HARDIN: Good morning. Welcome to Health and Human Services Committee. We feel we are the finest community [SIC] here in the building and we'll give you the opportunity to determine that on your own in a little while. My name is Senator Brian Hardin. I represent the 48th Legislative District, which is Kimball, Banner, Scotts Bluff Counties, way out west where it actually snows a lot. And I serve as the Vice Chair of Health and Human Services Committee. I'd like to invite the members of the committee to introduce themselves starting on my right with Senator Ballard.

BALLARD: Thank you. Thank you, Vice Chair. Beau Ballard, District 21, northwest Lincoln and northern Lancaster County.

DAY: Good morning. Senator Jen Day. I represent Legislative District 49 in Sarpy County.

WALZ: Good morning. Lynne Walz. I represent Legislative District 15, which is Dodge County and Valley.

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

RIEPE: Merv Riepe, District 12, southwest Omaha and the city of Ralston.

HARDIN: Also assisting the committee is our legal counsel Benson Wallace, research analyst Bryson Bartels, our committee clerk Christina Campbell, and our committee pages Sophia and Mataya. Thanks for being here. A few notes about our policies and procedures. Please turn off your cell phone or make it quiet, please. We will be hearing bills today and taking them in the order listed on the agenda outside the room. On each of the tables near the doors of the hearing room, you will find green testifier sheets. If you're planning to testify today, please fill one out, hand it to Christina when you come up to testify. This will help us keep an accurate record of the hearing. If you're not testifying at the microphone but want to go on record as having a position on a bill being heard today, there are white sign-in sheets in each-- at each entrance where you may leave your name and other pertinent information. Also, I would note if you are not testifying but have an online position comment to submit, the Legislature's policy is that all comments for the record must be received by the committee by noon the day prior to the hearing. Any handouts submitted by testifiers will also be included as part of the

record as exhibits. We would ask if you do have any handouts that you please bring ten copies and give them to the page. We use a light system up here on the desk for testifying. Each testifier will have five minutes to testify. When you begin, the light will be green. When the light turns yellow, what do you suppose that means? Speed up, don't slow down. OK? Speak like an auctioneer at that point. When the light turns red, it's 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 mike and then spell your first name and last. That's what the rookies typically fail to do. You don't want to be like them. OK? The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters of the bill, then from those in opposition, followed by those speaking in the neutral capacity. The introducer of the bill will then be given the opportunity to make closing statements if they wish to do so. On a side note, the reading of testimony that is not your own is not allowed unless previously approved. We have a strict no-prop policy in this committee. With that, we will begin with LB337. Welcome, Senator Riepe.

RIEPE: Thank you, Chairman Hardin and members of the Health and Human Services Committee.

HARDIN: I'm invested-- I'm worried because our, our main questioner is sitting there instead of here, so.

RIEPE: I have been known as Curious George so I do, of course--

HARDIN: Thanks for being here.

RIEPE: My name is Merv Riepe. It's M-e-r-v, last name is Riepe, R-i-e-p-e, and I represent the 12th District, which consists of southwest Omaha and the city of Ralston. Individuals with mental illness are over-- overrepresented at every stage of the criminal justice process. Effective responses for these individuals require and depend on collaboration between the criminal justice and behavioral health systems. A crucial component of this cross-system collaboration is information sharing, particularly information about the health and treatment of people with mental illness who are the focus of these responses. The Health Insurance Portability and Accountability Act of 1996, more commonly known as HIPAA, is often cited by a mental health practitioner as the greatest barrier to information exchange. However, it's not HIPAA that prevents this exchange but current Nebraska state law. Not unlike other states, Nebraska's mental health confidentiality

laws were enacted at a time when cross-system care was not a major part of healthcare, and most healthcare records were on paper. This has resulted in inconsistencies between federal and state laws. Ohio and Texas are two states who have recently revised their confidential-- confidentiality laws to be consistent with HIPAA. Current Nebraska statutes are far more restrictive and impede identifying individuals with mental illness and developing effective plans for appropriate diversion treatment entrance positions between the criminal justice system and the community. LB337 would revise Nebraska's state law to align with HIPAA, significantly decreasing the barriers associated with sharing information between the behavioral health and criminal justice systems, allowing mental health practitioners to share protected health information without consent to provide coordinated or managed treatments as allowed by HIPAA. On the record, LB337 is supported by the Nebraska Chapter of the National Association of Social Workers, the Nebraska Association of Behavioral Health Organizations, and the NACD [SIC], which is the association for county governments, who understand that by passing LB337 and eliminating the barriers of requiring the written consent to share necessary mental health information for continuity of care and treatment will in turn lessen the severity of interactions with law enforcement, provide for more appropriate care of incarcerated individuals, and shorten the period of involvement with the criminal justice system. I might note that there is no fiscal note associated with this request for LB337. Thank you for your time and attention. I would take any questions in hopes that I could answer.

HARDIN: Thank you.

RIEPE: Thank you.

HARDIN: Questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Senator Riepe. I felt like I should take up your mantle of asking questions. When was this-- what your-- so you're repealing something that was put in statute. Do you know when it was put in statute?

RIEPE: The original one I understand, and there may be people coming behind me, but I'm told it was 25 years ago.

M. CAVANAUGH: Do you happen to know the reason that it was put into statute?

RIEPE: Well, at that time of-- Nebraska, along with several other states, enacted its own, its own mental health confidentiality laws and that predated HIPAA.

M. CAVANAUGH: OK.

RIEPE: So they were very strict. But then HIPAA came along and there are some legislation that specifically that HIPAA does, in fact, allow for this at this time.

M. CAVANAUGH: OK.

RIEPE: And I-- in my notes here, I have some reference to that. It was under the final HIPAA issues or rules at 45 CRF [SIC--CFR] 164.506: covered entities, including healthcare providers, may disclose protected health information for treatment purposes. And that is HIPAA.

M. CAVANAUGH: Your bill goes beyond the treatment purposes and it says as allowed by law. And I saw one of the opposition letters had concerns over that being very broad. Let's see here, the law-- as otherwise permitted by law. Is that-- is it your intention to have it that broad or is that something that you--

RIEPE: I think the, the opposition letter was from a trial attorney--

M. CAVANAUGH: Yeah.

RIEPE: --and his biggest or her business-- biggest one was they wanted to have the one word in the bill that said-- I think it was they wanted it to change from preferred or, or--

M. CAVANAUGH: Required to permitted.

RIEPE: They wanted to change to required as opposed to permitted. I would let them speak to what, what their interpretation to oftentimes--

M. CAVANAUGH: Sure.

RIEPE: There can be great meaning in the change of one word, as you know.

M. CAVANAUGH: I do. And as you know, I'm not actually a lawyer so I will--

RIEPE: But you're awfully good at it.

M. CAVANAUGH: --I will, I will ask lawyers to explain that further. You've mentioned paper records, and I just wanted to note because you talked about the criminal justice system and paper records that currently our Corrections system does not have electronic records for patients, which is--

RIEPE: They do not, you say?

M. CAVANAUGH: They do not, which is, I believe, problematic in continuity of care when people are released from Corrections but the conversation for another day.

RIEPE: OK.

M. CAVANAUGH: Thank you.

RIEPE: Thank you.

HARDIN: Thank you, Senator Cavanaugh. Other questions? Seeing none, Senator Riepe, will you stick around--

RIEPE: Yes, I will.

HARDIN: --for later?

RIEPE: I will.

HARDIN: Thank you.

RIEPE: Thank you, sir.

HARDIN: Those in support of LB337, feel free to make your way to the microphone.

KIM ETHERTON: Who am I handing this to?

HARDIN: Welcome.

KIM ETHERTON: Thank you. Good morning. Good morning, Vice Chair Hardin and members of the Health and Human Services Committee. My name is Kim Etherton, K-i-m E-t-h-e-r-t-o-n. I am a licensed independent mental health practitioner and the director of Lancaster County Community Corrections, and I am here to support LB337. The Department of Community Corrections works closely with agencies across the criminal

justice intercepts to identify individuals eligible for one of the 16 programs available through the department. Once identified, we move these individuals out of the criminal justice system as soon as reasonably possible and into a program tailored to meet their needs. These programs provide support, structure, access to behavioral health services, cognitive restructuring, and case management or supervision. Community Corrections' five pretrial diversion programs administered in partnership with the city and county prosecutors' offices are examples of interventions at the early intercepts of the criminal justice system. Diversion programming, specifically mental health diversion, veterans and treatment diversion will benefit from LB337 as it removes the barrier created by state statute, which restricts information sharing between the prosecutors and my department staff. The sooner we're made aware of behavioral health history and the circumstances surrounding their interface with the criminal justice system, the sooner we can begin service coordination. In January 2019, I was invited to attend a training in Omaha sponsored by Region 6 Behavioral Health, where the focus was behavioral health data and information sharing. The expert trainer at this session was John Petrila. Mr. Petrila is an attorney and national expert on mental health law and policy and information sharing. Mr. Petrila was on the team of attorneys who drafted the HIPAA legislation, and he wrote the chapter on confidentiality for the 1999 Surgeon General's report. At that training, Mr. Petrila explained that HIPAA is not what is getting in the way of Nebraska sharing limited behavioral health information. In almost all cases, it is state statute that stands in the way. LB337 addresses this barrier. We all work with limited resources and removing barriers that impede the process of identifying the behavioral health needs of individuals will help us use time and resources more efficiently. In addition, we can stop further progression of these individuals into the criminal justice system. Thank you, Dr.-- Senator Riepe. Almost made you a doctor. Thank you, Senator Riepe, for introducing LB337 and thank you senators for your time. I'm happy to answer questions.

HARDIN: Thank you for being here. Questions?

KIM ETHERTON: [INAUDIBLE]

HARDIN: Seeing none, thank you. Anyone else in support of LB337? Thank you for being here.

SHARON PRICE: Thank you. Hello. My name is Sharon Price, and that's spelled S-h-a-r-o-n P-r-i-c-e. Thank you, everyone. I'm honored to be

here. I'm a behavioral health coordinator, statewide in the state of Nebraska. I graduated from the Nebraska School for the Deaf in 1997 and graduated from Chadron State College with a bachelors in social work. I got my masters at Gallaudet University. After that, I worked in Cincinnati, Ohio, as a community health case manager for approximately 13 years, working with the deaf and hard of hearing population who have severe and, and ongoing mental health problems. I followed HIPAA and they allowed us to exchange information, sharing that with corrections and hospitals. If the person maybe was not in the right frame of mind, we could make sure that the person had the appropriate level of care needed, the right medication to get them stabilized again. Since I've been here of April of last year with my position here, I happened to have an opportunity to meet the father of a person who contacted us. The person was deaf and lived in Omaha. They were off their medication for a while and they got involved in some legal issues and some hospital issues because of the law that we have in the state of Nebraska which prevented them from sharing any information. The father had to drive here from Texas to try to get his son the help that he needed. If LB337 is passed that would help situations such as that, especially for people who are deaf or hard of hearing not only to get stabilized, but to make sure that they have interpreters, access to communication, accommodations that they need, just like what we did in Ohio. So not only services for their drug and alcohol use, but also for communication access. Thank you very much for your time and I'll answer any questions if you would like.

HARDIN: Thank you. And thank you from a fellow CSC Eagle.

SHARON PRICE: Oh, thank you.

HARDIN: Questions committee? Seeing none, thank you for being here.

SHARON PRICE: Thank you.

HARDIN: Anyone else in support of LB337?

VICKI MACA: Good morning. My name is Vicki Maca, spelled V-i-c-k-i M-a-c-a, and I am the director of Criminal Justice and Behavioral Health Initiatives with Region 6 Behavioral Healthcare serving Cass, Dodge, Douglas, Sarpy, and Washington counties. I'm a licensed mental health practitioner and a licensed clinical social worker, and I'm here to testify in support of LB337. For the past five years, I've been responsible for leading the Stepping Up Initiative, a national initiative that provides technical assistance and support to

communities working to reduce the number of individuals with a serious mental illness who are in jail. This data-driven initiative is heavily focused on collaboration and driving systems-level improvements. National data shows that 20 percent of individuals in jail have a serious mental illness. These individuals remain in jail longer than other inmates, are victimized in disproportionate numbers, and experience worsening of their mental illness symptoms. To improve these and other outcomes for this very vulnerable population, information regarding their care and coordination of treatment activities must seamlessly flow back and forth between the criminal justice and mental health systems. Without the ability to share information across systems, individuals experience delays in accessing community-based services and needed-- and their needed medications, changes in treatment providers, and multiple assessments which result in a loss of continuity of care and duplication of treatment efforts. Stepping Up provides a monthly opportunity to formally meet with representatives from behavioral health and criminal justice in both Douglas and Sarpy County. Both of these teams have consistently identified information sharing between the mental health and criminal justice systems as a primary system challenge impacting incarcerations, their length of stay, connections to care, and recidivism. In January of 2019, Region 6 Behavioral Healthcare hosted a conference featuring John Petrila, president of the Meadows Mental Health Policy Institute in Texas, and an attorney with 40 years of experience in mental health law and policy. Mr. Petrila provided valuable information about the value and impact of information sharing. He delivered a comprehensive review of HIPAA and then took time to brainstorm next steps with us to improve our cross-system information sharing. The brainstorming session was very short as it quickly became clear that when it comes to information sharing in Nebraska, HIPAA was not our barrier but Nebraska Revised Statute 38-2136 was and still is today. Current law only allows those who are licensed pursuant to the Nebraska Mental Health Practice Act to disclose information about their client with written consent of the person or when there is a duty to warn circumstance. Unfortunately, there are many situations where individuals are unable or unwilling to consent. From the criminal justice perspective, it is extremely difficult for a jail to conduct effective discharge planning, make referrals to community-based agencies, or prescribe the most effective medications without having the necessary information or history. On the other hand, without consumer consent, community-based mental health practitioners are unable to share information with jail personnel even when they know the individual they have been treating

is incarcerated. LB337 aligns state law with the federal privacy HIPAA laws and permits the disclosure of information without consent in certain situations. HIPAA does not allow unlimited disclosure of information or infer that obtaining consent is never necessary. HIPAA permits healthcare providers to disclose to other healthcare providers protected health information for the purposes of treatment activities and coordination of care. LB337 will ensure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high-quality care. LB337 strikes a balance that permits important uses of information while protecting the privacy of people who are seeking care. I'd be happy to answer any questions you might have.

HANSEN: Thank you for your testimony.

VICKI MACA: Thank you.

HANSEN: Are there any questions from the committee? Seeing none, now you're free to go.

VICKI MACA: Thank you.

HANSEN: Thank you. Is there anybody who wishes-- who else wishes to testify in support? Welcome.

JACOB BETSWORTH: Good morning, Chairman Hansen and members of the Health and Human Services Committee. My name is Jacob Betsworth, spelled J-a-c-o-b B-e-t-s-w-o-r-t-h, and I'm a lieutenant with the Sarpy County Sheriff's Office appearing before you today in support of LB337. I would like to thank Senator Riepe for introducing this bill, which would provide a much needed tool for law enforcement to help individuals get the assistance that they need. When law enforcement responds to incidents with individuals having a mental health crisis, our response is only as good as the information that we can obtain. Self-attestation is the primary source of information we receive, which can be minimal during a mental health crisis. Knowing what mental health services an individual has or are currently receiving will allow law enforcement to intervene quickly and effectively, law enforcement can then take the individual to the place they have received services before, or call on a doctor that the individual knows and trusts. I'll go off script here for just a second. I've been a law enforcement officer for 22 years, and when I first started mental health and law enforcement were two very separate entities, and that is not the case anymore. We actually started a mental health unit

at the sheriff's office with deputies who are sensitive to mental health issues to respond to those in crisis. And so one of the things that we're trying to do is embed a co-responder, a mental health professional, to actually ride with the deputies, it's best national practice, and respond to the calls. As the state statute sits today, that co-responder could go to, to John Doe's house and have met with John Doe 20 times before, and when they go get in the car and leave that co-responder can not tell the deputy who was in the car with them the history of that person or where they, where they seek care before. And so that's a barrier for us. And so it's one of the things that we're trying to fix. Law enforcement wants to be a good steward and to get people who are in mental health crisis to the care that they need the most and to divert them from the criminal justice system when it's appropriate so that they can get the care that they need. And so that there's not, you know, repeated calls that we can get them the help that they need. And so LB337 will keep the people we serve and law enforcement safe and safer. And I urge the community to advance LB337 out of committee. I thank you all for your time and I'm happy to answer any questions that you have.

HANSEN: Thank you for your testimony. Are there any questions from the committee? Yes, Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thanks for your testimony.

JACOB BETSWORTH: Yes.

M. CAVANAUGH: And for your service to serve the county.

JACOB BETSWORTH: Happy to serve.

M. CAVANAUGH: How does this work? Because, I mean, when you get a call,--

JACOB BETSWORTH: Sure.

M. CAVANAUGH: --I'm just very intrigued by this process--

JACOB BETSWORTH: Yeah, absolutely.

M. CAVANAUGH: --and I appreciate that mental health is being put forward a little bit more. But when you get a call and somebody is having a mental health crisis, how would this particular bill give you access in that situation--

JACOB BETSWORTH: Sure.

M. CAVANAUGH: --with the information you need?

JACOB BETSWORTH: Absolutely, in many ways. First of all, it allows the co-responder that we're with and criminal justice to share information. So we'll use John Doe as an example. John Doe is a frequent caller, has mental health issues. Let's say that co-responder has a history with John Doe and--

M. CAVANAUGH: And who would the co-responder be?

JACOB BETSWORTH: The co-responder is a mental health professional who's embedded with the deputies.

M. CAVANAUGH: Oh.

JACOB BETSWORTH: Yeah.

M. CAVANAUGH: OK, now I'm getting it.

JACOB BETSWORTH: Kind of like, like a ride along program--

M. CAVANAUGH: Sure.

JACOB BETSWORTH: --but with an expert. And so law enforcement are not mental health experts. We are quickly being thrown into the arena where we have to learn to, you know, be cognizant of those things. But we are not the experts. And so what we want to do is have that co-responder with us. And then when we go to a call for service-- well, I guess, backing up this will help. Most mental health crises, law enforcement is called. That's how we know there's a crisis, right, they, they don't necessarily just show up to the hospital, although they do. But most of the time there's a 911 call, deputies respond. And so we're trying to divert people in mental health crisis out of the criminal justice system when we can. And also because we're serve-- we're servants, we're trying to get them to mental health help as soon as we can. And so this will allow us to share the information to get them to the right help sooner, if that makes sense.

M. CAVANAUGH: And this co-responder, is this a program that's been going on for a while or is this new, is this just Sarpy County?

JACOB BETSWORTH: Yeah, in, in some way. Sarpy County is not the first in the state of Nebraska. My understanding is, I think, Lancaster or

Lincoln maybe has a, a co-responder unit. I think Douglas County has one within the last year. And our goal is to get one hopefully in the next six months.

M. CAVANAUGH: OK. Cool. Thank you.

JACOB BETSWORTH: Yeah, it is very, very--

M. CAVANAUGH: I learned something new today.

JACOB BETSWORTH: Yeah, it's new stuff and it's very good for law enforcement and it is very good for practitioners in mental health as well.

M. CAVANAUGH: Thank you. Thanks for testifying.

JACOB BETSWORTH: Absolutely.

HANSEN: Any other questions from the committee? Seeing none, thank you.

JACOB BETSWORTH: Thank you.

HANSEN: Anyone else wishing to testify in support? Welcome.

ASHLEY BERG: Good morning. My name is Ashley Berg, spelled A-s-h-l-e-y B-e-r-g. I am a member of the Nebraska Chapter of the National Association of Social Workers. I'm a licensed independent clinical social worker and have worked in the field of criminal justice for the last seven years. I'm here today to support LB337. Through my work in the criminal justice field and from a criminal justice perspective, Nebraska statute 38-2136 is a major barrier to providing treatment and informed continuity of care to individuals with a mental illness who become involved in the criminal justice system. Aligning Nebraska statute 38-2136 with HIPAA would allow for the disclosure of confidential information for purposes of treatment or continuity of care when written consent cannot be obtained. HIPAA specifies that when this disclosure is allowed without written consent, it applies only to the minimum amount of protected health information needed to accomplish the intended purpose of the disclosure. I find it important to point out that while LB337 seeks to align Nebraska statute 38-2136 with HIPAA, the bill does not allow for unlimited disclosure of information, nor does it say that one should not try to obtain written consent, nor does it say that one should proceed with the disclosure of information without consent when consent can be obtained.

Successful collaboration between criminal justice and mental health is only as good as the information available to the professionals working in those fields. At so many points on the spectrum of criminal justice, individuals are met with uninformed responses because the individual cannot provide written consent to allow for the disclosure of their medication, crisis plan, treatment providers, and overall mental health treatment plan. Uninformed responses can lead to chaotic and risky interactions with law enforcement, longer stays in jail, and mental health relapse. From a provider perspective, all of the progress an individual has made with treatment and medication compliance while in the community can be thrown out the window if the individual experiences a crisis, comes into contact with law enforcement, and is then booked into jail. If the treating provider is unable to contact the jail to inform them of the medication that individual is taking, the jail is forced to operate without any information. Not all jails have fully staffed mental health units either. So if we're looking at a small rural jail, this could mean the individual may be sitting for days or even weeks before being seen by a prescribing provider to even get back on medication. This would likely cause an extended stay in the jail and ineffective discharge planning and potentially a duplication of services upon release. If I was the provider and able to share the necessary information with the local jail, all of this could be avoided. LB337 seeks to remove barriers to the treatment and continuity of care in these types of situations. Nebraska statute 38-2136 predates HIPAA and has been in place since at least 1999, whereas HIPAA privacy regulations went into effect in 2002. So I think it is time for Nebraska to look at why our state statute remains in conflict with the federal regulation. It is for these reasons that I'm asking that LB337 be advanced out of committee. Thank you.

HANSEN: Thank you for your testimony. Are there any questions from the committee? Yes, Senator Ballard.

BALLARD: Thank you, Chair Hansen. You said you've been working in the criminal justice for the last-- field for the last seven years.

ASHLEY BERG: Yeah.

BALLARD: Have you had an experience where this has been a barrier?

ASHLEY BERG: Yes.

BALLARD: OK.

ASHLEY BERG: So I work in the public defender's office as a social worker. And when we have individuals get booked in experiencing an acute psychosis, maybe they're intoxicated, what I find actually more frequently is that they can't remember who their provider is. So from my experience, there is a daily arrest report that goes out to the community providers so they are able to see who was booked into the jail, which would give them the opportunity to call into the jail and say, hey, we're treating this person, here's the medication that they're taking. But Nebraska statute doesn't allow for that if they don't have that written consent.

BALLARD: Thank you.

HANSEN: Any other questions? I have one question. And if you can't answer it, maybe something behind you can or unless I missed it already. At the end of the, the section that's underlined that they're to trying to change, do you know what or as otherwise permitted by law means?

ASHLEY BERG: I, I don't know that I can answer that. I'm not an attorney.

HANSEN: OK. You just look like you knew everything.

ASHLEY BERG: Thank you. I love that.

HANSEN: OK. No, that's fine. Maybe somebody else can answer it or, you know--

ASHLEY BERG: I can look into it, too. I can ask and, and get back to you.

HANSEN: More for curiosity sake. Just-- OK. All right, thank you.

ASHLEY BERG: Thank you.

HANSEN: All right. And thank you for your testimony. Anybody else wishing to testify in support of LB337? All right. Seeing none, is there anybody wishing to testify in opposition to LB337? Seeing none, is there anybody who wishes to testify in a neutral capacity? OK. Seeing none, well, we'll welcome Senator Riepe to close. And for the record, we did have six letters in support of LB337 and one letter in opposition.

RIEPE: Chairman Hansen, thank you. I just want to come and, and summarize a little bit with four points: cross-system care is the key, individuals benefit, families benefit, the community benefits, it complies with HIPAA. And now is the time for Nebraska to join Ohio, Texas, and other states in updating statutes to promote cross-system care. Thank you.

HANSEN: Thank you. Any questions from the committee? All right.

RIEPE: Thank you, sir. Thank you.

