonstrate compliance with the signed written consent requirement. Both these sections of the law have been waived during the pandemic, and these are requirements that have been shown to be unnecessary barriers. Second, LB400 would prohibit insurers from excluding coverage solely because a service is delivered through telehealth, including services originating from any location where the

patient is located. The originating site requirement was one of the top areas of interest identified by the study stakeholders. The Telehealth Act already allows for the delivery of telehealth services, regardless of the patient's location or originating site. So for Medicaid. And most insurance providers do not take originating site into consideration. However, there was a time in the past when a patient had to go to a clinic or like place, hospital, in order to access reimbursable telehealth services. We want to ensure that we don't go backwards and that this is ever able to be a requirement again. So I thought it best to put the prohibition directly into statute. So in particular what this originating site, a clause does, is it, is it ensures that a patient can receive care in their home. That's really what it addresses versus having to drive. And, and I, I put the originating site requirement in here understanding that the provider, the physician, whomever the provider might be, has that medical judgment to determine whether or not that's appropriate. There may be times when the patient does need to travel to a clinic. The, the physician needs vital signs. The physician needs some type of a-- of-- of a, of a nurse, for instance, to, to take a look at the patient and to talk to the physician about, about their observation. So there may be times, but there are other times when that's not necessary and in that I felt as though that should be left to the medical judgment of the provider. Finally, the definition of telehealth in the Nebraska Telehealth Act and in provisions of statutes covering commercial insurers is amended to include audio-only services for the delivery of behavioral health services only. So audio only. Just pause there for a moment. So in other words, that, that a provider would be able to provide services for behavioral health using just a phone without the video connection, but just for behavioral health. Limited broadband in some areas and limited access to technology has led Medicaid and commercial insurance to temporarily reimburse for some services delivered through audio-only means or the telephone. This, too, is one of the top areas of interest for those in the survey group. I decided to limit the use of audio only to behavioral health services as I see those services that can actually be delivered effectively through the telephone. I do know that the Department of Health and Human Services is coming in opposition to this bill based on a concern with this provision. The department has communicated to me it believes this section is written too broadly with respect to what is meant by behavioral health, which services can be audio only. There may be behavioral health services for which use of audio only is not

practical, and there may also be issues with federal government prohibitions. So I've agreed to work with the department to better define the types of behavioral health services that would be allowed to utilize audio only. I also have a companion bill, LB463, which is in the Banking, Commerce and Insurance Committee dealing with payment parity for behavioral health services. I've introduced that bill to the committee already and I've been asked how that payment parity bill and the audio only allowance will be reconciled if both bills pass. So I need to have further discussions regarding that as well. This bill will need an amendment, but I think it is an important bill and I am committed to working with interested parties to get LB400 in shape for it to be advanced to General File. And with that, I will close on my opening. Be willing to answer any questions you might have.

WILLIAMS: Thank you, Senator Arch. Questions for the senator? Senator Walz.

WALZ: Thank you, Senator Williams. And thank you, Senator Arch, for bringing this very important bill. I'm just curious audio only or the other options are?

ARCH: Video and audio.

WALZ: Right.

ARCH: So FaceTime, whatever, whatever that, whatever, whatever software they're using, it would have both video and audio.

WALZ: Right. OK. And you don't see any cost difference regarding--

ARCH: No, I don't see.

WALZ: --whether or not they use audio or video or Zoom?

ARCH: No. No, that was one of the questions and that was my last comment about this payment parity bill that I have in Banking and Insurance and how exactly that's going to connect to audio only. So that'll be part of the discussion. But this-- I, I don't see a cost difference for them.

WALZ: OK, thank you.

ARCH: Yeah.

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WILLIAMS: Other questions? I just have one just for, just for clarification--

ARCH: Sure.

WILLIAMS: --here and you mentioned LB463 in front of the Banking Committee.

ARCH: Um-hum.

WILLIAMS: The elephant in the room with telehealth has generally been payment parity.

ARCH: Um-hum.

WILLIAMS: The bill that we are looking at here, LB400, in front of HHS, doesn't deal with the actual payment itself, is that correct?

ARCH: That is, that is correct. That is correct. The actual payment.

WILLIAMS: Yeah.

ARCH: It requires payment, but it doesn't deal with the actual payment.

WILLIAMS: Right. Just wanted to make that distinction. So as a committee, we're not trying to determine in here the issue of payment parity--

ARCH: That is correct.

WILLIAMS: --kind of an issue.

ARCH: That is correct.

WILLIAMS: Thank you.

ARCH: Um-hum.

WILLIAMS: All righty. Thank you for your opening. We would invite the first proponent to come and testify. Welcome to HHS.

ANDREA SKOLKIN: Thank you. Good morning, Vice Chairman Williams and members of the Health and Human Services and Chair-- Chairman Arch. My

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name is Andrea Skolkin, A-n-d-r-e-a S-k-o-l-k-i-n, and and I'm the chief executive officer of OneWorld Community Health Centers. I'm here today on behalf of the Health Center Association of Nebraska, representing the seven Nebraska federally qualified health centers. And I am pleased to speak in support of LB400 and thank Senator Arch for introducing this important legislation. Nebraska's health centers serve over a 115,000 patients in the state, providing primary medical, dental, and behavioral healthcare, as well as a number of enabling or support services like transportation, interpretation, translation, regardless of insurance status or ability to pay. Nearly half of health center patients are uninsured and uninsured and underserved patients contribute to the cost of their care based on a sliding fee scale. Nebraska health centers have increasingly used telehealth to respond to the COVID-19 crisis. In 2019, slightly less than one-half of 1 percent of health center visits were performed virtually. The majority of which were behavioral health. Since March 28, over 42 percent of health center visits have been performed virtually. Telephonic services were a crucial element of this service. Telephonic services have played a key role in maintaining access to behavioral health during COVID due to the extreme difficulty of our clients in accessing services with the shortage of behavioral health providers statewide. Ongoing therapy, addiction treatment services, and addressing the immediate impact of trauma and stress from COVID-19 are all areas in which we maximize the use of tele-behavioral health. We would also respectfully ask the committee to consider expanding the use of this telephonic support beyond behavioral health and into primary care as well. We have seen enormous benefit. Increased access to telehealth, and especially telephonic, has supported health centers' efforts to develop robust case management programs for COVID-positive patients, including wellness checks, follow up on remote monitoring through devices like pulse oximeters and blood pressure. Medication management and chronic disease management are other areas where access to telephonic services have been impactful. Lack of access to reliable transportation and technology are significant barriers experienced by our patients on a daily basis. Moreover, limited digital literacy and no access to adequate technology and scarce broadband resources can all be barriers to accessing telehealth for our patients. Digital barriers are more likely to impact racial and ethnic minority populations, people with limited English speaking proficiency, people at lower socioeconomic status, and individuals over 85, as well as people with different

abilities. Coupling demographic barriers with the fact that these populations are also more likely to suffer disproportionate impacts from COVID and chronic disease, the ability to deliver care telephonically is a lifeline for our patients and can play a key role in improving equitable access to care. Again, our sincere thanks to Senator Arch and each of you for your continued engagement and support of community health centers. We welcome the opportunity to work together to innovate how healthcare can be delivered to all Nebraskans. And I'm happy to answer questions.

WILLIAMS: Are there questions? Seeing none, thank you, Miss Skolkin. We'd invite our next proponent. Welcome.

REBECCA OHLINGER: Thank you. Thank you, Chairperson Arch and members of the Health and Human Services Committee for the honor to testify before you today on LB400. My name is Rebecca Ohlinger, R-e-b-e-c-c-a O-h-l-i-n-g-e-r, and I'm the manager of virtual care at Children's Hospital Medical Center, the pediatric safety net provider for children throughout Nebraska and the region, serving over 150,000 unique patients each year. I am also here to testify on behalf of the Nebraska Hospital Association. I want to say thank you to Senator Arch for giving us the opportunity to discuss how the current public health emergency amid a global pandemic has strengthened telehealth delivery in Nebraska. In order to effectively illustrate what is working, we need a quick history lesson on where we were before COVID-19 impacted our ability to reach patients. Telehealth is not a new type of medicine. It is simply a care delivery mechanism. It is one possible modality or a mechanism for delivering care, not a different form of care. It has grown as a strategic initiative to deliver high-quality care and increase access to care and will continue to be an essential tool for providers and patients to compliment the quality of care we provide in person with our clinics and hospitals. Despite the fact that no other developed country spends what the United States spends on healthcare, access to care remains an issue. Telehealth helps to provide better access to quality, convenient healthcare, while also keeping costs down and improving health outcomes and population health. It allows patients to access physicians and specialists located across the state while those patients remain in their own communities, surrounded by their own support systems. At Children's, many of our families, under the care of multiple pediatric specialists, often face a geographic burden of care as their complex chronic conditions require regular visits to Omaha. Over the last

three years, Children's has seen significant growth in telehealth. In 2018, we were proud to accomplish 1,800 visits, predominantly within child psychiatry, which was our first true experience in mobilizing telehealth opportunity. In 2019, our volumes grew to 2,300 with a goal to increase by 10 percent. In 2020 we completed over 50,000 visits. That's 2,000 percent growth. We now have over 32 specialties practicing telehealth alongside seeing patients in their clinic, including primary care, urgent care, PT/OT speech therapy, and with the ability to support over 192 languages. Our patient satisfaction scores suggest telehealth is now acceptable and preferred means to access a provider when medically appropriate. And that's the key phrase here, medically appropriate. Physicians receive and gather sufficient information needed to make decisions about care. This is actionable information and it warrants specific attention as it recognizes that providers might not always be able to make a diagnosis with a single visit, whether caring for a patient in person or via telehealth. After a complete evaluation in the ED, a patient may need lab testing, imaging, or a consult. The same is true for an outpatient setting. The same is also true for telehealth. The most important thing is that the provider recognizes whether they have sufficient information to determine the right next step, which is the actionable information. The most appropriate comparison is not the care of the patient would have received given the other alternatives, it is simply an in-person visit. For some patients, the alternative is no care at all. Maybe it's due to lack of access or avoidance of care because of a high deductible plan. Some patients may not be able to be treated by telehealth. They may require in-person care, or they might have to go to the ED or to an urgent care center. Others might have to go to a primary care office. The standard of care should be defined by the medical issue, by the provider, and whether or not care was delivered, not by whether it was done in person. Telehealth provides different and sometimes enhanced information. For example, the telehealth provider may see inside the home that the asthma exacerbation was actually due to a pet being in the home. They would have not gathered that from an office visit. The pandemic has changed our willingness to utilize telehealth, and it is difficult to imagine a future without these increased opportunities. It will always remain necessary for providers to see their patients. But if we are able to maintain the current allowances and flexibilities provided by the public health emergency, like the location of the patient, remove the consent form requirements, we will have our families and our population access to

care when they need it and where they need it. Hospitals and health systems and healthcare in general have transformed and are transforming and will continue to transform. Thanks to the constant evolution of technology, telehealth has transformed the landscape of how we care for our patients. Our providers and clinicians are in the business of making and keeping patients healthy. Innovation has fundamentally changed how we shop and bank, yet one of our most prized possessions, health, lags behind. We should use all tools made available to us in order to improve health. Telehealth is one of those life-saving and life-improving tools. One day, telehealth may simply be just medicine, just like telebanking is just banking. Thank you for your time and consideration, and I'm happy to answer any questions that you might have.