HANSEN: Thank you very much. And that'll close the hearing on LB337. And we'll move on to the next one, which is LB345 and welcome up, welcome up Senator Armendariz who, I think, is the first time she's been in front of HHS. Right?

ARMENDARIZ: First time, yeah. I'm trying to keep it to a minimum.

HANSEN: The best committee.

ARMENDARIZ: So I heard from--

HANSEN: All right. See, we're--

ARMENDARIZ: I, I believe--

HANSEN: --communicate with each other, that's why.

ARMENDARIZ: --I believe you, but it is yet to be seen, so we'll find out. Thanks, Chairman Hansen, for having me today and the rest of the Health and Human Services Committee. My name is Christy Armendariz, C-h-r-i-s-t-y A-r-m-e-n-d-a-r-i-z, and I represent Legislative District 18 in northwest Omaha and Bennington. And today I appear before you to introduce LB345. LB345 amends the Health Care Facility Licensure Act to include a definition for palliative care. We probably have all heard this term and associate it with hospice care. But exact-- it is, it-- that is exactly why we need to pass this bill. Palliative care is separate and different than hospice care. So after today's testimony, we hope that we clarify why we need a clear definition that is separate and different from hospice. Palliative care is specialized treatment that is for anyone with a serious illness and not for-- not just for those with a terminal diagnosis. It is a team-based healthcare approach. That means there are at least two health providers who work collaboratively with patients and caregivers to the extent preferred by each patient and may also include a

spiritual leader, a mental health therapist, social workers, or additional components as needed to support the patient. The need for palliative care can occur at any age and at any stage of a serious illness, including those who may, may be expected to recover. Palliative care can be provided in many settings: a hospital, a nursing home, or a private home, and may include curative care like chemotherapy. This bill is important to get everyone on the same page, and we hope that we all understand it better and can, and can be provided to more patients who need it. I additionally have provided AM205, which is just a simple language cleanup to harmonize the definition of LB345 with DHHS rules and regulations after I spoke with them. I have several experts coming up behind me, including a representative from Palliative Care Council, a Nebraska hospice association representative, and a physician who directly works a palliative care program at Children's Hospital. And they can provide more information on how they provide this care. I do have some-- two friends in particular that have encountered this. One was a woman my age whose husband was diagnosed with incurable cancer and was in and out of the hospital for seven years during that term, seriously ill the entire time. So this is the exact kind of treatment that you would engage that type of patient with. And then another whose husband is still with us but has had Stage 4 cancer for two and a half years already and has engaged the palliative care treatment team to help negotiate the, the immense issues that happen while you're-- while you have a serious treatment. Also helps get the family involved because they go through an awful lot. And that kind of helps have a seamless approach to a, a definitely bad issue. So if there's any questions of me.

HANSEN: All right. Thank you for your opening. Are there any questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you so much. I appreciate you bringing this. It's an issue that's near and dear to my heart as well. And making the difference of understanding the difference between hospice and palliative care is such a significant thing. I know my mother-in-law passed away from cancer after a ten-year battle and she did not have palliative care. And this would have been-- and she did not want to do hospice for a lot of the reasons that people want to not have that end-of-life care. So just really appreciate it and thank you for your work on this.

ARMENDARIZ: Thank you.

HANSEN: Any other questions? All right. Seeing none, I'm assuming you're sticking around to close.

ARMENDARIZ: Yeah.

HANSEN: OK. All right. So with that, we will take our first testifier in support of LB345. Welcome.

MARCIA CEDERDAHL: Good morning, Chair Hansen and members of the Health and Human Services Committee. My name is Marcia, M-a-r-c-i-a. Frequently people think it's Marcia, but it's Marcia. Last name is Cederdahl, C-e-d-e-r-d-a-h-l. I'm a registered nurse. I'm also certified in palliative nursing. I serve on the Nebraska Palliative Care and Quality of Life Advisory Council, and I'm also a two-time cancer survivor. In 2017, Senator Mark Kolterman introduced LB323, which established the Palliative Care and Quality of Life Act. And this legislation created two entities, the Palliative Care Consumer and Professional Information and Education Program, in which the Nebraska Department of Health and Human Services provides key palliative information via its website. And then the, the Palliative Care and Quality of Life Council, which consults and advises Nebraska DHHS on matters related to palliative care. The nine-member council includes physicians and nurses certified under hospice and palliative medicine certification and other experienced palliative care professionals. The council is now in our sixth year and our goal continues to be increasing public awareness of palliative care and ensuring that all Nebraskans living with a serious illness have access to high-quality palliative care that will improve their life and potentially reduce avoidable emergency department visits and as well as hospital visits. As we've talked about, there continues to be much confusion about palliative care and who's eligible for the services. Passing this definition in Nebraska will create a shared understanding for what palliative care is. It is the specialized medical care for people living with a serious illness that carries a high risk of mortality or negatively impacts the quality of life. This type of care addresses the symptoms and stress of a serious illness, including pain. Palliative care is team based, providing care not just to the patient with the diagnosis, but their family and caregivers as well. And sometimes they need it more than the patient, which results in a better quality of life for everyone involved. Who is eligible? Palliative care is appropriate, appropriate at any age and at any stage of a serious illness. Actually, when, when someone is diagnosed with a serious illness, that's when palliative care should start. It's based on the needs of the patient, not their prognosis. It can be

provided and often is provided along with curative treatment. Where it can be provided. It can be provided across all care settings, including hospitals, nursing facilities, assisted living, skilled facilities, independent living, outpatient clinics, and home. I was diagnosed with Stage 2C colon cancer in June of 2012 and Stage 3 parotid gland cancer in November of 2020. My treatment regimens have included surgery, chemotherapy, and 30 radiation treatments. I'm so blessed to still be here and to have oncologists who are certified in palliative medicine. Sorry. As a career-long hospice and palliative care nurse, a sister whose brother died from an excruciating cancer battle in 2014, and as a survivor myself, I feel strongly there must be greater access to palliative care across Nebraska in both the urban and the rural areas. I know this isn't the case currently. Having a clear understanding of what palliative care is can assist with our council goal and help people across the state. My greatest hope is that having served on this Palliative Care and Quality of Life Advisory Council, I can use my personal and professional experience to ensure that all Nebraskans will have access to this essential care moving forward. Thank you for hearing my testimony. We want to be sure that all of your constituents are able to receive this type of care, and I'll be happy to answer any questions. Thank you.

HANSEN: Thank you for your testimony. Are there any questions from the committee? I might have a couple.

MARCIA CEDERDAHL: Sure.

HANSEN: More about, since you're on the council, what the council actually does. You talk about the goals to increase the public awareness. How do you do that?

MARCIA CEDERDAHL: Well, we, we have the website that we currently keep up to date and it's-- if you Google Nebraska DHHS and put in palliative care, the, the website will pop up. We meet quarterly and we have done a lot of education. Several-- myself and several other members of the council started doing that probably in 2018. Had a bit of a slow down during the pandemic because we couldn't get out, but tried to speak to all the different boards through DHHS. A lot of public presentations talking about it whenever we get the chance.

HANSEN: OK. So educational as well?

MARCIA CEDERDAHL: Um-hum.

HANSEN: More to the department?

MARCIA CEDERDAHL: And anyone else who would ask.

HANSEN: OK. All right.

MARCIA CEDERDAHL: Yeah.

HANSEN: Just kind of curious. We tend to have a lot of councils and boards and commissions in HHS and so--

MARCIA CEDERDAHL: Yeah.

HANSEN: --sometimes I always like to get a greater understanding of what each one means, what they do, you know, what their place is and a lot of that kind of stuff. So I appreciate you filling us in on it, too.

MARCIA CEDERDAHL: Sure, you bet.

HANSEN: So that helps us a lot. Thank you for coming to testify. Oh, we may have one question from Senator Walz.

WALZ: Thank you, Chairman Hansen. And maybe you said something about this already. Does palliative care have to be prescribed or can it be prescribed or is it just if you want this service you call and-- do you know-- I mean, when he said how, how does this get out--

MARCIA CEDERDAHL: Um-hum.

WALZ: --I was thinking about, well, obviously, maybe through doctors' offices or--

MARCIA CEDERDAHL: It sure can come that way. You know, one of the, one of the areas we see it a lot is in the hospital. There are physicians and nurse practitioners who specialize in palliative care. The problem is once it gets out in the community, there really isn't a lot of areas that provide community-based palliative care. So hopefully this would help that. I worked for the Health Care Association for a couple of years and I would get people that would call me and say, how do I get-- my doctor said I need palliative care. So a lot of times it starts with a physician.

WALZ: All right.

HANSEN: OK. Any other questions? All right. Seeing none, thank you very much.

MARCIA CEDERDAHL: Thank you.

HANSEN: Take our next testifier in support. Good morning.

MARILEE MALCOM: Good morning. Good morning, Chairman Hansen and members of the committee. Thank you for allowing me to speak today. I'm Marilee Malcom, M-a-r-i-l-e-e M-a-l-c-o-m. I'm the executive director of Nebraska Hospice and Palliative Care Association. We're a statewide partnership to improve the quality of life for all Nebraskans who have chronic conditions or who are near end of life and to support the various communities who care for them. I'm a registered nurse and I've worked in hospice for more than 20 years. I'm here today to support LB345 and to-- which defines palliative care in Nebraska statute. Nebraskans use the term hospice and palliative care interchangeably as though they are the same, when in fact they are not the same. While hospice always includes palliative care through symptom management, psychosocial support, spiritual support, assistance with bathing, personal care, volunteer support, nursing and physician expertise, hospice can only provide this care to patients who are in the last six months of their life and who are no longer seeking curative treatment for their disease. Patients with chronic and serious illness need support at every age, at every stage of the-- of their disease process from diagnosis until death. And so do their caregivers and families. Picture the three-year-old with a new diagnosis of cancer suffering from the side effects of chemotherapy. Picture the 29-year-old mom with a new diagnosis of MS, the father diagnosed with congestive heart failure following COVID-19 or the juvenile diabetic now in renal failure, and the list goes on. There are many Nebraskans who are diagnosed with serious illnesses every day who are seeking aggressive treatment but need palliation of the symptoms of the disease and the side effects of the medications they're taking. They need emotional support. They need to understand their options and they need a team. These patients may live with these disease processes for 20 years or more. They need palliative care services. They may only need it once or they may need it intermittently throughout their disease process. Palliative care teams prevent unwanted and unnecessary hospitalizations, improve quality of life, improve patient satisfaction, and save costs for our healthcare systems. These seriously ill patients have a need for a team-based support in the community, and at this time we can't offer it. The Council to Advance Palliative Care recommendation is to first define

palliative care, so then we can develop standards for this care. Their study shows we have some palliative care available in the larger hospitals across the state. But if you live in rural areas of Nebraska, like Senator Hardin and myself, this care is not available. Currently, we have very, very few providers going into the homes of patients living with serious illness to assist with their needs. At best, we can visit them when we're a patient in the hospital. So why do we need palliative care? We need to-- or excuse me, why do we need to define palliative care? We need to define it to assure we understand these points. First, palliative care is a specialized medicine to improve quality of life for those with serious illness at any age and any stage and wherever that patient lives. Secondly, palliative care is not hospice. Patients can receive treatment for the symptoms of the disease or the side effects of their treatment and can receive curative treatment and palliative care at the same time. People are living longer and should be afforded a quality of life free from pain and suffering with a team of people working together to meet their needs, to answer their questions, to provide support, and ensure that their wishes are honored throughout their disease process, just as hospice does at end of life. Thank you for the opportunity to speak in favor of LB345. I'm happy to answer any questions.

HANSEN: Thank you for your testimony. Are there any questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for your testimony. There's only one letter in opposition and it's one sentence, and I just wanted to see if you could address it. It's from someone who's a psychiatrist who said they would support the bill if it specifically included mental illness as eligible for palliative care. And what I see doesn't prohibit mental illness. In your experience, does-- is mental illness something that can be covered under palliative care? Would that be appropriate?

MARILEE MALCOM: I'm going to have to honestly say I'm not prepared to answer that question.

M. CAVANAUGH: That's fine.

MARILEE MALCOM: You know, it's not been something that I've seen mentioned in any studies or literature that I've read on palliative care, but I'm going to defer to Dr. Macfadyen, he's going to testify next.

M. CAVANAUGH: OK. Thank you.

MARILEE MALCOM: Um-hum.

HANSEN: I have a couple questions again.

MARILEE MALCOM: Sure.

HANSEN: More like, again, in the interest of understanding all the, you know, different committees and associations. So you get-- I'm assuming you guys are based in Nebraska since you're Nebraska.

MARILEE MALCOM: Correct.

HANSEN: OK.

MARILEE MALCOM: Correct.

HANSEN: And then what is the Council to Advance Palliative Care? Is that one federal?

MARILEE MALCOM: No, that was-- I was referring to the, the Palliative Care Council that Governor Ricketts established. So I, I believe--

HANSEN: OK.

MARILEE MALCOM: --on Marcia and Dr. Macfadyen's council.

HANSEN: OK. Just wondering what that meant. OK. All right. And do you guys do a lot of the same stuff that the Palliative Care and Quality of Life Council do? Like, you educate, like, public or, or--

MARILEE MALCOM: We do. So we're the association that all of our members are involved in providing hospice, providing palliative care, or even some coalition members who may be providing those services to residents in their building through hospice agencies that serve there. So our role is to educate them, to advocate for hospice and palliative care in Nebraska and to-- we have a statewide conference every year where we provide continuing education credits to those people. We provide expertise on regulatory issues if they have questions. We're the place that they call. So we were previously based in Lincoln. But when I became the director, we closed our office and moved it to my house. So I live in Cozad, Nebraska.

HANSEN: OK. All right. I just appreciate everything you, you do.

MARILEE MALCOM: Thank you.

HANSEN: Because having seen it multiple times, you know, in different arenas, whether it's in my home or whether it's in hospitals, you know, I think it's very, very important. I think sometimes people don't feel alone or they don't feel like, you know, that no one cares for them. And so it's nice to have somebody there to help them out, so.

MARILEE MALCOM: Thank you so much.

HANSEN: Any other questions from the committee? Seeing none, thank you very much.

MARILEE MALCOM: Thank you.

HANSEN: We'll take our next testifier in support.

LINA BOSTWICK: Good morning.

HANSEN: Good morning.

LINA BOSTWICK: Thank you for listening, Chair Hansen, the committee members. I am Dr. Lina Bostwick, and I'm a registered nurse and I've been a registered nurse for 39 years. I'm going to go off script just a little bit here because you've heard some testimony that I have as well in here. For that 39 years, I've been in hospital acute care setting for 29 years and med-surg and ICU, a lot of different settings. And there are several times a registered nurse in acute care could bring up the topic of palliative care. And a lot of times it's resisted or families, patients don't know much about it and they have a fear of it thinking it means hospice. It does not. But a bill like this will help support and set the stage for those of us that can educate our patients and our families. We could refer to this definition that's given that seems so appropriate of what palliative care is. You know, it's a specialized medical care. And you-- we've heard about this. I have a lot of evidence listed here in my letter, which you will get. But I just want to point out, there can be some curative care in palliative care as, for example, my own father, who had a devastating stroke at the age of 59, lived in a nursing home for 15 years. And we finally, finally did get palliative care. And it was the best thing we ever did for him. Best thing ever. It took so much relief away from our own worry as a family and the care that he was getting. He could decide if he wanted his tube feeding. If he needed some different kinds of medications, it would be discussed. And it was

so incredibly powerful for the rest of his life. You know, there's just so many diseases, definition of serious illnesses acquired or genetic conditions. My own father had to have-- he had esophageal stricture, so he often had to be dilated. You know, that's what he wanted because he wanted to be able to eat. But if he chose he didn't want to do that and wanted to just be more comfortable, that would have been just fine. It was what my dad wanted. You know, we talked-- you've heard about children. There are 400,000 children are currently living with a serious illness. LB345 provides clarity on the definition, which we so badly need. Patients and families navigate conversations that are very difficult, and this just makes it so much easier. You know, I do have evidence here that according to data from the National Cancer Institute, Health Information National Trends, 71 percent of U.S. adults never have heard of palliative care. Another study using the same data found that Americans who identified themselves of knowledgeable, 60 percent held at least one misperception. So revisions of this bill is an excellent representation of what palliative care means in Nebraska. It sets the stage like I had mentioned before. So the Nebraska Nurses Association asks that you would move LB345 out of committee to General File.

HANSEN: All right. Thank you for your testimony.

LINA BOSTWICK: You are very welcome.

HANSEN: Are there any questions from the committee? Not seeing any. All right. Thank you for coming. Appreciate it.

LINA BOSTWICK: Thank you.

HANSEN: Is there anybody else wishing to testify in support? Welcome.

ANDREW MACFADYEN: Yeah, thanks. Good morning, Chairman Hansen and members of the HHS committee. My name is Dr. Andrew Macfadyen. That's spelled A-n-d-r-e-w M-a-c-f-a-d-y-e-n, and I'm here today on behalf of the Nebraska Hospital Association and the Nebraska Palliative Care and Quality of Life Advisory Council in support of LB345, which will define in state statute what palliative care is for all Nebraskans. I have the distinction of being the first board certified pediatric hospice and palliative care doctor in Nebraska. For almost 17 years now, I've been the medical director of the pediatric palliative care program at Children's Hospital and Medical Center, during which time our palliative care team has served nearly a thousand children from all parts of Nebraska who are going through serious life-limiting

illnesses by providing guidance, care coordination, and symptom relief to make their lives and the lives of their families better. Our patients have a multitude of medical and ancillary specialists and must navigate home healthcare companies, insurance companies, and even school systems. Their homes are sometimes mini ICUs, equipped with home nurses and medical technologies such as monitors, BiPAP machines, mechanical ventilators, oxygen tanks, and feeding pumps. Plus, they usually have a garage stacked floor to ceiling with medical supplies. In 2018, we published a study showing that on average, our palliative care families in Nebraska provide 73 hours a week of direct patient care to their children. They also missed 23 hours of work every week on average because of shortages in home nursing care. Beyond that, our families are faced with monumental, life-altering, sometimes life-and-death choices that they must make for their child. We help them navigate those choices in line with their values. With all that our families are facing, medical, financial, emotional and spiritual burdens, the extra layer of support palliative care provides is vital to their success. Sometimes we can rejoice with the families when a cure is found. Most of the time we will celebrate small wins whenever we can find them, and sometimes we cry with them when the illness is too much and their child dies. Regardless of the circumstance, though, we are always there for the family providing support to them, along with their primary medical team, to make sure their quality of life is the best it can be. We are there for them walking hand in hand. So why do we need a definition of palliative care in the statutes? Well, most people associate palliative care with hospice and dying, even though the vast majority of our patients are not actively dying. Currently, palliative care is only mentioned in the state hospice statutes. We would like the clear and separate definition of palliative care in LB345 to help us overcome the confusion between hospice and palliative care. This confusion exists among medical professionals, payers, and laypeople alike. The confusion is understandable, though. Hospice and palliative care are often lumped together since the principles of palliative care underpin the practice of hospice. The differences are very important, though. Palliative care helps improve quality of life from the beginning of their illness even when the patient is not actively dying. Even if a cure is possible. In addition, having palliative care involved at the beginning of an illness improves the transition to hospice later if that transition is needed. The need for palliative care and the practice of palliative care is growing steadily in Nebraska. The definition in LB345 will help us to set standards in the future and give guidance to medical professions who want to join the effort in providing palliative care in a variety of

settings across the state. It's time to set palliative care apart. Thank you for your consideration. I kindly ask you to advance LB345 from committee, and I'm betting I'll have some questions.

HANSEN: Thank you for your testimony. Are there any questions from the committee? I actually don't have any, so.

ANDREW MACFADYEN: OK. So I-- can I address the question about the mental health--

HANSEN: Yes, sure.

ANDREW MACFADYEN: --mental illness? So there's-- there really would be no reason why mental illness would not qualify for palliative care. Probably the biggest impediment is just everybody's bandwidth. They don't-- you know, people just don't have enough. There, there aren't enough resources for that, but.

M. CAVANAUGH: But the current definition would include--

ANDREW MACFADYEN: Would not, would not.

M. CAVANAUGH: --or exclude.

ANDREW MACFADYEN: Exclude mental health, mental Illness.

M. CAVANAUGH: It didn't read like it did so I just wanted to check. Thank you.

ANDREW MACFADYEN: You're welcome.

HANSEN: I have a question.

ANDREW MACFADYEN: OK.

HANSEN: The definition that palliative care that we're, that we're introducing in this bill, is that typically a definition that most hospitals use, like such as your pediatric palliative care team?

ANDREW MACFADYEN: Yes, so it is. And, and also that's written-- it's in line with national organizations as well.

HANSEN: OK. We're just putting it in statute so we have a, a clear definition--

ANDREW MACFADYEN: Correct.

HANSEN: --for the most part. OK.

ANDREW MACFADYEN: Correct.

HANSEN: All right. Thank you.

ANDREW MACFADYEN: OK.

HANSEN: And thank you for your testimony. Take the next testifier in support. Welcome.

ADRIAN SANCHEZ: Good morning, Senators. Good morning, Chair Hansen and senators of the Health and Human Services Committee. My name is Adrian Sanchez, spelled A-d-r-i-a-n, last name Sanchez, S-a-n-c-h-e-z, and I'm here on behalf of the Nebraska Association for Home Healthcare and Hospice. Please submit into-- or please accept into record this letter submitted on behalf of Executive Director Janet Seelhoff in support of LB345. Unfortunately, she could not be with us here today. We would like to thank Senator Armendariz for introducing this bill and we respectfully request the committee's support of LB345 to help ensure Nebraskans are fully aware of this care option as a way to ensure that they or a loved one receive the support they need to help preserve their quality of life. I'd be happy to answer any questions that you have. And I want to thank you for your time and consideration on this matter.

HANSEN: Thank you. Short and sweet. I like it.

ADRIAN SANCHEZ: Yes.

HANSEN: Are there any questions from the committee? Yes, Senator Riepe.

RIEPE: I have a question. I simply want to get it on the table so that we don't have a waive at the close and, and my question is, is the Advisory Council a volunteer group? And I don't know whether you know--

ADRIAN SANCHEZ: I am not familiar with that as I am not--

RIEPE: And the other one that I would try to get on the table would be the, you know, the commercial, is it commercial or Medicaid insurance is it reimbursable?

ADRIAN SANCHEZ: I think that's what--

RIEPE: I'm not trying to put you on the spot, I'm just trying to [INAUDIBLE].

ADRIAN SANCHEZ: --this definition helps lay the stage for is to help define it in statute so that we can get recognition of it and potentially coverage of it.

RIEPE: OK.

HANSEN: Any other questions from the committee? So just to be clear, you are separate from the Nebraska Hospice and Palliative Care Association.

ADRIAN SANCHEZ: Correct, we are. Yes.

HANSEN: Nebraska Association for Home Healthcare and Hospice.

ADRIAN SANCHEZ: Yes. Yes. We have a number of members that do both home healthcare as well as in-home hospice services. So, yes.

HANSEN: OK. Do you do much with palliative care or is it more to kind of stick with more the hospice side of it?

ADRIAN SANCHEZ: So because it's defined in the state, we do have some members that provide palliative care that are hospice providers, but we don't necessarily have home health members that provide palliative services. But this definition may open the doorway for that to occur.

HANSEN: OK.

ADRIAN SANCHEZ: Yeah.

HANSEN: Makes sense. All right. Well, thank you for your testimony.

ADRIAN SANCHEZ: Thank you very much.

HANSEN: Is there anybody wish-- anybody else wishing to testify in support? Welcome.

JINA RAGLAND: Good morning, Chair Hansen and members of the Health and Human Services Committee. My name is Jina Ragland, J-i-n-a-R-a-g-l-a-n-d, here today on behalf of AARP Nebraska testifying in support of LB345. AARP strongly believes that all individuals have the right to be self-reliant and live with dignity and respect. And we support efforts to update the definition and improve access to palliative care services and the elimination of barriers as outlined

in LB345. Most people hear the words palliative care and think hospice, but they are different types of care. And much of what you've heard today, hospice is reserved for when curative treatments have been exhausted and patients have less than six months to live. Palliative care is a team-based medical specialty focused on providing relief from the symptoms and stress of serious illness. It's based on need and not prognosis and can be appropriate at any age and during any stage of any illness, often provided alongside curative treatments such as chemotherapy, radiation or surgery. Palliative care can have an enormous impact on the quality of life and outcomes in people experiencing serious or terminal illness and to support their families and their caregivers. Some of the benefits include symptom management support, improved quality of life, reduced risks of depression, longer survival, support in making decisions, and support again for family members and caregivers and overall improved caregiver satisfaction. To illustrate the importance of palliative care, I want to share with you a story of David Griffiths [PHONETIC], who's one of our members. David couldn't breathe, and the 69-year-old had been losing his voice for months and had woke up grasping-- gasping for breath and was admitted to the hospital. The next day, an ear, nose and throat doctor probed his throat and discovered a huge white tumor wrapped around his larynx, crushing his windpipe, his esophagus, and his vocal cords. Doctors rushed him into surgery to place a breathing tube in his throat, and over the next few days inserted a feeding tube in his stomach, and [INAUDIBLE] for delivering medication. He would need five kinds of chemotherapy plus radiation to shrink the tumor and kill the cancer. He'd spend the next six months traveling to and from the hospital several times a week for outpatient treatment and IV rehydration. He was unable to work and had to avoid public places and being around people because he couldn't risk catching an infection. The unrelenting pain in his neck made it nearly impossible for him to sleep. But unlike most people who enter the hospital with a severe illness Mr. Griffiths had a secret source of strength, his palliative care team. Comprising of specially trained doctor, nurses and other practitioners, the team helped him deal with the pain, stress, and logistics of his treatment. In addition to making sure he was on the right dosage of morphine, his palliative care team helped him get rides to and from the hospital, provided a nutritionist, helped coordinate his care with all of, all of his other doctors and answered any questions he had in between visits. Why should someone have to be dying to have someone focus on their quality of life? People who get palliative care feel better, avoid preventable 911 calls, ER visits and hospitalizations, and they stay independent in a better control at

home. They have someone who can help if a crisis arises in the middle of the night, and a palliative care provider acts like a quarterback working closely with the other team members, nurses, chaplains, social workers, patients, other doctors, and, and anyone else that's involved in the team. Communication is critical because one of the major issues people living with serious illness face is the fragmentation of our healthcare system. Communication through palliative care is easier by coordinating care. The specialist focuses on treating the disease, prolonging their life, and ideally curing them while the palliative care team focuses on everything else. Approximately 6 million people in the U.S. have a need for palliative care, but most patients don't know about their options. The great majority who could benefit from care are not getting it, and often due to the misunderstanding of what it actually is. AARP believes that patients should have access to improved palliative care including better treatment for emotional distress and the elimination of all barriers to the appropriate management of pain and suffering and improve access to palliative care services regardless of the patient's setting including excluding limitations based on life expectancy and the prohibition on the use of acute and other curative services. Much like you heard of when I talked about Mr. Griffiths. For these reasons, AARP strongly supports LB345 and would ask the committee to support and advance the bill. We would like to thank Senator Armendariz for introducing the legislation and for the opportunity to comment. And I would also like to thank the committee for your time. I know you've had a very long week, so I appreciate your, your listening today. I'd be happy to answer any questions.

HANSEN: Thank you for your testimony. Are there any questions from the committee? All right. Seeing none, thank you.

JINA RAGLAND: Thank you.

HANSEN: Anybody else wishing to testify in support of LB345? Welcome.

MARION MINER: Good morning. Good morning, Chairman Hansen and members of the Health and Human Services Committee. My name is Marion Miner, M-a-r-i-o-n M-i-n-e-r, and I'm here today on behalf of the Nebraska Catholic Conference, which advocates for the public policy interests of the Catholic Church and advances the gospel of life through engaging, educating and empowering public officials, Catholic laity, and the general public. I'm here today to express the Conference's support for LB345, which would define palliative care and distinguish it more clearly from hospice. The Conference has been supportive of

public policy that promotes palliative care and makes it more available for many, many years. And I'll go ahead and, and make my planned testimony much briefer so as not to be too repetitive. But I will just say palliative care recognizes and addresses not only physical, but also psychological, emotional and spiritual symptoms resulting from illness and suffering. Palliative care is not reserved for one specific group or purpose. It exists for the benefit of all who suffer. LB345 makes that clearer. Mitigating the negative effects of suffering physical, psychological, social or spiritual is a moral good. It would benefit the general public and those in the medical professions to know that palliative care can be offered alongside curative treatment and in its greater scope accomplishes something equally important to curative treatment, it values and recognizes the whole person. For these reasons, the Conference supports LB345 and we encourage you to advance it to General File. Thank you.

HANSEN: Thank you for your testimony. Are there any questions from the committee? All right. Seeing none, thank you.

MARION MINER: Thank you.

HANSEN: Anybody else wishing to testify in support? All right. Seeing none, is there anybody who wishes to testify in opposition to LB345? Seeing none, is there anybody who wishes to testify in a neutral capacity to LB345? Seeing none, we will welcome back Senator Armendariz to close. And with that, we did have three letters in support of LB345 and zero in opposition.

ARMENDARIZ: Thanks. I just want to thank everybody for coming and testifying for this bill. And thank you so much as the committee for listening to us. And hopefully we have shared the importance of what we're trying to do here with LB345. I have to also say this does not have a fiscal note because it's important to me.

HANSEN: All right. Any questions from the committee? Yes, Senator Riepe.

RIEPE: And thank you for closing. I appreciate that. My question was then, if there's no fiscal note then there's-- they are volunteers in terms of the council?

ARMENDARIZ: I, I haven't talked to them in particular whether they're volunteers or paid.

RIEPE: Can you help me out, too, is this reimbursable-- service reimbursable under a [INAUDIBLE], office visit codes?

ARMENDARIZ: I have known people that have taken advantage of it, but I haven't asked them on how their insurance pays for it. They were engaged in a hospital setting and directed to you should probably engage palliative care at this point.

RIEPE: And just also appears for Medicaid [INAUDIBLE] at this point. Thank you.

ARMENDARIZ: Yeah, hopefully that's a possibility to open it up for more reimbursement for the people that need it.

RIEPE: I think it's a good care bill, so thank you.

ARMENDARIZ: I appreciate it.

HANSEN: Any other questions? I think for clarity, I think with the original bill in LB323 with Senator Kolterman I think there was a fiscal note when they first started it, and that's pretty much-- so I think they are volunteers, but I think they get a per diem for their meetings and stuff like that's minimal is my understanding. All right. Thank you--

ARMENDARIZ: Thank you.

HANSEN: --for your closing. And with that, we will close the hearing on LB345. And we will now open the hearing for LB548 and welcome Senator Beau Ballard.

BALLARD: Just glad the, the pharmacists don't care about natural hair braiding.

HANSEN: All right. Well, welcome.

BALLARD: All right. Good morning, Chairman Hansen and members of the Health and Human Services Committee. My name is Beau Ballard. For the record, that's B-e-a-u B-a-l-l-a-r-d. I represent Legislative District 21, which is northwest Lincoln and northern Lancaster County. I'm here today to introduce LB548, which makes changes to the examination and compounding requirements under the Pharmacy Practice Act. Under Section 1 of the bill, it amends Section L-- or it amends Section 38-2852, which contains provisions relating to the required examination of jurisprudence in the pharmacy examination. Under the

law, the applicant of the, the licensure as a pharmacist is required to obtain a grade of exactly 75 percent. LB548 would clarify the issue by removing the specific grade requirement in statute and authorizing the Board of Pharmacy to determine the grade requirement for the examination. Under Section 2 of the bill, the person authorized to compound the process of combining, mixing, and altering ingredients to create a medication to be tailored to the need of individual patients would require to be in compliance with the standards of Chapter 795 and 797 of the United States Pharmacopeia and National Formulary existence on January 1, 2023. Current law references the standard as they exist on January 1 of 2015. I encourage the committee to advance LB548 to General File and thank you for your time and consideration.

HANSEN: Thank you for that. Is there any questions from the committee? Yes, Senator Day.

DAY: Thank you, Chair Hansen. Senator Ballard, is this your first bill introduction?

BALLARD: This would be my third.

DAY: Oh, it's your third. Well, you did excellent.

BALLARD: Well, thank you so much. I appreciate it.

HANSEN: All right. Any other questions? All right. Seeing none, we'll see you at close.

BALLARD: Yeah.

HANSEN: All right. We're staying. We'll take our first testifier in support of LB548. Welcome.

ROBERT J. HALLSTROM: Chairman Hansen, members of the committee, my name is Robert J. Hallstrom, H-a-l-l-s-t-r-o-m. I appear before you today as registered lobbyist for the Nebraska Pharmacists Association in support of LB548. My wife always tells me I have a way of clearing out a room and I've pretty much done it again today. I hope that doesn't detract from the importance of the bill. When I first approached Senator Ballard-- sometimes bills are presented and we say they make technical corrections, I think I'm pretty confident that this is clearly a technical corrections bill. Senator Ballard has done a nice job of telling you about the twofold purpose of LB548. The first one is to address the applications that is connected with the request for licensure as a pharmacist. There are two specific exams.

One is an exam regarding proficiency in pharmacy knowledge. The second, which is referred to as a jurisprudence exam, is one that demonstrates proficiency in both state and federal pharmacy law knowledge. The technical aspect of this is that the statute does specifically say that a grade of 75 is required. It does not say at least 75. And in fact, my understanding is that this exam is being graded on a pass-fail basis. So we're just making that technical correction and putting it in the board's hands to make that determination. The second issue, which is also somewhat technical, we have many bills before the Legislature that make references to federal laws, standards or regulations. This is another one of those. This particular reference to the USP Chapter 795 and 797 have not been updated since January 1 of 2015. There have in fact been some very significant changes as of November of 2022 that will be updated by enhancing that reference to January 1 of 2023. I had told Senator Ballard that I was going to have a pharmacist here today. Unfortunately, there was a conflict at the last minute. I can do some basic explanation of compounding if the committee is interested, but I am certainly Senator Hansen not going to be mistaken for that witness that you said earlier looked like she knew everything, so. But basically when we talk about compounding, it's putting together pursuant to a prescription order a medication that for some reason or another the patient might not be able to tolerate the commercially available drug, whether it's due to the dosage or intolerance to a specific ingredient contained within the drug. And then we look under Chapter 795 and 797 to two separate types of compounding sterile and nonsterile. That doesn't have to do anything with clean and unclean. It has to do with the purpose for which the compounded medication is used. When we look at sterile compounding that involves typically injections, infusions or applications to the eye, while nonsterile medications include production of solutions, suspensions, ointments, creams, powders, suppositories, capsules and tablets. And there are a whole list of standards that pharmacists must comply with with regard to USP 795 and 797. Those standards will go into effect. They were adopted in November of 2022. They have until November of 2023 to be in compliance, but this will be update it so that they will be applicable to those actions on a going forward basis. We'd ask the committee to advance the bill. I'd be happy to address any questions that you might have.

HANSEN: Thank you for your testimony. Are there any questions from the committee? I just learned the difference between sterile and

nonsterile products. I didn't know that either, so. Thank you for your testimony.

ROBERT J. HALLSTROM: Thank you, Senator.

HANSEN: Is there anybody else wishing to testify in support? Seeing none, is there anybody who wishes to testify in opposition to LB548? Seeing none, is there anybody who wishes to testify in a neutral capacity? Seeing none, we'll welcome-- Senator Ballard is waiving closing. So with that, that will close the hearing for LB548 and close our hearings for this morning. We come back at 1:30.

HANSEN: All right. Good afternoon and welcome to the Health and Human Services Committee. My name is Senator Ben Hansen. I represent the 16th Legislative District in Washington, Burt, Cuming and parts of Stanton Counties and I serve as Chair of the Health and Human Services Committee. I would like to invite the members of the committee to introduce themselves, starting on my right with Senator Ballard.

BALLARD: Beau Ballard, District 21, northwest Lincoln and northern Lancaster County.

WALZ: Lynne Walz, Legislative District 15. I'm just so glad it's Friday today, sorry. Legislative District 15, which is Dodge County and Valley.

HARDIN: Brian Hardin, District 48: Kimball, Banner, and Scotts Bluff Counties.

M. CAVANAUGH: Machaela Cavanaugh, District 6, west-central Omaha, Douglas County. Also glad that it's Friday.

RIEPE: Merv Riepe, District 12, which is southwest Omaha and Ralston.

HANSEN: OK. Also assisting the committee is our legal counsel, Benson Wallace, and our committee clerk, Christina Campbell. And our committee pages for this afternoon are Payton and Delanie. A few notes about our policy and procedures. Please turn off or silence your cell phones. We will be hearing three bills and we'll be taking them in the order listed on the agenda outside the room. On each of the tables near the doors to the hearing room, you will find green testifier sheets. If you're planning to testify today, please fill one out and hand it to Christina or one of the pages when you come up to testify. This will help us keep an accurate record of the hearing. If you are not testifying at the microphone but want to go on record as having a

position on a bill being heard today, there are white sign-in sheets at each entrance where you may leave your name and other pertinent information. Also, I would note if you are not testifying but have an online position comment to submit, the Legislature's policy is that all comments for the record must be received by the committee by noon the day prior to the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. We would ask if you do have any handouts, that you please bring ten copies and give them to the page. We use a light system for testifying. When you testify, you will have five minutes to testify. When you begin, the light will be green. When the light turns yellow, that means you will have one minute left. When the light turns red, it is time to end your testimony and we will ask that you 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 names. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters of the bill, then from those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given the opportunity to make closing statements if they wish to do so. On a side note, the reading of testimony that is not your own is not allowed unless previously approved and we do have a strict no-prop policy in this committee. So with that, we will begin the hearing with LB430 and welcome up, welcome up Senator Walz to open. Welcome.

WALZ: Thank you, Chairman Hansen and fellow members of the Health and Human Services Committee. My name is Lynne Walz, L-y-n-n-e W-a-l-z, and I serve District 15, which is Dodge County and Valley. In 2021, this committee advanced LB100 unanimously, which provided protection for continued access to occupational therapy, physical therapy and speech pathology services in the state of Nebraska's Medicaid managed care system. Since this bill became law, these professions have not had the issue of dramatic payment reductions for their, for their services. LB100 prohibited the use of multiple provider payment reduction, or MPPR. If MPPR had been implemented in our Medicaid system, it would have made it very difficult for these providers to continue to serve low-income Nebraskans and their children. Now I'm coming back with a similar bill, similar bill to restrict this multiple provider payment reduction, but on the private insurer side. Implementing MPPR on the private insurers side will impact a huge portion of Nebraskans' access to care. This bill is about access to healthcare and I would contend that rehabilitative services are much less costly than a knee replacement, a back surgery or a lifetime loss

of employment because no one-- or someone can no longer work. In addition, these services are also critical to reducing the need for opioids long term for patients with chronic pain. MPPR is the policy that reduces rates paid to providers when multiple procedures, procedures are delivered to the patient on the same date of service. These-- this bill focuses only on three rehabilitative service-- healthcare services: physical therapists, occupational therapists, and speech, speech pathology because this is where the problem of reimbursement mainly lies. During our discussions on LB100, I had anticipated that there may be other providers that are concerned that such a policy may be implemented for their services at some point. Although larger facilities and clinics can perhaps sustain this model for a long period of time, smaller clinics will have difficulty sustaining patients that have an insurer that implements this policy and could consider closing altogether. Additionally, I would like to note that my staff has spoken with the Nebraska Insurance Federation in regards to how this would affect ERISA, which are self-funded plans that are governed by the federal government. We can provide additional language to distinguish only plans the state can govern to clarify the intent of the bill. There are providers coming up behind me that will go into detail on how this works in practice and the impact it has on our patients. Unfortunately, I do have to run after I get done opening so I will waive my closing. I would be happy to answer any questions you have now, but if you have questions following the hearing, please feel free to send my office an email and I will, and I will get you an answer as soon as possible. Thank you.

HANSEN: Thank you. Are there any questions from the committee? All right, seeing none, thank you very much.

WALZ: Thank you.

HANSEN: All right and we will start with our first testifier in support of LB430. Hello.

NICK WEBER: Chairman Hansen and members of the Health and Human Services Committee, my name is Nick Weber, N-i-c-k W-e-b-e-r. I'm a physical therapist and currently serve as president of the Nebraska Chapter of the American Physical Therapy Association. I'm here today on behalf of over 1,400 physical therapist assistants and student members of our association to speak in support of LB430. Physical therapists are licensed healthcare professionals with expertise in movement analysis and work to restore function and movement for people with many conditions, including those affecting muscles, joint--

joints, bones and nerves. We help people safely manage pain and recover from injury, illness or surgery. This frequently requires multiple visits over an extended period of time, as the practice of physical therapy works in conjunction with the healing process. Like other medical billing processes, physical therapy billing relies on matching services rendered with standardized codes, knowing as-- known as CPT codes. They let insurers and other parties know exactly what treatments a patient received. Therapy services are labor intensive and most services are reimbursed based on time spent actively treating a patient. Any reduction of reimbursement affects our ability to pay rent for clinic space, maintain a qualified staff and afford practice expenses for things like electronic health records and technology for telehealth services. Almost exactly two years ago to the day, my predecessor sat here to speak in support of a similar bill that prohibited multiple procedure payment reduction policy, abbreviated MPPR, from being utilized by the managed care organizations in the Nebraska Medicaid system. That bill passed on Final Reading by an unopposed vote and was signed into law by Governor Ricketts in 2021. Unfortunately, just 18 months later, Blue Cross and Blue Shield of Nebraska, the state's largest private health insurer, implemented that same policy unilaterally. MPPR was originally designed to avoid duplicate payment for practice expenses when multiple procedures were delivered to the same patient on the same date of service. Each procedure code is reimbursed based on a relative value of unit, or RVU, which includes three components: the actual work performed by the provider, the practice expense and the malpractice insurance overhead costs. MPPR policy results in only paying 50 percent of the practice expense part of the RVU for any subsequent, subsequent units of service after the first unit. This results in approximately 10-20 percent reduction in payment for therapy providers treating patients with a health insurer like Blue Cross and Blue Shield of Nebraska. The utilization of this is both unfair and flawed because the practice, practice expense for therapy services was already reduced per unit when the codes were reevaluated in 2017 by the American Medical Association's relative value committee. Therefore, an additional cut to the practice expense of therapy service codes is in itself duplicative. So Blue Cross and Blue Shield of Nebraska implemented this unjustified policy during an already precarious time for healthcare workers. We are battling inflation, healthcare worker shortages and an economic slowdown. At first glance, you might see that-- see this as an only provider issue. It is not. This is sure to have ramifications on the accessibility to therapy services in lower socioeconomic regions of the metropolitan and rural areas of Nebraska.

When access to care changes so dramatically, patients delay the start of care or fail to complete their plan of care. As a result, opioid usage, patient falls, surgical readmissions, emergency room visits and imaging costs all increase. This bill will ensure that Nebraskans do not lose access to the conservative care they deserve. As such, I strongly ask you to prioritize LB430 and advance this bill into the General File to be debated and voted on. On behalf of APTA Nebraska, thank you for your time and attention to this matter.

HANSEN: Thank you for your testimony. Are there any questions from the committee? Seeing-- oh. She snuck it in there. You were almost off the hook. Go ahead. Yes, Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here. I just want to make sure that I'm understanding. So what, what is happening-- what we're-- what this bill seeks to undo is if you have multiple services when you go in, like physical therapy, speak-- speech pathology, you're not being charged if you had them individually. You're being charged a reduced amount because you're having them in one visit.

NICK WEBER: Yeah. So traditionally in physical therapy, a patient's in our care for 45 to 60 minutes and roughly every 15 minutes is a unit. So what this is doing is after that first 15-minute block, they're reducing the reimbursement for the practice expense portion by 50 percent for every unit thereafter. So it's going to encourage providers to either shorten the time they spend with the patient and then put the burden on that patient to come more frequently, thus exhausting their patient visits they're allotted for the year, or kind of take it in the shorts and just see the patient for the time that they actually deserve and figure out how to maintain their staff and keep their doors open.

M. CAVANAUGH: OK, thank you.

NICK WEBER: Yes.

HANSEN: Yes, Senator Hardin.

HARDIN: Have you done the math to determine at what threshold you no longer entertain Blue Cross as a provider?

NICK WEBER: No, not myself, but as it being-- that patient population being the largest in the state, you're talking about a huge percentage of patients not. And so small businesses may have to make that decision. And what that would do is then drive those patients to

larger, probably hospital systems, OK, which is counterintuitive in regards to saving costs because small practices don't get reimbursed at the same rates as large hospital systems. So for that same patient receiving the same care, the insurance company is going to have to pay more for that patient to get the same services just being in a larger facility.

HARDIN: If I can follow up, so a smaller community like mine in Scottsbluff might see more of what you just described faster than an area like Lincoln or Omaha.

NICK WEBER: I would suspect that, yes.

HARDIN: Thank you.

HANSEN: If I can ask a question--

NICK WEBER: Yeah.

HANSEN: --why 15-minute units? You just-- just because the way that CPT codes are laid out, you can't do a 30-minute--

NICK WEBER: Correct.

HANSEN: Like, charge for a 45 minute as a whole or as a block?

NICK WEBER: It works on the eight-minute rule, very similar to Medicare.

HANSEN: OK. And there's no way to change that? That's up to the insurance company?

NICK WEBER: Correct.

HANSEN: Or it's up to CPT codes, a federal kind of thing?

NICK WEBER: It's a-- everybody follows most of the CMS rules.

HANSEN: OK.

NICK WEBER: Yes.

HANSEN: Cool. Thank you. All right, any other questions? All right, thank you very much.

NICK WEBER: Thank you.

HANSEN: All right, we'll take our next testifier in support. Welcome.

MARY WALSH-STERUP: Good afternoon. Senator Hansen and committee, thank you for allowing me to testify today. My name is Mary Walsh-Sterup, spelled M-a-r-y W-a-l-s-h-S-t-e-r-u-p, and I'm here to testify on behalf of myself and as an occupational therapist working in the state in Nebraska. I am a-- in support of LB430. I'm currently an occupational therapist. I work for Central Nebraska Rehabilitation Services. We have a private practice and 13 outpatient clinics, but I also serve in an appointed position through the Occu-- American Occupational Therapy Association to the American health care professional advocacy committee to the Relative Value Update, a division of the American Medical Association. Since the early 1990, most commercial peers, as Nick had indicated, use CPT codes and resource-based values to determine reimbursements based on the cost of providing each specific service. The cost of providing each service is defined by these individual CPT codes. And for therapy practices, because CPT has defined them, all of our codes are based on 15-minute increments and so we don't have the ability outside of our evaluations and very limited codes to build a continuous service. Everything is based in 15 minutes and a variety of different CPT codes. Each one of these CPT codes is divided into three components: physician work, practice expense and professional liability insurance. The HCPAC, or the health care professional association, a division of the AMA RUC, is responsible then for determining the relative value of each one of these CPT codes for therapy by adding the three components. Updates to these values are based on recommendations and a structured, resource-based methodology outlined by the American Medical Association. During the AMA's RUC 2017 reevaluation of the 19 commonly used therapy codes, the RUC established the updated values based on the perceived presumption that duplication of the practice expense when more than one 15-minute increment of the codes were provided. This update addressed the Multiple Procedure Payment Reduction policy, or the MPPR. The MPPR, as they indicated, reduces the practice expense of the second subsequent codes provided on the same date of service. In essence, the issue here is that the AMA RUC, when they evaluated the codes, already applied the MPPR to these codes. Thus, anyone that would be applying the MPPR further is only duplicating this policy and further reducing the codes. An example of the reduced PE reductions when a third party pays is if you look at the practice expense often goes over, like, cleaning and equipment. The other thing to note is if you have equipment for this CPT code, it's a completely different set of equipment for this CPT code and so on. But cleaning would be

something that would be duplicated. So based on standard RUC survey and standard guidelines, cleaning of room and equipment after a procedure requires three minutes. The AMA RUC, when they valued these codes, reduced that time to one minute to account for the multiple procedures being applied, thus applying the MPPR already to the code value. Furthermore, if you analyze what's actually contained in the practice expense, the true duplication is only 5 percent opposed to the 50 percent that is currently being applied to the practice expense, indications that this is purely an arbitrary number. Applying the MPPR to a standard therapy visit of four units results in about an 18 percent reduction in reimbursement to the provider. Since the reduction to the practice expense has already occurred through the structured HCPAC process and is reflected in the overall value of these codes, we feel that further reduction through MPPR causes unnecessary harm to the provider community and ultimately limits access to medically necessary care for individuals needing therapy services in Nebraska. Again, thank you for allowing me to testify and I'm here to answer any questions that you may have.