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

M. CAVANAUGH: Thank you. Thank you for being here. Did you know that Senator Williams is a banker?

REBECCA OHLINGER: No, I did not.

M. CAVANAUGH: I thought maybe that, that analogy was just for him. Thank you so much. I have benefited from the pediatric telehealth over the last several months and seen how it's worked with my children. And I appreciate your testimony today.

REBECCA OHLINGER: Thank you.

WILLIAMS: Seeing no additional questions, thank you for your testimony. We'd invite an additional proponent. Welcome to HHS.

CAROLE BOYE: Thank you. Good morning. My name is Carole Boye, B-o-y-e, and I'm coming to you today in my role as CEO of Community Alliance, which is a mental health agency serving adults with serious mental illness in Omaha and surrounding counties, and also representing the Nebraska Association of Behavioral Health Organizations, testifying in support of LB400. First, we want to add our thanks to you, Senator Arch, and to all of you on this committee for taking on the subject of telehealth and, and looking beyond the pandemic to what's, what's next. We all recognize that the use of telehealth services has grown exponentially since last March, and it's proven to be a lifeline during the pandemic for those in need of healthcare services, none

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more so than those facing mental health issues and substance use issues. We're appreciative and support the bill's provisions related to obtaining consent to services, not restricting telehealth service based on location of the patient and allowance for audio-only communication. We also want to offer some perspective and context about some concerns that have been raised and ask for your consideration of added language to further clarify and strengthen access to telehealth services. One significant point of concern is the applicability of this bill's provisions to the entire continuum of behavioral health services. The way the bill and statute is currently written could be read to limit the scope of telehealth visits primarily or perhaps exclusively to psychiatrists, psychologists, and licensed therapists. This was an interpretation applied by state regulators very early in the pandemic, then eventually relaxed as the result of advocacy and demonstrated need. Our behavioral health system is so much more than doctors and therapists. It also offers a wealth of rehabilitation and recovery-oriented services provided by trained, but not necessarily licensed, but trained mental health, substance use, and peer support workers. These services are the ones that help assure someone is taking their medicine, reporting side effects, helping with refills. They help the client work on and implement their relapse prevention plans. They practice to help practice personal and community safety and cope with the stress and anxiety of isolation. They are the workers who focus on the daily living skills and wellness strategies that help people sustain their recovery between doctor and therapy appointments. They perform well-checks and they reach out when we haven't heard from someone. Rehabilitation and recovery services have been shown to reduce hospitalizations, emergency room visits, and acute crisis. And they extend our workforce. Left unaddressed in this bill, consumers could again be restricted to receiving these services, only be a face-to-face interaction. We ask you to include language in Section 3 that makes clear that the provisions of the statute are also applicable to all nonresidential rehabilitation and recovery support services, both mental health and substance use that are already included within the Medicaid State Plan and DBHS service definitions. We see that CMS is relaxing rules. We know that, that Medicare has already made more than a third of the 144 services that were made eligible under telehealth under the emergency public health directive. Over a third of them have already been made permanent. We also note that the State Medicaid and CHIP Telehealth Toolkit has been issued by CMS for the specific purpose of promoting the ongoing use of

telehealth within, within services. And it includes provisions allowing or encouraging flexibility by states on both what types of services to cover and what types of practitioners or providers may deliver services via telehealth. I underscore this because we're looking to use public policymakers to help form our future telehealth policy and deflect efforts to erect statutory barriers diluting its transformative impact. We do not want, we should not have to be driven by prior federal and state practices, preconceptions, or interpretations. We all know that the pandemic has brought trauma and anxiety across all age groups, races, ethnicities, and socioeconomic levels. We know that where pre-pandemic statistics indicated that one in five citizens were experiencing mental health challenges, today that has grown to one in three. We need to make it easier, not harder, for Nebraskans to get the help that they need. We need to recognize that the more barriers we put up and the more we restrict access to services, whatever the modality, the more we are reinforcing already entrenched disparities and unnecessary costs. We urge you to advance LB400 with the added language requested. And again, we thank you for your efforts and your leadership in this area.

WILLIAMS: Thank you, Miss Boye. Are there questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thanks for being here this morning. Do you have any examples of how or data of how the telehealth has worked in your organization during the pandemic?

CAROLE BOYE: Thank you for that question. We, we clearly have data very similar to what in terms of utilization, very similar to what other organizations are reporting. The most difficult thing in-- is to measure what you've prevented. We can't tell you quantitatively how many lives have been saved, how many lives have been, have been helped by this. But we, we know we have done that. And, and if I could just give you a couple of examples of, of, of how we know that. And it also speaks to this whole thing about whether we should be including recovery services and rehab services and, and that type of thing. When we had to close our day rehab program early in the pandemic and pull, and pull back on face-to-face visits in people's homes and communities, we immediately set up staff to start calling people on a regular basis, well-checks, relapse prevention, all of those types of things. We tried telehealth where-- the virtual, the two-way audio visual, wherever we possibly could. For most of the people that we

see, didn't have tablets. Homeless people don't tend to have iPads sitting around. And those that did have tablets or even phones, the connectivity, the cost of connectivity was a, was a serious barrier. So we took to telephone calling where necessary, and our calling was very structured and very planned. I'm thinking of one person right now in terms of an example that we were calling regularly and then she stopped answering the calls. And after a very short period of time, we decided we needed to go knock on that person's door. And what we did was we found because we weren't able to maintain telephone contact, which is the only way that we could and on a regular basis, she was sick. She had COVID. We got her to the hospital. She was put on a ventilator immediately. She lived. A day later, she would not have lived. Telephone services at that point saved a life. We know that. How many of those can we measure? I don't know. Another example would be that we got a phone call. I, I actually got this phone call from a long-ago client that we served well into her 60s who said, Carole, I'm sitting at home. I'm doing all of the, all things I need to do. I'm in trouble. I need some help. I'm going down that dark hole again. And, and what can I do? She wasn't a preestablished patient any longer with that, but yet she was reaching out for help. The problem we had is: (a) she she wouldn't leave her home because of COVID; and (b) she doesn't have a computer. She doesn't have an email address because that's part of her illness. That's part of her paranoia. She can't-- she doesn't have digital access. She doesn't allow that in her life. So we set up a series of telephone calls, safe visits to her home, and eventually got her her need. Again, we know we prevented a hospitalization. We know we prevented somebody who had been in years in recovery from making a difference. But these are services also that rehab people did. Therapists and doctors don't go visit people at the home. They don't call them every other day to see how they're doing. We, we really want to encourage that. I'm sorry.

M. CAVANAUGH: No, that was--

CAROLE BOYE: Those are long stories.

M. CAVANAUGH: --very helpful. Thank you.

WILLIAMS: Any additional questions? Seeing none, thank you, Miss Boye.

CAROLE BOYE: Thank you.

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WILLIAMS: Invite our next proponent. Welcome, Senator Nordquist.

JEREMY NORDQUIST: Good morning. Good morning, Vice Chair Williams and members of the Health and Human Services Committee. Thank you for holding this important hearing today on Senator Williams' birthday. Happy birthday, Senator. I am Jeremy Nordquist, J-e-r-e-m-y N-o-r-d-q-u-i-s-t, Government Affairs Director for Nebraska Medicine. Nebraska Medicine is a nonprofit integrated healthcare system affiliated with the University of Nebraska Medical Center. We have over 9,000 employees, 1,000 affiliated physicians, and our providers perform over one million outpatient visits, and about 100,000 emergency room visits every year. Today, Nebraska Medicine offers our strong support for LB400. We are grateful to Senator Arch and his outstanding staff for their leadership on these issues and for working with providers to understand how we can best improve telehealth in our state. Telehealth is absolutely critical, and you all know this for the future of healthcare in Nebraska. Since the start of the COVID-19 pandemic, telehealth services have been a lifeline for Nebraskans in need of care. From border to border, Nebraska residents have been able to access primary care and specialist when in-person visits were not possible. In 2019, Nebraska Medicine performed around 2,400 telehealth visits. In 2020, we performed over 95,000 telehealth visits, reaching all corners of our state. Since the ramping up of telehealth early in the pandemic, our patient surveys consistently show patients are more likely to recommend telehealth than in-person visits and say that staff get to know them better through telehealth than in person. Moving forward, telehealth is not going to replace in-person healthcare, but it's a valuable tool needed for-- needed to care for all Nebraskans. LB400 makes three important changes to help accomplish this goal. First, it fixes written consent requirements with telehealth that does not make sense to require physical written consent. And previously it was not clear if electronic signatures were allowed. It also ensures that patients can be seen in their homes, at work or wherever is convenient for their busy lives. Convenience for the patient is probably the greatest benefit of telehealth. We also support adding audio-only services to the definition of telehealth. LB400, adds audio only for behavioral health services. Nebraska Medicine would ask the committee to consider broadening, as previous testifiers have said, broadening the definition to include physical health services. While audio only isn't ideal for forming new patient relationships, it can be very valuable for visits that require a

check-in to review lab results or to see how a post-operation patient is feeling. In cases like these, our providers are not using the video component of telehealth to make their medical decisions. One physician I spoke to frequently uses audio-only services for her elderly osteoporosis population. By phone, she can follow up to make sure the patients have not fallen recently, are getting enough calcium, and are tolerating their medicines. Another specialist recently had an audio-only visit with a seed store owner with diabetes. Medicare patients on insulin pumps need to be seen every three months in order for Medicare to keep providing their supplies. There was too much snow for the gentleman to make it to Omaha. So through the phone, they were able to discuss his blood sugar levels and provide the appropriate documentation needed for him to get his supplies from Medicare without interruption. Obviously, this bill just applies to Medicaid and commercial pay, but that's an example of how patients can benefit from those audio-only check-ins. Our providers don't want to replace in person or video telehealth with the phone. But not allowing phone visits entirely means we cut off access to very vulnerable populations, elderly, elderly citizens without Internet or technology capabilities, and patients from rural communities with limited or no broadband access that are already geographically isolated from where our healthcare providers are in the state. So with that suggestion, I thank the committee for your consideration and I'm happy to take any questions. There is-- I just want to point one piece of data that I got last night just to give you an idea of, of what these numbers are for us. This is from July 1, which is when our fiscal year started to last night. About 81 percent of our total visits since time have been in person, 15.5 percent have been telehealth video, and only 3.3 percent have been telehealth or through phone audio only. So it's even in the, the heat of the pandemic here, when we shifted a lot to, to telehealth, it isn't a, a huge amount and our physicians aren't going to, you know, replace other types of visits with the phone, but it is important for certain populations. So with that, happy to take any questions.

WILLIAMS: Are there questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here, former Senator Nordquist. It's nice to see you. I didn't recognize you with the beard. Do you know how many, if, if you've had fewer missed visits as a result of telehealth?

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JEREMY NORDQUIST: It does sound like, yeah, there is, there is more compliance with visits and appointments. I can get you the exact numbers on that. But that-- that's my understanding.

M. CAVANAUGH: Got it. Yeah.

JEREMY NORDQUIST: Yeah. And it, it really, you know, I know in parity, we talked a lot about kind of the cost to the provider and, and really for our physicians, you know, walking down the hall between room to room versus clicking on a link, there isn't that much difference in, you know, the time they spend with the patient. The time they spend preparing for a visit, looking over, documenting, that's all the same. But the convenience really is on those individuals. And we had to testifier in Banking last-- earlier this week on parity. She does diabetes management and she was talking of teachers who from rural Nebraska who can click in after school, homeschooling mothers who, you know, find time in their busy families, so really for people who are living busy lives and, and don't have to drive in, you know, for visits that aren't necessary. It's a huge, huge benefit.