HANSEN: Thank you. Are there any questions from the committee? Not any questions, thank you for testifying. We'll take our next testifier in support of LB430. Welcome.

MELISSA KIMMERLING: Welcome. Thank you very much. Senator Hansen and members of the Health and Human Services Committee, my name is Melissa Kimmerling, M-e-l-i-s-s-a K-i-m-m-e-r-l-i-n-g, and I'm an occupational therapist here in Nebraska. I'm here today on behalf of the Nebraska Occupational Therapy Association and its members as the vice president of policy and advocacy for the association. NOTA would like to ask you to support LB430 by advancing it to General File. As you have heard from the proponents speaking before me, LB430 aims to restrict the implementation of this multiple procedure payment reduction, or MPPR, policy to occupational, physical and speech-language pathology services. As you have heard and to reintegrate because we know it's so confusing, MPPR was designed to avoid those duplicate payments for practice expenses when multiple procedures are delivered to the same patient on the same day of service. Originally, it was created for something like surgeries and it's our belief that it's misapplied when applied to therapy services because it was already taken into account when the reimbursement for therapy services was determined in the first place. Our services almost always involve delivering multiple procedures to the same client on the same day as we build those timed units. And as you heard before, we have no control in the fact that that is the system in which we operate. We bill for those minutes

spent with our clients in increments of about 15 and each 15-minute increment is then assigned a procedure code. It would be very uncommon for someone to drive to therapy services to participate in an appointment that was only 15 minutes in duration. As you've heard, most therapy sessions are 45 to 60 minutes, depending upon the severity of that client's condition, and therefore the more complicated the client, the longer it is that we would be spending with them and therefore the more units served. It's been found by the medical community that in therapy services, application of MPPR is a flawed policy because the practice expense values for these services were already reduced when the American Medical Association determined how much those codes reimburse for. That is, those inefficiencies that did exist when multiple therapy services were provided in a single session were already explicitly taken into account when the reimbursement rates were established in the first place. A colleague of ours was involved with this process. You just heard her speak and hopefully was able to explain that to you. Any additional cuts to the practice expense of therapy services is arbitrary and will restrict patient access to vital healthcare services, services that are well documented to be those that reduce costs and are more conservative in nature; the more complex things such as surgeries or long-term use of pharmacological interventions. Reducing reimbursement by 50, 50 percent of that practice expense to those complex clients reduces the effectiveness of services, it devalues the services being provided by the clinician and leads to poorer health outcomes for the client, ultimately costing the client and that payer source more. Policies like this place small clinics such as those found in rural areas of our state, like you mentioned, Senator Hardin, are in challenging situations, often determining the only way forward for these small businesses is to cut ties with those payor sources or to develop a way to work within the restrictions, such as reducing the amount of time you're spending with a patient, reducing the type of services you're providing, so on and so forth. This could also involve something like asking a patient in a rural community to travel to therapy five times per week for shorter sessions versus two to three times per week for longer sessions where that reimbursement is cut. These things lead directly to an access-to -are issue in our state. In no other industry would greater complexity lead to reduced payment. Nebraska already has precedents for preventing the application of MPPR to therapy services, as outlined by LB100 in 2021, which passed unanimously, unanimously at General File. Please help us continue to ensure access to preventative and restorative healthcare for all Nebraskans by advancing LB430 to General File. Do you have any questions?

HANSEN: Yes, Senator Riepe.

RIEPE: Thank you, Chairman Hansen. My question would be this is have you brought this similar legislation to the Unicameral, to the Legislature recently in the past year or two?

MELISSA KIMMERLING: Related to private insurance, we have not because it has only been recently that we are starting to see these things implemented in that private insurance market.

RIEPE: OK. I see that in part because I know last session, they ran out of time and a number of things got tabled, so. Thank you--

MELISSA KIMMERLING: Sure, not last year.

RIEPE: --so much for being here.

MELISSA KIMMERLING: Thank you. Um-hum.

HANSEN: Any other questions from the committee? I think I might have a, I think I may have a couple.

MELISSA KIMMERLING: Sure. Awesome.

HANSEN: I appreciate, first of all, everything you do--

MELISSA KIMMERLING: Well, thank you.

HANSEN: --in physical therapy, etcetera, from-- because I think-- I'm a chiropractor too.

MELISSA KIMMERLING: Um-hum, um-hum.

HANSEN: So I think it's our job to keep people out of hospitals.

MELISSA KIMMERLING: Right. We think so too, yeah.

HANSEN: And so being on-- being a noninvasive approach to healthcare, I think the more time we have to spend with people like you, the better in my opinion.

MELISSA KIMMERLING: Right, right.

HANSEN: However, how have your conversations with the NOTA been going with Blue Cross and Blue Shield? Have you guys just sat in a room and said, here's our concerns?

MELISSA KIMMERLING: Yeah, yeah, we have. So we became aware, I believe it was last summer, that these policies were going to be implemented. And we always attempt to work with the payor sources behind the scenes. We have great relationships. Different members of our associations are on boards with the different payors in the state and we absolutely tried to resolve those things outside of legislative action. And we had multiple meetings and some of them went OK and then some of them-- there was one in which the payor did not show up to the meeting and there were 17 representatives on the meeting and the payor did not come. Another time, a different payor left. And so it-- we try, you know, to address these things without legislative action. And we've had successes in the past, you know? That's what we hope is to have the ability to collaborate with everyone because like you said, we think we reduce cost so we think it's good for us and that payor to help us help clients get access to our services. We're talking about reimbursement rates of $40, $50, $60 for these codes, not $20,000 or $30,000 or tens of thousands of dollars like some more invasive procedures could be. So we definitely want to work with them and help them see how we can help them achieve their goals as well. But it's a difficult, a difficult conversation sometimes.

HANSEN: And I, and I agree with you, I think the are ROI of if I was a payor, to send my patient to someone like you--

MELISSA KIMMERLING: Right, right.

HANSEN: --keep them out of a, you know, more costly procedure--

MELISSA KIMMERLING: Right

HANSEN: --makes sense.

MELISSA KIMMERLING: We agree.

HANSEN: Here's where I have heartburn--

MELISSA KIMMERLING: Sure.

HANSEN: --is telling a private industry what to charge and how to charge.

MELISSA KIMMERLING: Yeah.

HANSEN: It'd be kind of similar to somebody going into, like my clinic or yours and saying, Well, we think you should charge your--

MELISSA KIMMERLING: Right.

HANSEN: --patient less because X, Y and Z, right?

MELISSA KIMMERLING: Right.

HANSEN: And so I'm curious. I'm just-- that's just where my kind of, my issue is, but I'm kind of curious to see how, how this all plays out.

MELISSA KIMMERLING: Yeah.

HANSEN: Are you able to charge-- like, you could send the first unit to insurance and then are you-- but you're still able to charge the patient cash then after that or no?

MELISSA KIMMERLING: No, we are not.

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

MELISSA KIMMERLING: So that's a difficult situation too that we, we can't pick-- you know, like any other industry-- you know, my husband's an engineer, for example-- costs go up, the cost of the engine goes up. And he gets to do that. We don't get to do that. And we have to work within these ramifications. And we don't get to-- if we have a contract with that payor to work with that payor, then we cannot do cash, correct?

HANSEN: And that's where I have heartburn too.

MELISSA KIMMERLING: Right.

HANSEN: And so it's like if, if-- I think if you're going to have your, your hands tied here--

MELISSA KIMMERLING: Right.

HANSEN: --the patient who really might want to have your services should have the ability to pay themselves--

MELISSA KIMMERLING: Right.

HANSEN: --which they very well may do.

MELISSA KIMMERLING: Yeah and when we are-- enter into the agreements with those payor sources, that eliminates our ability to do cash pay

with them. If someone was not-- did not have a payor, we could cash pay and have cash pay rates and cash pay structures in those situations, but not once we are in a relationship with a payor and agree to work with that payor. We're not able to do that. So--

HANSEN: Yeah.

MELISSA KIMMERLING: --we don't really have a way of saying, let's just bill you for that other, other 50 percent that you can pay cash. We just can't do that.

HANSEN: That's kind of the rub then, huh?

MELISSA KIMMERLING: Yeah.

HANSEN: And one more thing-- if you can, like, expound on one thing?

MELISSA KIMMERLING: Sure.

HANSEN: You said in your testimony originally MPPRs was created for surgeries.

MELISSA KIMMERLING: Yeah, that's our understanding. So think of something like a complex trauma, like a car accident where there-- the person's in the operating room and they're getting more than one surgery at the same time because complex trauma, right? You're not paying for that OR to be set up a second time. There's a lot of things that don't happen because these two things are happening at the same time. And that's an incredibly costly situation, right? So that's what our understanding is, where it kind of came out of. And it makes sense in that case, right? But we're-- I'm not doing something that's 50 percent as involved in the second 15 minutes as I would be in the first. That, that doesn't exist. That doesn't make sense for us. Like I said, we're, we're with our patients longer if they're more complicated, if they need more of our clinical reasoning, more of our expert, you know, background, more of our specialties, right? That's when we're with them longer. They're-- simpler cases, they're shorter, right? So it doesn't, doesn't make sense that you would pay us less in the situations where we are, you know, working with more complex and more needy clients.

HANSEN: And if I could ask one more question if that's OK.

MELISSA KIMMERLING: Sure.

HANSEN: You do have-- you do or do not have the ability to just drop Blue Cross and Blue Shield and charge all cash?

MELISSA KIMMERLING: We do, yeah.

HANSEN: Is that common at all? I don't know for sure.

MELISSA KIMMERLING: Some-- sometimes people do that for things that we haven't succeeded at getting reimbursement for, like, you know, codes that wouldn't reimburse or you're, like, an emerging practice area or something like that. You might be, you know, doing a cash pay system or some people just don't want to work in the insurance market. Some people, when they're first starting out, will do things like provide their client a super bill, which they would then submit to insurance for reimbursement if they want it. But they just-- they don't want to pay. You know, they don't have the money yet or the income yet to have the office staff to even do those claims. So some people start off that way, but it's, it's not common once you get larger to do that.

HANSEN: Gotcha, kind of like a no-par provider type thing.

MELISSA KIMMERLING: Yeah.

HANSEN: OK. I was just kind of curious if that's common or if that's not common, so.

MELISSA KIMMERLING: Yeah.

HANSEN: OK. Any other questions? Sorry to--

MELISSA KIMMERLING: That's OK.

HANSEN: --manipulate the time.

MELISSA KIMMERLING: I hope I did all right.

HANSEN: OK.

MELISSA KIMMERLING: OK.

HANSEN: All right. Thank you very much.

MELISSA KIMMERLING: Thank you very much.

HANSEN: OK. We'll take our next test for our support of LB430. Welcome.

JESSICA THOENE: Hi. Thank you, Chairman Hansen and members of the Health and Human Services Committee. My name is Jessica Thoene, spelled J-e-s-s-i-c-a T-h-o-e-n-e, and I'm a speech-language pathologist and owner of Alpha Rehabilitation in Kearney. And I also serve as a legislative cochair for the Nebraska Speech-Language-Hearing Association and today, I'm testifying on behalf of the members and myself. I grace-- I greatly appreciate Senator Walz's willingness to introduce this LB430 addressing our concerns of applying this MPPR to all of our therapy services. Speech-language pathologists are also impacted, like occupational therapists and physical therapists, by MPPR. I'm going to give you a scenario that may cause a reduction in payment with MPPR being applied to speech-language pathology services that are billed. When two different services are performed on the same day by a speech-language pathologist using our CPT codes, 92507, which is the treatment of speech, language, voice, communication and auditory processing, also billed on the same day as our CPT code 92526, which is treatment of swallowing dysfunction and oral function for feeding, we will be subject to a 50 percent reduction in one of those codes' bills. These two codes are very distinctive services that require different supplies, different service models, and should not be reduced for a duplication of expense because there is no expense that is shared. Cost savings is already accounted for, as you heard from Mary, when these codes were introduced by the committees that, that made the billing for the codes. In Nebraska, we are facing shortages of speech-language pathologists and patient, patient care is impacted. I have experienced this firsthand not being able to provide coverage for rural hospitals, nursing homes due to short staffing, leaving patients with no resources. Inflation has increased all of our expenses to deliver services. Speech-language pathologists allow patients to regain their ability to swallow, eliminate the need for feeding tubes, treat aspiration pneumonia and prevent costly hospital stays. Our services restore or give the ability to patients to communicate and be productive in the workforce. MPPR is a day-per-day policy that applies across disciplines. Another example is if a speech-language pathologist and a physical therapist provide treatment on the same day. MPPR is applied to all codes that day, regardless of the discipline so MPPR full payment is given to one unit of the highest practice and then reduced for the additional services provided. Practices are now making patients, as you've heard multiple times, come on various days in order to receive these services. Coming on a day for physical therapy and speech therapy is not feasible to the practice. In rural Nebraska, this creates a larger problem for travel

to medical facilities and because time is a lot greater and distances a lot farther. This is a time commitment. Not participated in-- not participating in recommended therapy plans does result in higher medical bills. We encourage the practice, the practice to delay therapy and multiple visits required for patients, causing further setbacks to critical time of rehabilitation. The current MPPR model isn't sustainable by providers and puts Nebraska at risk for not receiving speech-language pathology services in order to communicate, in some cases, being able to swallow and to live independently. I have actually attached a letter from the American Speech-Language-Hearing Association to Blue Cross and Blue Shield of Nebraska discussing the impact on patient care and also the coding expenses, as we've been talking to in these discussions. The Nebraska Speech-Language-Hearing Association respectfully requests the committee to advance LB430. Thank you for allowing me to testify. That's my formal testimony for the Speech, Language and Hearing Association. I also would welcome questions. I am rural Nebraska healthcare. I am small business. I started a practice when I was 26. We had zero patients, zero money. Last year, we celebrated 18 years in practice and I'm telling you, it's hard to operate, especially when facing these cuts. I have given up contracts in rural Nebraska. Today, on my way here, I stopped to see a patient in Red Cloud, Nebraska, because there's no speech pathologist that can serve that individual. They're bringing from Omaha to Red Cloud. So these procedures do impact patients and they do impact small business. So I would welcome any questions on the effects of this MPPR on rural healthcare and small business practice.

HANSEN: OK. Are there any questions from the committee? Seeing none, I think you are in the same boat. I started when I was 27. We've been-- I'm a-- in private practice with zero patients and eating nothing but macaroni and cheese and hot dogs for a while.

JESSICA THOENE: Yep.

HANSEN: That was, like, the worst experience ever.

JESSICA THOENE: Yep.

HANSEN: In a one-bedroom apartment, so I know what you mean. OK, well, no questions from the committee--

JESSICA THOENE: All right.

HANSEN: --but thank you for coming.

JESSICA THOENE: Thank you.

HANSEN: OK, we'll take our next testifier in support. Welcome.

CANDICE MULLENDORE: Thank you. This is a really high seat. Good afternoon. Chairman Hansen and the members of the Health and Human Services Committee. My name is Candice Mullendore, C-a-n-d-i-c-e M-u-l-l-e-n-d-o-r-e, and I appreciate this opportunity to testify in favor of LB430. I'm going to address two questions that came up just to kind of let you guys know. Just for your information, there-- nationwide, there's less than 2 to 5 percent of patients that can pay cash or do pay cash pay for therapy services. So I wanted to get you that statistic. And then also when we tried to meet with BlueCross and BlueShield, it took a long time and they met with us once before they refused to meet with us again so just wanted to clarify that for you. I am here today representing my small business and small businesses across Nebraska. MPPR is a policy that negatively impacts patient care immediately and over the long term in the state of Nebraska and puts our small businesses in jeopardy. My business, Pediatric Therapy Center, has been providing occupational, physical and speech therapy services to thousands of children since 2008. I am a proud small business owner. I am a fierce advocate for my patients and providers and they are your constituents. Today, you are listening to testimony from both sides of the debate with a lot of data, acronyms and opposing views. This is a complex subject and can be difficult to grasp, even for healthcare providers. After the testimony today, you may go back to your offices and look at the data where the codes were developed from CMS and understand that those big statements made that practice expensive or duplicated are false. Mary testified to explain why this methodology is false. The statement the practice owners are overcharging is false. The reality is quite different. For one private insurer, I have not had a single raise in 15 years. How many of you can say that you haven't had a raise in 15 years? For another insurer, I've had an 11 percent decrease in payments for the past five years. That is before MPPR payment is applied. With the application of MPPR, I am looking at a reimbursement cut of 11 to 22 percent. One dollar in 2008 would be worth $1.38 today. That means I should be getting a 38 percent increase rather than the decreases that I have over the past 15 years. Instead, daily, I am faced with trying to cut expenses to be able to provide therapy to the hundreds of families that come through my clinic each month. I did not open a therapy clinic to make millions of dollars. I opened it to make sure that children and their caregivers have access to quality care. Small business owners across Nebraska care about those we serve and we are constantly looking for

ways to heal our neighbors and our friends quickly and in the most cost effective manner. We understand the impact that overutilization and cost inflation can have on our healthcare system and we stand against it. I am here to tell you a story and I want to humanize the nature of LB430, which Jessica alluded to. Bob is a farmer out in Ansley, Nebraska. One day, Bob isn't feeling well so he gets out of his tractor and with jumbled speech and weakness on his right side, he tries to tell his wife that something is wrong. It turns out Bob is suffering a stroke. Bob is transported to a rural hospital and stays a few days till he can return home. Bob struggles with balance, weakness and can't think of words when talking to his friends and family. He needs continued rehab to get better. Bob is a hard-working Nebraskan so he still has all the responsibilities of his farm and his family. Bob starts therapy at the closest place, which is 45 miles away. He's told he needs speech and PT two days a week and-- two days for physical therapy and two days for speech therapy. Why can't Bob do therapy on the same day? The small business owner-- that's me. That's Jessica-- we cringe when we have to tell Bob it's because of the methodology that insurance uses. It cuts the payment and we have to do PT and speech on separate days. This means four trips a week totaling six to seven hours of travel time and 360 miles. Bob comes to therapy for three weeks. The travel is a burden because he has chores and farm responsibilities. And the cost of gas and time of driving, he cannot afford to go to therapy for four days a week. He cuts back on his rehab and he does not make the progress that he and his therapist hope he would. Therapy providers are being put in difficult positions. Do we see Bob two times a week or do we try to keep our doors open so that we can serve all members of our community? A second story I want to tell you about is Sarah, a very similar story in which she had a brain injury. After months of hospitalization, she needed therapy intensively. Unfortunately, I was going to have to see her four to five times a week with an application at MPPR, which puts a huge burden on her parents. I don't know very many parents that can take off work four to five times a week to get their child to the therapy that they deserve. Another reality is that the small business owners, which are the heart of Nebraska, will be forced to close their doors. That means that Bob, who is driving 45 miles one way for therapy, may now have to drive 75 miles. I am here to speak for small business owners, for patients, for their caregivers, and ask-- and against reductions from large insurers. I represent all the small business owners in Nebraska that are working hard to continue provide patients who are your constituents with quality care in their small communities. I am here to tell you that we are not making millions of

dollars. Private insurers should not have record profits at the expense of the patients and the providers. I am here to tell you that we do not put forth this legislation without trying to work the insurance companies first. And I am happy to take any questions.

HANSEN: Thank you. Are there any questions from the committee? Seeing none--

CANDICE MULLENDORE: Thank you for your time.

HANSEN: --thank you for coming. We'll take our next testifier in support of LB430. Welcome.

MIKE MORAVEC: Thank you. Good afternoon, Senators. My name is Mike Moravec, M-i-k-e M-o-r-a-v-e-c. I'm a physical therapist and an owner of a private practice in bluffs-- or named Bluffs Physical Therapy in Scottsbluff, Nebraska. I currently employed two other physical therapists, two physical therapist assistants, and three physical therapy technicians and two office administrators. I come here today from rural western Nebraska in support of LB430. At Bluffs PT, we provide physical therapy services for a patient population that has a radius of 80 miles. Needless to say, our footprint in western Nebraska is quite large and therefore, our impact on our patients' daily lives must be such that they would travel up to 80 miles one way for a physical therapy visit. The basis of physical therapy is that we are providing a service of exercise to correct-- excuse me-- to correct mechanical faults of the human body. To achieve our goals, we commonly supplement exercises with manual therapy and occasionally provide some type of modality that will reduce inflammation, improve muscle activation, relax muscles, or inhibit pain in the area of injury. This type of therapy session typically takes a full hour. What we're being forced to do with MPPR is make a choice. We can continue to offer the same services we have offered in years past and take a 15 percent reduction in reimbursement or cut our therapy sessions in half and ask the patient to come twice as often. Not only would this create a burden on the patient in regards to traveling more often, but it would also exhaust their insurance-alloted therapy visits for the year at a faster pace. I'm not the type of owner who is comfortable placing the burden on the patient so I'm trying to figure out how to sustain the company while getting reimbursed at a severely reduced rate. This year, I was looking to hire a new physical therapist due to continued increased need for physical therapy services in our area. However, after looking at my Blue Cross and Blue Shield of Nebraska patients alone, I will net $56,500 less this year compared to last year, which

is the salary of one of our physical therapist assistants that's had seven years of experience. So instead of meeting the needs of our growing patient base, I may actually need to reduce the size of my staff, which will negatively impact patient access to care in my very rural area in which I live. Putting it plainly, a single act by a state's largest private healthcare insurer has the potential to affect thousands in rural Nebraska-- of, of rural Nebraskans' ability to receive quality medical care. I urge you to not let that happen. Most of us in this great state know that it is very rural and we harbor, harbor values Nebraska is known for; good quality and the most appropriate care that has been backed up time and time again by good research. Please stand with greater Nebraska and vote to bring LB430 to the floor and help support my patients and the other small businesses that see patients just like I do throughout western Nebraska. Thank you.

HANSEN: Thank you for your testimony and for driving all the way here.

MIKE MORAVEC: It's important.

HANSEN: I don't know if you did or not, did you spell your name when you first started?

MIKE MORAVEC: I did. It's M-i-k-e M-o-r-a-v-e-c.

HANSEN: I just wanted to make sure before I--

MIKE MORAVEC: Yes, thank you.

HANSEN: Are there any questions from the committee? Yes, Senator Riepe.

RIEPE: I have a question. I don't know what the typical copay is, but on many of these plans, it's $35, $40.

MIKE MORAVEC: Correct.

RIEPE: So that each time they would visit, they would have to repay that copay, I assume.

MIKE MORAVEC: Correct, yes.

RIEPE: I wanted clarification on that. Thank you.

MIKE MORAVEC: Yes.

HANSEN: Any other questions? Yes, Senator Hardin.

HARDIN: What percentage of your patients utilize Blue Cross?

MIKE MORAVEC: What percentage? Thirty percent of my clientele. I will say that's actually a little bit less noticing in this year, just early on. But that's just my early numbers. But I also know-- I think there's a lot, a lot of switching over going into new or different insurances that are also private pay but are also following the same MPPR reduction rates.

HARDIN: Is that to say that you have patients who are switching flavors?

MIKE MORAVEC: Switching flavors because they're getting charged quite a bit by the same insurance company. But like I said, there's already other major medical insurance-- insurers that are following the same MPPR rates due to following the, the status of what they're seeing Blue Cross and Blue Shield do.

HARDIN: Thank you.

HANSEN: Any other questions from the committee? All right, seeing none, thank you very much.

MIKE MORAVEC: Thank you.

HANSEN: Is there anyone else wishing to testify in support of LB430?