M. CAVANAUGH: Thank you.

WILLIAMS: Additional questions? Seeing none, thank you--

JEREMY NORDQUIST: Thank you.

WILLIAMS: --for your testimony. We'd invite any additional proponent. Good morning and welcome to HHS.

JULIE STEINMEYER: Good morning. Thank you for having me this morning, Senator Arch and members of the Health and Human Services Committee. My name is Julie Steinmeyer. J-u-l-i-e S-t-e-i-n-m-e-y-e-r, and I am currently the legislative chairperson for the American Physical Therapy Association, Nebraska Chapter. I'm speaking on behalf of the Nebraska Chapter and I am here to testify in support of LB400. I would encourage you to consider the addition of all video and audio and other telehealth services so that physical therapists and other rehabilitation professionals can continue to serve Nebraskans who would likely not have access to care. We currently have full capacity to evaluate and treat a patient using audio and visual technology due to the public health emergency. We believe we have demonstrated the value of telehealth as a tool to provide medically necessary and

skilled therapy services. I've been a physical therapist for 25 years. The last 16, I've spent most of my time traveling across rural Nebraska, caring for our community's elderly population. I believe that in the wake of the COVID-19 pandemic, our profession has seen some amazing growth and opportunity to allow access to physical rehabilitation to our Nebraskans that otherwise would have been isolated and not received adequate care. In fact, as a therapy manager for nine facilities in rural Nebraska, I am witnessing better access than ever before. We have locations in Franklin, Ord, Madison, Fullerton, Hartington, O'Neill, and Neligh, to name a few. Our rural communities are vastly underserved for rehabilitation services across the state due to most of our providers being located near or in Lincoln and Omaha. Our rural providers are often overworked, understaffed, and traveling between multiple facilities to ensure at least some coverage can be provided. Many evaluating therapists are having to minimize services due to the extensive travel time between facilities and are often unable to ensure visits with the inconsistency of weather conditions, emergency situations, and most recently with the COVID-19 restrictions. As policies have been modified during this public health emergency due to the COVID pandemic, rehabilitation providers have been given the privilege to utilize telehealth for the first time in history. Telehealth has given therapists the opportunity to serve the underserved population of Nebraska. We are currently able to access residents in nursing homes, assisted living facilities, and that are isolated at home that have not had any consistency in therapy services for years. My company recently acquired a facility in, in Ord, Nebraska, and there is only one therapist, a physical therapist assistant that lives within a 65-mile radius of this facility. She had been unable to provide appropriate care to the 25 residents that live in that facility for several years, as the physical therapist supervisor could only come to this facility one time per month. CMS regulations do not view that as adequate supervision for an assistant so cares had to be limited based on availability. In this area, no occupational or speech ther-- or speech language pathologists were willing to drive greater than two hours one way just to see a couple of patients. So limited access to cares were provided. Since the emergency order for telehealth, we can provide supervision visits to this facility and many others like it with consistency via telehealth. Therapist assistants are able to practice at the top of their license with appropriate contact to their PT or OT. We are seeing residents that have not walked in years

walking again, people who have been 100 percent dependent on mechanical equipment for mobility, standing and transferring. They're moving about again. We are seeing residents taking on the reins of their activities of daily living instead of relying on caregivers to do all of the work. I have personally seen a decline in behavioral outbursts in our residents that have dementia because they have access to increased activity and are in therapy programs to help them with anxiety, memory and strength. They are flourishing and it has been an exciting time for our rural providers. In our urban areas, this has been a beneficial tool. In both the outpatient and skilled nursing facilities, families with small children can receive the needed direction and education for their children with developmental disabilities without taking a time away from jobs and other responsibilities. Our profession is much more than hands-on care and many interventions we can provide safely and effectively through telehealth technology. Our association implores you to consider strongly adding an amendment to this bill to allow physical therapists and all rehab professionals to use telehealth for the benefit of Nebraskans even after this public health emergency has ended. All the benefits we have seen should not be lost. Please understand, we see the ability to provide needed therapy services by telehealth as a tool and will need to be fully assessed each and every time if this tool will benefit patients. This is needed to continue the positive advancements we have made in our rural communities, treating our most vulnerable population in the state to have effective and efficient care. Thank you. Julie Steinmeyer.

WILLIAMS: Thank you, Miss Steinmeyer. Are there questions? Seeing none, thank you for your testimony.

JULIE STEINMEYER: Thank you.

WILLIAMS: Any additional proponent? Welcome, Mr. Schaefer.

MATT SCHAEFER: Good morning, Senator Williams, members of the committee. My name is Matt Schaefer, M-a-t-t S-c-h-a-e-f-e-r, and I'm testifying today in support of LB400 on behalf of the Nebraska Medical Association. I want to thank Senator Arch and, and the members of the committee for your interest in keeping the progress going that's been made on telehealth and ensuring that it can be used safely and, and appropriately, but also widely. I, I don't see a reason to repeat the

insightful testimony you've already heard today, so I'll just urge the committee to advance LB400 to the floor. Thanks.

WILLIAMS: Thank you, Mr. Schaefer. Are there questions? Seeing none, thank you for your testimony. Are there any additional proponents? Welcome, Miss Fox.

NICOLE FOX: Good morning, members of HHS Committee. Nicole Fox, N-i-c-o-l-e F-o-x, director of government relations for the Platte Institute. The Platte Institute supports LB400. During the pandemic, all 50 states implemented temporary measures to expand access to telehealth. It made it easier to treat people either because they were confined due to direct health measures or they had no alternative means but to travel long distances to the nearest provider. Telehealth was instrumental given the need for a lot of these directed health measures. Permanent reforms could help encourage patients, particularly those that are very vulnerable or those in rural areas, to seek care in a timelier manner and comply with the needed follow-up medical care that they need. Telehealth not only increases the number of providers that patients have access to, but it also increases the variety of healthcare disciplines that they can access. Nebraska is one of several states looking to make-- to take permanent action, and the Platte Institute applauds this. LB400 is the result of a 2020 interim study, as Senator Arch pointed out. Even though many of the barriers to telehealth tend to be more federal in nature, we, we saw that Senator Arch was able to identify some state-level measures that could potentially be made permanently lifted. Patients should be able to receive medical services from their-- from the location of their choosing, provided that that care is able to meet basic standards of care. Prior to the COVID pandemic, people were forced to seek, seek telehealth services at medical facilities. And what we're finding is that it was much more convenient for them to access needed services either through, you know, at their home or through their place of work. In fact, many of the telehealth proponents who testified at that interim hearing noted that eliminating geographic restrictions was probably one of the biggest benefits that they saw as far as improving access. Travel times were significantly reduced for those who had to travel from rural areas. And we also saw that a lot of people benefited just from being in their home environment. In fact, I recall one testifier that stood out to me was an occupational therapist, and she talked about a child that they were taking care of and they were doing so obviously in the home environment, trying-- this, this child

was having issues with feeding and needed a feeding tube. And so they were trying to transition that child off of the feeding tube. And obviously having access to the home environment was, was critical and being able to do so. Telehealth can be delivered in a variety of ways and delivery options should be up to the doctor and the, and the patient. Limiting delivery to only certain technologies can make telehealth unusable for some patients as, as some other proponents have pointed out. And I do agree that it would be nice. I, I understand that Senator Arch's survey results showed a significant improvement for those needing behavioral health services. But it would be nice to see delivery expanded through phone to other conditions, especially given the access to broadband, the problems there that we have in our state. A regulatory barrier that can block the utilization of telehealth also would be the fact that you have to have an existing patient-provider relationship. And so when people are needing to access telehealth in a timely manner and sometimes travel long distances, obtaining that written consent can be difficult. And so we do support LB400's "allowal" for verbal consent initially with the fact that obviously there has to be some sort of follow-up written consent and that that can be done through electronic means. So essentially, we feel that LB400 is a lot of just common sense, makes sense type reforms. And the Platte Institute thanks Senator Arch for bringing LB400 forward. We-- people for, for years have talked about how telehealth has a lot of potential and I think the COVID-19 pandemic revealed this. And so I say let's move forward and limit barriers to access. And we hope that this committee will decide to advance LB400 to General File. And with that, I'll be happy to take any questions.

WILLIAMS: Thank you, Miss Fox. Are there questions? Seeing none, thank you for your testimony.

***PAT CONNELL:** Chairman Arch and Members of the Health and Human Services Committee, my name is Pat Connell and I serve as the Health Policy Advocate for Boys Town and Boys Town National Research Hospital and am providing written testimony in support of LB400. Boys Town National Research Hospital has been providing telehealth services since 2014 in five rural locations. Our experience has shown that telehealth improves care access and facilitates treatment follow-up. In the past, we had patients driving one hundred plus miles, one way, to see their physician. Even today, there are areas and situations where telehealth is not a viable option and patients and their

families have to drive long distances to access services. Through telehealth, parents do not have to take off a half day, or sometimes even a full day, of work for their child to see a clinician. The pandemic has demonstrated that telehealth services work. Before the pandemic, Boys Town made a commitment to expand telehealth services across the State to improve access and continuity of care. Our goal is to work with rural hospitals to provide needed specialty services like child psychiatry, psychology, and pediatric neurology services. We envision adding an additional eight to twelve rural hospital telehealth sites in the next two years. We appreciate Senator Arch introducing LB400 and believe these changes are necessary to keep telehealth viable in Nebraska, and would like to offer the following points: Telehealth Services should also include audio-only services. Our treatment philosophy centers around in-person visits. With that said, there are many reasons, and during certain times, where telehealth has its advantages. Every year in Nebraska we have weather that makes travel difficult and hazardous. Parents may have difficulty getting off work for a half or full day to take their child to the doctor's office. This is an even bigger problems during bad weather to attend in-person appointments. There is also the additional travel expense for patients traveling long distance for a doctor's appointment. There are many other reasons where telehealth is acceptable in lieu of in-person appointments. While video telehealth is the preferred method, there are times because of necessity where audio-telehealth is needed as follows: 1. Video telehealth may not be possible due to poor internet bandwidth. 2. The patient does not own a computer, tablet, or smart phone. 3. The patient may not be able to travel to the clinician's office. 4. Audio-telehealth, as option of last choice, can provide timely access and continuity in communication between the patient and clinician. 5. When the video telehealth appointment is disrupted due to computer system and internet connection issues, having audio telehealth available to complete the appointment is critical. Audio-telehealth has been effectively adopted in behavioral health services, especially for initial evaluations, medication management, individual therapy, and family therapy. Modifying the Treatment Consent Process These changes are necessary to make telehealth work. While the consent process starts with the first visit by obtaining a verbal consent, additional time due to logistical reasons are necessary to complete the written informed consent process. In summary, we believe that advancing LB400 is in the best interest of Nebraska and we stand ready to answer any questions or

provide additional information. I may be reached by phone at 402-498-6392 or email at pat.connell@boystown.org. Thank you.

***DAVID SLATTERY:** Chairman Arch and members of the Health and Human Services Committee. I am David Slattery, Director of Advocacy for the Nebraska Hospital Association (NHA). The NHA is the unified voice for Nebraska's hospitals and health systems, providing leadership and resources to enhance the delivery of quality patient care and services to Nebraska communities. Nebraska hospitals employ more than 44,000 individuals who deliver care to over 11,000 patients each day. Thank you for this opportunity to present this testimony. I am expressing the NHA's SUPPORT for LB400 introduced by Senator John Arch. The way patients experience health care is shifting. Care that used to take place only in brick-and-mortar settings can now occur digitally. Accordingly, hospitals and health systems are exploring a variety of virtual care models, many of which are underpinned by telehealth technology. Telehealth is part of a larger digital transformation in health care. The electronic health record (EHR), omnipresent mobile devices and faster internet connections have provided new ways for patients and providers to interact. Patients are increasingly making decisions about who delivers their care and engaging in the delivery of that care digitally. As a result, hospitals and health systems need a strategy for their own digital transformation. Telehealth and digital health care enable a model of care that is ubiquitous and seamless, more affordable and integrated into patient's lives. In the shift to demand-driven health care, telehealth becomes the patient's first - and most frequent - point of access for urgent care, triage for emergent conditions, medication education, behavioral health counseling, chronic care management and more. LB400 adds audio-only services for the delivery of behavioral health services. Audio-only may be the sole option for care when in-person is inaccessible, and patients lack advanced technology. This option is extremely valuable to rural Nebraskans that may lack access to high-speed broadband and elderly people that may not utilize devices such as computers, smartphones, or tablets. This bill also removes the requirement for demonstrating compliance with the signed written statement requirement in section 71-8505. LB400 eliminates another barrier to telehealth whereas patients can give verbal consent during the telehealth consultation if a signed statement is collected within ten days after the telehealth consultation. In one of the largest barriers to telehealth, LB400 allows telehealth to be delivered through services

originating from any location where the patient is located. This bill ensures that patients can receive care where they are located, based on consumer choice and safety, while ensuring that providers can deliver services at an appropriate location, which may not always be at a hospital. As clinicians continue to deliver care to patients with ongoing conditions, they must be permitted to deliver care where patients need it, including their homes and other locations. Patients should not have to prove a hardship or access barrier to receive telehealth services. The NHA wants to thank Senator Arch for introducing this important legislation and we ask the Committee to advance the bill. Thank you for your consideration.

***NATALIE PEETZ:** Good morning, Senator Arch and Members of the Committee: My name is Natalie Peetz and I am a registered lobbyist for CHI Health and am providing the following testimony in support of LB400. I would like to thank Chairman Arch for introducing this bill. CHI Health is a regional health network consisting of 14 hospitals, 2 stand-alone behavioral health facilities, a free-standing emergency department, 136 employed physician practice locations and more than 11,000 employees in Nebraska and Southwest Iowa serving communities from Corning, Iowa, to Kearney, Nebraska. It was truly remarkable in the first few weeks of the pandemic how many legislative and regulatory issues were removed to allow for the rapid expansion of telehealth services across the country. And while CHI Health always believed the expansion of telehealth is the key for rural access and affordability in states like Nebraska, the "genie is out of the bottle" as they say, as a result of these innovations and the demand for them by the general public which will only increase over time. None of this would have been possible without the recent Medicare 1135 waivers and flexibilities allowed in the federal and state public health emergency orders that are still in effect. And while all of those provisions are important, LB400 would ensure that originating site and behavioral health services provided by audio that patients and providers now rely upon would not be in jeopardy of going away when the emergency orders expire. LB400 would also allow common sense flexibility as it applies to written consent for services when provided remotely. The passage of LB400, especially when paired with other legislation you are considering this year such as telehealth reimbursement parity and broadband expansion throughout the state, would recognize the importance of telehealth to the future of

healthcare delivery in Nebraska. On behalf of CHI Health, I encourage you to advance LB400 to the full Legislature.

***JASON HAYES:** Good morning, Senator Arch and members of the Health and Human Services Committee. For the record, I am Jason Hayes, Director of Government Relations for the Nebraska State Education Association. NSEA supports LB400 and thanks Senator Arch for introducing this bill. COVID has created a global crisis. That crisis is not only affecting the physical health of those who contract this deadly disease, it is also affecting the mental health of many who are struggling to deal with death, stress, isolation, financial fragility and more. Kaiser Family Foundation polling conducted in mid-July found that 53 percent of adults in the U.S. reported that their mental health had been negatively affected by worry and stress over the coronavirus. A Gallup study conducted in November found that reports of mental health issues are much worse than a year ago; in fact, it was the worst report on mental health in the 20 years Gallup has conducted the poll. The problem is compounded in Nebraska as we struggle to employ enough providers to meet the rising mental health needs of Nebraskans in all areas of the state, including rural and urban locales. As we have become seasoned to the isolation of COVID, we have learned to utilize technology to connect with others, not only at work but in our personal lives. Not only can grandma join the family for Christmas dinner via Zoom, but a patient can receive much needed services from a mental health provider by telehealth. LB400 would make sure that this much needed service would be reimbursed by insurance carriers, not allowing them to exclude coverage solely because a service is delivered through telehealth, regardless of the location of the service. COVID has changed our lives in many ways, and LB400 provides an opportunity for us to carry one of the good things - telehealth treatment - into what we hope will be a healthy future. The NSEA offers this testimony on behalf of our 28,000 public school teachers, higher education faculty and other education professionals across the state. We urge advancement and passage of LB400.

***JESSICA SHELBURN:** Chairman Arch and members of the Health and Human Services Committee, Thank you for the opportunity to submit testimony on LB 400, for the record. My name is Jessica Shelburn, I am the State Director of Americans for Prosperity Nebraska. As one of the largest grassroots organizations in the nation, Americans for Prosperity (AFP) is dedicated to bringing people together to change our government and public policies for the better. Through broad-based grassroots

outreach, AFP is driving long-term solutions to the country's biggest problems. AFP activists engage friends and neighbors on key issues and encourage them to take an active role in building a culture of mutual benefit, where individuals succeed by helping one another. AFP recruits and unites activists in 35 states behind a common goal of advancing policies that will help people improve their lives. We strive to help people break barriers - empowering people to live their best lives. A key to living your best life is having access to health care when you are in need. Unfortunately, due to the excessive regulations, access to health care can be challenging as we saw in the early days of the coronavirus pandemic. Nebraska has a drastic need for improvements in access to quality and affordable health care. AFP is working with several organizations around the country to permanently enact and enhance the emergency telehealth reforms implemented to combat COVID-19. Our experience in the ongoing public health crisis has demonstrated the value of increased access to telehealth to enable all health care professionals and facilities to virtually consult, treat, and monitor patients. This would improve health care across the state, especially for those in rural or remote areas. These reforms have empowered physicians, nurses, and other physical and mental health professionals across the country to deliver high-quality virtual care, resulting in privately insured patients increasing their use of telehealth services by 3,552% since last year. In addition, providers increased the number of weekly telehealth consultations to Medicare enrollees from 13,000 to 1.7 million. Today, nearly half of all patients use telehealth services, compared to just 11 percent in 2019. Identifying obstacles to the accessibility of telehealth must continue to be addressed. LB400 would broaden the scope of telehealth in the state statute to include services that are audio-only services for behavioral health needs. It allows patients to provide verbal consent during an initial visit and provide written consent within ten days. Additionally, allowing for consent to be given with electronic signature. LB400 is a critical step forward in ensuring that all Nebraskans have access to health care services when they are needed. We would encourage the committee to advance LB400 to General File for debate.

***AMBER BOGLE:** Chair Arch and members of the Health and Human Services Committee, my name is Amber Bogle (A-M-B-E-R B-O-G-L-E) and I am the Executive Director of the Children and Family Coalition of Nebraska (CAFCON). CAFCON is a non-profit association comprised of 10 of the

state's largest providers of children and family services. We serve Nebraskans in all 93 counties, providing everything from foster care and adoption assistance to mental and behavioral health services. I am expressing our support for LB400 which expands access to telehealth medicine. I thank Senator Arch for bringing this important legislation. LB400 would expand access to important telehealth services to the benefit of Nebraskans across our state. The changes proposed help modernize our ability to offer telehealth services and address the medical needs of patients when a visit to an office is not practical and, sometimes, not the most safe option. LB400 will not only address these emergency circumstances, but can also help ensure healthcare access to more rural areas of our state. As the ongoing COVID-19 pandemic has shown us, telehealth services are important to Nebraskans and can effectively address many patients' medical needs when used appropriately. I urge your support of this legislation and ask that you advance LB400 to General File. Thank you for your time and consideration.

***JINA RAGLAND:** Vice-Chair Williams and members of the Health and Human Services Committee: My name is Jina Ragland, submitting written testimony in support of LB400 on behalf of AARP Nebraska. We support the concept that coverage, payment and health services be readily made available for consumers and family caregivers in improving access and quality of care, while allowing them to remain safely in their community and home. More and more of the 50+ population and their caregivers are using their computers, mobile devices and tablets to access information and services as it applies to their health. The use of telehealth technologies (especially those that include family members in virtual visits with providers) has the potential to result in better access to care, especially in rural areas; reduced transportation barriers and improved outcomes for the care recipient. In June, AARP research released a report about older adults' awareness of and attitudes toward telehealth. The research shows that older adults are increasingly comfortable with telehealth and are willing to use technology to interact with health providers. As the pandemic continues and emotional and economic stressors are present, telehealth has been a useful tool for older adults and their family caregivers to access health care from the safety of their own homes. The use of telehealth can result in improved outcomes for family caregivers themselves. These include: time saved with less time spent transporting a love one to appointments, less wear and tear, better

mental and physical health: less anxiety, depression, and stress as caregivers reduce the hassle of traveling to appointments and potentially better mental health as they seek treatment via telehealth technology, better preparation and training: improved caregiving knowledge and skills and higher satisfaction/ confidence in their caregiving roles through telehealth education platforms, in addition to overall better physical health. Family caregivers need help if they are to continue doing what they do, and telehealth is one way to provide this needed support. In Nebraska, there are over 240,000 caregivers in Nebraska who provide unpaid care to a friend or loved one, many of whom could benefit from broader adoption and access to telehealth. The pandemic has further reinforced the idea that telehealth can bring routine and specialty health services home when trips out are challenging or not safe. Working and long-distance family caregivers can also virtually join their loved ones' medical visits to assist in helping to manage their care. When family caregivers sacrifice their own health care to care for others, a telehealth visit for themselves can help them save time and still take care of their own needs - physical, mental or emotional. LB400 expands the definition of an acceptable telehealth originating site. Originating site will now include "any location where the patient is located." AARP has seen in survey after survey that individuals want to age in their homes and communities for as long as possible. The inclusion of "any location where the patient is located" supports that finding while also recognizing that more and more individuals are accessing quality care through their phones, tablets, and laptops right at home. Allowing telehealth to connect patients from any location allows the greatest flexibility for patients and their family caregivers to access care. LB400 also expands the definition of telehealth to include audio-only services for the delivery of behavioral health services and telemonitoring a patient's vital signs. AARP supports this expansion of the definition of telehealth which will positively impact seniors especially those receiving home and community based long-term care and their family caregivers. Allowing patients to receive health care via audio-only telephone is an important advancement in increasing access for seniors and their families who may not have access to or are not comfortable using interactive audio-video technology. It is also a matter of health equity for underserved populations including those in rural communities. Once this telehealth expansion is successfully implemented, AARP Nebraska hopes that this Committee and leadership

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will consider further telehealth expansions to allow for audio-only telehealth services beyond behavioral health. As COVID-19 has demonstrated, telehealth is an invaluable tool to delivering healthcare services to patients, particularly vulnerable populations and those who may have access issues due to living in rural regions or have difficulty with transportation. Thank you to Senator Arch for introducing the bill and his ongoing work on telehealth. We would ask you to support and advance LB400 from committee. Thank you for the opportunity to comment.