BRENT TODD: Good afternoon. All right. Good afternoon, Chairman Hansen and the members of the committee. My name is Brent Todd. I'm a practicing physical therapist in Omaha. I'm representing Athletico Physical Therapy. I've also been authorized on behalf of the SAFE Project to speak for them and provide a testimony for them as well.

HANSEN: Hey Brent, sorry, sorry to interrupt you. Can you--

BRENT TODD: Yes, spell your name.

HANSEN: --spell your name--

BRENT TODD: Brent--

HANSEN: --spell your first and last name?

BRENT TODD: --B-r-e-n-t, last name is Todd, T-o-d-d.

HANSEN: Thank you.

BRENT TODD: Um-hum. I'm approaching my 21st year of practice and currently manage a clinic that consists of three physical therapists, including myself, a physical therapist assistant, and two support staff. We're an outpatient orthopedic clinic that has been serving the community for 20-plus years and we treat a variety of conditions, including back, neck and joint pain, post-fracture care, pelvic floor physical therapy, balance and fall prevention, work and sport injuries and post-operative care just to name a few. I've found an extremely rewarding profession and am grateful to have been able to assist individuals improve their strength and mobility, decrease their pain and improve their overall function and quality of life. It is no secret that our country has challenges in healthcare, including an ongoing opioid epidemic, rising costs and an aging population. As a physical therapist, I believe we can utilize our skill set to evaluate, educate and manage patients' pain and functional limitations in a non-pharmacological manner, thus decreasing the burden on our healthcare system. Athletico recognizes the magnitude of the problem that opioids are having in our society and have partnered with the SAFE Project to bring awareness and develop solutions to opioid addiction. Part of the solution is early access to physical therapy before patients go down the path of opioids or other lower value treatments. Early access to physical therapy has been shown to decrease opioid use and the overall costs of an episode of care. Unfortunately, I believe that our knowledge, skill and opinion in the healthcare arena continue to be undervalued marked by a pattern of reduced resources for our services time and time again via various means, the Multiple Procedure Payment Reduction policy being one of them. I am speaking today in support of LB430. Policies such as the Multiple Procedure Payment Reduction that limit resources for physical therapy will ultimately limit access to physical therapy services. This has the potential of impacting approximately 65 percent of patients that we serve. I fear policies like these will lead to a need to reduce our staff, make it difficult to attract and retain quality providers, and not to mention overwhelm our current providers. This effectively will limit timely access to our services and the quality of care at a time when they're needed most. I am aware that our healthcare spending is a growing problem. However, addressing pain and functional limitation earlier rather than later will lead to downstream cost savings in the form of reduced imaging, surgeries and the overuse of opioids and the associated cost, especially as our society ages. And in conclusion, I ask for your support of LB430 as a

forward-thinking strategy of getting in front of the issues that are driving our healthcare challenges. With support, early access to physical therapy can be part of the solution. I thank you for your time and the opportunity to speak today on behalf of my staff, fellow colleagues, and most importantly, the patients that we serve.

HANSEN: Thank you for your testimony. Do we have many questions from the committee? Seeing none, thank you very much. Is there anybody else wishing to testify in support of LB430? All right, is there anybody that wishes to testify in opposition to LB430? Welcome.

JEREMIAH BLAKE: Thank you. Good afternoon, Mr. Chairman, members of the Health and Human Services Committee. My name is Jeremiah Blake, spelled J-e-r-e-m-i-a-h B-l-a-k-e. I'm the government affairs associate registered lobbyist for Blue Cross and Blue Shield of Nebraska testifying in opposition to LB430. I feel like a popular guy today. So as we've heard today, the basic premise of MPPR is to account for efficiencies when multiple services are delivered to a patient in a single visit. Provider reimbursement is intended to pay for not only the healthcare services delivered to the patient, but also the costs of other expenses, including medical liability insurance and the cost of running a clinic. Just like any business, medical professionals must pay for support staff, building space, heating and cooling and technology needs, for example. MPPR applies to this, this category of general business expenses only, not the reimbursement rate for professional services or medical malpractice insurance. MPPR recognizes that there is overlap in this category of business expenses when a patient receives multiple services in a single visit. For example, the health professional may perform three services during the visit, but the administrative staff scheduled one appointment with a single phone call and filed one claim with the payer. The clinic didn't incur additional rental expense, for example, as a result of providing more than one professional service. Congress recognized this overlap and began applying MPPR to Medicare in the mid 2000s and expanded this policy in the Affordable Care Act in 2011. While this, while this policy has been part of the Medicare program for nearly 20 years, the Blue Cross and Blue Shield only recently began applying this policy to our commercial insurance products within the last few months. Our policy is that the highest rank procedure is 100-- receives 100 percent reimbursement, while the second and subsequent lower ranked procedures receive a reduced payment to reflect this overlap within the category of business expenses. The other categories of reimbursement that is for professional services and medical malpractice insurance continue to receive the full

payment. Hopefully, that gives you a little bit better understanding of how we believe this or why we believe this is a reasonable policy. Regarding the bill from 2021 that was referenced earlier, Blue Cross is not a Medicaid Managed Care contractor so we were not involved in the discussions on that bill. However, there's an important policy distinction between that bill and what we're discussing today. The Legislature has every right and I think a duty to design the Medicaid program because you fund it and you operate it. The difference here is that what you're getting into is the private negotiations between two parties and the Legislature is conceivably just putting its thumb on the scale in support of one party over the other. The final point I want to make in regard to this bill is that most therapy services are subject to cost sharing under most health plans. While Blue Cross negotiates reimbursement rates with providers, the patient is often, often responsible for the cost of the visit until they meet their annual deductible. In the near term, this bill would have a greater impact on Nebraska families who pay out of pocket for their physical therapy, occupational therapy, or speech-language pathology services. In the long term, it limits our ability to fulfill our responsibility to offer affordable healthcare coverage to Nebraska families and businesses. For these reasons, I would ask you to not advance LB430. I'd be happy to answer any questions you have.

HANSEN: Thank you for your testimony.

JEREMIAH BLAKE: Yeah.

HANSEN: Are there any questions from the committee? Yes, Senator Riepe.

RIEPE: Thank you. Thank you for being here.

JEREMIAH BLAKE: Yes.

RIEPE: The question that I have, you have Medicaid Advantage.

JEREMIAH BLAKE: Medicare Advantage, correct.

RIEPE: I'm sorry, yes.

JEREMIAH BLAKE: Yes.

RIEPE: Do you have any control over the rates or do you simply contract with them to provide the services so they would set their own policy for how they would reimburse providers?

JEREMIAH BLAKE: I want to be careful here because I don't fully know for sure--

RIEPE: OK.

JEREMIAH BLAKE: --but I think under Medicare Advantage, we would determine the rates using Medicare policy.

RIEPE: Then my follow-up to that would be is do you apply the same policy to the Medicare recipients as you would to commercial recipients?

JEREMIAH BLAKE: Yeah, good question. Let me follow up on that and find out.

RIEPE: Just-- OK. Thank you. Good seeing you.

HANSEN: Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here, Mr. Blake.

JEREMIAH BLAKE: Um-hum.

M. CAVANAUGH: OK so you said-- you started out talking about the federal government made changes and that was to the Medicaid program.

JEREMIAH BLAKE: Medic--

M. CAVANAUGH: Medic--

JEREMIAH BLAKE: Medicare.

M. CAVANAUGH: Medicare program.

JEREMIAH BLAKE: Yeah.

M. CAVANAUGH: Could you tell me a little bit more about that first?

JEREMIAH BLAKE: Again, what I, what I understand-- again, I don't work in Medicare.

M. CAVANAUGH: Just kind of reiterate your points because I didn't quite--

JEREMIAH BLAKE: The point is, is that this policy has been part of the Medicare program for 20 years.

M. CAVANAUGH: OK so the policy--

JEREMIAH BLAKE: So this isn't new.

M. CAVANAUGH: --to-- to-- OK. Why did Blue Cross decide to do this now?

JEREMIAH BLAKE: Well, again, if you go talk to any business owner who is providing health insurance to their employees or anybody who's-- any family who's trying to buy health insurance, it's expensive. And so we try to find ways that make sense, are reasonable to hold down rates for our members to, to ensure that insurance is affordable.

M. CAVANAUGH: But you could have done this at any time--

JEREMIAH BLAKE: Sure.

M. CAVANAUGH: --over the last decades.

JEREMIAH BLAKE: Yes, we could.

M. CAVANAUGH: And so you decided to do it now to lower costs?

JEREMIAH BLAKE: Yes, yes.

M. CAVANAUGH: OK. I have-- if it's OK to-- so I-- and I appreciate what you said about holding the thumb in private negotiations.

JEREMIAH BLAKE: Um-hum.

M. CAVANAUGH: I truly do appreciate--

JEREMIAH BLAKE: Yep.

M. CAVANAUGH: --that. But the testimony that we heard was from a lot of people from more rural areas.

JEREMIAH BLAKE: Um-hum.

M. CAVANAUGH: And I'd like to give you the opportunity to address some of those concerns that they expressed, which I think are, are pretty valid, that the only way that they can maintain their business model is to then have these appointments separately. And if we have people in agricultural areas that are going to have to take multiple trips so that they can main-- the business side can maintain it, I think you can see how that's--

JEREMIAH BLAKE: Yeah, sure.

M. CAVANAUGH: --problematic and concerning. And while I might agree with you that it's not necessarily our role to get involved in private negotiations, it is our role to maintain a public good. And so I just want to give you the opportunity to kind of answer some of that.

JEREMIAH BLAKE: Yeah. So we, of course, want to make sure that individuals have access to services, whether that's access to hospitals, active to-- access to chiropractors, access to physical therapy services. So we're constantly monitoring utilization in our provider network in real time to make sure that if we see a decrease in, say, therapy services, we see an increase on the pharmaceutical side for prescription drugs that used the-- that are used to treat pain, that's a signal to us that something is wrong with the network and we have to go back and revisit that. You know, as it pertains to rural areas, that's certainly a concern we have. You know, we can-- with most providers, we actually reimburse our rural providers on the hospital side specifically at a higher rate than we do urban hospitals. And that's a recognition that those services are critical in those rural areas. I think you could talk to any professional provider in the state and in the country for that matter and they will tell you there's a shortage of providers in rural areas throughout the country, whether that's nurses, doctors, physical therapy services or anything else. So it's a struggle we all deal with.

M. CAVANAUGH: And I recognize that there might be other questions. Do you want to jump in?

HANSEN: Are there other questions? Yes, Senator Day.

DAY: Thank you, Chairman Hansen, and thank you, Mr. Blake, for being here today.

JEREMIAH BLAKE: Um-hum.

DAY: So does MPPR directly reduce costs for patients?

JEREMIAH BLAKE: Yes. If they're paying a deductible, it does, yes.

DAY: So it reduces costs for patients because you charge them less in terms of the deductible that they're paying?

JEREMIAH BLAKE: No. So we enter into a contract with the provider that specifies the rate for a service. If the service is subject to a

deductible and the patient hasn't met their out-of-pocket requirements--

DAY: Right.

JEREMIAH BLAKE: --they're going to pay that rate. So if we negotiate a contract that says it's $20 for this service--

DAY: OK.

JEREMIAH BLAKE: --versus $40--

DAY: Sure.

JEREMIAH BLAKE: --until they meet their deductible, they pay that $20, not $40.

DAY: Right. OK. And so going back to the question about the Legislature getting involved in private negotiations, 100 percent understand where you're coming from on that. It sounds like many of the providers here have attempted to negotiate with you directly and you have not been willing to do that. Do you have anything to say about that?

JEREMIAH BLAKE: Sure. We're always willing to meet with our providers. I think you heard that we did meet with some of our provider groups. We can't always come to consensus or agreement or make everybody happy. We try to do that to the best of our ability. I also say Blue Cross, Blue Cross's name was used a lot today. I don't think we're the only commercial insurer that's using this policy. We may be the largest in Nebraska, but this isn't unique to Blue Cross.

DAY: OK. So I just would-- from our perspective, we don't want to get involved in these types--

JEREMIAH BLAKE: Yep.

DAY: --of negotiations. I don't want to. But sometimes when small business owners are left with no other option, we are forced to get involved--

JEREMIAH BLAKE: Yep.

DAY: --unfortunately. And so if you want to come in and oppose a bill, I would encourage you to maybe more-- engage in good faith with some of the providers in, in negotiating in the future.

JEREMIAH BLAKE: Yep. I appreciate that and I'll certainly take that back to the company, OK?

DAY: Thank you.

JEREMIAH BLAKE: Um-hum.

HANSEN: Yes, Senator Cavanaugh.

M. CAVANAUGH: Senator Ballard can go first.

BALLARD: Go ahead. Go ahead, Senator Cavanaugh.

M. CAVANAUGH: I've already gone once.

BALLARD: Go ahead.

HANSEN: Senator Ballard, you are recognized.

BALLARD: Wow. Thank you, Chair Hansen. I appreciate it. Can you give me a little more history on MPPR, at least from Blue Cross? How long have you utilized this method?

JEREMIAH BLAKE: So as was mentioned here earlier, I think we announced it either later this summer, this fall, and it was implemented on December 1. So it's relatively recent.

BALLARD: Relatively-- and is it just-- you just use it for therapy services or for multiple?

JEREMIAH BLAKE: We use it for-- I think as was mentioned earlier, surgical is another area we use it. It's pretty common. It's been around--

BALLARD: Yeah.

JEREMIAH BLAKE: --for a number of years, but most recently, it's the physical therapy, occupational therapy and the speech-language pathology.

BALLARD: OK and just based on rising costs?

JEREMIAH BLAKE: Correct, correct.

BALLARD: OK. Thank you.

HANSEN: Any other questions from the committee? Senator Hardin.

HARDIN: I would agree with Senator Day. It would be better if we didn't even have this conversation. My experience in this industry is fairly significant--

JEREMIAH BLAKE: Um-hum.

HARDIN: --and you don't want the natives getting restless. And because if they walk, it's really hard to get them back--

JEREMIAH BLAKE: Yeah.

HARDIN: --in terms of those providers. I get it. It's a business. But when we water down the whiskey, we're going to hear about it and it sounds like that has happened. And if in fact it's going on in some other areas as well, the best thing for Blue Cross to do is to get ahead of it.

JEREMIAH BLAKE: Um-hum.

HARDIN: We need you--

JEREMIAH BLAKE: Yeah.

HARDIN: --in this state, but we need our providers too.

JEREMIAH BLAKE: Yes, we do.

HARDIN: So just want to encourage you to get together ASAP. Get a-- get, get together over a Valentino's pizza or something wonderful.

JEREMIAH BLAKE: Get some Runzas.

HARDIN: Something Nebraska.

JEREMIAH BLAKE: I had Runza for lunch, but that's not--

HARDIN: That's right--

JEREMIAH BLAKE: --a Runza, so.

HARDIN: --so. Thank you.

JEREMIAH BLAKE: Thank you. I appreciate that.

HANSEN: Senator Cavanaugh, do you have any more questions?

M. CAVANAUGH: Well, I was going to say something similar to Senator Hardin about our providers. I mean, I do think that there is a concern of losing providers in our rural areas, which is something that this committee hears a lot about on a regular basis. And I just-- I appreciate from the business side, you're concerned about the state getting involved. But if, if you are not actively working with the providers to make sure that they're able to keep their doors open, I feel like this committee is going to feel pressured--

JEREMIAH BLAKE: Yeah.

M. CAVANAUGH: --to take action that we would prefer you took yourselves.

JEREMIAH BLAKE: Yeah.

M. CAVANAUGH: And so I just wanted to leave you with that thought that this is-- we'd love for this conversation to continue outside of this room. I don't know if--

JEREMIAH BLAKE: Yeah.

M. CAVANAUGH: --I'm speaking for the whole committee, but certainly for myself.

JEREMIAH BLAKE: Yeah.

M. CAVANAUGH: Thank you.

JEREMIAH BLAKE: And again, this is neither here nor there. But if I can just respond again to the rural piece, again, I sit on a task force, an internal task force within the company where we're exploring ways that we can support that rural healthcare delivery system. It's critical to our members. We have to have access to services in rural areas, robust access, and so that's important to us and something that we're looking at.

M. CAVANAUGH: Thank you.

JEREMIAH BLAKE: OK.

HANSEN: OK, maybe a question or maybe a comment.

JEREMIAH BLAKE: Yeah.

HANSEN: Is there another way to make this work? I'm just trying to think, like-- it's not my position to say anything.

JEREMIAH BLAKE: Right.

HANSEN: Is one way to continue keep paying for the repetitive services, instead maybe charge more of a copay for the second and third service?

JEREMIAH BLAKE: That's a good question. I don't know. As I sit here, I don't know the answer to that.

HANSEN: OK.

JEREMIAH BLAKE: I think--

HANSEN: I didn't know if that was legal or not or if that's a way to-- that you charge less for the first service then every--

JEREMIAH BLAKE: Yeah.

HANSEN: --subsequent service after that, you charge more with copays so it's a little bit more of a patient responsibility.

JEREMIAH BLAKE: Yeah, that's fair. One of the things I do want to clarify is that on kind of the percentages, right? So the, the first procedure is reimbursed at 100 percent. The second one, it's reduced by 50 percent. Any subsequent procedures after that are reduced at 25 percent, not 50 percent, so.

HANSEN: Gotcha.

JEREMIAH BLAKE: OK.

HANSEN: OK. Any other questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: Sorry, that, that just spurred another.

JEREMIAH BLAKE: If it's not right, I'll, I'll go back and confirm that. That's what I was told this morning--

M. CAVANAUGH: OK.

JEREMIAH BLAKE: --OK?

M. CAVANAUGH: Well, that just spurred another question--

JEREMIAH BLAKE: Yeah.

M. CAVANAUGH: --that I should have asked earlier. So when you-- you spoke about in your testimony that part of this is because of administrative services and, and that-- like you said, booking one appointment, all of those things. And again, not going to hold you to the numbers.

JEREMIAH BLAKE: Um-hum.

M. CAVANAUGH: --you've just cited because you said you're not sure. But if, if those numbers hold as to that's the charging, the administrative costs, I would imagine and I would hope that the cost for booking an appointment is not 50 percent of the cost--

JEREMIAH BLAKE: Correct, yeah.

M. CAVANAUGH: --of the appointment. And so there seems-- if-- there seems like maybe there needs to be more parity if that's the intention behind this.

JEREMIAH BLAKE: Yeah. Again, I was just making an illustration--

M. CAVANAUGH: Sure.

JEREMIAH BLAKE: --right? It wasn't trying to categorize every expense that a business may have.

M. CAVANAUGH: OK. Thank you.

JEREMIAH BLAKE: OK.

HANSEN: OK. All right, thank you for your testimony.

JEREMIAH BLAKE: All right. Thank you. Have a good weekend.

HANSEN: Thank you. All right, we'll take our next testifier in opposition to LB430. Welcome.

ROBERT M. BELL: Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Robert M. Bell. Last name is spelled B-e-l-l. I'm the executive director and registered

lobbyist for the Nebraska Insurance Federation. I'm here today in opposition to LB430. The Nebraska Feder-- Insurance Federation is the state trade association of insurance companies. The federation currently has over 40 member insurance companies. Members of the federation include companies who write all lines of insurance and who provide over 16,000 jobs to the Nebraska economy and over $14 billion of economic impact to Nebraska on an annual basis. Perhaps most importantly, though, the Nebraska Insurance Federation member companies provide high-value, quality insurance products that protect Nebraskans during difficult times. LB430 amends the Uniform Credentialing Act and would appear to prohibit the application of Multiple Procedure Payment Reduction policy, MPPR, for physical therapy, occupational therapy and speech-language pathology, pathology services-- excuse me-- by either a Medicaid or a private insurer. MPP-- MPPR, as you've already heard, has been used in the Medicare space, which is the healthcare services mainly used by seniors for many years and is a needed tool for all payors of healthcare services to reduce payments when services are bundled by healthcare service providers. According to the latest information from the Center of Medicare and Medicaid Services, CMS, U.S. healthcare spending grew 2.7 percent in 2021, reaching $4.3 trillion or $12,914 per person in the United States. As a share of the nation's gross domestic product, healthcare spending accounted for 18.3 percent. One of my ongoing themes in speaking with the Legislature is finding ways to shrink the cost of healthcare. And to fend off any attempts by other parties who seek to limit the ability of payors of healthcare, whether individuals, employers or the government, to create and implement new creative ways to limit healthcare spending that will still provide first-class care. As a result, Nebraska insurance companies are fundamentally opposed to LB4360's attempt to limit the applicability of MPPR reduction by insurers. Technically, my member insurers are also confused by the provisions of LB930 [SIC, LB430]. For one, the language is placed in the Uniform Credentialing Act, not the insurance code. Second, LB100 from 2021 already banned MPPR from the Medicaid program, yet it is also included in LB430 and does not remove the previous prohibition. Finally, the legislation states that physical therapy, occupational therapy, or speech pathology-- language pathology services would not be subject to MPPR policy of a private insurer, but does not actually prohibit an insurer's use of MPPR, frustrating the ability of a group of willing providers and insurers to privately contract with one another if all parties agree. Another point, state law will not apply to most federally-- and I believe Senator Walz brought this up-- most federally regulated self-insured

large group plans governed by the Employee Retirement, Retirement Income Security Act of 1974, otherwise known as ERISA. According to research I have read, ERISA plans cover at least 50 percent of privately insured Nebraskans. Under most mandates in the insurance code, there is language making it clear that legislation would not apply to plans exempted by federal law, such as ERISA plans or Medicare plans. For these reasons, the Nebraska Insurance Federation respectfully opposes LB430. I appreciate the opportunity to testify. And just a, just a couple of notes on, on some things that I, that I heard or questions. You know, I think Mr. Blake did address the issue of out-of-pocket costs to consumers. If I walked in under my health plan right now to a physical therapist, I'm paying that out-of-pocket under the way my plan is, is written now. Other plans, they may-- they-- there may be a copay related to that. In the insurance plan that my wife and I are covered under, we, we have a high deductible plan so we're paying for that out of our pocket until we reach our, our deductible for those types of services. Would also point out that Blue Cross and Blue Shield is not the only insurer that is using this. If you read the fiscal note from the Department of Administrative Services, you would see that this would cost the state, on the state health plan, about $175,000 if this was prohibited to be done. And that's I believe-- you probably know better than I do, but I believe UnitedHealth Group is the insurer for the state-- under their plan. And I think that's it on my notes. So sorry about that, but I do appreciate the opportunity to testify. Thank you.

HANSEN: Thank you for coming.

ROBERT M. BELL: Yep.

HANSEN: Are there any questions from the committee? Yes, Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thanks for being here.

ROBERT M. BELL: You're welcome.

M. CAVANAUGH: The out-of-pocket costs-- and also, yes, thank you for recognizing that Blue Cross is not the only insurer that we're talking about.

ROBERT M. BELL: I represent them all so, you know.

M. CAVANAUGH: The out-of-pocket costs, so--

ROBERT M. BELL: Sure.

M. CAVANAUGH: --let's, let's dig into that first.

ROBERT M. BELL: Yeah.

M. CAVANAUGH: So what I heard from the providers is you have-- say we have a farmer who needs-- has a stroke and needs physical therapy and--

ROBERT M. BELL: How old is this farmer?

M. CAVANAUGH: I--

ROBERT M. BELL: Let's make him under 65--

M. CAVANAUGH: OK.

ROBERT M. BELL: --OK?

M. CAVANAUGH: Let's make this--

ROBERT M. BELL: Because if he's over 65, Medicare is probably coming into play.

M. CAVANAUGH: She is 55.

ROBERT M. BELL: She, of course.

M. CAVANAUGH: She's 55--

ROBERT M. BELL: She's 55.

M. CAVANAUGH: --and she's had a stroke--

ROBERT M. BELL: Yes.

M. CAVANAUGH: --and she needs physical therapy and what-- speech therapy, thank you.

ROBERT M. BELL: And occupational therapy.

M. CAVANAUGH: I need speech therapy, apparently. Occupational therapy-- needs three therapies.

ROBERT M. BELL: Absolutely.

M. CAVANAUGH: OK. And she needs to drive an hour and a half to two hours each way to get those therapies.

ROBERT M. BELL: Right.