***BRENNEN MILLER:** Chairman Arch and members of the Health and Human Services Committee, my name is Brennen Miller (B-R-E-N-N-E-N M-I-L-L-E-R) and I am here today as the registered lobbyist for the Nebraska Association of Regional Administrators, or NARA. I appear before you today in support of Senator Arch's LB400. We ask that this testimony be made of the official testimony of the committee on this legislation. As way of quick background, Nebraska is split into six "regions". These are local units of governments that the state partners with to engage in planning and service implementation for behavioral health. Each county is part of a region, and as a result appoints one county commissioner to sit on their regional governing board. This commissioner will represent that county and participate in the decision making of the board. The regions purchase services from providers in their area. If necessary, services are purchased from other service providers across the state. The region is staffed by an administrator who in turn hires additional personnel to manage and oversee those contracts and services. We thank Senator Arch for bringing this important legislation forward so that the behavioral health services can not only continue to operate during this pandemic and any possible future emergencies- reaching more Nebraskans in need of services than ever before - but also to build these services into the future of quality healthcare for all Nebraskans. With each crisis we as Nebraskans face, from the flooding a few years ago, to the current pandemic, the behavioral health needs of our fellow community members can continue long past the receding waters and distributed vaccines. Ensuring quality accessible services for Nebraskans, no matter their area of residence, are key to our future prosperity and success as a community. We believe that LB400 and the work by Senator Arch are part of the great strides being undertaken to ensure that we are on the right track, and that barriers to telehealth are reduced

and procedures streamlined. Thank you fo your time, and should you have any questions we are, as always, happy to answer.

WILLIAMS: Additional proponents? Seeing no one coming forward, is there anyone here to testify in opposition to the LB400? Welcome back.

CARISA SCHWEITZER MASEK: Thank you.

WILLIAMS: If you'd like to go ahead.

CARISA SCHWEITZER MASEK: Good morning, Vice Chair Williams and members of the Health and Human Services Committee. My name is Carisa Schweitzer Masek, C-a-r-i-s-a S-c-h-w-e-i-t-z-e-r, and I'm deputy director for population health for the Division of Medicaid and Long-Term Care within the Department of Health and Human Services. I'm here to testify in opposition to LB400, which allows audio-only telehealth for behavioral health services. It also changes the telehealth statute on written consent, such that written consent can be obtained ten days after the service is provided so long as verbal consent is obtained at the time of service. Before I begin, I would note that Medicaid is working alongside Senator Arch's office on an amendment to this bill to address the concerns I will outline in my testimony. My testimony today is only specific to the bill as introduced. DHHS is concerned the phrase "behavioral health" within this legislation can be read to encompass all mental health and substance use prevention and treatment services. This is a very wide variety of services and not all of them can be provided effectively via audio-only telehealth. Some of these services cannot be provided at all in this manner, such as substance use disorder, treatments like detox. When providing behavioral health services, providers gather a great deal of information about their patients from nonverbal communication. Some nonverbal cues providers look for include eye contact, nervous behaviors, and the physical effects of medications or substance use, among others. None of these can be assessed without a visual element to the visit. Additionally, services such as treat-- day treatment or group therapy could not be effectively provided through audio only. DHHS has concerns that without this visual element, providing these services via audio only would not meet standard service definitions. Failure to do so could mean the federal government may not reimburse Medicaid for these services. This would have a fiscal impact, though to what degree is unclear. DHHS recognizes that the ongoing COVID-19 pandemic complicates face-to-face

visits. Telehealth, which is currently defined as audio and visual, has helped to ensure access to care during the pandemic. And Medicaid appreciates the partnership that we have seen with our providers. In summary, DHHS is opposed to LB400 as introduced because many behavioral health services require a visual element to be provided safely and effectively. We look forward to working with Senator Arch on an amendment to ensure appropriate treatment options are available. Thank you for the opportunity to testify today. I'd be happy to answer any questions.

WILLIAMS: Thank you, Deputy Director. Are there questions? Senator Murman.

MURMAN: Thank you, Senator Williams. Could you give us suggestions of what kind of amendment you would like to see?

CARISA SCHWEITZER MASEK: Yeah, there are some services that could be appropriate for patients such as individual services and for an established patient. There are-- is language that could allow appropriate services to ensure effective use while making sure that it wasn't confusing about some CPT codes or services that just clearly don't allow audio only.

WILLIAMS: Thank you, Senator Murman. Any additional questions? Thank you for your testimony.

CARISA SCHWEITZER MASEK: Thank you.

***JAMES WATSON:** Chairman Arch and Members of the Committee, Good Morning. 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 before your committee. I am here to respectfully express the Association's opposition to Legislative Bill 400 (LB400) as a measure which is overbroad in its provisions regarding telehealth and audio-only behavioral services. LB400 amends both §44-312 and §71-8503 to add the following language: "Telehealth also includes audio-only services for the delivery of behavioral health services;". NAMHP believes this language would allow unintended consequences and needs further clarification. Accordingly, the NAMHP supports the ongoing work between MLTC and Chairman Arch to 1) limit telephonic BH services

for individuals only and not for group therapy; 2) for established patients and when appropriate; 3) not for initial evaluations for non-established patients; and 4) for behavioral health crisis management/intervention for established patients.

WILLIAMS: Any additional opponents? Seeing none, is there anyone here to testify in a neutral capacity? Seeing none, Senator Arch, as you're coming up to close, we have three letters in support. And then we have written testimony from: Pat Connell from Boys Town National Research Hospital; David Slattery from the Nebraska Hospital Association; Jason Hayes from the NSEA; Jessica Shelburn from the Americans for Prosperity Nebraska; Amber Bogle, Children and Family Coalition of Nebraska; Jina Ragland from AARP Nebraska; and Brennen Miller from the Nebraska Association of Real [SIC] Administrators. All in support. And one opposition from James Watson from the Nebraska Association of Medicaid Health Plans. Senator Arch, you're welcome to close.

ARCH: Thank you. I, I think you can see from the testimony as well as the, the written testimony received this morning that we've got pretty wide, broad support for, for continuing to utilize telehealth and make sure that it's available to the citizens here in Nebraska. One, one of the challenges that we had when we entered this was recognizing that there are significant differences in regulations and statutes regarding Medicare, Medicaid, commercial insurance, and, of course, self-funded ERISA plans. And, and trying to navigate that was a challenge. Medicare primarily dictated by CMS. They, they tell us how Medicare services can be provided and there's not much there. Medicaid, as I mentioned, is, is one of those things where they tell you what you can do. But, but then there's, there's flexibility beyond that as well. And navigating that and commercial is the market. And so they are-- they're also determining, based upon the request of the employers as well as the employees, how, how best to provide that. So that's one of the challenges that we've had here. One of the reasons that you see behavioral health quite a bit in this, in this legislation, the proposed legislation, is that pretty much across the board it is-- it represents about 50 percent of the utilization of telehealth, not just in our state, but across, across the United States. While that, while that peaked and, and grew exponentially at first, it seems to have drifted down. And yet it's still holding at about the same percentage, about 50 percent behavioral health. So I thought, well, if we're going to, if we're going to, if we're going to move into this and, and, and have, and have some changes necessary,

that behavioral health certainly would be one of those areas since it's the primary utilizer that we would address, address. But it's evolving. Telehealth is evolving. And, and I think as a committee, we're probably going to see bills over the next several years on telehealth because it's evolving. It's evolving in a number of ways. One, of course, is just technology. We're seeing more remote monitoring of, of healthcare conditions. We're seeing people able to stay in their homes for long- term care because of, because of some of the technology that's being developed. So that, that in and of itself is going to move, is going to move telehealth. It's evolving in the patient's acceptance. It's evolving in the provider's acceptance of using telehealth, their familiarity and their, their growing comfort with using telehealth. So we're, we're going to see that over the next several years. So to me, to me, it's, it's very similar. And I, I know I've used this in, in some, in some forums. It's very similar to, I think, what we saw in the transition from inpatient to outpatient care on the hospital side. Now, this, this is more on the, on the clinic side, on the ambulatory care side. But in the, in the, in the hospitalizations, what we saw, of course, was as technology developed, laparoscopic surgery instead of, instead of full surgery, that opens up the patient where a number of days is required, you had outpatient surgeries where a patient could go in in the morning and, and come-- go home in the evening. And it was unheard of 10, 20 years ago that that kind of surgery could be performed. Well, that had profound impact on the medical community and on the economics of healthcare as well. I think we're seeing something very similar here now with telehealth and the ambulatory clinic area that, that as this evolves, there will be more utilization of it. You still, you still need inpatient care in hospitals. It didn't eliminate inpatient care, nor will telehealth eliminate face-to-face visits in clinics. But it's definitely going to-- it's, it's going to grow. So this is a step, this is a step that we've identified, the market will continue to adjust as well. Commercial insurance products will change over time, whether it be for the inclusion of other specialties or, or other ancillary services, what-- whatever it might be, those are going to change over time. So we'll see, we'll see more of this. One of the challenges, of course, we have is that CMS regs will also change. And what exactly is the federal government going to do now with the maintaining of some of the, of some of the regulations that they waived? What will be-- what will remain after, after COVID? And how, how will that impact us as well? So I, I say stay tuned. With regards

to the department's testimony in opposition, one of the-- one-- there, there were two key bulletins that were provided by the department. One was, one was March 17 of 2020, and it was, it was Bulletin 20-06 and then April 10 of 2020, Bulletin 20-10 where, where audio-only telehealth was, was identified and the use of that. So we're, we're referencing those trying to get the language that, that will work on audio only for behavioral health, what behavioral health services. So we're in, we're in discussions with the department and we'll be bringing-- I'm sure we'll be bringing an amendment to this bill to the committee for consideration as well. And with that, I will close.

WILLIAMS: Any questions for Senator Arch? Seeing none, thank you for bringing this forward. That will close the public hearing on LB400, and close our morning session.

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

WALZ: Hi, my name is Lynne Walz. I represent Legislative District 15, which is all Dodge County.

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

ARCH: Also assisting the committee is one of our legal counsels, TJ O'Neill, and our committee clerk, Geri Williams, and committee pages, Kate and Rebecca. A few notes about our policies and procedures. Please turn off or silence your cell phones. This afternoon 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 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 will find green testifier sheets on the table

near the entrance of the hearing room. Please fill one out, 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 and 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. If you are not testifying at the microphone but want to go on record as having a position on a bill being heard today, 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. 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 agenda posted outside the door will be updated after each hearing to identify which bill is currently being heard. The committee will pause between each bill to allow time for the public to move in and out of 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. 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 LB592. Welcome, Senator Stinner.