M. CAVANAUGH: And so she is-- but because she's going there multiple time-- a different time for each therapy so that her insurance covers each therapy fully in order for her therapist to get reimbursed, wouldn't it cost her less if-- even if she's paying out of pocket first to have one visit fully charged at each--

ROBERT M. BELL: That's, that's an interesting hypothetical. It could. I mean, I think you can come up with a lot of different hypotheticals--

M. CAVANAUGH: I sure could.

ROBERT M. BELL: --and that hypo-- and that hypothetical--

M. CAVANAUGH: How many hours do we have?

ROBERT M. BELL: Well, yeah. And, and I do believe a lot-- I mean, a number of Nebraskans do have to drive to--

M. CAVANAUGH: But it would, it-- wouldn't it ultimately be a cost savings to Farmer Jane Doe to go two days a week instead of five days a week to two, two appointments that covers all three therapies?

ROBERT M. BELL: Maybe. It's going to depend on the provisions of her plan and how much her provider is charging her, everything like that. I would also say if--

M. CAVANAUGH: But if she's paying--

ROBERT M. BELL: --if she had a stroke--

M. CAVANAUGH: Yes.

ROBERT M. BELL: --if she, if she spent some time in the hospital, there's no way she hasn't burned through her deductible already.

M. CAVANAUGH: It's a new year. She, she did all--

ROBERT M. BELL: OK. Well, that's fair. That's-- it's unlikely that--

M. CAVANAUGH: She had the, she had the stroke last year.

ROBERT M. BELL: She had-- and so if she's still going to therapy, that's fine.

M. CAVANAUGH: And she's still going to therapy. She had a stroke in November.

ROBERT M. BELL: So to travel to--

M. CAVANAUGH: So she's showing up for an appointment on Monday and she gets all three appointments-- she pays for the actual appointments out of pocket--

ROBERT M. BELL: Um-hum.

M. CAVANAUGH: --but then she only has to come two days a week.

ROBERT M. BELL: OK.

M. CAVANAUGH: So isn't that--

ROBERT M. BELL: It-- are these separate appointments or are these all together?

M. CAVANAUGH: They're all together--

ROBERT M. BELL: They're all together.

M. CAVANAUGH: --being charged the way that they were prior to this December 1 of this year.

ROBERT M. BELL: Boy, math is not my strong suit. I'm an attorney, not a, not an accountant, but--

M. CAVANAUGH: Theoretically, changing this--

ROBERT M. BELL: There could be, there could-- I mean honestly--

M. CAVANAUGH: It's not a cost-- what I'm asking is-- theoretically, is that this could not be a cost savings to somebody who's paying direct out of pocket.

ROBERT M. BELL: Theoretically.

M. CAVANAUGH: If you have, if you pay to distribute that--

ROBERT M. BELL: If there-- if the provider is deciding, hey, we're not going to bundle those services, you're going to need to come back so that we can charge higher reimbursement to you and, and your insurance company, you're absolutely right. It's going to cost them more money, so.

M. CAVANAUGH: OK. That was my question. Thank you.

HANSEN: Yes, Senator Hardin.

HARDIN: The other challenge that was brought up earlier by one of the testifiers has to do with how major medical plans are typically constituted with the number of available visits for any kind of therapy.

ROBERT M. BELL: Right.

HARDIN: Generally, they come in at 16, 24, or 32. I don't know why they don't make it 33, but that's the way they do it. And so unless you apply for and receive once again from the insurance carrier-- let's say it's from some other carrier like, oh, Aetna.

ROBERT M. BELL: That's sitting close to home.

HARDIN: There you go. In a nutshell, you're not going to get more than the prescribed number of options that come inside of your summary benefits coverage, whether you've got group insurance or individual.

ROBERT M. BELL: Um-hum.

HARDIN: And so you're going to burn through those at about a rate three times faster than you normally would. And so I'm saying that that's where the other problem is because whether you've met your out of pocket with your deductibles--

ROBERT M. BELL: Right, if there's a limitation on the number of visits that you have within your policy, yeah.

HARDIN: And so we, we have to-- even for things like chiropractic, we, we-- those number of visits are limited and so I'm just pointing out that--

ROBERT M. BELL: Yeah, there are. There are, there are-- we have all kinds of limitations--

HARDIN: Right.

ROBERT M. BELL: --in, in insurance policies to keep the cost down--

HARDIN: Right.

ROBERT M. BELL: --to do something to make it just-- I mean, I'm not going to sit here and tell you that--

HARDIN: Right.

ROBERT M. BELL: --$12,000 per-- for my family of five, that would be-- at $12,000--

HARDIN: Yeah.

ROBERT M. BELL: --that's--

HARDIN: Yeah.

ROBERT M. BELL: --$60,000-- at least I can do that math. Sorry about that-- but $60,000. You know, we're-- we do have limitations in our policies, yes.

HARDIN: Right and everyone does.

ROBERT M. BELL: Absolutely.

HARDIN: But I'm just saying that that's what that forces on the consumer then is burning through those available number of visits exponentially faster.

ROBERT M. BELL: I mean, there's-- kind of going down to a dark place, Senator Hardin, on what's the solution for that, so.

HARDIN: I would be glad to work with all of you, so.

HANSEN: Yes, Senator Riepe.

RIEPE: Thank you, Chairman Hansen. Mr. Bell, at one time, I'm-- might be-- I'm not up to date on this, but--

ROBERT M. BELL: Sure.

RIEPE: --Medicare had a most favored nation thing that no one could charge or provide a service less than what the Medicare would charge.

And so that limits all of the providers in terms of what they could charge someone that's paying out of pocket.

ROBERT M. BELL: Yeah, I-- we'd have to talk about that a little bit. I would like-- I, I'd like to, I'd like to bring in a Medicare expert on that.

RIEPE: I thought you knew everything.

ROBERT M. BELL: I-- well, that's what I tell, that's what I tell my kids and my wife, but they know better, right, so.

RIEPE: OK.

ROBERT M. BELL: But if we want to-- like to talk about that a little bit. You know, the question on-- like, on a, on a piece of legislation like this is that if you do come in with a Medicare plan, whether or not it's a Medicare Advantage or Medicare Medigap, is the State Legislature stepping into a place that has already-- it's been dictated by the federal government that, yes, MPPR must apply, right?But apparently for these and the licensing laws, it's saying that MPPR does not apply to, to this in the state law. So we get a conflict and then the deep insurance nerd or legal nerd, I mean, it's, like, how do-- how does that whole conflict resolve itself on, on how LB430 is drafted? Certainly, there are, there are ways to, to draft the legislation to take care of those particular concerns. And I'm not trying to say that there aren't. I'm not saying that if they were, that our opposition would be lifted because it would not. But certainly if I was sitting in your seats, I would be, I would be curious on the best way to, to fix that if that's an issue that the Legislature sees as well.

RIEPE: On anything with reimbursement, Medicare is the 800-pound gorilla in the room, that they dictate--

ROBERT M. BELL: Sure.

RIEPE: --not-- I mean, all Medicare would be the same. They even-- in essence, in a way maybe de facto dictate or very directly dictate what therapists could charge. If I walk in and say I want to pay cash, they have to charge through the Medicare, right?

ROBERT M. BELL: Well, it wasn't like Blue Cross and Blue Shield-- not to pick on Jeremiah-- or Mr. Blake or his company, which is a very good member of the Nebraska Insurance Federation, they didn't learn

this. They didn't come up with this idea on their own. I mean, it was in the Medicaid-- Medicare, excuse me, Medicare space first. And, you know, the federal government put these-- this produce-- you know, policy in place for a reason and I believe it-- likely to keep down costs, which is hard, right? I mean, insurance-- a lot of the fights of the insurers are with people that we pay to provide services to our consumers, right? So whether or not it's physical therapists or occupational therapists or doctors or hospitals or auto body shops or roofers or pick your pick your service provider who is paid money by an insurance company to provide a service to the insured. And, and everybody wants to get paid more and in some cases-- not, not saying that I would-- if I was in their shoes, that I wouldn't want to do the same thing, but we are looking at ways to keep down those costs because those costs are paid by our policyholders, right? You know, particularly in the health space, there are limitations on how much a health insurer can spend on administrative costs, right? You know, the Affordable Care Act, you know, tied their hands a little bit on that. And there's, there's been escalating costs ever since. So, yeah, it's been a long week. Maybe I should just be quiet now so sorry about that.

HANSEN: We know what you mean.

ROBERT M. BELL: Yeah.

HANSEN: Any other questions? Yes, Senator Hardin.

HARDIN: You're absolutely right, Mr. Bell, that the ACA absolutely tied hands for the carriers in that way. But Medicare, to Senator Riepe's point, is the 800-pound gorilla. In fact, it's 1.0 in everything-- from all of the carriers is constituted on multiples of Medicare. They are the standard.

ROBERT M. BELL: Sure.

HARDIN: Right. And so-- but those rates are, are negotiated carrier to carrier and so on and so forth.

ROBERT M. BELL: Right.

HARDIN: Yeah.

ROBERT M. BELL: Right, right. I mean, when you look at, like, the-- like, who pays for healthcare, it's, it's really interesting, like, how much is coming from private individuals, how much of it is coming

from private insurance, how much that's coming from ERISA plans, which are usually employer-sponsored plans, right? So that's-- a lot of that's being paid by employers, not all, but the employees pick up some of that cost too. A lot of it is being paid by the government, whether or not that's Medicaid or Medicare or governmental health plans like the state employee health plan, University of Nebraska health plan or TRICARE. There's, there's a lot of layers to it, which is prob-- is why it's, it's a difficult thing to solve. You know, for us, it's, it's that overall cost that makes it really hard. And then so if, if you're not receiving subsidies on the ACA exchange, if you're one of those individuals that has to go grab a plan, you know, price it out yourself. It's, it's, it's unaffordable for most Nebraskans.

HARDIN: Thanks for the clarification.

ROBERT M. BELL: Yep.

HANSEN: Senator Cavanaugh.

M. CAVANAUGH: Thank you. I wanted to provide some clarification on some remarks you made in your opening.

ROBERT M. BELL: Uh-oh.

M. CAVANAUGH: It's not, not--

ROBERT M. BELL: Fact-checked, good.

M. CAVANAUGH: No--

ROBERT M. BELL: What did I say wrong?

M. CAVANAUGH: No, just I remembered that you mentioned about-- that this is under the universal credentialing-- or what is it under?

ROBERT M. BELL: Uniform Credentialing Act.

M. CAVANAUGH: Thank you. Uniform Credentialing Act. And I don't know if you know this or not, but we kind of had a few bills introduced this year.

ROBERT M. BELL: Yes.

M. CAVANAUGH: And--

ROBERT M. BELL: It wasn't a criticism, just pointing it out.

M. CAVANAUGH: No and, and we also had-- we have some newer Bill Drafters so things like that. I think-- like, I appreciate them. It's something that we can definitely look at if this were to move forward. So I just wanted to note that because you had mentioned it.

ROBERT M. BELL: Yes.

M. CAVANAUGH: And I also want to circle back on the fiscal note because it did say-- the department did say that they couldn't actually accurately say how this would impact or increase costs and services. But also, thank you for letting us know that the state currently is potentially forcing employees to go on multiple visits and burn through their days.

ROBERT M. BELL: You know, that's-- it's really a-- that's what came first, the chicken or the egg? I mean, it's--

M. CAVANAUGH: Just giving you a hard time.

ROBERT M. BELL: Yeah, no it's fair. Did it not say $175,000?

M. CAVANAUGH: It said that they--

ROBERT M. BELL: Yeah.

M. CAVANAUGH: --they estimated that but that they can't actually--

ROBERT M. BELL: Oh, OK. I gotcha.

M. CAVANAUGH: They can't actually say--

ROBERT M. BELL: It-- look, it's insurance. Everything is an estimate. But I appreciate you pointing that out.

HANSEN: Any other questions?

ROBERT M. BELL: I'm, I'm going to get a call from DAS. Thank you, Senator.

HANSEN: I'm glad we can all come to agreement that whenever government gets involved in anything, whether it's insurance or healthcare or etcetera, it always seems to get more expensive for some reason

ROBERT M. BELL: It does.

HANSEN: So with that-- the conservative in me had to say that so I couldn't help it, but thank you for coming to testify.

ROBERT M. BELL: You're welcome. Have a good afternoon and a great weekend.

HANSEN: Thank you. We'll take our next testifier in opposition to LB430. Anybody else wishing to testify in opposition? OK. Seeing none, we'll-- is there anybody wishing to testify in a neutral capacity? All right, so seeing no more testifiers and Senator Walz has waived closing. That will close the hearing for today almost, but first I'd mention we do have eight letters in support of LB430 and one letter in opposition. All right. Now that will close the hearing for LB430. And now we will open it up for LB561 and we will welcome Senator Blood to open.

BLOOD: That was a long hearing.

HANSEN: You are free to open whenever you want.

BLOOD: Thank you. So good afternoon to Chair Hansen and members of the HHS Committee. My name is Senator Carol Blood, spelled C-a-r-o-l B-l-o-o-d, and I represent District 3, which is the western half of Bellevue and southeastern Papillion, Nebraska. I appreciate the opportunity to bring forward LB561 regarding the Cosmetology Licensure Compact. So today's interstate compact is the result of the Council of State Governments partnering with the Department of Defense in support of our military families and their spouses' employment. Nebraska has passed previous compacts for licensed professionals, including-- and I know some of you heard this yesterday-- physical therapists, psychologists, nurses, occupational therapists, audiology and speech-language pathology, EMS and doctors to name a few. This compact will allow cosmetologists to obtain a multi-state license to practice in all states that join the compact rather than individually applying for a license for each state that they move to. They do this by utilizing their original home state license if that state belongs to the compact. Member states of the compact then agree to mutually recognize licenses issued by every other member state. LB561 will significantly help military families and their spouses find employment if relocated in Nebraska and help Nebraska become a more military-friendly state, as I believe that is everyone's goal in the Legislature. Military spouses suffer from severe unemployment or underemployment, with recent estimates putting this demographic at 22.2 percent unemployment. This high unemployment can be attributed to

the frequent relocation of military families and their spouses often having to search for new work and licensure if their career requires it, when moving to a different state. This leads to financial instability for military families, making it difficult for them to maximize their long-term retirement benefits or find careers for themselves post military that offer competitive salaries that match their professional experiences. It's already stressful experience for-- it's already a stressful experience for military families to relocate on an average of two to three years between finding new schools for their children, healthcare providers and again, employment. The interstate compact can ease some of the stress, cutting down on the arduous process of obtaining a new license in a new state. This compact, like the others, will make Nebraska a more welcome state for veterans' families and a boon for small businesses in the state, specifically cosmetology businesses. Spouses of veterans will be fast tracked by having a multi-state license and can immediately work in Nebraska, which benefits our labor force, which is currently facing struggles filling workforce vacancies. Nebraska will also be able to collaborate and have a shared database with the other states' cosmetology boards, ensuring licensed cosmetologists entering Nebraska adhere to the compact standards. This database has proven within our other contacts to not only protect consumers but also the organizations that hire these professionals. Unlike reciprocity, the compacts allow professionals to easily move between stage-- states, which is why it's been preferred over reciprocity by the DOD. However, reciprocity really works together well with the compacts because we need more than one tool in our toolbox to, to address our workforce issue here in Nebraska. Compacts continue to show that Nebraska can easily attract talent into the state and help small entrepreneurs have more candidates to choose from for a hire. I'd also like to clarify that this is not mandatory for any licensed professional to join the interstate compact should it not benefit them. It is an option that will be offered to those who may be transient or need to cross state lines for a closer job opportunity. In tradition with other compacts we've supported in the past, it eases burdens for military families when they are relocating frequently, not only helping them financially, but emotionally as well. Nebraska continues to strive to be a more military-friendly state. We can back this talk up by passing these interstate compacts quickly. Spouses of active-duty military families should be able to pick up employment as efficiently and quickly as allowed. And this compact is part of a long series, as you are all aware,in this committee, backed by the DOD that accomplishes

that. I thank you for your time today and consideration for LB561 and I'm happy to answer any of your questions today.

HANSEN: Thank you. Are there any questions from the committee? Could you just briefly explain the fiscal note from the State Patrol? Is it-- is that just because of the hiring of staff they'll need to do mainly to process the new compact licenses?

BLOOD: Where are you showing this on the State Patrol here?

HANSEN: That-- you have, I think, a couple of fiscal notes.

BLOOD: So the applicants pay $45.25 for the fingerprint background check. That's standard for the interstate contacts that we're talking about. And then the fees are paid in Nebraska state control-- State Patrol for the criminal background checks that they run to the FBI.

HANSEN: OK.

BLOOD: So that's part of the interstate compact is all the compacts that we've passed in Nebraska have the FBI fingerprinting.

HANSEN: Yep. I-- so yeah, you got one from the DHHS and you got one from the Nebraska State Patrol saying the expenditures for the first year will be $682,000 and expenditures for '24-25 will be $381,000.

BLOOD: OK. Show me where you're at here.

HANSEN: Page 4 of the revised. OK.

BLOOD: OK. There we go.

HANSEN: Or maybe you can answer them later. It's not a big deal.

BLOOD: No, I'm not seeing what you're seeing. That's why I'm asking.

HANSEN: OK.

HARDIN: I'm seeing it, Senator Blood, on the last page of the revised.

HANSEN: On closing-- you can always address on closing too.

BLOOD: I don't think I've been given a revised one on LB561--

HANSEN: OK.

BLOOD: --because my revision says zero. What does your revision say in the right-hand corner?

HANSEN: OK. That's all right. Maybe on closing, you can address it too.

BLOOD: OK.

HANSEN: It's not a big deal.

BLOOD: Yeah, I'd like to look at that while--

HANSEN: But my number-- mine can be wrong too, but I'll just-- we'll, we'll verify just to make sure.

BLOOD: But the cost of the interstate compacts are the same no matter whether it's cosmetology, whether it's psychologists, whether it's doctors. And it's never been a burden for DHHS ever, so.

HANSEN: Sure. OK.

BLOOD: All right.

HANSEN: Any other questions just to make sure? Not seeing any, thank you.

BLOOD: Thank you.

HANSEN: All right. We'll take our first testifier in support of LB561.

GREG HOWARD: Good afternoon. My name is Greg Howard. It's G-r-e-g and H-o-w-a-r-d and I am excited to be able to testify in favor of LB561. Just a little background, I've lived in this world of cosmetology and hairstyling education for about 40 years. I'm a graduate of cosmetology program at College of Hair Design. I'm currently the owner of the College of Hair Design. We have an enrollment of about 60-plus cosmetology students and we also teach over 20 esthetics students and have a barber program in Lincoln, Nebraska. So a little trivia. I first testified at this-- at a hearing like this about 40 years ago because when I graduated from barber school, you had to get an apprentice license and then you had to later take a second test to become a fully licensed barber. So we-- I was in favor of eliminating that apprenticeship element of it too, so. But my dad was a barber in the Navy in the 1950s. He later opened several barber shops and later opened a Lincoln barber college, which has grown into what is now

called College of Hair Design. And we have two locations and-- but I'm speaking to this in, in favor of it because over the last 20-some years, I've attended a lot of national conventions. I've been on a state relations committee on a national level regarding how to help people in our industry move from state to state. Reciprocity is currently the way a lot of people move around, but there are some hiccups in that and some difficulties in how that works. So this, this compact is really a good solution to this issue of licensed mobility that's never been available before. Today, I did some-- I've been doing some homework for the past couple of weeks when I became aware of this bill from Carol Blood's office. And I actually called the Lexington office of the Council of State Governments today to just check on-- so I made sure I really understood and I really wanted to step forward and be an endorser of this. And I, I really have to say that this is an amazing step forward. Their website is tremendously helpful. I think you received a handout, looks like this, and it has kind of a little map of how it will work, how the person gets their-- they have to have a license in their home state and then they apply for the multi-state licensure that that-- then they can have, say, two or three licenses and only pay one fee. So there's a number of benefits. I have mainly-- my handout says four talking points. I actually have five. First of all, number one, this will be an affirmation of their commitment to licensure in, in cosmetology. Number two, the main benefit is it will reduce the burden of licensees often have when holding licenses in multiple states. So simplifies that fee process, renewal process. My wife is from California. She had to move from there to Nebraska at one point and had to, like, go through the details of reciprocity and so I'm familiar with that just in her experience. Number three, three and four of my handout has to do with really the fact that Nebraska still retains its sovereignty over the license and the regulations. So we're not losing anything in moving forward to this. There's no dilution of what-- who we are as a license cosmetologist and this is simply a focus in this bill to cosmetology. It is not going to affect other trades in the beauty/spa industry. Lastly, number five, there is some benefits to military families who are highly mobile and designated in a home state and just some simplification of their licensure, licensure. But overall, I just want to say, you know, this is-- I work with students and graduates. I get phone calls at least several times a month, maybe even some weeks more often, from graduates or people from other states wishing to move to Nebraska. And the process of, of moving from state to state is a-- is confusing. It depends on the state. Nebraska is fortunate that their offices are manned really well. The barber board, the

cosmetology board are both really good organizations and they are pretty helpful with helping people move from state to state. But anyway, I just want to say that this will really be a tremendous step forward. There's never been a solution like this ever before me and I think this is a tremendous bill. And I really do thank Senator Blood and her staff for putting this together.

HANSEN: Thank you for your testimony. Are there any questions from the committee? I have one question. I probably could have asked it of Senator Blood. What are the, the hours that are required of cosmetologists currently in the state of Nebraska versus what's required in the compact?

GREG HOWARD: The compact doesn't state a minimum.

HANSEN: OK.

GREG HOWARD: OK, like Nebraska is 1,800 hours, for example. Iowa is currently 2,100. Kansas is 1,500, so-- and then the way Nebraska has-- is sit-- the way their reciprocity is currently, if you've held a license in another state, they'll give you credit for the time you've held that license to bring your hours up to our 1,800, say. Like, for instance, California just lowered theirs to 1,000. So if you come from there, as long as you've worked for a year or so, it's not really a problem to move your license here--

HANSEN: OK.

GREG HOWARD: --so.

HANSEN: OK. So, so-- OK, so it's not-- OK, just kind of curious. It's, it's like a compact, but it's not. It's just reciprocity.

GREG HOWARD: Well, it creates-- this is what-- I actually want to just mention I did call Matt Shafer in Kentucky today because I had some questions about it. And so it creates kind of a-- basically a way where people can get their license without having to gather, like, a diploma from their school that they attended before or transcripts from that school they went to way back 20 years ago or there's a lot of states that have really weird rules.

HANSEN: OK.

GREG HOWARD: And there, there's a few states that it's just really a hindrance to try to move around and so--

HANSEN: It's almost like this just simplifies the reciprocity.

GREG HOWARD: It really does.

HANSEN: OK because that's what I--

GREG HOWARD: It's a tremendous step forward. It's like-- like I said, I've been on the state council of-- like, state relations meetings that very much a problem because, like, in Nebraska-- for instance, I just talked to the rep from Sport Clips and she has people that want to move from Council Bluffs to Omaha and work for Sports Clips. And to get that license, if they can just-- if it's-- if they have-- if this was all in place and we get everything going the way this is planned to work out, it just makes it quicker and simpler and more seamless.

HANSEN: OK.

GREG HOWARD: Yeah.

HANSEN: Thank you. Seeing no other questions, thank you for your testimony.

GREG HOWARD: OK, you're very welcome.

HANSEN: We'll take our next testifier in support of LB561. Is there anybody else wishing to testify in support? OK, is there anybody wishing to testify in opposition to LB561? If you're ready, you can come on up here. Welcome.