STINNER: Good afternoon, Chairman Arch and members of the Health and Human Services Committee. For the record, my name is John, J-o-h-n, Stinner, S-t-i-n-n-e-r, and I represent the 48th District, all of Scotts Bluff County. LB592 allows assisted living facilities, which are collocated with long-term care facilities to utilize automated medication dispensing machines, providing procedures are followed regarding the Automated Medication Systems Act. This bill was brought to me by the Nebraska Department of Veterans' Affairs to increase the efficiency of its operations. Currently, there exist automated pharmacy infrastructure in its long-term care facilities. However, due to existing language in the statutes, its assisted living facilities within the same physical structure cannot-- cannot be used, cannot use those machines, thereby having to dispense medication manually, which

can be inefficient and time consuming. This bill is a fairly straightforward fix, which adds permissive language so that a dispensing machine located in the long-term care facility can also be used across the hall in the assisted living facility. This bill requires compliance with the Automated Medication Systems Act, with grants-- which grants some flexibility for pharmacies that may not be able to utilize the efficiency of an on-site dispensing machine. Director Hilgert, director of Veterans' Affairs, here to give you more detail on LB955 [SIC] and answer more technical questions. With that, I thank you and I would ask for questions. But before I ask for questions, I will say that we've had discussions with the Pharmacists Association. There are some amendments that I think we can easily agree to, to ferret out whatever language differences we have. So there will be an amendment to this. But what it does for me, I've got a veterans' facility in Scottsbluff, has assisted living with long-term care. Obviously, this adds to efficiencies and will help the-- the Veterans' Administration dispense drugs not only more efficiently, but more accurately. So with that, I'll take questions.

ARCH: Thank you. Any questions for Senator Stinner? Will we have a pharmacist here today to talk to us?

STINNER: I think you have somebody from the association--

ARCH: I see somebody waving.

STINNER: --that's going to--

ARCH: So, OK.

STINNER: --eventually, yes.

ARCH: I agree. Thank you.

STINNER: I will not be closing by the way.

ARCH: All right, thank you, waive closing.

STINNER: I've got hearings across the hall so.

ARCH: OK.

STINNER: Thank you.

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ARCH: Thank you. First proponent for LB592.

JOHN HILGERT: I think I'm on a basketball court and someone took a spill.

ARCH: Oh.

JOHN HILGERT: Thank you very much. Good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is John Hilgert, J-o-h-n H-i-l-g-e-r-t. I am the director of the Nebraska Department of Veterans' Affairs. I want to thank Senator Stinner for introducing this bill at the request of the agency. As Senator-- Senator stated, this is a fairly straightforward bill, and I want to take this opportunity to discuss the process as it relates to our automated medication dispensing machines and how this bill will assist our process and our teammates. Our Western Nebraska Veterans' Home is located in Scottsbluff. We have an automated medication machine that our pharmacist loads with member data and prescriptions. The machine then processes the pharmacy orders and dispenses them in clear packets. I brought some. I won't hold them up, the clear prop thing, I will certainly-- I'm glad you said that or else I would have-- into our medication carts. This process for all of our long-term care beds licensed as skilled nursing beds. Since we have started using this automated medication machine across our system, the agency has realized the time savings of hundreds of hours as a reduction in medication sorting and packaging, and a reduction, a huge reduction in medication waste of approximately 5,000 doses per month agencywide. Separately, in the Western Nebraska Veterans' Home, we have licensed assisted living beds as part of the same building. Everywhere else in all the other three homes, they're all licensed as skilled. And in Western Nebraska, again, they're part of the same building and offer medication assistance to our members who do not self-administer their medications. For these members, our pharmacist enters their data and medications into a separate system, which then generates printed blister packs, which are then loaded and then sent out on a medication cart. This process of manually loading information and blister packs consumes approximately eight hours a week and results in a larger chance of human error and certainly more medication waste. The language in LB952 [SIC] is structured to allow our teammates to utilize the same automated dispensing machine that is already on site for our assisted living members, creating this large efficiency of time and process while reducing medication waste and reliance on

blister packs and manual data entry. I am aware, too, as far as today, that there has been expressed some concerns. We reached out to the Assisted Living Association and so forth, and we believe we-- we tried to get there. If there's any technical amendments that would ultimately result in allowing not only the Western Nebraska Veterans' Home, but other long-term care facilities that have a skilled nursing unit at the same place as an assisted living to realize the efficiencies that today's technology can offer, we'd certainly support that. Thank you, Mr. Chairman.

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

JOHN HILGERT: Thank you very much for having me, appreciate it.

ARCH: Next proponent for LB592. Seeing none, are there any opponents for LB592? Welcome.

MARCIA MUETING: Good afternoon. Senator Arch and members of the Health and Human Services Committee, my name is Marcia, M-a-r-c-i-a, Mueting, M-u-e-t-i-n-g. I'm a pharmacist and I am the chief executive officer of the Nebraska Pharmacists Association, and I am grateful to be here to express my concerns about LB592. I understand that the changes requested in the Automated Medication Systems Act were specific to a unique facility in Nebraska. We have not had the opportunity to work with the stakeholders and understand the circumstances which brought forth this bill. I want to assure you that automation in any facility offers better recordkeeping, security, and reduces waste. The Automated Medication Systems Act is one of many, one of many acts that govern the practice of pharmacy in Nebraska. I'm certain that the party requesting the law changes is unaware of the impact of inserting the words "or assisted living facility" on page 2, line 8. Assisted living facilities and skilled nursing facilities are licensed as separate entities with separate requirements, especially for pharmacy. The provision of medications for patients at these facilities is different as well. Adding the proposed language will not be helpful to most assisted living facilities in Nebraska, as they are often staffed by medication aides to provide medications to residents. It's important to note that medication aides are not allowed by law to remove medications from an automated system. Assisted living facilities are not allowed to have an emergency box of medications either. So why does this matter? Why am I here? Well, the federal law

requires that an automated medication system in a facility like that must be owned by a licensed pharmacy, placing the responsibility for those medications on the pharmacist at that pharmacy. I would be happy to meet with the stakeholders to further discuss technical concerns. But we would need to discuss not just the Automated Medication Systems Act, the Emergency Drug Box Act, and any other laws that are impacted by a potential change. But this can't be done by just inserting a few words on one page in one act. And I'd be happy to take any questions.

ARCH: Questions? Are there any questions? Senator Walz.

WALZ: I just need you to, ple-- thank you for being here first of all.

MARCIA MUETING: Sure.

WALZ: Thank you, Senator Arch. Could you please explain that reasoning again? I-- I was trying to follow you, but I-- I kind of got lost so the reasoning behind your opposition is, again.

MARCIA MUETING: Is that the rules for pharmacy are very different for skilled nursing facility patients versus patients that are in assisted living. For example, a skilled nursing facility patient, they may receive medication pursuant to a chart order, whereas people in assisted living have to have a prescription.

WALZ: Um-hum.

MARCIA MUETING: And if you look at the language as it's inserted, there's a couple of "ors" in there that might be interpreted incorrectly, either by a facility, someone administering the drug, or the pharmacist. And I just don't want the pharmacists to get into trouble. We want to make sure that this is made clear. I mean, automation is the way to go. This makes sense.

WALZ: Um-hum.

MARCIA MUETING: But-- but currently, what I think the addition of that language is, is a technical problem and creates conflict in the rest of the act.

WALZ: OK. All right, got it. Thank you.

MARCIA MUETING: Sure.

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ARCH: Other questions? I have one.

MARCIA MUETING: Sure.

ARCH: So an automated dispensing system in an assisted living is almost like a retail pharmacy.

MARCIA MUETING: Well--

ARCH: If it requires a prescription,--

MARCIA MUETING: Right.

ARCH: --then-- then who's dispensing?

MARCIA MUETING: The pharmacist is-- is actually loading the machine with the medication in the-- in the right bucket, in the right box, in the right--

ARCH: Right.

MARCIA MUETING: --container cassette, such that when the-- whoever is administering those medications would type in the patient's name and say, I want, you know, Marcia Mueting's 8:00 a.m. medications. It would put a, you know, the pink pill in there, the thyroid medication and the antipsychotic and the, you know, whatever into one little pouch. And it would all be labeled appropriately per federal and state law for administration to that patient. Does that make sense?

ARCH: Yes. Does the patient own the medication then in their particular box?

MARCIA MUETING: Well, the boxes are boxes full of-- of enalapril 10 milligrams. So, no, the patient doesn't own those medications. In a nursing home, remember that, too, that--

ARCH: I'm talking about assisted living.

MARCIA MUETING: Right. In assisted living, the medications are provided to them most often by a med aide, who is not a credentialed individual in Nebraska. OK. In the majority of assisted living facilities in Nebraska, medications are provided to the residents of

that facility by someone who is not credentialed, which is different than skilled.

ARCH: Right.

MARCIA MUETING: Which is why the difference between allowing someone to remove a medication from an automated system to provide it to a patient versus not. I mean--

ARCH: Yeah. I-- yeah, the script, the prescription versus the-- the order, right?

MARCIA MUETING: Um-hum.

ARCH: So in a nursing home, a physician may order a particular medication be provided, like a hospital.

MARCIA MUETING: Right.

ARCH: But in that assisted living, it's-- it's a very different-- a very different relationship of the medication to the patient.

MARCIA MUETING: It is. And, you know, a lot of times assisted living, those people they're, you know, they are able to eat and feed themselves, dress themselves. They go to their own visits, to their-- to their doctor's office and get a prescription e-prescribed, sent to a pharmacy to be filled for them. Whereas with skilled nursing, the delivery of the prescriptions is really just very different.

ARCH: Yeah, I don't want to go too deep into it. But as I was thinking about it, the assisted living, the patient may also have their own supply of medication.

MARCIA MUETING: Absolutely, yeah.

ARCH: So this-- so this coming out of the Pyxis Omnicell is-- is not their medication. This is something-- this is a special script that is written for a particular issue--

MARCIA MUETING: Right. And--

ARCH: --by their physician, by their physician.

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MARCIA MUETING: Right. Not to confuse the issue, but in skilled nursing and assisted living, either one of those, the medications are sent for a specific patient. When you're thinking about a hospital and a Pyxis or an Omnicell, those-- those drugs are not labeled for anyone.

ARCH: Right.

MARCIA MUETING: So and hence there's differences for hospital administration, skilled nursing, and for assisted living. I just think that we need to get together to work out the technical difficulties because I don't want a pharmacist getting in trouble.

ARCH: OK, thank you.

WALZ: I have one other question.

ARCH: Senator Walz.

MARCIA MUETING: Sure.

WALZ: So if a person living in the facil-- living facility had a prescription from their doctor or several in this case that I'm trying to make, they can still go to their own-- they can go to HyVee. I'm just going to throw one out there. And are those automated as well? I mean, can-- can they be given those pills in?

MARCIA MUETING: It's really important whether you're talking-- when you're talking-- whenever you're talking about providing patients medications that they use one system. Mistakes are made. If-- if we have bottles from HyVee that-- that we're just opening up and we're giving them, you know, one of each out of the pills, mistakes are made. So oftentimes it's a condition of living in a facility that the drugs will be packaged by a specific pharmacy or in a specific way. Have you ever seen a med cart?

WALZ: Yeah. And I guess the reason I'm bringing that up is because, you know, I was just trying to think of how it could be easier for a family member as myself when I was trying to dispense meds to my mom who didn't get them from the med aide, you know, 30 pill bottles or 30 pills. So I was just wondering if-- if that was a possibility or is that--

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MARCIA MUETING: There are pharmacies that actually will package, we call it compliance packaging.