LINDA POCHOP: Hello again. Yesterday was Groundhog's Day, but I feel like I'm here again, just like in the movie. So my name is Linda Pochop, L-i-n-d-a P-o-c-h-o-p, and I am in opposition of LB561. This bill is being presented as something for military spouses, but in reality it is an allowance for all licensed individuals in the states in this compact to freely enter licensure in our state. During the 2018 LB343 transition, accommodations were made to our reciprocity application with special allowances for military spouses. So what I provided you for in that documentation is the allowance that was made already. And so we kind of already asked, answered and took care of that in 2018 for the military spouses. It's something that we were for. It makes the transition for them-- it's actually relatively easy for them to become licensed in the state of Nebraska if they are a military spouse. So what we're really looking at here is in that reciprocity thing with those 100 hours that they get from-- in order-- if they're coming from a 1,500-hour state, it's three months that they

worked full time in a shop and they're going to be already allowed to have their license. So this is not them going back to school and getting more debt and anything along that line for them to become licensed already in our state. My fear is that what it's going to do is open us up to special interest groups like the Platte Institute, who when we went up against them in 2018, were trying to drop our hours to 15. And so with most of the states in that compact being at 1,500 hours, I see that that would be the next step that's going to come is that they're going to come back after the number of hours that we have and try to reduce it to the 1,500 or the 1,000 that California just dropped to. And so for us, I guess, like, what I wanted to-- what my question was is how many people are they-- is the state being asked for reciprocity from, specifically for our military families? Because while we do get calls, there's probably about one or two people a year, sometimes maybe three, that have to come back to school and it's because they did not complete any hours in the actual salon after they got their license. So they got their license and moved, but they didn't actually go to work in a salon there. Because if they had, the state would already recognize that they got those extra hours and give them their license. So it's not something that is really stopping somebody from becoming licensed, but I think it is a gateway for them to ask to reduce our numbers again. And so that's kind of like-- because it's not just for the military people in the way that this bill is written. It actually would be for anybody that's in those states. So I know the other thing that when we're looking at this and when we're trying to have an understanding is there's a big difference between what our scope of practice is under our license at 1,800 hours than somebody who has 1,000 hours of training. And so when they move into our state, that license would allow them to do the work that we do at our 1,800 hours of training when they may not have got an actual education for it at the 1,000 hours, specifically in skincare, waxing. Because our scope of practice in Nebraska, we can do everything and in other states, it's very much they don't do skincare practices. They don't get to learn that under their cosmetology license in some of those states. How do I know that? Because I've seen their transcripts when they have transferred. And the thing that I have to do as a director of education is put them through those classes to make their license the same as what my license is because they're going to go work on the public with the "allowment" to do any of those services and it's something they may not have had any training on. But because we're going to go ahead and let them have their license without that stipulation in there, there's, you know, not-- it's apples and oranges sometimes. Any questions for me?

HANSEN: OK. Yeah, thank you for your testimony. Are there any questions from the committee? Seeing none, all right, thank you.

LINDA POCHOP: Thank you.

HANSEN: Is there anybody else wishing to testify in opposition to LB561. Welcome.

STEPHANIE MOSS: Hello. Welcome. Thank you for having me. Appreciate it. My name is Stephanie Moss, S-t-e-p-h-a-n-i-e, last name, Moss, M-o-s-s, and I am opposed to LB561. Little introduction-- same as yesterday, but some new faces here. I have been a licensed cosmetologist for the last 20 years and I also owned Stephanie Moss Salon in west Omaha and the Xenon Academy beauty school. We have a campus here in Omaha and also in Grand Island. I do have some concerns and questions about this bill. A lot of things is what Ms. Pochop had just addressed here, but the first being the difference between the hours between the states to be licensed. Like she said, Nebraska is an 1,800-clock-hour state, while most of the others are significantly lower on this. Do we know what each of the state's curriculums look like? Are they similar, what they're taught and able to do when they leave school? As a salon owner, for myself on the other side of it, that would be a concern for me to employ these staff and what I'd need to get them caught up on. And their education and just their knowledge on how to deal with the general public, as a cosmetologist in the state of Nebraska is licensed to work with hair, skin and nails. According to page 8, line 14 through 15, the licensee practicing in a member state is subject to all scope of practicing law governing cosmetology services in that state. That would be concerning to myself for the safety of others if not all states taught this in their curriculum, as some states allow for, for their estheticians to perform more aggressive treatments than our state. I do see and believe Virginia is actually one of the states in this compact and they actually do not certify for esthetics in their state. There is a master's program that one can go through. Us, as being licensed estheticians underneath our cosmetology license, would most likely be able to walk into that state and prefer-- perform some of these services that they can do in a master's program which are prohibited in our state, such as lasers and some more aggressive treatments. So that would be concerning to myself because our students coming out of our school would have absolutely no training any of those devices. I have attached Nebraska's scope of practice there for you guys as well. I've also attached every state and the required hours of completion. California is on here for 1,000 hours. And as a salon owner, I can

tell you there's a lot one can learn in an 800-hour timeframe. This bill is written again to help support our military spouses and I'm all in favor for it. Nebraska, as has already been discussed here today, has a great reciprocity program for our military families, allowing them to work under their temp license if there's hours that need to be made up. My last thought for the day is how important it is to keep our Nebraskans in Nebraska. This would give students the opportunity to seek their education elsewhere for maybe some less clock hours and then come back into their home state and work. As a small business owner myself, I don't see how this would protect myself or any of the other small business owners that are out there. Thank you very much.

HANSEN: Thanks for your testimony.

STEPHANIE MOSS: Yeah.

HANSEN: Are there any questions from the committee? Yes, Senator Day.

DAY: Thank you, Chair Hansen, and thank you for being here today, Ms. Moss. I have visited your salon many times--

STEPHANIE MOSS: Thanks.

DAY: --so it's nice to officially meet you in person.

STEPHANIE MOSS: You too, appreciate it.

DAY: Do you, by chance, know the other states that are in this compact?

STEPHANIE MOSS: So from the ones that I did get a list of-- I have them on my phone.

DAY: OK.

STEPHANIE MOSS: Hold on, let me see if I have it highlighted here. That was one question from the things that I have. I was told it was Alabama, California and I-- one of my questions was how did we pick them, one--

DAY: Yeah.

STEPHANIE MOSS: Alabama, California, Iowa--

DAY: OK.

STEPHANIE MOSS: --Kansas, Kentucky, Maryland, Minnesota, Nebraska, North Carolina, Tennessee-- I believe Virginia is our last one-- and Virginia.

DAY: Tennessee and Virginia. OK. Thank you. I was just wondering so I could kind of look over--

STEPHANIE MOSS: Nope.

DAY: --hours and--

STEPHANIE MOSS: It did not scan. I did highlight it, sorry.

DAY: Do you know-- so I know that in Nebraska, continuing education hours are required.

STEPHANIE MOSS: Correct.

DAY: If Nebraska were to join this compact and someone were to move from out of state, would, would they would then be required to follow through with those continuing education hours or--

STEPHANIE MOSS: That's a great question.

DAY: OK.

STEPHANIE MOSS: Yep. And I think that's just there's a lot of-- as to could this be a simpler form of reciprocity issue, sure it could. I just think as a school owner and a business owner--

DAY: Sure.

STEPHANIE MOSS: --there's a lot of kinks that would need to be definitely worked out and looked at. And one of them for myself is I would hate to see our hours drop down. It's a lot to cram in 1,800 hours alone and then to try to do it and even less, it's, it's just the time gets cut from them working on the floor and the general public and practicing that under the supervision of a licensing professional. And that's not the best thing.

DAY: Concerning.

STEPHANIE MOSS: Yeah.

DAY: OK. Thank you.

STEPHANIE MOSS: Thank you.

HANSEN: Any other questions from the committee?

STEPHANIE MOSS: Perfect.

HANSEN: Seeing none, thank you.

STEPHANIE MOSS: Thank you, guys.

HANSEN: Is there anybody else switching to testify in opposition to LB561? All right, seeing none, is there anyone who wishes to testify in a neutral capacity to LB561. Good afternoon.

LAURA EBKE: Good afternoon, Chairman Hansen and members of the HHS Committee. My name is Laura Ebke. That's L-a-u-r-a E-b-k-e and I'm the senior fellow at the Platte Institute, which is a free-market think tank here in Nebraska. We're going to try neutral testimony again today. In the last five or six years, one of the areas of focus for the Platte Institute has been reducing barriers to employment and encouraging workforce growth. We have worked to make it easier for people in our state and those who would like to come to our state to find work. Somewhere between 170 and 200 occupations are licensed in our state. Interstate compacts like the proposed cosmetology compact have become very popular, and we have no inherent objection to licensing compacts. As I suggested in my testimony briefly to you yesterday on LB280, it's important to remember, though, that while licensing compacts can help to normalize requirements across state borders and can simplify multi-state licensure for those who seek to work or move to another state while providing a central database for member states of the compact to report license status as well as license problems to other members of the compact. It also adds a compact level layer of added bureaucracy, which can have a significant amount of power, as you can see on pages 12 and forward on page 561 [SIC]. Understand that by entering a compact, Nebraska agrees that concerning this occupation, rules and regulations promulgated by the compact commission have the force of law in Nebraska and we see that on page 23. Compacts help guarantee movement between states that are in the compact. It appears that along with the massage therapy compact bill, this is the first legislative session that the cosmetology compact has been proposed anywhere. And so this compact doesn't go into effect until seven states have enacted it. So no other states have enacted it yet that I know of. If they have, they did it really fast since their session started. Again, we take no position on

compacts per se, as they can be a useful way to increase mobility along-- among member states. Still, until multiple states have enacted, Nebraska would see little benefit in terms of adding to our workforce numbers, which is our, our priority. In case you missed it yesterday, I've handed out with my testimony a comparison between compacts and universal recognition. Both can be useful tools to increase mobility of workers. Compacts require both the originating state and the state the worker seeks to go to to be part of the compact. I hope that you can see that compacts can be useful in attracting workers or sending workers away as part of the compact. Universal recognition can be used in addition to compacts to bring workers to our state by allowing the state to recognize licenses and experiences from non-compact states unilaterally. If you have any questions, I would be happy to try to answer them.

HANSEN: Any questions from the committee?

LAURA EBKE: Yeah.

HANSEN: We-- are-- so we already kind of have universal recognition to some extent don't we or not kind of broadly--

LAURA EBKE: We have universal rec-- well, we have effectively universal recognition for some occupations. So LB389 and LB390, which all passed in 20-- let me think-- 2021, did that for many licenses that are covered under the Uniform Credentialing Act. That was LB390. That was Senator Murman's at the request of the Governor. And then Senator Sanders had LB389, which did much the same thing for military spouses that were educators. But, but what this would-- what, what a universal recognition scheme would do is expand it to other occupations. And we'll be hearing that bill next week in another committee.

HANSEN: OK. All right. And just for clarification, we then have the ability to get out of the compact, don't we?

LAURA EBKE: You can get out of the compact, sure. It, it-- once you've, once you've signed, signed that contract, it becomes a little bit more complicated. And the other thing you have to remember with the compact is you have to send somebody to be part of the commission that that-- and it's-- the commission is made up of members from each of the member states, so

HANSEN: Somebody from that-- the field or the, the--

LAURA EBKE: Probably from either the board or, you know, depending on how the, the-- different, different compacts work, work differently. But it's either usually from the board, for instance, from cosmetology, or else from HHS.

HANSEN: OK. And that would be a-- the state would incur that cost then right, wouldn't they?

LAURA EBKE: Yeah, I think so as far as sending them to meetings.

HANSEN: Yeah, I didn't see anything in the fiscal note about that so I was just kind of curious. OK. All right. Thank you for your testimony.

LAURA EBKE: Thank you, um-hum.

HANSEN: Is there anybody else wishing to testify in a neutral capacity? All right, seeing none, we'll welcome Senator Blood back to close. And with that, we did have some letters. We had four letters in support of LB561 and one letter as neutral.

BLOOD: My only regret is that I left my pen at this table so I couldn't take notes of everything that was said. But there was a lot of misinformation and I'm really happy to unpack that. So let's-- you know, the unfortunate part about when people get involved with policy is that they don't always see the actual bill or they see a draft online. This is a brand new compact. There are no states that belong to this interstate compact. There are four states, Nebraska being one of them, that picked up this compact, which was not available until about a week before we went into session, by the way, as was the teachers' compact and whatever the third compact was this year. So first, I want to clarify that that's misinformation. Now, this odd comment about how they can come in and do whatever they want because they did it in their state and now they're going to try and do it in Nebraska, as we know, it's set in state statute in all interstate compacts what you can and cannot do. If you look at page 8 of our actual bill, LB561 and you look at line 14, a licensee, licensee practicing in a Member State is subject to all scope of practice laws governing Cosmopology Services-- Cosmetology Services in that state. So if they used a laser in Kentucky, they can't use a laser here unless our licensure says they can do that, which was the example I believe that was used.

HANSEN: I--

BLOOD: So-- I'm sorry.

HANSEN: No, you're fine.

BLOOD: So that, that, that guardrail is put into every single compact. The people that put these compacts together are lawyers and professionals, national professionals on these topics. Each compact takes approximately two years to put together. It's not put together willy-nilly. And to think that it's some kind of ploy to lower hours, these people work really hard. This is set in stone. There-- you've not seen that with any of the other medical fields. Interstate compacts have been around for decades, for decades, from roads to government. Now the medical professions are doing so and thank goodness they were doing so before the pandemic because that was very beneficial, especially for our traveling nurses, to have the mobility that they had. I represent Bellevue and south, and southeastern Papillion. The vast majority of my constituents have had some connection with the military. And to say that reciprocity is the way to go, well, maybe for some of them, but this is what I heard. And why I was so happy to finally see a cosmetology one is that they find it burdensome to have to find certificates and, and things that they have to prove who they are and what they did in other states in order for them to practice in our state. They-- the people on our end that, that are supporting reciprocity and not compacts are saying, oh, it's really easy. They have to do this, this and this. If they have hours, they don't have hours, we'll figure it out. With an interstate compact, you utilize your home state license and if you go to another state that is part of that compact, the guidelines are set in place of what you can and cannot do. [RECORDER MALFUNCTION] you can get to work. That's what we always talk about every single time we talk about interstate compacts. And they aren't just for military spouses, they're right, they're for people that tend to be transient. If your husband is in construction and travels all over the United States, which we see more and more of, we see a lot of people in the trades that come with their trailers and camp out for a year and work on our highways or work on a building in Omaha. And then the wife has to again change their career and if it's a licensure career they appreciate having interstate contact, especially in the medical field. This cosmetology compact since the very first one that I brought forward six years ago is the one that I get asked to do the most. And reciprocity is a burden for some of them, whether we believe that or not. If you're buying a house and getting new doctors and trying to find a new church and trying to find your way around town, here's one more burden we are going to create for you in order to get your license in our state. And, and by the way on the fiscal note, we never

got a copy of that. And it's so blatantly wrong, it's almost silly. It's saying there are currently 6,805 licensed cosmetologists in the state. That has nothing to do with interstate compact. We don't change how we license people in Nebraska. The only people that will utilize this background check for the interstate compact are the people that come over on the interstate compact. And if you look-- and I don't know if you ever saw the original fiscal note, but if you look at all of the fiscal notes that we've had over the years on interstate compacts, basically the, the criminal background check with fingerprinting is like 45 bucks. So to see this fiscal note-- now you know why I didn't know what the heck you were talking about, that's ludicrous. They've got their math wrong. Six thousand people-- I mean, it would be kind of awesome if we get 6,000 people to come and work in Nebraska right now, but that's not reality. Likely, I'm going to be able to count on both hands maybe the first year, but that's ten more people that we've gotten to Nebraska. And you heard former Senator Ebke talk about it a little bit yesterday. We can't have one tool in the toolbox. We need multiple tools in the toolbox. You know, if you're OK with people going through extra hoops for reciprocity, so be it. But I'm telling you, having served the area where the military is most concentrated in Nebraska, I have been begged for this interstate compact more so than any other one outside of our psychologist one. And not one thing that was said today is correct. And I don't mean to be rude to these people, but I'm telling you that the hours aren't going to be lowered. That's not how compacts work unless all the states that belong to the compact agree to it, by the way. Nebraska might decide to do that, and that's fine. But when it comes to the compact, the compact stays the same. There's no ploy. It's just like the compact yesterday where they thought that the ploy was to create sweatshops so we could bring people in that were illegal immigrants to, to do massages. That's also the problem with these smaller communities in certain demographics is they talk amongst themselves. And, well, they should, which is great. I love that they have a sense of community, but it does make what they're sharing correct. Interstate compacts never change. The template never changes. It's not one person that creates a template. It's a group of attorneys, a group of professionals. And it's done under the guidance of the Council of State Governments. This compact is brand new. There are no other states that belong to this compact. And by the way there is a website that I wrote down, I believe it's csgcompacts.org. I'm not sure what page I wrote it-- it's cosmetologycompact.org-- csgcosmetologycompact.org, and it'll show you the four states that are in motion right now to considering the compacts. Once there's seven,

it will be approved and then more and more states will come on. And as I said yesterday, I think there's 41 states that participate in interstate compacts. Most have more than one, and almost all of them are in motion for all the other compacts that they don't have. Sorry, I, I just-- lots of misinformation today. And, and it says right in your compact what they can and can't do. So to bring up scope of practice when it clearly says that doesn't change our scope of practice is a misnomer.

HANSEN: See if there's any questions from the committee. Yes, Senator Day.

DAY: Thank you, Chairman Hansen, and thank you, Senator Blood. So-- I mean, from my perspective just listening to testimony and from my personal experience with people who do work in this industry, I don't fault people for wanting to protect the professionalism--

BLOOD: Absolutely.

DAY: --of the industry that they work in. And as I understand it, Nebraska has very high standards when it comes to the education of both cosmetologists and estheticians. And the concern is that the majority of other states in the United States have lower hour requirements, number one, and then also I think the concern is that, you know, different schools teach different things, different methodologies. And so I, I understand what you're saying within the bill, but I'm not sure that it articulates exactly what-- how someone coming from another state who is-- I think the, the example that was used of lasers is not trained in lasers were to come to our state.

BLOOD: But they cannot use lasers because that would be outside our scope of practice that they're not qualified to do that.

_____: But if I [INAUDIBLE].

HANSEN: Should not-- please, we'll just keep [INAUDIBLE]. Thank you.

DAY: OK. And so then the other question I-- so the, the compact has to agree on the hours. Is--

BLOOD: The group that puts together the initial compact are the ones that decide on the hours and they, they bring people from all over the United States from the industry. And I don't know if indeed in this case if anybody from Nebraska participated, the only one I'm for sure

of was for the teachers' compact this year because I recruited somebody for that compact.

DAY: OK.

BLOOD: But if you go to the website, it'll tell you everybody who participated. They list all participants in the process. So there's attorneys, there's industry people, and it's always, it's always people that are boots-on-the-ground people. It's not big companies or politicians or-- it's experts. And the attorneys are usually the same because this is a very unique thing that you have to understand, because if you screw up the scope of practice, if you screw up how your license-- your home state license will work in another state, then the compact doesn't, it doesn't work. And they don't want that to happen. So they're very cautious about how they put these together. So I do understand them trying to protect their business. But, but again, it's very clear that when it comes to scope of practice, that if there's something that's not allowed in this state but is allowed in their home state, they cannot practice it in our state. So say that-- you know, estheticians aren't included in this, it's cosmetology and they're actually looking to do a interstate compact for that now, too, is my understanding. It's-- I lost my train of thought. So it's, it's, it's not meant to do anything but allow somebody the ability to come into our state. They talked about reciprocity as being the option that they like and how if they didn't have the hours that they'd figure it out, maybe work on it, and they'd, they'd, they'd choose to maybe utilize experience. And I, I, I think it's, it's kind of cherry-picking because here's somebody that's qualified with a state license who's coming to practice in Nebraska, if they want to practice something that's not in our scope of work in their license, they can't do it. But they can cut hair and they can color hair and they can do the things that they need to do to at least get their foot in the door.

DAY: OK. I guess I'm not grasping the difference between reciprocity and, and the compact.

BLOOD: I would say the simplest thing is that with a interstate compact, you have a home state license that you can utilize and you're allowed to travel between any other states that belong in a compact and practice whatever that compact is that you have the license for. If you get your license in Nebraska and you never want to leave Nebraska, you don't have to join-- you have the option to join the compact. Nobody is forced to join the compact. It's an option. But if

you're a military spouse, you get your hours in Nebraska, you can make it your home state license, you'll be allowed to move to all the other states where-- with your spouse and practice in those compact states. So with reciprocity, you have to create paperwork. You have to verify things.

DAY: Is there not paperwork with a compact?

BLOOD: You don't have to verify, like you don't have to show your-- you don't have to verify all the stuff that they ask for in reciprocity. Reciprocity, you have to bring, you have to bring documents and you have to bring proof. You already have your home license in the interstate compact, you're already in the database so we know that you're already qualified so you don't need the documents.

DAY: OK.

BLOOD: And that's the other difference between reciprocity and, and the interstate compact is all interstate compacts have that database that protect consumers and protect the people who hire these people. And so if you're a ne'er do well and you've done something bad in another state, which is what we hear lots of times in opposition with compacts, we're going to know that. So we're going to prevent a lot of people from being hurt that you really can't track easily otherwise.

DAY: OK. I just sometimes I think there's a lot of confusion with the reciprocity on compacts and--

BLOOD: I agree.

DAY: --so I don't fault people again who don't sit here in front of these bills all day not understanding all of the details of, of the ins and outs of bills and, again, wanting to protect their businesses, so.

BLOOD: Fair enough. It would have been great if they contacted our office because we would have been more than happy to have met with them and walked them through it and helped them with it too. And that wasn't done.

DAY: OK. Thank you.

HANSEN: If-- I, I just got one question. I think this is maybe what they were leading to is I was looking at some of the opinions of what's in the scope of practice for cosmetologists and they have

something on here called microcurrent. And so right now it's currently in Nebraska within, within the scope of cosmetology practice. I think maybe the example they're using, and maybe you can correct me if I'm wrong or right, I'm just not sure, so say somebody comes from California where they are not trained in microcurrent because it's not within the scope of practice in California, and then they come to Nebraska where now it is in the scope of practice, they can-- they are now allowed to do that.

BLOOD: No, they're still not qualified to do that, not for something like that. So that would only be if, if indeed they were qualified to do that. They can't, they can't do something like that without proper training. I mean, you, you can't just pick it up and start doing it.

HANSEN: Could they legally do it?

BLOOD: No. You mean legally if they were trained to.

HANSEN: I think they probably could if they wanted to. I wouldn't think--

BLOOD: I don't think on that they can. But I can find out for you and I'll verify [INAUDIBLE].

HANSEN: I'd appreciate it because I'd be curious-- because out, out of curiosity because if I'm thinking if it's under the scope, they're able to do it. You would hope they have training to do it.

BLOOD: Right,--

HANSEN: I mean--

BLOOD: --if it's within our scope--

HANSEN: Yeah.

BLOOD: --and they are trained to do it.

HANSEN: OK. All right. Any other questions from the committee? All right. Seeing none,--

BLOOD: Thank you.

HANSEN: --thank you very much.

BLOOD: I can sincerely tell you that out of all of our compacts, and Senator Riepe has been in on multiple compacts, that these last two have probably had more opposition than all of them combined. But I will point out there's not been any glitches with any of these compacts that we've voted in and that we have become a part of. So just want to point that out.

HANSEN: All right. All right.

BLOOD: All right.

HANSEN: Well, thank you.

BLOOD: Thank you.

HANSEN: All right. And that will close our hearing for LB561. And we are going to take a pretty quick ten minute break here before we get to the next one.

[BREAK]

HANSEN: All right. Welcome back after that short break. And so we will now get ready to open on LB572 and welcome Senator Riepe to open. Welcome.

RIEPE: Thank you, Chairman Hansen, and good afternoon and to members of the committee. My name is Merv Riepe. It's M-e-r-v R-i-e-p-e. I represent District 12, which consists of Omaha's southwest corner and also the city of Ralston. Today, I am introducing LB572, a bill to update the Medical Nutrition Therapy Practice Act. My interest in this legislation comes in part from my long career in healthcare delivery. I started that career as a Navy corpsman. Following my service, I trained as a respiratory therapist so I've had some experience at bedside healthcare and the importance of it. I share that to reflect my commitment to providers of direct care as individuals qualified in a given discipline such as nutritional assessment and management. Such management is especially significant in serious medical conditions. I have introduced this bill at the request of the Nebraska Academy of Nutrition and Dietetics to update the Medical Nutritional-- Nutrition Therapy Practice Act and to rename the professional license to conform with how these professionals are known and titled throughout the rest of the nation. The current status-- statutes have been in place since 1995. Obviously, they're dated. The Nebraska Academy of Nutrition and Dietetics brought this proposal to the Department of Health and Human Services and completed the 407 review process. We've received

unanimous approval from the 407 Technical Review Committee, received approval by the Board of Health, and have received approval by the Public Health Director. To bill does three important things. One, it updates the license title to conform with other states, reducing confusion for patients and third-party payers. Two, it modernizes the scope of practice to better reflect the way medical nutrition therapy is now being delivered. Medical nutrition therapy is currently practiced in consultation with a physician. The bill would also allow for practice in consultation with physician assistants and nurse practitioners for expanded access to care, and this was in agreement and support with practicing physicians. The bill provides a new alternative pathway to licensure for purposes or for providers who are nonregistered dietitians who meet certain educational and supervisory practice requirements. You may recall Chairman Hansen introduced a similar bill last year, LB1249. Since that time, stakeholders have worked to improve the bill to sharpen the definition of medical nutrition therapy and have worked with opponents to expand the list of exclusions. Those activities not related by this-- not regulated by this practice act and for which no license is required. This bill is not intended to impact those who are providing general nutrition recommendations, health coaching, wellness education, or other nutritional care services that do not constitute medical nutrition therapy. Further, the bill is not intended to require assisted living facilities or nursing facilities to provide medical nutrition therapy or hire or consult with medical nutrition therapists beyond requirements of the federal law. And we have added language in the very last section to expressly state just that. Today, I am offering an amendment, AM245 [SIC--AM390], at the request of an opponent of last year's bill, which was a nonlicensed nutrition therapy practitioner. The amendment would add further clarification to the exemptions adding the word "individualized," stating that no license is required to provide individualized nutrition information and to perform individualized general nutrition care services. We are pleased we could reach agreement with this group of nutrition therapy practitioners who we do not wish to be negatively impacted by this bill. The bill has been thoroughly vetted through the 40k-- 40k-- 407 process and, and work of stakeholders following last year's hearing. LB7-- LB572 is ready to be passed into law to ensure our statutes reflect current practices. Thank you for your consideration and following me will be, I think, four experts in the field and they will try to address some of the specific questions that some of you may have. Given that, I will obviously take questions that you might have of me.

HANSEN: Thank you. Are there any questions from the committee? Seeing none,--

RIEPE: Thank you.

HANSEN: --see you at closing. Yep, thank you. And with that, we'll take our first testifier in support of LB572. Welcome.

KELLY SATTER: Hi. Thank you. My name is Kelly Satter, K-e-l-l-y S-a-t-t-e-r. This is my son, David Satter, Jr. We live in the Clinton neighborhood here in Lincoln. As you can see firsthand, DJ is very medically complex. He was not expected to live to his first birthday. However, we just celebrated his fifth birthday this past November. DJ struggled with eating from day one, starting with his NICU stay at Children's Hospital and Medical Center in Omaha. Not only did he have a double cleft palate, but also a recessed chin that required surgery when he was just four days old. Eventually, genetic testing determined that he has a rare disorder that causes his body to process proteins and sugars at a unique rate. At that time, he was also diagnosed failure to thrive and struggled to gain weight. He was unable to hold his food down and working with the dietitian enabled us to adjust his nutrients and help him grow and gain weight. A dietitian working with us also taught us about a medical ketogenic diet which can benefit people with seizures. Another daily struggle for DJ. I spent months giving my son rescue breaths during these epileptic episodes. If I didn't have the help of a dietitian during this time, his seizures would be out of control and I fear he wouldn't be with us here today. Since starting the ketogenic diet in the spring of 2019, his seizures have improved. His acid reflux has also improved and he has been able to grow and gain weight. His growth is something we monitor closely and a dietitian helps us adjust his diet based on changes in height, weight, and nutrition-related labs. For a short time in his life, DJ was able to participate in feeding therapy. At that time, I made all his food from scratch at a very specific ketogenic ratio based on recipes his dietitian provided to us. Due to his medical complexity, he now receives nutrition and hydration through a feeding tube. Dietitians play a crucial role in his ongoing nutrition needs. In my heart and soul, I am truly grateful for every dietitian that has crossed our path. There's no doubt in my mind that my son is still here and doing as well as he is because of their education, experience, and kindness of being on his team. The data doesn't lie. Thank you for your time and letting me share a small bit of our testimony and how dietitians have helped save my son's life. Please advance LB572 so parents like me are better able to work with

dietitians for the health and safety of our kids. I'd be happy to answer any questions you guys might have, but there's a lot of more professional people coming up right behind me that can get more specific, too. Thank you.

HANSEN: OK. But we had a whole list of very complex questions to ask specifically so we might hold up on it.

KELLY SATTER: Try me.

HANSEN: When was David's birthday in November because my daughter's birthday is in November too?

KELLY SATTER: Oh, his is the 9th.

HANSEN: OK. My daughter's is the 15th and she just turned six.

KELLY SATTER: Oh, mine is the 17th. Oh, six, nice.

HANSEN: Yep. OK. Any questions from the committee? Yes, Senator Day.

DAY: I don't have a question. I just want-- have you ever testified before--

KELLY SATTER: No.

DAY: --in a hearing? OK. You did fantastic.

KELLY SATTER: Can you tell in my voice?

DAY: No, I just-- you did a, you did a wonderful job. I know how difficult--

KELLY SATTER: Thank you.

DAY: --it can be to get here, especially with little ones, so I appreciate you and DJ being here today. And congrats on five years. So thank you for coming.

KELLY SATTER: Thank you. Thank you.

HANSEN: All right. Any other questions from the committee? All right. Seeing none, thank you for coming.

KELLY SATTER: Thank you, guys.

HANSEN: We'll take our next testifier in support. Welcome.

PAULA RITTER-GOODER: Good afternoon. My name is Paula Ritter-Gooder, P-a-u-l-a R-i-t-t-e-r-G-o-o-d-e-r. I'm a licensed medical nutrition therapist with a Ph.D. in nutrition, and I practice in skilled and long-term care facilities. I'm here on behalf of the Nebraska Academy of Nutrition and Dietetics to ask for your support for this bill as it modernizes, it updates our current scope of practice, and our practice that currently in effect, which was passed like the Senator said in 1950-- 1995, about 25 years ago. It's been largely unchanged since then and we have about 727 individuals licensed in Nebraska that practice under this bill right now, under the current bill, under the current statute. You know, as was, as was said earlier, the bill was unanimously approved through the 407 process in 2021. Four key reasons for updating our bill: title change, changing our title to licensed dietitian nutritionist, LDN, aligns with other state titles. It removes confusion insurance companies have experienced in resulting in some Nebraskans being denied coverage because our current title that we have is the-- we are the only state that uses that title, LMNT. To describe our scope of practice was another reason for updating the bill, including that endorsed by the Center for Medicaid-- Medicare and Medicaid Services in 2014, 2017. For example, therapeutic diet order writing. That helps to cut the red tape if done under physician approved protocols of delegation so that the, the resident, the individual, the patient receives timely, efficient, and cost-effective nutrition care. It reflects changes-- thirdly, reflects changes in providing medical nutrition therapy with current practice informed by research. The nutrition care process is a national framework for, for providing medical nutrition therapy. We use consistent terminology in the health record to enhance communication and coordination of care between one setting to the other setting that the patient travels in. To increase access to medical nutrition therapy, like Senator Riepe pointed out, we've added the nurse practitioner and the physician assistant to the list of the medical doctor who we consult and confer with when providing medical nutrition therapy. So that creates better workflow efficiencies for Nebraskans and for the profession. Finally, medical nutrition therapy is not used for disease-- medical nutrition therapy is used for medical diseases and conditions. It is not defined as therapy for nutrition, health, and wellness promotion. This bill will not affect individuals providing general nutrition information, nor does it prevent the guidance or sale of food products for supplements to meet general nutrition needs. Thank you. Please support the bill.

HANSEN: Thank you for testifying. Any questions from the committee? Yes, Senator Day.

DAY: Thank you, Chair Hansen. And thank you, Ms. Ritter-Gooder, for being here today. So I think you outlined a few of the differences between last year's bill and this year's bill. Are there any other significant differences from last year to this year because I do remember the hearing that we had on this last year?

PAULA RITTER-GOODER: Yes. Just to, just to quickly go through that, we removed the title protection. We removed the credential nutrition-- nutritional therapy practitioner from the title protection section, because we have those individuals that are practicing within their current scope of practice in Nebraska. We, as Senator Riepe alluded to, we included the, the language that the Nebraska Health Care Association requested, basically saying that a licensed individual supervising medical nutrition therapy in healthcare facilities could be a full-time, part-time, or consultant basis. And nothing in the act requires medical nutrition therapy to be, to be provided in that healthcare setting, assisted living, skilled nursing unless afforded by law, required by law. And nothing requires those entities to employ or consult the, the licensed medical nutrition therapist.

DAY: OK. Perfect. Thank you. I do have another question.

HANSEN: Yes.

DAY: OK. And you mentioned this not affecting people who provide general nutrition information. One thing I specifically remember as a former CrossFit gym owner is I remember some people from the CrossFit community coming in and talking about their opposition to this bill. Can you help me understand the difference between this and what they do and what triggers the need for a license?

PAULA RITTER-GOODER: Basically, the bottom line is health condition-- medical condition or health condition requires nutrition for a medical condition. Medical disease requires a licensed individual to provide that.

DAY: OK.

PAULA RITTER-GOODER: The CrossFitness-- CrossFit, for example, on their website that I accessed in December of last year and January of this year, specifically says in the scope of practice that they do not treat-- they do not diagnose or treat medical conditions.

DAY: OK. So, yeah, so yours is specific to treating medical conditions?

PAULA RITTER-GOODER: Correct. And in addition to that, realize that we do have the exemption that we had last year that, that opens-- that, that specify-- OK, we specify what is general nonmedical nutrition. Secondly, we in the exemption section specify what individuals practice within that scope. For example, health coaches, wellness coaches. And then thirdly, we actually get into the weeds and say that an individual that is not licensed can provide a general program of medical weight control for prediabetes and obesity if that program meets the qualifications that that goes on to say it's been approved by a licensed individual [INAUDIBLE]. So that would be like a health coach walking-- being the, the guide by the side of an individual who has medical nutrition therapy and had it prescribed to them and the health coaches assisting that individual to implement that medical nutrition therapy prescription, but not directing it or prescribing it.

DAY: OK. Fantastic. Thank you so much.

PAULA RITTER-GOODER: You're welcome, Senator Day.

HANSEN: Any other questions? Seeing none, thank you for coming.

PAULA RITTER-GOODER: Thank you.

HANSEN: We'll take our, take our next testifier in support of LB572. Welcome.

CARRIE NIELSEN: Thank you. Thank you. Make sure you guys can hear me here. Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Carrie Nielsen, spelled C-a-r-r-i-e N-i-e-l-s-e-n, and I am testifying in support of LB572 as the president of the Nebraska Academy of Nutrition and Dietetics, and I represent licensed medical nutrition therapists across the state of Nebraska. First, we'd like to thank Senator Merv Riepe for introducing this bill and recognizing the importance of health and well-being for Nebraskans. LB572 will update the scope of practice for practitioners of medical nutrition therapy to better align with the current realities of the provision of nutrition care in hospitals, healthcare facilities, private clinics, and even retail establishments that currently provide patients and customers with the services of a licensed medical nutrition therapist. I'm a registered dietitian

working as a licensed medical nutrition therapist serving pediatric patients in Omaha. I provide direct patient care to families requiring assistance with the management of chronic health conditions such as celiac disease, where the prescription to treat is simply a gluten-free diet. Individualized education is key for the success of these particular patients. My employer, Boys Town National Research Hospital, understands the necessity of providing nutrition education and interventions as part of interdisciplinary teams for patients throughout our health system. Without the collaboration of dietitians and physicians, nurse practitioners and physician assistants, patient outcomes would look much different than they do for our patients, especially the most medically complex. Much of my work is with our expanding pediatric neurosciences department at Boys Town, where we manage nutrition through a variety of personalized methods. These include the medical ketogenic diets for seizure management and as well as enteral nutrition, also known as tube feedings, for patients unable to meet nutrition needs through a regular diet. In addition to the testimony that you will have-- will hear and have heard today, I want to highlight the letters of support from many of our members who are practicing licensed medical nutrition therapists who support this bill as vital to their work and protective of patient safety. Letters came from those serving geriatric patients, individuals with eating disorders, cancer patients undergoing radiation and chemotherapy, needing help managing side effects, impacting oral intakes, and more. Additionally, I would like to call your attention to the letters of support from our national organization, the Academy of Nutrition and Dietetics, who has helped us and our corollary organizations in other states to update their scopes of practice. I would like to distribute a couple of key letters, which is probably what she distributed there, including a letter in support from the Nebraska Medical Association, who we worked with closely throughout the 407 review and Bill Drafting process. So on behalf of our 476 members at, at the Nebraska Academy of Nutrition and Dietetics, we respectfully request your support and advancement of LB572 and thank you for your time and attention. I can answer any questions that you have.

HANSEN: Thank you for your testimony. Are there any questions? Seeing none,--

CARRIE NIELSEN: All right.

HANSEN: --thank you.

CARRIE NIELSEN: Thank you very much.

HANSEN: We'll take our next testifier in support. Welcome.

ANNA TRAUERNICHT: Thank you. Good afternoon, Chairman Hansen, and members of the Health and Human Services Committee. My name is Dr. Anna Trauernicht, MD, spelled A-n-n-a, last name T-r-a-u-e-r-n-i-c-h-t. I maintain board certifications in pediatrics as well as pediatric gastroenterology, hepatology, and nutrition. I'm currently a pediatric gastroenterologist at Boys Town National Research Hospital in Omaha, Nebraska. I work in both the hospital and medical clinics, performing inpatient and outpatient consultations and management. Prior to my current role, I was previously the director of Pediatric Enteral Nutrition Services, also known as the PENS Clinic, at Children's Hospital and Medical Center in Omaha. I'm providing testimony in support of the Nebraska Hospital Association, and I'm providing testimony in support of LB572. In pediatric gastroenterology, the spectrum of patients receiving nutritional services is vast. I work directly with medical nutritional therapists daily. It's essential that dietitians are prepared through education, experience, and licensure to be critical parts of the medical team for patients. Utilization of medical nutritional therapy is not limited to gastroenterology, but it's rather utilized in all fields of medicine to optimize, optimize patient outcomes. This bill helps to update the scope of practice for medical nutritional therapists to better serve the patients. Pediatric gastroenterology is ever evolving. The Internet has granted easy access to nutrition information, some of which is good and others possibly bad. It's essential that nutrition information disseminated from my medical practice is consistent with research-based evidence, and it's the collaboration and collaborative work between medical providers and medical nutritional therapists that results in the research and education needed to answer current questions posed by our patients. Some patients are looking for guidance and recommendations for symptom management or promoting of positive health outcomes, maybe weight loss or possibly weight gain. Others are using nutrition in combination with medicines for disease management. So optimal nutrition and nutritional status helps promote rapid recovery from disease and injury. And some of my patients require nutrition as lifesaving interventions due to surgeries, injuries, or unexpected changes to the gastrointestinal tract's ability to absorb nutrition. Medical nutritional-- nutrition therapists are required to utilize their expertise to help develop nutrition plans for all of these patients. Collaborations between dietitians and medical providers allow for the opportunity to generate clinical questions which lead to research and innovation. Some

exciting recent innovations include the use of nutrition in the treatment of severe autoimmune conditions in the gastrointestinal tract, such as celiac disease and Crohn's disease, as well as neurologic conditions, the ketogenic diet for seizures. This bill will support the goal of medical nutritional therapy to be used for evidence-based practice for the optimization of treatment and management of medical diseases and conditions. Thank you for letting me testify today. I'd be happy to answer any questions.

HANSEN: Thank you for your testimony. Are there any questions from the committee? All right. Seeing none, thank you very much.

ANNA TRAUERNICHT: Thank you.

HANSEN: Is there anybody else wishing to testify in support?

CHRIS YOUNG: Good afternoon,--

HANSEN: Welcome.

CHRIS YOUNG: --Chair Hansen and members of the committee. My name is Chris Young, C-h-r-i-s, last name Y-o-u-n-g, here in support of LB572. And you've heard from my colleagues the details of, of what this represents. And so my contribution to this hearing really has to do with individual application of that and long-term care setting. I serve as a nursing home administrator in Nebraska and have for several years in various communities, and most of that has been done in a rural setting. And so when Dr. Ritter-Gooder spoke of workforce and perhaps limitations, and we've heard that throughout the, the bill process and so on, that, that's impactful in this bill as well. And so we want to see if we can't make more opportunities for these providers to work in partnership with the primary care physicians or the, the mid-level practitioners and the like to provide very important nutritional and, and, and medical help for our residents. So our residents, again, would have-- some are very clinically complex and oftentimes we find ourselves treating nonmedical reasons with medical solutions and we really need to introduce or further introduce the, the dietitian, dietitian and nutritional portion of that. Part of our challenge is, of course, is access to these professionals throughout the state. Some of us have the good fortune of working with a registered dietitian very closely and, and, and have the good fortune of their expertise and working in partnership with our other providers. Many of our communities don't have that same benefit. And so then in this example, perhaps if this were pushed forward, we would

have other licensed professionals that could fill in that void working with, again, the medical providers and the medical mid-level providers to continue to provide that service. But certainly we've seen recently with the impact of COVID with workforce difficulties, but even as you all know long before COVID, we've had difficulty in rural areas providing medical coverage in, in a variety of areas so that, that would be point number one. The other point that I have, again, would be would just an option of an alternative for licensure to have this level of practitioner providing the service for, in my case, particularly for elders and meeting their needs, particularly within the, the rural communities and, again, a licensure that allow them to do so in partnership with our other providers. That was my goal for today is to present that information to you. So I would take any questions.

HANSEN: All right. Thank you for your testimony. Are there any questions from the committee? You did such a great job, none of us have any questions, so. Thank you.

CHRIS YOUNG: Thank you, Chair.

HANSEN: Any other testifiers in support of LB572? All right. Is there anybody wishing to testify in opposition to LB572? OK. Seeing none, is there anybody wishing to testify in a neutral capacity to LB572? Welcome.

JACOB CARMICHAEL: Hi. Yeah. Yep. Good afternoon, Senator Hansen and members of the Health and Human Services Committee. My name is Jacob Carmichael. I can spell it out, but it's also on the testimony--

HANSEN: We need you to spell it out for transcript stuff so if you could, please.

JACOB CARMICHAEL: OK.

HANSEN: Thank you.

JACOB CARMICHAEL: J-a-c-o-b C-a-r-m-i-c-h-a-e-l, and I am here today to testify neutral on LB572. I want to be clear upfront. I struggled with anorexia for three years, and navigating medical information around actual medical information is incredibly important and unfortunately harder and harder in our age. I do think the purpose laid out in the statement of intent is worthwhile. Sorry if I'm talking fast, I had a lot of coffee this morning on accident. However, there's a glaring issue in this bill, naturopathic medicine. I would

urge the senators, any of you on this committee to propose an amendment. On page 3 strike-- I believe it's actually page 7, that's my bad-- strike "naturopathic medicine" in lines 14 to 15. Naturopathic medicine is, by definition, alternative medicine. It is not based on any actual scientific study and is in no way equivalent to every other degree listed in that subsection. If you look at degrees offered in these fields by various institutions, accredited, respected universities include a variety while specifically excluding this field. Many studies conducted by other countries and, and major American medical groups, including the American Medical Association and the American Cancer Society, have denounced naturopathic medicine and noted its detrimental effects towards patients. Cancer cannot be solved by a metaphysical life energy. Changing a diet won't solve rare diseases. These doctors have been sued all over the world for giving false solutions to real problems and actively causing their patients real harm. These fraudulent practitioners often rely on an unfortunate reality of the medical world. Doctors, especially specialists, don't-- lost my place. Sorry. Doctors, especially specialists, frequently don't have the best bedside manners. I can't blame doctors. They have an incredibly difficult job and I can't imagine being in a field where I would frequently watch my patients die. However, it creates an unfortunate reality for both sides. Naturopaths will spend time and connect with their patients on an emotional level, drawing them in at some of their most vulnerable, at some of their most vulnerable points where they are willing to try to solve-- and to try anything to solve an issue, typically saving their life or the life of a loved one. My mother received a heart transplant in 2012 at UNMC and is likely to be listed again soon at the Mayo Clinic in Rochester, Minnesota. One of the main reasons that she and we have went to such lengths, both figuratively and quite literally, it's a five-and-a-half-hour drive through mostly cornfields, is that she felt heavy frustration at the cardiac team treating her as just another statistic. We have luckily found a team that truly cares at one of the best hospitals in the world. But it was a hard process. Naturopaths smooth that process, make the patients feel care-- feel cared for, and present their contradictory advice to patients as if it's on an equal level. I can-- I could have easily see us-- seen us courting natural medicine as I was a teenager and neither of my parents are scientists. But I can truly affirm that I would watch my mother wither and die before my eyes, and a charlatan of a naturopath would be responsible. I have additionally included two pictures of my mother and I before and after of her transplant on the next page of my testimony. She went from a maximum of three days left to live to decades. Her life and my family

was saved by decades of studies and the slow, careful march of science. Medicine is science. Evidence is science. Naturopathy is not. Thank you.

HANSEN: Thank you for your testimony. Are there any questions from the committee? OK. Seeing none, thank you for coming.

JACOB CARMICHAEL: Thank you.

HANSEN: Is there anybody else wishing to testify in a neutral capacity?

JALENE CARPENTER: Good afternoon,--

HANSEN: Welcome.

JALENE CARPENTER: --everybody. Thank you, Chairman Hansen and members of the Health and Human Services Committee. My name is Jalene Carpenter, J-a-l-e-n-e C-a-r-p-e-n-t-e-r, and I'm the president and CEO of Nebraska Health Care Association. On behalf of our 418 nonprofit and proprietary skilled nursing and assisted living community members, I am here to testify in the neutral capacity for LB572. NHCA has worked cooperative with the bill's proponents in this process, beginning back in 2020 with the Board of Health's credentialing review process. We appreciate the work that has been done by the dietitians and their team to improve the health of Nebraskans, and we support the efforts to clarify their practice. Our members only concern was that that we ensure that their process of redefining their scope no way added any unnecessary requirements or costs for nursing facilities or assisted living providers. As mentioned, the food and nutrition operations at nursing and assisted living facilities are already regulated at the federal and state level. Our goal is to prevent any additional or conflicting requirements in the bill that could at the very least result in a misunderstanding or confusion for providers or regulators. Based on the current version of the bill and the expression of the intent of the changes by the bill's proponents, it appears to align with the Board of Health's direction to clarify their scope of practice without impacting the current operations of nursing facilities and assisted living providers. We appreciate greatly the proponents' collaborative approach and their efforts to address our members' concerns. I'm happy to answer any questions. Otherwise, thank you for your time.

HANSEN: Any questions from the committee? Not seeing, thank you.

JALENE CARPENTER: Thank you.

HANSEN: Anybody else wishing to testify in a neutral capacity? Last chance. OK. Seeing none, we'll welcome Senator Riepe to close. And with that-- I buried all my-- over here-- and with that, we did have some letters, 44 letters in support. We did have ten letters in opposition and one letter in the neutral capacity. Welcome back.

RIEPE: Thank you, Mr. Chairman. I will be brief. We will address, I think we have addressed the concerns of the nursing homes. But I-- and I respect the fact of the testimony in a neutral fashion. I think that's clarified. So I will leave that up to the experts if it's not. On the young man that first spoke, we will take a look at that and see if his concerns, if there is concerns, they may be concerns of others in terms of that particular language. We want to be sensitive to that. The intent of this is to bring better healthcare to needed patients, patients that would be under the care of a physician or a nurse, a clinical nurse practitioner. It's not the intent to override that and so we would be part of that team, if you will. Those are the two points I wanted to, to cover in closing.

HANSEN: OK. Thank you. Are there any questions from the committee? Not seeing any, thank you very much.

RIEPE: Thank you. Have a great weekend after a long week.

HANSEN: Thank you. That will close the hearing for LB572 and that will close the hearing for today.