WALZ: Um-hum.

MARCIA MUETING: So there are pharmacies in communities all over Nebraska that will package medications for patients that live in their own homes or assisted living or whatever that are self-administering.

WALZ: OK.

MARCIA MUETING: And they can provide the medications in that compliance packaging where it's kind of like a strip pack where here's your 8:00 a.m. meds, here's your noon meds.

WALZ: OK.

MARCIA MUETING: It has your name on it. It has the names of everything on it. Yeah, there's pharmacies all over Nebraska that do that.

WALZ: OK, that was my question.

MARCIA MUETING: All right.

WALZ: All right. Sorry it took a very roundabout way.

MARCIA MUETING: It's OK. We got there.

WALZ: Thank you.

MARCIA MUETING: We got there.

WILLIAMS: Any additional questions? Seeing none, thank you for your testimony.

MARCIA MUETING: Thanks for the opportunity.

WILLIAMS: Any additional opposition testimony? Is there anyone here to testify in a neutral capacity? Seeing none, Geri, did we have any letters on this? OK, we-- and we have no letters and Senator Stinner waived closing. So that will close the public hearing on LB592. You're going to do it, Lynne?

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WALZ: Yep. OK, and that opens our hearing on LB59-- oh, LB252 with Senator Williams.

WILLIAMS: Thank you, Senator Walz, and good afternoon, members of the Health and Human Services Committee. I am Matt Williams, M-a-t-t W-i-l-l-i-a-m-s. I represent Legislative District 36 and I'm here to introduce LB252 for your consideration at the request of the national or excuse me, the Nebraska Cattlemen's Association. LB252 is an uncomplicated bill and simply proposes to authorize veterinary drug distribution companies to continue to refill prescribed drugs to livestock on farms, ranches, and in feedlots for up to 30 days after the death of a prescribing veterinarian. Current Nebraska law requires a client-veterinarian relationship in order for a drug distribution company to supply and refill prescribed drugs. But the law is silent on how to refill drugs when that relationship is severed due to the death of a veterinarian. And you're going to hear a story in a little bit that happened this fall in Nebraska that put a lot of livestock and many feedlots at jeopardy because of the untimely death of a veterinarian. The bill allows a 30-day window for drugs to be refilled while ranchers, farmers, and feedlot operators establish a relationship with a new veterinarian. With that, I would try to answer any questions that you might have. But there are professionals following me that can answer those also. Thank you for your consideration.

WALZ: Thank you, Senator Williams. Do we have questions? I see none. First proponent.

JARED WALAHOSKI: Good afternoon. Senator Arch and members of the Health and Human Services Committee, my name is Jared, J-a-r-e-d, Walahoski, W-a-l-a-h-o-s-k-i, and I serve as the vice chairman of the animal health and nutrition committee for the Nebraska Cattlemen. I'm also a licensed large animal practitioner at Overton Vet Services in Lexington, Nebraska. I'm here to testify in support of LB252 on behalf of the members of the Nebraska Cattlemen, Nebraska Farm Bureau, Nebraska Pork Producers Association, and the Nebraska State Dairy Association. I want to express a significant amount of gratitude to Senator Williams for working with the Cattlemen to address an unforeseen issue we discovered last fall after the untimely passing of a dear friend, fellow board member, and veterinarian, Dr. Jeff Fox. To provide some context, Dr. Fox is a-- was a consulting veterinarian who lived in Beemer, Nebraska, who primarily worked with feedyards across

the state of Nebraska. He was the only veterinarian in his practice, and following his untimely death, it was discovered that all of the prescriptions that he had with his consulting feedyards were null and void based on his passing. After extensive research to find guidance as to why this was the immediate case, we discovered it was due to an interpretation of Nebraska's definition of the veterinarian-client-patient relationship, or VCPR, and that statute is listed there. At the heart of our concern with this interpretation are the animal health, safety, and welfare of those animals that were under his care. If a farmer or rancher has a valid prescription that was issued under a bona fide VCPR, we feel it reasonable for that farmer/rancher to have 30 days to refill those prescriptions as needed to administer for preventative measures or administer as treatments while working to develop a new client-patient relationship. In a specific instance I referred to earlier, feedlot members did not have immediate alternatives to reissue their prescriptions for needed veterinary products. To operate within the valid client patient relationship, a veterinarian must have sufficient knowledge of the animal to initiate at least a general or preliminary diagnosis of the medical condition of the animal, meaning that the veterinarian has recently seen and is personally acquainted with the keeping and care of the animal by virtue of an examination of the animal or by medically appropriate and timely visits to the farm or ranch where the animal is kept. This type of information cannot be relayed over the phone. And a shortage of large animal veterinarians makes scheduling immediate farm calls a struggle and essentially unnecessary if the prescription issued was done so under a valid VCPR. Additionally, choosing a new veterinarian is a very personal choice. These professionals become members of the farm and ranch teams, and establishing a new relationship does take some time. We took great care when working with Senator Williams, his staff, and other stakeholders to ensure that this amendment to the Veterinary Drug Distribution Act did not allow for the abuse of any controlled substances, as well as ensuring that veterinary drug distributors had the flexibility needed to operate their business in ways they deem appropriate. Thank you again to Senator Williams and thank you to the members of this committee for your time today. I'm happy to answer any questions.

WALZ: Thank you. Any questions from the committee? Senator Murman.

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MURMAN: Thank you, Senator Walz, and thank you for coming in to testify. As a former dairy farmer, I realize how difficult it is to, especially in Nebraska, to find a veterinarian that's knowledgeable about dairy. Could you tell us a little bit about how difficult it is to find a veterinarian that would have the knowledge necessary to take care of animals?

JARED WALAHOSKI: Depending upon the part of the state you're in, it could be very difficult. Jeff, Dr. Fox covered feedlots in six different states so not just Nebraska, but most of the surrounding states. He traveled a lot. And, you know, in that venue or in the dairy sector, specifically in Nebraska, the people who you would consider to be experts in that field would be few and far between. So one, logistically getting them on site would be difficult; and two, finding one that your relationship becomes the one you would want long term is going to take some time and this would allow for those discussions to be had.

MURMAN: Thank you very much.

WALZ: Thank you. Other questions from the committee? I see none. Thanks for coming in today.

JARED WALAHOSKI: Thank you very much for having me.

WALZ: Next proponent. Any opponent? Anybody who would like to speak in a neutral position?

RICK COCKERILL: Good afternoon, Chairman Arch and members of Health and Human Services Committee. My name is Dr. Rick Cockerill, R-i-c-k C-o-c-k-e-r-i-l-l. I'm testifying today on behalf of the Nebraska Veterinary Medical Association. The NVMA is testifying neutrally on Senator Williams' LB252. We were approached about the idea of this bill earlier this fall, and we greatly appreciate the proponents' willingness to work with us to get LB252 in a shape that is workable for Nebraska cattlemen while still respecting the essential role of the veterinarian. It is an important tenet of this legislation and of our work as veterinarians in general that a veterinary drug order is only valid if it is based on a veterinary client-patient relationship. Nebraska statutes state that a veterinary client-patient relationship requires the veterinarian to sufficiently know the animal. After an untimely death of the veterinarian, that veterinary client-patient

relationship is no longer in existence. All the-- although the instances are limited, this bill allows the veterinary drug order to be fulfilled when there's not yet another veterinarian who sufficiently knows the animal and is able to write a new veterinary drug order. Our work on the language as follows in finding the right balance between respecting the producers' need to continue to fill a veterinary drug order with the crucial need for a veterinary who sufficiently knows the animals for which the drug was ordered to be part of that mix. We agree that a 30-day maximum refill allowed under the bill is an acceptable length of time. We appreciate the committee's attention to these important animal health issues, even when they seem a bit outside of the health issues you usually see. I'm happy to take any questions.

WALZ: Thank you. Questions? Senator Murman.

MURMAN: Thank you, Senator Walz, and thank you for testifying. That-- the prescriptions that would need to be filled through a vet-client relationship would often include medicated feed. Is that correct?

RICK COCKERILL: Correct.

MURMAN: And those prescriptions could need to be filled maybe weekly as feed is delivered.

RICK COCKERILL: Correct.

MURMAN: So-- so--

RICK COCKERILL: But it's--

MURMAN: --30 days would-- would not be excessive for, you know, that relationship to be established.

RICK COCKERILL: In my opinion, I would say no. But like Dr. Walahoski said, that you need to get a new client-patient relationship with a veterinarian. And so the 30 days hopefully would be sufficient time to establish that because it's probably critical to the type of, you know, feedlots or dairies or whatever to get somebody on board with them as soon as they-- if-- if they run into a situation like this. And fortunately, this type of situation rarely happens. So we were just unfortunate this fall with the passing of Dr. Fox.

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MURMAN: Thanks.

WALZ: Thank you, Senator Murman. Any other questions from the committee? I see none. Thank you for coming today.

RICK COCKERILL: All right. Thank you.

WALZ: Anybody else that would like to speak in the neutral? Senator Williams, you're welcome to close. And we had no letters in lieu of testimony and no position letters to report.

WILLIAMS: Thank you, Senator Walz, and thank you again to the committee. As you heard the story, none of this is new. The veterinary client-patient relationship. This is a process that's been in place for years. It was an unusual circumstance that happened this fall with the untimely death of Dr. Fox that pointed out this kind of flaw in the system. And so I appreciate the Cattlemen fixing this. You know, we think of our-- of the livestock, especially in a state like Nebraska, where it's not just cattle. We're talking hogs, we're talking dairy, we're talking chickens, lots of things that this can apply to. It was important to me and they took this into consideration. This committee has worked hard on prescription drug monitoring over the years that many of us have been here. So the control issues of controlled substances are removed and are not included under this. So that is not an issue to be looked at. We're talking normal drugs, antibiotics and anti-inflammatories primarily. So I would encourage us to-- to fix this for the Nebraska Cattlemen and the other industries that are represented. And I would encourage your advancement of LB252. Thank you.

WALZ: Thank you, Senator Williams. Any other questions from the committee? I see none. This closes our hearing on LB252.

WILLIAMS: Our last bill on the agenda this afternoon is LB583 to require electronic prescriptions of controlled substances. Senator Murman.

MURMAN: Good afternoon. Senator Williams and members of the Health and Services-- Health and Human Services Committee. For the record, my name is Dave Murman and that's spelled D-a-v-e M-u-r-m-a-n, and I represent the counties of Clay, Webster, Nuckolls, Franklin, Kearney, Phelps and southwest Buffalo County. I come before you today to

introduce LB583, which essentially requires that prescribers utilize electronic prescription technology to prescribe controlled substances beginning January 1, 2022. I would note that this bill is similar to LB922 introduced by Senator Kolterman last year. As all of you are aware, the opioid crisis in Nebraska, as well as all across this country, has been a real problem adversely affecting many individuals and families. As a result, more than half of the states are requiring or will soon require the utilization of electronic prescriptions for controlled substances. This bill is an essential step in curtailing abuse of overprescribing opioids and keeping individuals from shopping for doctors who would readily write a script. Because of this problem, last year, thanks to Senator Howard and the members of this committee, we enacted the opiad-- Opioid Treatment Act. Additionally, please note that this bill would bring Nebraska law in line with federal law, which will mandate the use of e-prescribing for Medicare Part D by next January, January of 2022. Further rationale for this bill would include safety and limiting errors. Electronic prescribing of controlled substances adds new dimensions of safety and security. As you would expect, electronic prescriptions cannot be altered, cannot be copied, and are electronically tracked. The Federal Drug Enforcement Administration rules for electronic controlled substance prescriptions established strict security measures such as two-factor authentication and reduce the likelihood of fraudulent prescribing. Notably, the state of New York saw a 70 percent reduction in the rate of lost or stolen prescription forms after implementing its own mandatory e-prescribing law. Second, studies show that electronic prescriptions are less prone to errors. According to a study conducted by Johns Hopkins Medication Outpatient Pharmacy, 89 percent of handwritten prescriptions failed to meet best practice guidelines or were missing information that would otherwise be prompted by an elect-- prompted by an electronic prescription system. With electronic prescriptions in contrast to the prescription is understandable and do not-- and you do not see these types of errors occurring, I mentioned earlier that more than half of the states are requiring or will soon require the utilization of electronic prescriptions for controlled substances. All of Nebraska's neighbors, with the exception of South Dakota, have enacted this type of legislation. Since the introduction of this bill, we have received several concerns from affected parties, and I am offering an amendment to address these concerns. And you should all have that amendment. I would like to commend and thank those who expressed their legitimate concerns and for their good faith

discussions. Those discussions have resulted in this amendment, which I believe addresses such concerns and improves the bill. The amendment does the following: At the request of Nebraska Pharmacists Association, it removes the exemption for mail order prescriptions. At the request of Nebraska Medical Association, it removes the requirement for prescribing doctors to report prescriptions to the Health Information Exchange, or NeHII. This does not lessen the effective-- effectiveness of the legislation as the actual dispensed medications are being reported. At the request of the Nebraska Dental Association, it relays the effect-- it delays the effective date for dentists to January 1, 2024. Dentists prescribe opioids less frequently than medical doctors. This will allow those who need to adjust their procedures a reasonable amount of time to do so. At a minimum, this amendment also substantially reduces the fiscal note. Cost factors in the fiscal note deal with HHS reporting to the Health Information Exchange and the University of Nebraska Dental College acquiring new software. The amendment eliminates or addresses both of these concerns. But I did notice this week that the Attorney General in Nebraska entered into a settlement with a company, resulting in $2.6 million settlement to Nebraska to be used to combat the opioid epidemic in the state. So some funding may be available there if it is needed. Thank you for consideration of this bill. And at this time, I'd be open to questions. But there are individuals behind me that would take questions also.

ARCH: Are there any questions? Seeing none, thank you. First proponent for LB583. Good afternoon.

RICH OTTO: Good afternoon. I'm Rich Otto, R-i-c-h O-t-t-o. Chairman Arch and members of the committee, thank you for the opportunity to speak in front of you today and a special thanks to Senator Murman for introducing LB583. I'm testifying in support of LB583 for the Nebraska Retail Federation, the Nebraska Grocery Industry Association, and the National Association of Chain Drug Stores. This legislation would require all controlled substance prescriptions to be issued electronically through a secure transmission from a prescriber to the pharmacy. We support the use of electronic prescribing for many reasons. Those include improving safety and security in the prescribing process; it reduces medication errors and handwriting errors; it makes patient care more efficient; improves-- improves tracking of prescriptions that would allow you to know if the prescription was actually filled, how many times it was refilled. It

also reduces fraudulent and altered prescriptions. Sometimes people can alter the strength or the quantity on a paper script. Across the nation, there continues to be substantial growth in the use of e-prescribing. Recent data from Surescripts 2019 indicates that 85 percent of all prescriptions were issued electronically. However, within that total, only 31 percent of those controlled substance prescriptions were e-prescribed. So there is room for improvement in e-prescribing of controlled substances. Recognizing the importance role of e-prescribing to curb the opioid crisis, Congress enacted federal legislation covered under Medicare Part D to electronically-- require electronic transmissions starting this year. That was-- the penalties for that were rolled back to January of 2022, which coincides with the language of this bill as well. So we've seen a lot start, but if they haven't done it so far, there is no penalty till next year. So long story short, electronic prescribing is just one essential step-- step to help curb the opioid addiction and controlled substances. Our pharmacy members truly support this. I did want to address the amendment. We appreciate all the associations and parties that came forward. It was a good faith effort in the negotiation of the amendment. As Senator Murman pointed out, there is the two-year delay for dentists. Dentists are probably at a lower rate currently of utilizing e-prescribed. Two years gives them a little more time to get to that point and to budget for it. Some have asked, it's going to be about $400 per year per prescriber for dentists if you want to know the costs going forward. Cost is another factor as far as the fiscal note and some of the other parties with the Medical Association. As Senator Murman said, the reporting to CyncHealth, formerly NeHII, has been eliminated. That does reduce costs for dentists, doctors, and the state because the fiscal note, nearly all of it was [INAUDIBLE] in my impression, to that reporting. The School of Dentistry did factor in there. But again, they get two more years to try to budget for that cost. And then finally, there was a third portion for the pharmacists in regard to mail order. I believe they're testifying and can talk about that portion of the amendment if you have any questions there. Appreciate your time. I'll answer any other questions, but we urge you to advance the bill.

ARCH: Questions? Senator Hansen.

B. HANSEN: Thank you, Chairman Arch. I don't know if I missed it or not, but did they mention what the penalty would-- would be?

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RICH OTTO: There is no penalty in the bill so some may question that. Our answer to that is when it's the law, most Nebraskans follow the law. And so it is just one that we would encourage the doctors to do it there. We assume that most will do it. There are some other exemptions so there will still be paper scripts. This doesn't get every control, not every single prescription that's a controlled substance will be electronic because of the exemptions. And we feel that the penalty isn't necessary for doctors to comply, doctors and dentists.

B. HANSEN: Is that a state penalty or a federal penalty?

RICH OTTO: There is none.

B. HANSEN: OK.

RICH OTTO: Now, there may be under Medicare Part D and others could-- the Medical Association is testifying later. They could answer the penalties under Medicare.

B. HANSEN: That's what I was wondering. OK, all right. I'll ask somebody later so.

RICH OTTO: Appreciate it.

ARCH: Other questions? I just have one. The statistic that you quoted, the 80 percent e-prescribing now, the 31 percent controlled substance prescribing. That's stark difference in-- in electronic prescribing, e-prescribing,

RICH OTTO: Right. The one comment I would say on that, that's 2019, I would assume that has narrowed since 2021 and the Medicare portion going into effect this year. So I would-- we can get you more current numbers. There was a stark difference. We see some progress, but we feel this bill is needed to keep closing that gap.

ARCH: I mean, honestly, that it would be very concerning that-- that there would be less, that much less e-prescribing going on just for controlled substances.

RICH OTTO: Absolutely. I agree, Senator.

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

RICH OTTO: Thank you.

ARCH: Next proponent for LB583. Seeing none, first opponent for LB583. Seeing none, is there anyone that would like to testify in a neutral capacity?

BOB HALLSTROM: Chairman Arch, members of the committee, my name is Bob Hallstrom, B-o-b H-a-l-l-s-t-r-o-m. I appear before you today as registered lobbyist for the Nebraska Pharmacists Association in a neutral capacity on LB583. As both Senator Murman and Mr. Otto have indicated, we had some, raised some concerns with regard to the provisions of the bill that would have excluded mail order pharmacy from the e-prescribing requirements. We didn't think that was appropriate. When you listen to Senator Murman talk about the safety and the security, those we think ought to apply equally to mail order pharmacy scripts as well. And in addition, it's not excluded under the federal law with regard to the Medicare Part D requirements. So we don't think there should be an exception on the state level either. My pharmacist friend, Marcia, back here indicated to me that one of the issues that might result in less of a percentage, the question that you rendered, Senator Arch, is that it's a different system. It's more costly. So without the requirement, it may be that there's a reluctance to expend those monies prematurely. So that may give some explanation as to that differential. We appreciate Senator Murman's willingness to go with the amendment that we've proposed. We're neutral here today, but with that amendment, we would be supportive of the concept moving forward. We also want to thank Rich Otto and his grandfather, Jim, for working with us to put the amendments together.

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

BOB HALLSTROM: Thank you, Senator.

ARCH: Is there anyone else that would like to testify in a neutral capacity?

DEXTER SCHRODT: Good afternoon. Happy Friday. Chairman Arch and members of the committee, my name is Dexter Schrodt, that's

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D-e-x-t-e-r S-c-h-r-o-d-t, vice president advocacy and regulation for the Nebraska Medical Association. We are here neutral on LB583 with the amendment presented to you today. We'd like to thank Senator Murman for addressing our concerns and for signaling that he does not want to place additional burdens on Nebraska's physicians with this bill. For your reference, the piece of LB583 we had concerns with can be found on page 9, lines 5-9 of the green copy. This language would have increased cost to physician offices because adding capabilities such as transmitting prescription information to the health information exchange or the prescription drug monitoring system to the existing software platforms physician offices already had in place and already under contract would be quite cost-- costly to add. The NMA did not see the purpose in this language because prescriptions covered by this bill are already entered into the PDMP when dispensed, hence the bulk of this information would be duplicative and therefore unnecessary to require. With the amendment taking care of that concern, we do still remain neutral on LB583 because the NMA has a standing policy not to support mandates on the practice of medicine. However, as you've heard before, in the case of requiring electronic prescriptions for controlled substances, we do recognize the horse is out of the barn on that one due to the CMS requirement for electronic prescribing that went into effect last month on January 1, and the enforcement delayed until January 1 of next year due to the COVID emergency. Also, I'd add, while nothing official has been announced, we have heard some conversations that commercial payers might begin to go this route in the near future. So again, the NMA would like to thank Senator Murman for his desire to work with stakeholders and to find a balance between moving technology forward in healthcare without overburdening physicians with unnecessary regulations. With that, I thank you for your time. And real quick, Senator Hansen, to answer your question, I believe typically the federal punishments either come in the form of fines or hindrances on the DEA licenses required to prescribe controlled substances.

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

B. HANSEN: So would that fine, since we're moving dentists back two more years, will they-- will they be fined at all? Because is this-- is this pertaining to all prescribers?

DEXTER SCHRODT: That I'm not sure, Senator. I'm not sure how that CMS requirement applies to dentists. I do know that it's Medicare--

Medicare Part D and Medicare Advantage plans are what's required. How that pertains to dentists, I'm unsure.

B. HANSEN: Just curious.

DEXTER SCHRODT: Yep.

B. HANSEN: All right, thanks.

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

DEXTER SCHRODT: Thank you.

ARCH: Is there anyone else that would like to testify in a neutral capacity? Seeing none. I don't have any information on letters received or--

GERI WILLIAMS: [INAUDIBLE]

ARCH: I don't know. Well, I will-- we'll make sure we communicate that. Senator Murman, you're welcome to close.

MURMAN: Thank you all for consideration of this bill. For the reasons stated, I ask you to support this bill that adds an additional layer of safety for our prescriptions in the state and brings Nebraska in line with most of the country. I'd ask you for timely consideration and to move this forward out of committee.

ARCH: Thank you. Any questions? Any final questions for Senator Murman? Seeing none, thank you very much. This will close the hearing for LB583 and it will close the hearings for the day. And we're going to go into Executive Session.

WILLIAMS: Are we going to do that here?